STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neilson Place	1000 Anne Street Northwest Bemidji, MN 56601

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** 35569 Based on interview and document review the facility failed to immediately identify code status and act on resident wishes for 1 of 3 residents (R1) reviewed for resuscitation status. This resulted in an immediate jeopardy for R1 when staff initiated cardiopulmonary resuscitation (CPR) against R1's wishes. The IJ began on [DATE], at approximately 5:40 p.m. when R1 was found by a nursing assistant (NA)-A in the common area of the unit. R1 was pale, lips blue and unable to speak. R1 was administered the Heimlich Maneuver, CPR was initiated and was sent to the hospital where she subsequently required mechanically assisted ventilation. The IJ was identified on [DATE], and the administrator was notified of the IJ on [DATE], at 11:13 a.m. The immediate jeopardy was removed on [DATE], as the deficient practice was corrected prior to the start of the survey and was therefore issued at past noncompliance. Findings include: R1's Advance Health Care Directive dated [DATE], indicated R1 wanted CPR attempted if R1's heart or breathing stopped based on current health. However, in the future if her health changed her agent or R1, if able, would discuss CPR with the health care team. R1's hospital history and physical dated [DATE], identified patient is DNR (do not resuscitate). R1's Physician Order Report dated [DATE], identified a code status: DNR, dated [DATE]. R1's annual Minimum Data Set (MDS) dated [DATE], identified intact cognition. R1's care plan dated [DATE], identified an advanced directive of DNR. Long term goal identified an advance directive would be followed. The care plan directed staff to determine code status upon admission and quarterly thereafter. R1's undated, Resident Face Sheet indicated R1 was readmitted to the facility on [DATE]. Diagnosis included respiratory failure, chronic obstructive pulmonary disease and dysphagia (difficulty swallowing). R1's face sheet identified a DNR status. (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	R1's Resident Progress Note dated [DATE], identified at approximately 5:40 p.m. writer was alerted to watch R1 in the dining room. R1 was having dyspnea (shortness of breath) and was slouched to the side with green stuff draining out of her nose and mouth. Writer tipped R1's head up to open the airway and called another nurse. R1 was removed from the dining room and 911 was called. The team assisted R1 to the floor and initiated CPR as advance directives indicated full code. Emergency services (EMS) worked on R1 and brought her to the emergency department. During interview on [DATE] at 11:07 a.m., registered nurse (RN)-A stated she received a phone call at home on [DATE], and staff reported to RN-A, R1 had coded [heart and breathing stopped] and CPR was initiated. R1 had been DNR for a long time. RN-A stated the facility previously utilized a resuscitation form but transitioned to use a Provider Orders for Life Sustaining Treatment (POLST) form a few months prior. RN-A stated the paper chart was the fastest place to find the code status and said the next place to look was the banner in the electronic record. (When the electronic record was accessed for a resident, a banner presented at the tope of the record which included the resident name and just below was the residents code status). R1 had a care conference on [DATE], at which time her code status was reviewed, and the director of nursing (DON) attended the care conference. During interview on [DATE] at 11:27 a.m., licensed practical nurse (LPN)-A stated she was working on a different unit the evening of [DATE]. The phone on the unit alerted a 911 call had been placed. LPN-A looked at the phone to determine which unit had placed the 911 call and immediately called the unit. LPN-A stated the (former) DON answered the phone and said the call was made on behalf of R1. When LPN-A arrived on the unit LPN-A asked why staff was administering CPR as R1 was DNR and the DON said there was no POLST in the chart'; although, the code status was easily found on the banner in the electronic record and said the information was manually entered by staff. Further, R1 recently had a care conference, attended by the DON and R1's DNR status had been discussed. During interview on [DATE] at 11:47 a.m., RN-B (interim DON) stated she was working on [DATE] and one of the nurses came to her and reported what was happening. RN-B stated R1's status was DNR. When RN-B arrived on the unit staff had not yet started CPR. The DON was holding R1's advance directive and despite multiple staff telling the DON R1 was DNR, the DON insisted staff initiate CPR. RN-B stated when the POLST form could not be found, staff should have looked at the banner in the electronic record to verify the code status. RN-B said following the incidents, three ring binders were implemented that contained each resident's POLST document for immediate verification. