STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245617	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carondelet Village Care Center	525 Fairview Avenue South Saint Paul, MN 55116

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** 47264 Based on interview and document review, the facility failed to respect resident wishes for 1 of 3 residents (R1) reviewed for resuscitation status, resulting in receiving cardiac pulmonary resuscitation (CPR) against her wishes established in her Provider Orders for Life Sustaining Treatment (POLST). The IJ began on [DATE] when R1 was found unresponsive in her room and staff performed CPR based on an outdated POLST that was not corrected in R1's electronic medical record (EMR). R1's current POLST on [DATE] indicated DNR/DNI. The IJ was identified on [DATE]. The administrator, the director of nursing, and the regional clinical director were notified on [DATE] at 1:30 p.m. The IJ was removed on [DATE] and the deficient practice was corrected on [DATE], prior to the start of the survey and was therefore issued at past noncompliance. Findings include: R1's hospital discharge paperwork indicated R1 was full code status, dated [DATE]. A physician order dated [DATE] at 9:36 a.m. was entered by a health information management (HIM)-A and verified by the clinical coordinator RN-A at 1:14 p.m. The order identified R1 to be a full code. R1's POLST, witnessed by RN-B and R1 on [DATE], and signed by the practitioner on [DATE], indicated R1 wished to be Do Not Attempt Resuscitation / DNR (Allow Natural Death). R1's POLST was uploaded to R1's EMR on [DATE]. R1's medical diagnosis list indicated R1 admitted to the facility on [DATE] for a displaced fracture of the left femur. R1's relevant diagnoses included fractures of the thoracic vertebrae, chronic pain, history of falling, and generalized muscle weakness. R1's Minimum Data Set (MDS) dated [DATE], indicated R1 admitted to the facility on [DATE]. R1's Brief Interview for Mental Status (BIMS) was 15, indicating she was fully cognitively intact. (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	A progress note dated [DATE] at 5:12 a.m. indicated on [DATE] at approximately 11:40 p.m., RN-C and RN-D were alerted by the nursing assistant (NA)-A there was an emergency with R1. RN-C and RN-D responded to R1 and determined she was unresponsive without breathing or pulse. RN-C and RN-D began CPR. At 11:45 p.m. emergency medical services (EMS) were contacted. At 11:58 p.m., EMS arrived, assumed care, and continued providing CPR. The clinical administrator (DON) was contacted at 12:00 a.m. EMS pronounced R1's time of death at 12:15 a.m. on [DATE]. R1's family and provider were contacted. During an interview on [DATE] at 12:53 p.m., RN-E stated a resident's code status is displayed on the resident's home page in the EMR and in the physician order's tab. Part of their admission process is to obtain a POLST from the resident. The facility previously process was to have the resident sign a new POLST, then place it in the provider's box for review, which lead to a gap in communication of code statuses. They recently received training on the new process for changing code status. RN-E stated if a resident wants to change their code status and the provider is not available, they must go through POLST paperwork with the resident, and then call the on-call provider to get a verbal order, which is immediately entered into the resident's EMR. Entering the new code status order automatically changes the resident's banner in the EMR. The nurse must then fax the POLST form to the provider, and have the provider sign the POLST and fax it back. RN-E stated then they must scan the POLST into the EMR, put the physical copy in a box for filing, or give it directly to the HIM, then write a progress note detailing the resident's new code status. During an interview on [DATE] at 1:48 p.m., RN-F stated a resident's code status can be found in the resident's EMR profile on their banner. If a resident wants to change their code status, they need to complete a POLST form with them and call a provider for a verbal order. Then enter the verbal order on the resident's EMR, fax the form to the provider, and when a nurse receives the provider's signature, then uploads it to the EMR. RN-F stated then the POLST is put in the HIM's box for filing. During an interview on [DATE] at 2:18 p.m., RN-C indicated he was coming onto his shift the night of [DATE]. RN-C stated NA-A came running to him while he was receiving report from RN-D. RN-C and RN-D ran to R1's room and immediately took action. He retrieved an ambubag, and when he returned, R1 did not have a pulse. He and RN-D used the EMR to verify R1's code status as full code. He and RN-D initiated CPR, and EMS were contacted. RN-C stated when EMS arrived, they assumed care and requested R1's code status documentation and when they checked the paper chart, they found the physical POLST indicating R1 was DNR/DNI and informed EMS of the current POLST. R1 was pronounced dead shortly afterwards. POLST reeducation was received from the DON regarding respecting resident wishes and rights. Their process for new code statuses is to complete a POLST with a resident and then contact a provider for a verbal order immediately. RN-C stated once the POLST is faxed and signed by the provider, he would upload it into the computer and put the document on the HIM's desk for filing. