STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Healthcare Rehabilitation and Skilled Nurs	2501 Rice Lake Road Duluth, MN 55811

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** 47790 Based on interview and document review, the facility failed to follow a Physician 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 resulted in an immediate jeopardy (IJ) when R1 was found absent of pulse and respiration, CPR was not initiated and R1 died . The facility implemented immediate corrective action, and was issued at past non-compliance. The IJ began on [DATE] at 8:03 p.m. when licensed practical nurse (LPN)-A found R1 unresponsive in her room and did not initiate CPR per R1's wishes. The administrator and the director of nursing were notified of the IJ on [DATE] at 4:12 p.m. The IJ was removed on [DATE] when deficient practice was corrected on [DATE], prior to the start of the survey and therefore was issued at past noncompliance. Findings include: R1's Provider Orders for Life Sustaining Treatment (POLST) dated [DATE], signed by the medical provider on [DATE], and verbal confirmation by R1's family member (FM)-A on [DATE], indicated CPR/attempt resuscitation if patient has no pulse or is not breathing. On [DATE], facility video surveillance indicated (LPN)-A entered R1's room at 8:03 p.m. and left R1's room at 8:04 p.m. LPN-A returned to R1's room at 8:06 p.m. Nursing assistant (NA)-A entered R1's room at 8:07 p.m. At 8:09 p.m. NA-A left R1's room. At 8:10 p.m. LPN-A left R1's room. At 8:24 p.m. both LPN-A and NA-B entered R1's room and both left the room at 8:25 p.m. At 8:59 p.m. Registered nurse (RN)-B entered R1's room. On [DATE] at 9:18 a.m., trained medical assistant (TMA)-A stated on [DATE] at 8:07 p.m., when she was off duty at home, LPN-A had sent her a text message asking her to call. On the phone, LPN-A told her R1 had passed away, and she did not know what to do. She told LPN-A she needed to call the on-call nurse, and check R1's CPR resuscitation status. She was confused because LPN-A was not doing anything. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	On [DATE] at 11:25 a.m., director or nursing (DON) stated at 8:37 p.m. on [DATE], LPN-A called her at home and told her R1 had passed away. She asked LPN-A what R1's resuscitation status was, and LPN-A stated she didn't know. She told her to go and check it now. The DON was able to check R1's resuscitation status, and saw R1 was a full CPR status. She left home to go to the facility, arriving at 8:55 p.m. She told RN-B to go into R1's room. RN-B told her R1 was not breathing, was cool to the touch, and did not have a pulse. R1 did not have any irreversible signs death (rigor mortis, dependent lividity, decapitation, transection, or decomposition). RN-B started CPR on R1. The DON called 911, and went into R1's room with the crash cart (resuscitation cart) and helped RN-B provide CPR to R1. Emergency medical services (EMS) arrived at 9:10 p.m. EMS pronounced R1 deceased at 9:15 p.m. On [DATE] at 11:53 a.m., LPN-A stated on [DATE] around 8:00 p.m., she entered R1's room to check on her and noticed she was not breathing, didn't have a pulse, but was warm to the touch. R1 did not have signs of irreversible death. She panicked and stated she did not know why she didn't start CPR or call a code. On [DATE] at 1:36 p.m., nurse practitioner (NP)-A stated R1 was a full code resuscitation status, and the staff should have started CPR when she was found with no pulse and not breathing. On [DATE] at 2:38 p.m. RN-B stated on [DATE] at 8:59 p.m., RN-B entered R1's room and checked R1 for a pulse and listened for breathing. R1 had no pulse and was not breathing. R1 had no irreversible sings of death. RN-B moved R1 to the floor and started CPR until EMS took over. On [DATE] at 2:49 p.m. NA-B stated on [DATE] at 6:30 p.m., she went into R1's room to try and see if she would eat but R1 declined. When she came back from break around 8:20 p.m., NA-A stated R1 had passed away. She asked LPN-A what the plan was and LPN-A acted like she did not know what to do. NA-B went into R1's room to confirm she passed away, then went back to the nurses station and helped LPN-A find R1's chart. NA-A found R1's POLST and saw R1 was to be resuscitated. She told LPN-A to start CPR. LPN-A did not start CPR and just looked at her. RN-B and the DON came into the facility and started CPR. The facility Cardiopulmonary Resuscitation Procedure reviewed [DATE], directed staff to identify the need for CPR (assessment, vital signs) locate resident POLST, call for help, if no pulse start compressions, give breaths, use an automated external defibrillator (AED), and place in recovery position. The past non-compliance immediate jeopardy began on [DATE]. The IJ was removed, and the deficient practice was corrected by [DATE], after the facility implemented a systemic plan that included the following actions: Reviewed their policy and procedure on CPR, and re-educated all staff on the CPR policy and procedure. Assessed all residents to ensure their POLST were completed and accurate. Conducted a mock CPR drill on [DATE] during morning and evening shift to ensure staff respond correctly. Reviewed the daily schedule to ensure each shift had at least three staff of nurses or TMAs who were CPR certified. Completed audits to ensure all crash carts had all essential equipment and supplies, and the AED was functional and will bring the results of the audits to the Quality Assurance and Performance Improvement (QAPI) committee. Verification of corrective action was confirmed by observation, interview, and document review on [DATE].