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on [DATE] at 2:30 p.m., the (former) DON stated she was working on [DATE], and explained the following events. DON was working on the unit when a nursing assistant asked her to keep an eye on R1 while she grabbed an emesis bag. The DON went to the dining room and found R1 gasping and gagging with green stuff coming out of her mouth and nose. The DON called LPN-B for help, and they brought R1 to the nurse's station from the dining room. The DON retrieved R1's paper chart while LPN-B was performing the Heimlich maneuver and could not find a POLST form in the chart. R1's chart contained an advance directive that indicated CPR. The DON showed the advance directive to LPN-B who said she thought R1 was DNR. The DON reiterated she also thought R1 had been DNR but said, this is what we got, referring to the advance directive in the chart. The DON stated another nurse came to the unit and also questioned R1's status being full code. When emergency services arrived, DON pulled a document from R1's electronic record that identified R1 had requested DNR. EMS did chest compressions and used the LUCAS ([NAME] University Cardiopulmonary Assist System device provides mechanical chest compressions to patients in cardiac arrest). The DON confirmed she had not verified R1's code status with the electronic record but, a few weeks prior, the DON was involved in a conversation with R1 about a hospice consult so the DON was confused on what the status was. On [DATE] at 2:55 p.m., the licensed nursing home administrator (LNHA) and campus administrator (CA) were interviewed. The LNHA stated when the incident occurred on [DATE], the DON had looked in R1's paper chart for the code status. The LNHA was not sure if any other staff looked in other locations for the code status. The LNHA stated there had been inconsistent information as to what should have been done. The CA stated R1 had a signed document in the paper chart as well as the banner and physician's orders in the electronic record identifying a DNR status. The CA stated the DON had erred on the side that it was better to do CPR and she had to make a split decision. The CA said the DON had been out a few weeks and thought R1 had changed her mind during that time. The CA stated moving forward, staff were directed to use the banner as the primary source of information that was fed by the POLST form. The CA stated POLST forms were now in binders on each unit and readily available. The CA stated staff received education and daily audits were being performed to ensure accuracy. During interview on [DATE] at 3:12 p.m., LPN-B stated she had been working on [DATE] and the DON had asked her to come to the dining room. When LPN-B got to R1, her lips were blue/purple and LPN-B tried to lift R1's head and arm up. Staff brought R1 to the nurses' station from the dining room and placed R1 on the floor to check her pulse and initiate CPR. LPN-B stated the DON looked for R1's code status. During interview on [DATE] at 8:07 a.m., doctor of nursing practice (DNP)-A stated she had been part of the discussions with R1 and her family regarding code status. DNP-A stated the situation was unfortunate and felt it could have been prevented. R1 had been DNR for over a year and said, what if the advance directive had said DNR and the banner said full code? DNP-A stated there was no excuse for what happened and R1 having to go through that process and family having to live though that too. DNP-A reviewed R1's chart which identified R1's DNR wishes in multiple places. DNP-A stated the whole time R1 was hospitalized she was on a ventilator, was vomiting and had to be suctioned continuously. When asked about LUCAS, DNP-A stated there was nothing left of her and said there was a potential for bruising and broken bones. The facility policy Advance Directive including Cardiopulmonary resuscitation and Automated External Defibrillator dated [DATE], indicated the following: If cardiac arrests occurs, CPR must be initiated unless the resident has: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. A valid DNR order on file that includes the medical order issued by a physician or other authorized non-physician practitioner. b. A valid Advanced Direction on file that includes written instructions such as a living will or durable power of attorney for healthcare, recognized under state law (whether statutory or a recognized by the courts of the state), and relating to the provision of healthcare when the individual is incapacitated. The policy indicated each day the nursing staff will print a report of all advance directive orders and keep them in a three-ring binder easily accessible to nursing staff. Any advance directive forms will also be kept in this binder. The IJ that began on [DATE], was removed on [DATE], when it was verified through interview and document review the facility had reviewed their policy for advance directives, educated staff to the policy and procedure for immediate verification of advance directives and initiated the use of a binder for immediate verification of code status along with a daily audit process to ensure accuracy.