STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245164	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at New Brighton	825 First Avenue Northwest New Brighton, MN 55112

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** 43080 Based on interview and document review, the facility failed to follow the Provider Orders for Life Sustaining Treatment (POLST) to provide cardiopulmonary resuscitation (CPR) for 1 of 3 residents (R1), who wished to have CPR in the event of cardiopulmonary arrest (absence of pulse and respirations). This deficient practice resulted in an immediate jeopardy (IJ) when R1 was found absent of pulse and respirations, no CPR was initiated, and R1 experienced certain death. The facility implemented corrective action, so the deficient practice was issued at past non-compliance. The IJ began on [DATE], when R1 was found unresponsive with an absence of pulse and respirations, CPR was not initiated, and R1 experienced certain death. The facility administrator and director of nursing (DON) were notified of the IJ on [DATE], at 5:00 p.m., which was identified at the scope and severity of an isolated IJ. The IJ was removed on [DATE] when the facility implemented immediate corrective action to prevent recurrence, therefore, the IJ was issued at past non-compliance. Findings include: A Facility Reported Incident (FRI) report was submitted to the State Agency (SA) on [DATE]. The report identified, on [DATE], at 5:50 a.m., R1 was found unresponsive in her room, cool to the touch, and absent of vital signs. R1 was full code (wished CPR); however, CPR was not performed. R1's significant change Minimum Data Set (MDS), dated [DATE], identified R1 was cognitively intact. R1's POLST, dated [DATE], identified R1 wished for attempted resuscitation/CPR [Full code], if she were found with no pulse and/or active breaths. The POLST was signed by R1 and a medical provider. An IDT (interdisciplinary team) Care Conference form, locked [DATE], identified R1 was a Full code and wished to remain as such. A provider visit note, dated [DATE], identified R1 was seen by physician assistant (PA)-A. The note identified R1's Code Status as Full Scope of Treatment. R1's Order Summary Report, active orders as of [DATE], identified an active CPR order. A progress note, entered on [DATE], at 7:23 a.m., identified the following timeline of events: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

-12:00 a.m., during rounds, R1 slept with no issues.

-2:00 a.m., R1 was changed, repositioned, and she interacted with staff normally.

-5:40 a.m., the nurse was updated by a nursing assistant after the nursing assistant discovered R1's condition. The nurse responded and found R1 unresponsive. The nurse grabbed the defibrator [sic] with the other nurse to start resuscitations, but it was too late, [R1] had ceased to breath, no pulse no respiration. The administrator, family, and the provider were updated. The note lacked identification R1 was provided CPR or that the AED was utilized.

When interviewed on [DATE], at 2:44 p.m., licensed practical nurse (LPN)-A stated when a resident was found unresponsive, she was expected to assess for a pulse and respirations - if absent, she was to first verify their code status. If the code status indicated Full code, she was expected to immediately initiate CPR, send others to grab the crash cart and the defibrillator (AED), page a code blue overhead, and call 911. CPR was stopped only when the paramedics gave the okay. She explained that around 2:00 a.m., R1 slept without concerns. Around 5:40 a.m., a nursing assistant called her into R1's room. Right away, LPN-A approached R1 and found her on her back in the middle of the bed. LPN-A checked R1's pulse, shook her, and called her name; however, R1 lacked a response and was without a pulse or respirations. R1 was not cold but her feet were cooler than the rest of her body. Her body was clammy, her color was faded, and she lacked any stiffness when LPN-A shook her hand. LPN-A stated, It was too late. LPN-A added, I was very confused as this has never happened to me before. I was very shaken and confused. It was scary. LPN-A indicated she left R1's room and sought registered nurse (RN)-A for guidance. Once they returned to R1's room, RN-A assessed R1 and confirmed R1 lacked a pulse or respirations. LPN-A identified the AED was brought into R1's room and opened; however, after they verified R1 was a Full code, the AED was not used as it was too late. LPN-A stated after, she contacted the administrator and was told, It was okay; however, she explained, in hindsight, she learned the administrator thought LPN-A had performed CPR and there was miscommunication during that call as she was just providing the administrator with an update on R1's passing - not looking for guidance on what to do during this situation. LPN-A denied she contacted the DON, the on-call nurse, nor the provider for guidance. She stated she should have contacted the DON as the DON is clinical, whereas the administrator was not. LPN-A stated she failed to follow the facility's policy for timely code status verification and CPR initiation. LPN-A identified she was suspended right away and was since provided education that included paper education, conversations with management, and mock drill participation's in which she has to be the champion.