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:15 p.m., RN-D stated when she and RN-C arrived in R1's room, R1's respirations were shallow, and her pulse was thready. She checked R1's code status in the EMR while RN-C retrieved an ambubag, and identified R1 was a full code. When she and RN-C reentered the room, R1 did not have a pulse and was not breathing, so they initiated CPR. RN-D stated EMS was called and when they arrived, they assumed care, pulled R1 onto the ground, continued CPR, and asked for R1's code status paperwork. RN-D went to the nursing station, retrieved R1's POLST, and saw R1 had a signed POLST indicating she was DNR/DNI. RN-D stated she immediately called the DON for guidance, and the DON directed her to have EMS stop CPR. EMS stopped CPR and announced R1 was deceased . RN-D stated she received reeducation that night from the DON about honoring a resident's wishes and signed it before leaving the facility on [DATE] at approximately 2:30 a.m. During her shift on [DATE], the DON held an all-staff meeting regarding code statuses. Their process if a resident wants to change their code status is to go through a POLST form with the resident and then call the provider. They will receive a verbal order from the provider and enter it as an order in the resident's EMR. RN-D stated the POLST is then uploaded to the EMR by herself or the HIM. During an interview on [DATE] at 3:34 p.m., RN-A stated any orders entered by the HIM must be confirmed by a licensed RN. Their new process for changing code status documentation is to obtain a new POLST from the resident and contact the provider for a verbal order. RN-A stated the nurse would enter the order into the EMR. This would either be done by the resident's nurse, or herself or the DON if they were available. It was the responsibility of the nurse who completed the POLST that did not match their current code status to contact the provider and update the EMR. RN-A stated there was reeducation completed with all staff regarding this process and their preexisting expectations and policies, including individual education for RN-A, RN-B, RN-C, and RN-D. During an interview on [DATE], the DON stated on [DATE] at approximately 12:00 a.m., he got a call at home from RN-D. RN-D explained she and RN-C completed CPR under the understanding R1 was full code per the EMR, but discovered when reviewing the paper charts R1 had a DNR/DNI POLST signed by the provider on [DATE]. He instructed RN-D to inform EMS of R1's code status, at which point CPR stopped and R1 was pronounced dead. The DON stated he immediately conducted an audit of all other remaining residents to ensure their documented code statuses matched their most recent signed POLST orders. Starting [DATE], he and RN-A completed reeducation for all staff on their new process for changing a resident's code status. Their new process if a resident wants to change their code status is for nursing staff to receive a new POLST, and then immediately contact the on-call provider to receive a verbal code status order. The nurse must then enter the verbal order into the EMR, then either upload it directly to the EMR, or give it to the HIM for uploading if they are present in the building. The POLST then goes to the in-house provider's box for review. This process can either be completed by the resident's nurse, or by himself or RN-A. RN-A received reeducation on ensuring the POLST orders match in PCC prior to giving it to the HIM for filing. RN-B received reeducation to make a progress note if a resident wants to change their code status. RN-C and RN-D received reeducation about respecting resident rights and wishes immediately following R1's death. The DON stated the facility has added this process to their QAPI initiates. The facility began conducting Code Blue drills for unresponsive residents on [DATE] and will continue with these initiatives monthly for four months, and then quarterly. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 8:50 a.m., RN-B stated she admitted R1 to the facility on [DATE]. R1 informed her she wanted to be DNR/DNI, and she completed a POLST with R1. She then put the POLST in the provider's box to be reviewed. She did not know R1 had been full code in the hospital, and that she could not see the order on her EMR. RN-B stated orders can be entered by the HIM but will not become visible on the EMR until they are approved by an RN. RN-B stated if she had known R1 wanted to change her code status, she would have called the provider immediately and gotten a verbal order, then placed the POLST in the box for provider review and HIM to file. During an interview on [DATE] at 10:45 a.m., HIM-A stated she is no longer allowed to put code status orders from the hospital into the EMR. HIM-A stated she does not remember if she saw R1's POLST order. During an interview on [DATE] at 10:45 a.m., RN-A stated POLSTs go to the HIM for scanning if they are in the building, otherwise it is the responsibility of the RN obtaining the new POLST. RN-A stated the HIM does not enter the code status orders for residents. A RN must enter new code status orders. This IJ was called at past noncompliance due to action the facility took prior to the survey entrance. Action included all staff were educated on how to change a resident's code status. The Code Status: Physician's Order for Life Sustaining Treatment policy reviewed by management and reviewed with all licensed staff. All staff directly involved in the incident and inputting code status order were reeducated on existing system and the importance of a code status. All the facility residents were audited to ensure their code status was correctly input in the software system and was current. A policy titled Code Status: Physician's Order for Life Sustaining Treatment Policy, dated [DATE], indicated resident orders must match the resident's POLST. The policy indicated if a resident chooses to become DNR/DNI, a telephone order should be obtained until the original document can be reviewed and signed by the physician.