STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525438	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Manor of Lacrosse	2902 East Avenue South LA Crosse, WI 54601

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** 41945 Based on interview and record review, the facility failed to have a system in place to ensure the code status of residents (R), as indicated in the advance directives, is followed. This affected 1 of 1 resident reviewed (R1) whose Cardiopulmonary Resuscitation (CPR) wishes were not followed. R1's Physician Orders for Life Sustaining Treatment (POLST) indicated R1 wanted CPR. The facility failed to initiate CPR upon finding R1 with no respirations and pulseless. The facility's failure to follow the code status identified in the advance directives and failure to begin cardiopulmonary resuscitation created a finding of immediate jeopardy that began on [DATE]. The Nursing Home Administrator (NHA) A and Director of Nursing (DON) B were notified of the immediate jeopardy on [DATE] at 1:55 p.m. The facility took steps on [DATE], immediately after the incident, to correct the deficient practice and to ensure compliance. The immediate jeopardy was removed on [DATE] and corrected on [DATE]. Based on this determination, the citation issued is past non-compliance. Findings include: The facility policy titled, Initiation of CPR/AED (Automatic Electric Defibrillator) and BLS (Basic Life Support) Associate Training Expectations, dated 2018, states in part: Procedure: Cardiopulmonary Resuscitation/Automatic Electronic Defibrillator (CPR/AED) will be initiated on a resident who is found unresponsive, except when: 1. A provider medical order states a code status of Do Not Resuscitate (DNR); 2. A resident Declination of CPR form is present: or there are signs of obvious, long-standing death of the resident present. In all cases, Emergency Response Service (EMS) will be activated, and CPR/AED will be initiated by a Basic Life Support (BLS) certified BHS associate when present at the scene. The facility's policy also states: Reasons to NOT Initiate CPR/AED upon finding someone pulseless, per CMS are: *A Provider medical order stating a code status of DNR. *A resident Declination of CPR Form is present. (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	*Obvious signs of clinical death (e.g., rigor mortis, (chemical changes in the muscles after death, causing the limbs of the corpse to become stiff and difficult to move/manipulate), dependent lividity (purplish discoloration of the skin following death due to the settling of blood in the most dependent tissues), decapitation, transection, or decomposition are present. *Initiating CPR would cause injury or peril to the rescuer. R1 was admitted to the facility on [DATE] following hospitalization for pyogenic arthritis of the left knee joint and left knee arthrotomy. R1's additional diagnoses included end-stage renal disease, hypertension, and type 2 diabetes mellitus without complications. R1's medications included allopurinol 100mg by mouth daily, amlodipine 5mg by mouth daily, aspirin 81mg DR (delayed release) by mouth daily, bumetanide 5mg by mouth twice daily, metolazone 2.5mg by mouth as needed, reno caps 1mg by mouth daily, and sevelamer carbonate 1600mg by mouth three times a day. R1's Minimum Data Set (MDS) assessment, dated [DATE], indicated R1 required assistance of one staff with bathing, dressing, grooming, and hygiene. R1 required assist of one with a gait belt and a four-wheeled walker. R1's Brief Interview for Mental Status (BIMS) score was 14 out of 15, indicating intact cognition. R1 had a Power of Attorney for Health Care (POA-HC), which was not activated. R1 was R1's own person. R1's advance directive, POLST, indicated R1 requested CPR and full treatment. A Physician Assistant (PA) note, dated [DATE], stated R1 was hospitalized from [DATE] through [DATE] with septic arthritis of the left knee. R1 had an Incision and Drainage (I and D) with insertion of an absorbable drug delivery device. During hospitalization , R1 had atrial fibrillation with rapid ventricular rate (RVR) and was back in sinus rhythm at discharge. R1 was on two weeks of apixaban for deep vein thrombosis (DVT) prophylaxis and discharged on a 7-day cardiac monitor. The monitor showed no atrial fibrillation or atrial flutter. R1 