On [DATE] and [DATE], interviews were attempted with NA-D, the nursing assistant who updated LPN-A on R1's unresponsive status; however, these were unsuccessful.

During a telephone interview on [DATE], at 9:38 a.m., physician assistant (PA)-A stated the facility updated her that R1 was found unresponsive, and the attempted CPR was unsuccessful. If a Full code resident was found unresponsive, with no pulse or respirations, she identified she expected staff to initiate chest compressions and AED use if the AED advised a shock. In addition, she expected 911 to be called. When she was updated that R1 was not provided with CPR, she wished to reserve any comments related to the lack of CPR, as she was unaware of the event details, especially considering not being initially provided all the facts. She indicated she was present at the facility and observed at least two mock CPR drills.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], between 10:22 a.m. and 11:35 a.m., the following staff were interviewed respectively: LPN-B at 10:22 a.m., nursing assistant (NA)-A at 10:30 a.m., NA-B at 10:39 a.m., RN-B at 10:49 a.m., NA-C at 10:56 a. m., LPN -C at 11:06 a.m., and LPN-E at 11:35 a.m. The nurses stated if a resident was found unresponsive, they were to assess for a pulse and respirations. If none found, they were to verify the code status and if full code, CPR was to be initiated right away. The nurses were able to identify where the code status identification was located. In addition, all the nurses indicated there were no reasons why CPR would not be initiated if a resident were Full code. All nurses acknowledged they were up to date on their CPR certifications. All the NAs identified if they found a resident unresponsive, they were to update a nurse immediately. All the NAs identified they were not allowed to perform CPR, only to assist in the accompanying code processes such as getting the crash cart and AED. All staff explained they were to use the overhead paging system for a code blue call, the crash cart and AED were to be obtained, and call 911 when a resident's code status warranted Full code action. All staff were able to direct where the crash cart and the AED were located. All staff explained the education they had received, and the mock CPR drills they had participated in. All acknowledged the education and drills were very helpful. When interviewed on [DATE], at 11:18 a.m., LPN-D, identified herself as the long-term care (LTC) coordinator. She explained if a resident were found unresponsive, assessed to be free of pulse or respirations, and identified to be a Full code, she expected staff to yell for help, call a code and initiate CPR. LPN-D identified nurses were responsible for CPR, and she confirmed all nurses were CPR certified. She indicated there were no reasons why CPR would not be initiated for a Full code resident, and the paramedics were the only ones who could stop CPR once initiated. LPN-D confirmed R1 was a Full code. She was aware of CPR not being initiated and she identified she was confused by the whole episode as performing CPR on a Full code resident was nursing 101. She explained, it was her understanding there was a communication breakdown as LPN-A contacted the administrator versus the DON or the on-call nurse, along with confusion as to when LPN-A contacted the administrator. In response to the failed systems, education was provided to all staff and mock CPR drills were initiated daily for each shift. These drills continued and would continue until all nurses participated and demonstrated competency. During an interview on [DATE], at 11:47 a.m., the DON stated if a resident was found unresponsive, and CPR was assessed to be indicated based on a verified Full code status, the licensed staff were to initiate CPR no matter what. The DON explained she was contacted by the administrator on the morning of [DATE]. The administrator informed her that after a phone call with LPN-A, and the administrator had additional time to process the call, the administrator was concerned staff did not perform CPR on R1, despite the administrator's knowledge R1 was Full code. Both she and the administrator presented to the facility on [DATE] and initiated a plan to educate all staff going forward. This included paper education with an associated quiz and mock CPR drills. This education would continue until all the staff were educated and all the nurses demonstrated participation. She stated additional follow ups included LPN-A's suspension, review of licensed staff CPR certification statuses and a whole house review of residents' code status with verification to ensure the POLST, orders, and care plan reflected each other. No concerns were identified with the review and verifications. