STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. Building B. Wing	04/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terrace at Crystal LLC	3245 Vera Cruz Avenue North Crystal, MN 55422

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44650 Based on interview and document review, the facility failed to implement a system for immediate identification of resuscitation status during emergency situations for 1 of 1 residents (R1) who arrested and received CPR which did not honor his wishes for DNR status. This resulted in an immediate jeopardy (IJ) when EMS provided cardiopulmonary resuscitation (CPR) to R1, and this went against R1's wishes to not resuscitate. The IJ began on [DATE], at approximately 1:30 a.m. when R1 was found lying on his room floor bleeding profusely from his head. 911 was called and life sustaining interventions were provided for R1 by paramedics when the facility was unable to find a copy of R1's resuscitation status. CPR was initiated and defibrillating shocks were delivered in an attempt to revive R1 before facility staff provided R1's resuscitation status at 1:48 a.m. R1 was then pronounced dead. The administrator was notified of the IJ on [DATE], at 5:26 p.m. The IJ was removed on [DATE], at 2:01 p.m. when the facility successfully implemented a removal plan, but scope and severity remained at a level D, no actual harm with potential for more than minimal harm. Findings include: On [DATE], a report to the state agency (SA) indicated R1 was found unresponsive on the floor after falling and hitting his head. 911 was called and life sustaining interventions were initiated including CPR, defibrillating shocks, and attempted intubation, despite R1 being on hospice and with a code status of DNR. R1's Face Sheet printed [DATE], indicated R1's diagnosis included heart failure, malnutrition, weakness, and malignant neoplasm of prostate. R1's admission Minimum Data Set (MDS) dated [DATE], indicated he was moderately cognitively impaired. R1's Physician's Order for Life Sustaining Treatment (POLST) signed by R1 on [DATE], and signed by his primary medical doctor (MD) on an unknown date, indicated R1 checked the DNR election box. R1's Physician's Orders dated [DATE], indicated R1 was a do not attempt resuscitation (DNR) and do not intubate (DNI). In addition, R1 was receiving hospice care. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], at 6:00 a.m. a progress note written by licensed practical nurse (LPN)-A indicated at approximately 1:20 a.m. he was alerted to R1's room where he found him on the floor bleeding from the head. LPN-A called for LPN-C to assist, and LPN-A called 911. Paramedics arrived and immediately started CPR. LPN-A and LPN-C found R1's code status and passed it to the paramedics. On [DATE], at 9:20 a.m. hospice case manager registered nurse (RN)-A was interviewed and stated R1 had been admitted to hospice on [DATE], and he had indicated DNR status on his POLST when he admitted to hospice. RN-A stated R1 had chosen to be a DNR resuscitation status even prior to his admission to hospice. RN-A stated on [DATE], at 2:24 a.m. she was notified by law enforcement R1 had fallen at approximately 1:30 a.m. RN-A stated she spoke to licensed practical nurse (LPN)-A who told her he called 911 at approximately 1:30 a.m. and they couldn't find R1's resuscitation status until 1:48 a.m. RN-A stated LPN-A told her paramedics would not discontinue lifesaving interventions for R1 without proof of his code status. On [DATE], at 1:08 p.m. R1's family member (FM)-A was interviewed and stated R1's wishes were to be a DNR code status. FM-A stated he couldn't understand how something like this happened. FM-A stated R1 was on hospice for a reason. On [DATE], at 2:25 p.m. LPN-B was interviewed and stated she did not know where to find a resident's code status in the computer and she was never taught where to look. On [DATE], at 2:35 p.m. the director of nursing (DON) was interviewed. The DON stated she wasn't sure why staff couldn't find R1's code status. The DON stated a comprehensive investigation had not been completed; she had only reviewed the coroner's report, took a written statement from nursing assistant (NA)-A, and interviewed RN-B who was anxious. The DON stated the receptionist contacted her by text message and a phone call at 1:41 a.m. to notify her off R1's fall. The DON stated she told the receptionist she was pretty sure R1 was a DNR. The DON stated she was told LPN-C was trying to locate R1's code status and POLST. The DON stated she had only provided re-education to LPN-A and LPN-C and no facility wide training was implemented or completed but she was planning on doing so. On [DATE], at 3:02 p.m. NA-A was interviewed and stated she saw