STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525532	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - St Croix Falls	750 E Louisiana St St Croix Falls, WI 54024

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** 40181 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 their advance directives, was followed. This affected 1 of 1 resident reviewed (R1) whose Cardiopulmonary Resuscitation (CPR) wishes were not followed. R1's Critical Care Plan indicated R1 wanted CPR. On [DATE], R1 was found not breathing and without a pulse. Staff did not promptly begin CPR per resident's wishes. When CPR was initiated, it was not performed according to current standards resulting in ineffective procedure. The facility's failure to ensure R1 received basic life support, including CPR, in accordance with preferences on signed Critical Care Plan, created a finding of Immediate Jeopardy (IJ) beginning on [DATE]. Director of Nursing (DON) B was notified of the immediate jeopardy on [DATE] at 1:30 p.m. The facility began steps on [DATE] to correct the deficient practice and to ensure compliance. The immediate jeopardy was removed and corrected on [DATE]. Based on this determination, this citation is being cited as past noncompliance. Findings include: The facility's policy and procedure titled CPR-Cardiopulmonary Resuscitation Protocol, last reviewed on , d+[DATE], states in part, It is the policy of this facility to provide basic life support, including CPR-Cardiopulmonary Resuscitation, when a resident requires such emergency care, prior to the arrival of emergency medical services, subject to physician order and resident choice in the resident's advanced directives. Nurses and other care staff are educated to initiate CPR, as recommended by the American Heart Association (AHA) unless: A valid Do Not Resuscitate order is in place Resident presents with obvious signs of clinical death (e.g. rigor mortis, dependent lividity, decapitation, transection or decomposition) are present Initiating CPR could cause injury or peril to the rescuer . (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	Under the section of the policy titled Procedure, the policy includes the following statement, .If no pulse, begin CPR (please note: if AED is immediately available, use defibrillator as soon as possible when device is ready for use): 1. Place backboard under resident in bed or assist resident to a firm surface if possible . Review of R1's medical record identified R1 was admitted to the facility on [DATE] with diagnoses including in part, traumatic subarachnoid hemorrhage without loss of consciousness, other nontraumatic intracerebral hemorrhage, and chronic kidney disease stage 4. R1's Brief Interview for Mental Status Score at the time of admission was 11 which indicated R1 had moderate cognitive impairment. The medical record identified R1 was own health care decision-maker and did not have an activated health care power of attorney directive in place. The critical care plan, signed by R1 and R1's physician on [DATE], indicated R1 wished to have CPR. Nurses' notes, dated [DATE] at 8:16 AM, stated: Resident found unresponsive in bed by Med Tech at 6:15 AM, Pulse check performed with no pulse found. Full code was called, CPR was initiated immediately EMS contacted. CPR continued until EMS arrived and took over. Resident transported to hospital via EMS Family and DON. An additional nurse's note, dated [DATE] at 3:47 PM, identified R1 expired at the hospital. On [DATE], Surveyor conducted a telephone interview with Certified Nursing Assistant (CNA) I who stated they were present and responded when Medication Aide (MA) C called for help when R1 was found unresponsive on the morning of [DATE]. CNA I stated it was approximately between 6:05 AM and 6:10 AM. CNA I stated there were multiple staff members present in R1's room and no one was doing anything. CNA I stated someone said R1 was a full code and CPR should be started. Licensed Practical Nurse (LPN) D refused to start CPR, stating they would not do CPR on an [AGE] year-old person. When MA C insisted they start CPR, LPN D gave about 8 to 10 half-hearted chest compressions and stopped. Then MA C took over chest compressions but R1 was on the bed, and they did not put a back board under R1 or move R1 to the floor. CNA I stated CNA I was CPR certified and had participated in codes in the past. CNA I stated neither LPN D nor MA C appeared to know how to perform CPR. CNA I stated it was approximately 6:15 AM when LPN D started the ineffective chest compressions and LPN D and MA C continued to take turns doing the half-hearted chest compressions for about 10 minutes until the ambulance arrived. CNA I stated no other nursing staff intervened and no one put the defibrillator on R1. (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], Surveyor conducted a telephone interview with CNA H, who stated they had been in R1's room to reposition in bed and provide incontinent cares at approximately 5:45 AM. R1 was restless and complaining of shortness of breath. Shortly after 6:00 AM, MA C called for help over the radio that R1 was not breathing. CNA H stated when they responded to the room there were multiple staff members present including MA C, LPN D, LPN J and LPN G. No one was doing anything for R1 until LPN G stated that R1 was a full code and someone should start CPR. LPN G ran to the desk to call EMS. LPN J quickly left the room. LPN D refused to do CPR, stating the resident was [AGE] years old and already dead. MA C stated they had to do something because R1 was a full code and requested someone get the crash cart. LPN D did a few chest compressions but did not appear to know how to do CPR. R1 was still on the bed, and they did not put a back board under R1 or move R1 to the floor. CNA H stated MA C and LPN D sort of took turns doing chest compressions while R1 was in the bed until the ambulance arrived. CNA H did not know for sure how long the delay was from when MA C called for help and someone started CPR, but estimated it was maybe between 10 to 15 minutes. CNA H estimated it was approximately 10 minutes later that the ambulance crew arrived and moved R1 to the floor and took over CPR. On [DATE], Surveyor interviewed CNA F who stated they were with MA C when they found R1 not breathing on the morning of [DATE]. CNA F stated it was approximately 6:05 AM. CNA F stated MA C called for help right away over the radio and multiple staff responded but no one seemed to know what to do, and no one started CPR until someone stated R1 was a full code. Initially LPN D refused to do CPR stating they would not do CPR on an [AGE] year-old person. CNA F stated eventually LPN D did a few chest compressions after MA C