STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245381	A. Building B. Wing	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Gardens	1438 County Road C East Maplewood, MN 55109

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 - Minimal harm or potential for actual harm 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** 48300 Based on observation, interview and record review, the facility failed to follow standard of practice when cardiopulmonary resuscitation (CPR) (compressing the chest to pump blood through the body and blowing air into a persons lungs in attempt to revive a person with no pulse who is not breathing) was initiated on a resident who displayed signs of rigor mortis (the stiffening of the joints and muscles of a body after death) for 1 of 1 resident reviewed for death. R1's minimum data set (MDS) dated [DATE], indicated R1 had died in the facility on [DATE]. R1's diagnoses included acute osteomyelitis (infection of a bone) of left ankle and foot, end stage renal disease (kidney failure), gangrene (death of tissues in the body), non-pressure chronic ulcer (open wound) of leg, peripheral vascular disease (blood circulation disorder), atrial fibrillation (irregular heart beat), hypertension (high blood pressure), chronic obstructive pulmonary disease, and hyperlipidemia (high cholesterol). R1's Provider Order for Life Sustaining Treatment (POLST) signed by R1 on [DATE], and nurse practitioner on [DATE], indicated R1 desired staff to attempt resuscitation and to provide full treatment (use intubation, advanced airway interventions, and transfer to hospital and/or intensive care unit if indicated) if he was found with no pulse and was not breathing. Upon review of R1's progress notes on [DATE], the progress notes lacked evidence of a timeline of the steps of the code. On [DATE] at 2:08 p.m., emergency medical technician (EMT) stated staff were performing chest compressions when he arrived in R1's room around 8:30 a.m. on [DATE]. On [DATE] at 2:27 p.m., registered nurse (RN)-A stated went into R1's room for the first time on [DATE] at 7:25 a.m., called out to R1 and put on the light, but R1 did not respond. When RN-A observed R1, he didn't seem normal. RN-A called for help on the walkie. RN-A stated R1's body was cold except for his tummy. R1's right leg was crossed over the left and could not be moved because it was stiff. R1's arm was cold and hard when RN-A applied the blood pressure cuff. RN-B attempted chest compressions after RN-A and RN-B moved R1 to the floor. RN-A was unable to recall any type of timeline for the actions that took place during the code. (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 - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:16 p.m., RN-B stated he was called by the nurse on a walkie about an unresponsive resident. R1's face was observed to be very white in color. R1 had no response to a sternal rub, no blood pressure, and no pulse. R1's body temperature was cold, and staff could not bend R1's leg. Rigor mortis had set in. Code status was verified, then RN-A and RN-B moved R1 to the floor and began chest compressions. RN-B stated, It was obvious that he was gone. RN-B left the room to call the provider who gave an order to release the body to the funeral home after family was notified. RN-B notified family immediately after talking to the nurse practitioner (NP). RN-B was unable to recall any type of timeline for the actions that took place during the code. On [DATE] at 9:02 a.m., RN-B stated CPR was started after calling the provider and the family because R1 was full code. 911 was called then RN-B began compressions and utilized the automated external defibrillator (AED) which advised no shock. On [DATE] at 9:44 a.m., RN-C stated entered R1's room right away after RN-A called for assistance. RN-C observed R1's face to be light yellow and cold. R1's right leg was flexed, stiff, and unmovable. R1's blood pressure, breathing, and pulse were absent. RN-C left the room when RN-B arrived. RN-C did not observe CPR while in the room. On [DATE] at 10:59 a.m., NP stated was the person on call on [DATE]. NP was informed staff had found R1 cold, unresponsive, and not breathing. NP gave the order to release the body after the facility staff had talked to family. NP stated the fact R1 was cold makes resuscitation unlikely. It's tough if someone was cold to the touch. You just don't know if resuscitation will work. NP further stated, the facility staff did not inform me of R1's code status of full code. On [DATE] at 1:06 p.m., director of nursing (DON) stated a resident's code status should be checked immediately when a resident is not breathing and has no pulse. If the resident is full code, 911 should be called immediately unless there are signs of rigor mortis. CPR should not be attempted if the body is stiff and rigor mortis has set in. During review of the facility camera system on [DATE] at 1:23 p.m., the following was observed: [DATE] 7:25 a.m. RN-A enters R1's room [DATE] 7:26 a.m. RN-C enters R1's room [DATE] 7:29 a.m. RN-B enters R1's room and RN-C exits [DATE] 7:31 a.m. RN-A exits R1's room [DATE] 7:32 a.m. RN-B exits R1's room [DATE] 7:33 a.m. RN-B is observed using a facility telephone [DATE] 8:28 a.m. RN-B enters R1's room pushing the crash cart [DATE] 8:29 a.m. RN-B exits R1's room [DATE] 8:33 a.m. RN-B enters R1's room (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] 8:34 a.m. RN-A and nursing assistant (NA)-A enter R1's room [DATE] 8:36 a.m. emergency medical services (EMS) arrives On [DATE] at 2:16 p.m., NA-A stated helped RN-B place R1 onto the floor and observed RN-B do chest compressions right before EMS arrived. Facility CPR policy dated [DATE] instructs if an individual is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR shall initiate CPR unless: a) It is known that a Do Not Resuscitate (DNR) order is in place; or b) There are obvious signs of irreversible death (e.g., rigor mortis) The State Operations Maunual (SOM) revised [DATE], indicated, the American Heart Association (AHA) urges all potential rescuers to initiate CPR unless a valid Do Not Resuscitate (DNR) order is in place; obvious clinical signs of irreversible death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition) are present; or initiating CPR could cause injury or peril to the rescuer.