STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	1401 East 100th Street Bloomington, MN 55425

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** 44649 Based on interview and record review the facility failed to follow 1 of 3 residents (R1's) Physician Orders for Life-Sustaining Treatment (POLST) do not resuscitate, do not intubate, allow for natural death when R1 was found unconscious in his bed and registered nurse (RN)-A initiated CPR. This deficient practice had the potential to prolong R1's right for a natural death encumbered by potential complications of unnecessary life saving measures. The IJ began on [DATE] at 2:45 a.m. when RN-1 was found unresponsive in his room and RN-A initiated chest compressions. The IJ was identified on [DATE]. The Administrator and the Director of Nursing were notified on [DATE] at 5:00 p.m. The IJ was removed on [DATE] and deficient practice was corrected on [DATE], prior to the start of the survey and therefore was issued at past noncompliance. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 was severely cognitively impaired. His pertinent diagnoses were metabolic encephalitis (chemical imbalance in the brain), coronary artery disease and Diabetes. R1's care plan dated [DATE], indicated R1's POLST will be honored by staff per family specifications. Code status was do not resuscitate and do not intubate (DNR/DNI). R1's POLST form dated [DATE], indicated do not attempt resuscitation/DNR (allow natural death). R1's progress note dated [DATE] at 8:26 p.m., indicated R1's family was at his bedside and staff was called in as R1 was not responding at 2:45 a.m. On assessment R1's respirations ceased, no blood pressure (BP), no carotid pulse. R1 was transferred to the floor, code blue was activated. CPR started; AED applied with no shocked advised. Ambu-bag initiated. While CPR is ongoing written POLST was received. POLST verified and reviewed. EMS arrived. POLST directed indicated comfort focus. CPR stopped. Two nurses' pronouncement of death at 3:00 a.m. (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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(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	Upon interview on [DATE] at 12:50 p.m. RN-A stated he responded to R1's room at approximately 2:45 a.m. on [DATE] where he found R1 not breathing and no pulse. He initiated a code blue emergency and initiated chest compressions. He started the chest compressions in bed, then moved R1 to the floor. He stated he conducted chest compressions for approximately five minutes until another staff member brought him the AED machine and an Ambu-bag. He placed the pads on his chest and the AED indicated not to shock R1. He realized R1 was DNR at the same time EMS arrived. He stopped CPR and pronounced R1 dead at 3:00 a.m. R1 stated he believed he should start CPR until he finds out of the code status of the residents. RN-A was retrained to check the POLST prior to initiating CPR. Upon interview on [DATE] at 1:54 p.m. the director of nursing (DON) stated she became aware that RN-A initiated CPR on R1 immediately following the event. She stated the facility started education immediately on checking the code status prior to initiating CPR. Her expectation was that the staff check the code status prior to initiating CPR. Upon interview on [DATE] at 3:33 R1's medical provider stated he was informed that CPR was initiated on R1, who had a do not resuscitate order. He stated complications can arise when CPR is performed. His expectation was that the facility staff always check the code status of a resident before taking any action. Upon interview on [DATE] at 3:47 p.m. RN-B stated on [DATE] at around 2:45 a.m. R1's family member came out of his room crying and yelling [NAME] is unresponsive. She stated RN-A ran into the room and she stayed at the nurse's station to check R1's code status. RN-B heard a staff call a code blue, so more staff headed to R1's room. RN-B found R1's POLST form and brought to R1's room and found RN-A had moved R1 to the floor and was performing chest compressions on him. RN-B showed RN-A R1's POLST form. RN-A stated, are you sure? RN-A asked nursing assistant (NA)-A to check R1's electronic medical record as he continued with CPR. A crash cart was brought into the room and RN-A initiated the use of the Ambu-bag and placed the pads from the AED machine on his chest, but the AED signaled no shock advised. RN-A did not shock R1. NA-A and the police entered the room at the same time and NA-A verified that the electronic record also indicated to not resuscitate. CPR was stopped and R1 was pronounced dead at 3:00 a.m. NA-A was not available during the survey for an interview. This IJ was called at past noncompliance due to action the facility took prior to the survey entrance. Action taken included all staff were educated on to check the code status before initiating CPR. The Cardiopulmonary Resuscitation policy was reviewed by management and reviewed with all licensed staff. All the facility residents were audited to ensure their code status was correctly input in the software system and was current. A facility police titled Cardiopulmonary Resuscitation (CPR) (CODE) blue with a revision date of [DATE] indicated if a resident is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiate CPR unless the patient has a DNR order in place.