insisted, but LPN D did not appear to know how to do CPR. CNA F said someone got the crash cart and someone called 911, but no one put a back board under R1 or moved R1 to the floor to do CPR until the ambulance arrived. CNA F estimated it was 10 to 15 minutes before anyone started CPR and maybe another 10 minutes until the ambulance arrived. On [DATE], Surveyor interviewed CNA E who stated they responded to R1's room on the morning of [DATE] when MA C called for help. CNA E did not remember exactly what time it was, but right at the beginning of the shift. CNA E stated there were a lot of staff in R1's room and there was a lot of confusion. CNA E stated eventually LPN D started doing chest compressions on R1 when someone said R1 was a full code. CNA E stated R1 was in the bed and did not think there was a back board under R1 when LPN D started compressions. CNA E did not know how long it was between the time MA C called for help and someone started CPR but thought maybe 10 minutes. CNA E did not stay in R1's room, so did not know if staff continued to provide CPR until the ambulance arrived. On [DATE], Surveyor conducted a telephone interview with LPN G. LPN G stated they had worked the overnight shift on [DATE] and R1 was restless and complaining of shortness of breath off and on all night. LPN G and CNA H had just been in R1's room providing cares around 5:45 AM. LPN G gave short report to MA C and went to count the narcotics on the other medication cart with LPN J. Shortly after 6:00 AM, they heard MA C call over the radio for help in R1's room as she was not breathing. LPN G went to nurse's station to check on R1's code status and LPN J went to R1's room. When LPN G arrived at R1's room, R1 was unresponsive in bed, and everyone was just standing around doing nothing. LPN G informed them to start CPR as R1 requested a full code. LPN G heard LPN D state they would not do CPR on an [AGE] year-old. LPN G then went back to the nurse's station to call 911 and get transfer paperwork ready because LPN G felt there were enough staff in the room to handle the situation. LPN G did not go back to the room and did not know who started CPR or what time it was started. (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], Surveyor interviewed MA C who reported they were outside R1's room around 6:00 AM preparing R1's AM medications. LPN G and a CNA were in the room providing cares. LPN G said R1 not doing well when leaving the room. A few minutes later MA C entered room with AM medications and found R1 lying on right side facing the wall and unresponsive. MA C found R1 was without a pulse and not breathing and called for help over the radio. Multiple staff responded to MA C's call. MA C did not start CPR immediately because was waiting for direction from the nurses who arrived to help. LPN G entered and informed them R1 was a full code and instructed them to start CPR. LPN D refused to start CPR stating it was an [AGE] year old and they were already gone, there was nothing they could do. MA C insisted LPN D start CPR because it was R1's wish. LPN D then did about 10 chest compressions, quit and said, There are you happy? MA C said they couldn't do nothing and told someone to get the crash cart. MA C started chest compressions, but in the panic of the moment forgot to put a back board under R1 or move R1 to the floor. MA C did not know how long it was between finding R1 unresponsive and the start of CPR. MA C said the ambulance crew arrived around 6:30 AM and moved R1 to the floor to continue CPR. MA C stated they got a pulse back before transporting R1 to the hospital. On [DATE], Surveyor interviewed Registered Nurse (RN) K who was the nurse manager on call on [DATE] when R1 was found unresponsive. RN K received a phone call at 6:19 AM from LPN D who informed RN K that R1 was found not breathing and without a pulse and wanted to clarify if they should do CPR. RN K informed LPN D they should have already started CPR as R1 was a full code and they should call 911 right away. Review of the ambulance report identified they received the call at 6:22 AM on [DATE] and arrived on scene at 6:27 AM. They found R1 lying supine in bed with staff performing CPR. They moved R1 to the floor and resumed CPR. They inserted an airway, attached pads to R1's chest and noted an initial rhythm of asystole. They inserted an IV and administered three doses of epinephrine. Faint pulses were present at 7:02 AM and they transported R1 to the hospital. Review of the emergency room (ER) report identified R1 arrived at the ER at 7:26 AM. R1 was found to have a faint pulse, in bradycardia, with pupils fixed and dilated. Chest compressions were resumed. R1 was placed on a mechanical ventilator and provided emergency medical care until family arrived and requested to change code status to Do Not Resuscitate to stop the mechanical ventilation. R1 expired in the hospital. On [DATE], Surveyor interviewed Director of Nursing (DON) B and asked about the events involving R1 on the morning of [DATE]. DON B stated they began an investigation into the events on the morning of [DATE] and quickly identified there was a delay in the initiation of CPR for R1 due to staff refusal to perform CPR and staff confusion about responsibilities. Staff delay in initiating CPR for R1 after determining R1 was without a pulse was possibly as long as ten minutes. 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 (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Early Defibrillation to restart heart: Use AED as soon as possible on victim 4. Early ACLS to stabilize: Ambulance arrival time Failure to immediately begin CPR reduced the chances that this resident could recover and survive. 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 facility's failure to follow the code status identified in the advance directives and promptly begin cardiopulmonary resuscitation resulted in 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 began steps to correct the deficient practice on [DATE]. The immediate jeopardy was removed and corrected on [DATE] when the facility completed the following: All staff education of CPR policy, emergency medical services activation, and code status, crash cart location, delegation of duties, crash cart audits, code status audits, and mock code competency. On [DATE], Surveyor reviewed the following documentation: Education provided to all staff on CPR policy and Code Blue drills. Emergency Documentation form created and placed on both crash carts. Audits and restocking of both crash carts. Audits of all resident code status. Initiation of Code Blue drills to be completed periodically for all shifts. Based on this determination, the citation is issued as past noncompliance.