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	When interviewed on [DATE], at 12:34 p.m., RN-A explained if a resident were found unresponsive, without a pulse and respirations, he was to check the code status. If the resident were a Full code, he was then to initiate CPR right away. He denied there were any reasons why CPR would be withheld if the resident were Full code. RN-A acknowledged he worked the morning of [DATE] and was approached by LPN-A around 5:40 a.m. He stated LPN-A informed him that R1 was unresponsive and asked him to come and see R1. He denied knowledge R1 had passed until he arrived at her room and assessed her. RN-A explained R1 was absent of a pulse and respirations. This prompted him to direct LPN-A to verify R1's code status and to grab the crash cart. In response, LPN-A informed him she contacted the administrator and the administrator told LPN-A not to do CPR. RN-A confirmed he, nor LPN-A, initiated CPR, or used the AED on R1. After he exited R1's room, he consulted another nurse related to his concerns that R1 was a full code and CPR was not initiated, especially as CPR should have been performed. RN-A and the nurse conferred and felt maybe there were a change in the policy, and they had just not yet been updated. RN-A identified education since this incident which included his participation in three mock CPR drills so far. During a telephone interview on [DATE], at 1:24 p.m., R1's family member (FM)-A identified he never personally reviewed R1's POLST; however, [R1] always said she wanted to be Full code. Based on this, he expected they would have attempted resuscitations when they found her on [DATE]. Further, he expected, after they initiated CPR, they would have transferred her to the hospital so hospital staff could have taken over. During an interview on [DATE], at 1:32 p.m., the administrator confirmed LPN-A contacted her on [DATE] at approximately 5:50 a.m., and told her It was too late, it was too late, related to R1: LPN-A stated this matter of fact and did not sound panicked. The administrator initially understood during this first call that CPR was attempted on R1 and it was unsuccessful; however, during the investigation, it was discovered there were communication failures that started with that first call and continued through a third call. After the administrator was able to process the initial phone call once she woke up more, as the phone call woke her up, she called back to the facility and spoke again to LPN-A. She questioned LPN-A if the AED instructed them not to perform a shock. LPN-A responded to her, Yes, [RN-A] took the AED. After the administrator contacted R1's family, she again called back to the facility and spoke a third time to LPN-A. She questioned LPN-A if they took the AED into R1's room: LPN-A confirmed this. As the administrator continued to feel something was off with the events that occurred, she contacted the DON and instructed the DON they needed to investigate further. She arrived at the facility between 8:00 a.m. and 8:30 a.m. During staff interviews, the administrator discovered LPN-A informed RN-A the administrator directed LPN-A to not perform CPR. After this, the DON took over the remainder of the investigation. The administrator acknowledged an action plan was put into place on [DATE] to mitigate repeat episodes once it was confirmed R1 was not provided with CPR. She expected if CPR was indicated, staff were to perform it. Steps in the correction plan included LPN-A's suspension, prepped, and provided staff education which included paper education and mock CPR drills, along with audits. The administrator confirmed there were no concerns identified with the audits and the drills continued. The IJ that began on [DATE] was removed the same day, when it was verified through staff interviews and document review, the facility performed the following corrective actions all on [DATE]: -The facility implemented a full-on investigation that included staff interviews along with family, provider, coroner, and medical director notifications. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-LPN-A was suspended. -A FRI was submitted to the SA. -A full house CPR/POLST audit was conducted that verified POLSTs, orders, and care plans all reflected each other. -All licensed staff CPR certifications were verified and reflected all were current. -The CPR policy was reviewed, and no changes were needed. -All staff training on the Code Blue policy, which included a quiz, was initiated. - All staff participation in mock Code Blue drills were initiated. Drills have continued and will continue until each nurse has been deemed competent in the policy processes. -Audits related to CPR protocols would continue to be completed with five staff weekly for four weeks. A Cardiopulmonary Resuscitation policy, dated ,d+[DATE], directed care would be provided according to the resident and/or the resident's representative identified preferences indicated by the physician orders and within the plan of care. CPR was to be initiated, by certified staff, for a resident who experienced a cardiac or respiratory arrest after code status was verified and an assessment revealed no signs of irreversible death were present. If irreversible signs of death were present, CPR was not to be initiated. The policy defined irreversible signs of death based on the American Heart Association which included rigor mortis (body limb stiffening) and dependent lividity (purplish red discoloration to the skin).