STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245243	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avera Granite Falls Care Center	250 Jordan Drive Granite Falls, MN 56241

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** 42355 Based on interview and document review, the facility failed to follow physician orders for full code and did not initiate cardiopulmonary resuscitation (CPR) as per the residents wishes for 1 of 3 residents (R1) who wanted CPR. R1 was found without a pulse or respirations, staff did not initiate CPR and R1 expired and resulted in an immediate jeopardy (IJ). The facility implemented immediate corrective action prior to survey and IJ was issued at past noncompliance. The IJ began on [DATE], at approximately 1:00 a.m. when R1 was noted to have no respirations with a fast heart rate, and CPR was not initiated. The administrator and director of nursing (DON) were notified of the immediate jeopardy on [DATE] at 4:27 p.m. The facility implemented corrective action on [DATE], and the IJ was issued at past non compliance. Findings included: R1's 5-day Minimum Data Set (MDS) dated [DATE], indicated intact cognition, diagnoses of coronary artery disease (CAD), heart failure, high blood pressure and anxiety. R1's physician order dated [DATE], included Full Code start date [DATE]. The record did not include a corresponding POLST (physician order for life sustaining treatment) or signed advanced directives. R1's care plan printed on [DATE], did not include R1's code status. Review of R1 progress notes dated [DATE], included R1 will remain a full code with high risk of rehospitalization . Review of R1's progress note dated [DATE] at 2:12 a.m ., licensed practical nurse (LPN)-A documented At 1:15 a.m. was summoned to rm [room] by CNA [nursing assistant (NA)] and said to bring a stethoscope. Upon entering rm [room] could see res [resident] had no color other that [sic] yellowish blue. Listened for heart rate, heard very rapid light heart rate. Ran to call RAT [rapid assessment team] and grabbed AED [automated external defibrillator]. Returned to rm [room] and found no HR [hear rate] and was already cyanotic [bluish gray]. Ambulance crew here in minutes, entered rm [room] and they started CPR and tried to revive him. They worked on him for 40 min [minutes]. They then called [name of doctor] for further instruction and he called time of death at 0152 [1:52 a.m.] (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	Review of R1's ambulance report dated [DATE], indicated ambulance was dispatched on [DATE] at 1:13 a.m. , arrived at patient at 1:26 a.m. was met by LPN-A at nurses station, who stated He is gone. They asked for clarification and LPN-A restated he is gone. Confirmed that R1 was a full code. Ambulance crew continued to room to evaluate R1. R1 was found laying in bed, without oxygen on, no signs of rigormortis, no pulse, warm to touch and cyanotic dusky color in face, no effort in breathing, no palatable carotid pulse. LPN-A at bedside and stated around 1:10 a.m., NA-A was in room, came out of room and found her to get the stethoscope, LPN-A came to room and listened to R1's heart, she thought she heard a rapid heart beat but was unsure of what to do other than call 911. No attempt of compressions or ventilation until ambulance arrival. R1 moved from bed to ambulance cot and CPR initiated. Ambulance crew performed CPR until call placed to on call physician at 1:52 a.m. when R1 was pronounced deceased . During an interview on [DATE] at 1:50 p.m., NA-A stated she had checked on R1 during her water pass at about 1:15 a.m. and noticed R1 was breathing but then at 1:30 a.m. when she went back noticed R1 was not breathing. NA-A called for LPN-A to bring a stethoscope to R1's room over the radio and heard no response so stepped out in the hallway and called for LPN-A. LPN-A came into R1's room and listened for heartbeat. LPN-A told NA-A R1 heart rate was rapid and then LPN-A left the room to call 911 and get the AED. NA-A explained, LPN-A returned to R1's room about 5 minutes later and sat the AED on R1's bed. LPN-A did not apply the AED or start CPR, instead told NA-A that R1 was gone. LPN-A had NA-A return the AED to the storage place. NA-A stated the ambulance crew arrived and NA-A heard LPN-A tell them R1 was a full code and ambulance crew asked if they started CPR and LPN-A stated no she did not. The Ambulance crew started CPR and were not able to revive R1. During an interview on [DATE] at 1:10 p.m., LPN-A stated the evening of [DATE], R1 had been anxious and used her call light frequently. LPN-A had checked on R1 at approximately 10:00 p.m. and had appeared to be at baseline. LPN-A had medicated R1 with Tramadol (pain medication used to relieve moderate to severe pain) around 11:15 p.m. LPN-A continued to monitor R1 until she was called to his room around 1:15 a.m. on [DATE] and found R1 with a rapid heart rate and not breathing. LPN-A left the room and went to call a RAT/ 911. She then grabbed the AED and returned to R1's room but upon entrance she had noticed R1 had passed away. LPN-A stated R1 was a full code and CPR should have been started, but it was not. LPN-A stated this was her first code and she did not know why she did not start CPR. During an interview on [DATE] at 11:45 a.m , director of nursing (DON) stated she had not been aware CPR had not been initiated by staff on the night shift of [DATE], until it was reported to by a quality assurance nurse on [DATE]. DON stated she then interviewed LPN-A who confirmed CPR had not been initiated by facility staff. DON reviewed R1's record and confirmed R1 was a full code according to physician orders however a signed POLST could not be located in the record. DON stated CPR should have been initiated per physician orders. DON was unable to find the POLST in R1's record. Review of facility's policy titled, LTC- Emergency Response, CPR, section emergency guidelines: 1. in the event staff come upon a resident without obvious signs of clinical death, staff will start CPR and send someone to check code status. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. initiation of CPR- prior to the arrival of emergency medical services (EMS), nursing homes must provide basic life support, including initiating CPR, to a resident who experiences cardiac arrest in accordance with that resident's advanced directives or in the absence of advanced directives or a Do Not Resuscitate (DNR) order. The past non-compliance IJ began on [DATE]. The IJ was removed, and the deficient practice corrected on [DATE] when it was verified the facility had implemented corrective action that included: -Reviewed their policy and systems and made the following changes: A) Implemented full code residents have a red heart at the foot of their bed. B) Implemented the unit group sheets were all revised to identify full code status. -NA-A received education on [DATE], LPN-A was put on administrative leave on [DATE]. -All nursing staff participated in mock code with local ambulance service on [DATE]. -All staff received education on implementation of POLST orders/CPR on [DATE] and participated in a mock code drill with local ambulance. They were reeducated again on [DATE].