had physical therapy (PT) at the facility and was improving. R1 has been on hemodialysis since February of 2024 for end-stage renal disease with the amyloidosis light chain (AL) amyloidosis. The PA note stated vital signs were stable, with B/P ,d+[DATE], P 60, R20, T 96.8m, and O2 saturation at 96% room air. Labs from [DATE]: Sodium (Na) 133, Potassium (K+) 5.2, Creatinine 5.11 with a glomerular filtration rate (GFR) of 11, albumin 3.2, hemoglobin low but stable at 10.3, white count normal. PA did not make any changes to R1's care. R1's POLST form reads full code and full treatment. In March of 2024 during hospitalization , R1's POLST was completed. Upon further review, facility documentation was as follows regarding R1: On [DATE] at 4:45 a.m., R1 had transferred self to the bathroom. Certified Nursing Assistant (CNA) C made sure R1 was positioned on the toilet and gave R1 the call light. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 5:50 a.m., R1 was seen by the charge nurse, Registered Nurse (RN) E, kneeling on the floor, with R1's upper torso on the bed. R1's skin was grayish. R1 had no respirations or pulse. RN E last saw R1 at 2:30 a.m. RN E called for help. CNA C and RN D went into R1's room. RN E checked R1's POLST at 5:53 a.m. and confirmed R1 was a full code. RN E called 911. CNA C and RN D positioned R1's body on the floor and awaited instructions from RN E as to what to do. RN E told them to wait till RN E received direction from EMS. On [DATE] at 6:00 a.m., EMS/Police arrived at the facility. EMS started CPR. At 6:26 a.m., an update was given by EMS personnel to facility staff that resuscitation efforts were unsuccessful. On [DATE] at 6:30 a.m., the facility notified the on-call provider, and R1's death was pronounced. The facility notified the medical examiner, who came to the facility before releasing the body to the funeral home. The medical examiner verbalized no concerns, pending the final coroner report. R1's physician note dated [DATE] stated, overall, R1's clinical status had appeared to stabilize over the recent weeks, though R1 remained medically complex with amyloidosis light chain (AL) amyloidosis with renal involvement/end-stage renal disease (ESRD), smoldering myeloma, recent septic arthritis, hypertension, type 2 diabetes, mellitus, peripheral arterial disease, and history of atrial fibrillation. There did not appear to be any apparent modifiable factors or prodromal symptoms in the time leading up to R1's arrest. On [DATE] at 10:54 a.m., Surveyor interviewed CNA C via telephone and asked CNA C to walk through the event involving R1 on [DATE]. CNA C stated R1 self-transferred self to the bathroom at 4:45 a.m. CNA C stated that CNA C assisted R1 in making sure R1 sat on the toilet safely, gave R1 the call light, and told R1 to ring when finished in the bathroom. CNA C stated CNA C was busy with other residents and heard RN E yell for help. This was about 5:45 a.m. CNA C stated R1 was on both knees at the side of the bed, with R1's torso on the bed. At first, RN E and CNA C thought R1 fell but, upon assessment, R1's skin was gray. RN E went to call 911 and check R1's code status. CNA C stated that CNA C got RN D to help, and they placed R1 flat on the floor. CNA C stated that CNA C then left the room because call lights were going off, and RN D was in the room with R1. CNA C stated when CNA C left the room, it was a short time, sirens were heard, and EMS was arriving at the facility. CNA C stated it was probably a minute or two, and the ambulance was at the facility. According to EMS records, the ambulance service was dispatched [DATE] at 5:54 a.m. In route to facility at 5:57 a.m. At facility at 5:59 a.m. Initial CPR at 5:59:43 a.m. Resuscitation discontinued at 6:27 a.m. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:06 a.m., Surveyor interviewed RN D via telephone and asked RN D to walk through the events of [DATE] involving R1. RN D stated that RN D was working in the ,d+[DATE] hall and that R1 was not one of the residents in those halls. CNA C came to the nurse's station and told RN E that R1 was on the floor. RN D stated RN E went down to R1's room with CNA C. CNA C came back to the nurse's station and stated that RN E needed help. RN D stated RN D went down to R1's room, and R1 was kneeling next to the bed, arms next to R1's sides, and R1's torso was on the bed. RN D stated R1's arms and feet were purple/gray and was clearly deceased . R1 had no pulse and no respirations. RN E went to check R1's code status and call 911. RN E told RN D and CNA C to wait to see what EMS wanted them to do. RN D stated RN D and CNA C positioned R1 on the floor. No rigor mortis had set in, but R1's arms and feet were purplish. RN D stated R1 was obviously dead. RN D stated they did not undress him. EMS arrived then and initiated CPR but were unsuccessful. Surveyor asked why RN D did not initiate CPR. RN D stated, per policy, that if rigor or skin is purplish/gray, CPR should not be started. It should be noted that if a person knelt at the side of a bed, with their arms at their sides, and only the upper body from the waist up being on the bed---the arms, knees, and feet would be reddish, purplish from lack of proper circulation. According to RN D, RN D did not undress R1 and only saw his arms and feet. On [DATE] at 1:45 p.m., Surveyor interviewed NHA A and DON B and asked about the [DATE] incident involving R1 and R1's CPR status. NHA A stated the staff should have acted quicker for more efficiency and it was an issue of delegation of duties. Surveyor asked why the staff did not perform CPR when RN E verified R1 was a full code. DON B stated the length of time RN E was on the phone with EMS delayed action and duties weren't delegated quickly before EMS arrived at the facility. Facility staff delayed initiating CPR at least 7 minutes from determining R1 was full code at 5:53 PM until EMS arrived at 6 PM. Seconds and minutes count in an emergency situation. Brain death can occur within , d+[DATE] minutes of the brain being deprived of oxygen. Further, the chance for a successful outcome decreases 7% with each minute that CPR is delayed. The website http://www.AED.com notes that there is a 5 minute survival window for a victim of sudden cardiac arrest with the survival depending upon early CPR and having access to an AED within that 5 minute timeframe .The Chain of Survival steps must all occur within 5 minutes: 1. Early Access to get help: Call 911 2. Early CPR to buy time: Begin CPR Compressions Immediately 3. Early Defibrillation to restart heart: Use AED as soon as possible on victim 4. Early ACLS to stabilize: Ambulance arrival time The facility's failure to follow the code status identified in the advance directives and begin cardiopulmonary resuscitation created serious harm, thus leading to a finding of immediate jeopardy that began on [DATE]. On [DATE], the facility identified the deficient practice that occurred when the facility staff did not perform CPR when R1 was found without respirations and a pulse. The facility took steps to correct the deficient practice and ensure compliance on [DATE]. The immediate jeopardy was removed on [DATE], and corrected on [DATE] when the facility completed the following: The facility completed crash cart audits, including nightly checks and weekly verification by DON B. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility completed code status and POLST/POST audits for all facility residents. The facility reviewed/audited advance directives/care plans for all facility residents. The facility audited all in-house licensed staff on their CPR certifications. The facility provided all in-house licensed staff education, including RN D and RN E on the following: Facility CPR policy Nurse response and initiation of CPR for residents with a full-code status EMS activation POLST/POST and code status location/verification Crash cart location Delegation of duties CPR situational review The facility provided all staff (except licensed staff) with education on roles and responsibilities during a CODE. On [DATE], Surveyor reviewed the following: Audits for resident's code status Audit for staff's CPR certification Corrective action documents for RN D and RN E Quality Council agenda for discussion on self-report involving R1. Mock code competency audits were conducted on [DATE] through [DATE] on various shifts. Crash cart audits start on [DATE] through the date of the survey on [DATE] and will continue beyond. Documentation of the completion of education for RN D and RN E following R1's incident. Education for all staff. Based on this determination, the citation is issued as past non-compliance.