R1 lying on his floor and she screamed for help. NA-A stated LPN-A called 911. NA-A stated she did not know if R1 was a full code or a DNR status, and she did not know where this information was located. NA-A stated the nurses should know where to find code status information. NA-A stated she did not remember what happened after paramedics arrived as she was scared and nervous. On [DATE], at 3:16 p.m. LPN-A was interviewed and stated NA-A notified him R1 was on the floor bleeding. LPN-A stated when he found R1, he was unresponsive with shallow breathing. LPN-A stated he called for LPN-C who came to look at R1, and this was when they decided to call 911. LPN-A stated LPN-C went to look for R1's code status while he called 911 and the DON. The DON told him R1 may be a DNR status. LPN-A stated he was not aware R1 was on hospice. LPN-A stated they eventually found R1's code status and gave it to paramedics so they would stop CPR. LPN-A stated he had not worked in five days and had never worked with R1 before, and that was why he was unable to find R1's code status. LPN-A stated he did not receive any re-education after the incident. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], at 4:06 p.m. LPN-C was interviewed and stated someone came to get him to assist with R1 the night he was found on the floor. LPN-C stated he saw R1 on the floor and bleeding, and LPN-A called 911. LPN-C stated paramedics and law enforcement arrived around 1:40 a.m., R1 was unresponsive, and paramedics started CPR. LPN-C stated they tried to tell paramedics R1 was a DNR, but the paramedics stated they wanted to see proof before they would stop CPR. LPN-C stated he was later able to provide R1's POLST for them. On [DATE], at 9:18 a.m. LPN-D was interviewed. LPN-D was asked to locate a random resident's code status in the electronic medical record (EMR). LPN-A stated she was not aware where a resident's code status was located in the EMR. LPN-A was told to checked under R4's cover sheet banner and the Face Sheet, and both lacked R4's resuscitation status. LPN-D confirmed R4 had no resuscitation orders or a POLST on file for R4 indicating code status. The facility Emergency Procedure - Cardiopulmonary Resuscitation policy last reviewed [DATE], directed CPR certified staff members shall initiate CPR unless it is known that a DNR order that specifically prohibits CPR and/or external defibrillation exists for that individual; or there are obvious signs of irreversible death (e. g., rigor mortis). The IJ was removed on [DATE], at 2:01 p.m. when the facility implemented a systemic plan which included the following actions: reviewed and updated their CPR policy, mandatory education of all nursing staff on the CPR policy, mandatory education on location and use of DNR/POLST binder placed at each nursing station and in electronic medical records, DNR/POLST policies starting on [DATE], medical record audits for code status for all residents was completed on [DATE], then one time per month and then one time quarterly, initiating code blue mock drills capturing all three shifts staggered and unannounced monthly, staff knowledge checks done monthly for three months and then quarterly thereafter.

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F 0843 Level of Harm - Potential for minimal harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 44650 Based on interview and document review, the facility failed to develop and/or have evidence of a transfer agreement with a local Medicare/Medicaid participating hospital entity. This had potential to affect all 63 residents in the facility who could require hospitalization on an emergent basis. Findings include: On 4/8/22, to 4/11/22, multiple requests were made to the administrator to provide a transfer agreement with a local Medicare/Medicaid participating hospital entity. The administrator was unable to provide a transfer agreement. On 4/11/22, at 1:25 p.m. the administrator was interviewed and stated he was still working on locating the transfer agreement. The facility Emergency Transfer or Discharge policy undated, lacked indication of a transfer agreement with a hospital.

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F 0844 Level of Harm - Potential for minimal harm Residents Affected - Many	Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel. 44650 Based on interview and document review, the facility failed to provide a disclosure of ownership form. This had potential to affect all 63 residents residing in the facility. Findings include: On 4/11/22, at 1:25 p.m. the administrator was interviewed and stated he was still working on locating the disclosure of ownership documents. No further information or the Disclosure of Ownership form was provided.