STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	C 11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER POINTE, A PROSPERA COMMUNITY	**3500 21ST ST SE MANDAN, ND 58554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite investigation survey regarding a facility reported incident was completed on 11/16/22. A deficiency was cited related to the identified concern.	F 000		
F 678 SS=G	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility reported incident investigation, review of facility policy, personnel record review, and staff interview, the facility failed to immediately start Cardiopulmonary Resuscitation (CPR) on 1 of 4 closed resident records (Resident #1) who requested CPR in the event of absence of pulse or respirations. Failure to immediately start CPR may have contributed to Resident #1's death and placed all residents requiring CPR at risk for death. This citation is considered past non-compliance based on review of the corrective action the facility implemented immediately following the incident. Findings include: Review of the facility policy titled "Advance Directive including Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED)" occurred on 11/16/22. This policy, revised 07/21/22, stated, ". . . PURPOSE:	F 678	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 11/30/2022

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F 678	Continued From page 1 To provide each resident the opportunity to make decisions regarding future medical care . . . Initiation of Cardiopulmonary resuscitation (CPR): 1. If cardiac arrests [sic] occurs, CPR must be initiated unless the resident has: a. A valid DNR [do not resuscitate] order on file . . . 2. The resident has obvious signs of clinical death (e.g., rigor mortis [stiffening of the joints/muscles of a body a few hours after death], dependent lividity [settling of the blood in the dependent portion of the body postmortem, causing a purplish red discoloration of the skin.] . . .) 3. The initiation of CPR could cause injury or peril to the rescuer. . . ." Review of Resident #1's medical record occurred on 11/16/22. Diagnoses included severe protein-calorie malnutrition, adult failure to thrive, anorexia (eating disorder), interstitial pulmonary disease (group of lung conditions that causes scarring of lung tissue), atherosclerotic heart disease of native coronary artery (hardening of the arteries supplying blood to the heart), COVID-19 (coronavirus disease), and bifascicular block (conduction abnormality of the heart). A physician's order, dated 08/17/22, stated, "ND POLST [North Dakota Physician Orders for Life Sustaining Treatment] (A): CPR/Attempt Resuscitation. . . ." The progress notes, dated 11/09/22, identified the following: * 9:25 a.m., ". . . Level of consciousness: Alert. Verbal. Responds to stimuli. Orientation: Person. Place. Time. Situation. . . . Other circulatory issues: None. . . . Related System: Respiratory	F 678		

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Infection is potentially a result of COVID-19. . . . Resident is in isolation Airborne precautions. Contact isolation precautions. Single room isolation . . . All services are being rendered in the resident's room. All meals are brought to the room and cares are done in the room. Other Notes: Resident takes off oxygen."
* 9:28 a.m., ". . . Continues to have moist cough and oxygen dependent. She refuses to keep the oxygen in place. Remains in isolation. . . ."
* 12:40 p.m., ". . . Informed daughter that resident had stopped breathing and facility staff started CPR. Facility called 911 and will be transported to [name of hospital]. . . ."
* 1:27 p.m. [staff failed to note entry as a late entry], ". . . RN [registered nurse] called to room via floor staff. Upon assessment resident was not breathing and no pulse noted, body temp warm, CPR started. 911 called. EMS [emergency medical services] arrived LUCAS [automated chest compression system] in place, Artificial airway placed, Line accessed [sic] placed. Paper work given to EMS. Report called to Emergency department."
* 4:30 p.m., ". . . Late Entry: Date and time vital signs ceased: 1228 [12:28 p.m.] . . . Name/date/time Provider/Coroner pronounced death: Time of death 1319 [1:19 p.m.] [Name of hospital] ED [Emergency Department,] MD [medical doctor] notified via phone 1630 [4:30 p.m.] Date, time and details of family/responsible party notification: 1319 via ED staff . . ."

The initial report to the State Survey Agency (SSA) "Initial Allegation of Mistreatment, Abuse, Neglect, or Theft and Facility Reported Incidents Reporting Form" regarding an incident on 11/09/22 concerning Resident #1 and a nurse

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(#1) stated, ". . . Briefly describe the alleged incident and/or injury: Registered nurse on duty did not initiate CPR immediately on full code resident. . . ."

The facility's final report to the SSA stated, ". . . Date and time of the Allegation/Incident: 11/9/22 12:23 [p.m.] 8. Briefly Describe the Alleged Incident and/or Injury: C.N.A. [certified nurse aide] found resident unresponsive and called nurse on duty for assistance. Nurse promptly reported to resident room and staff called for additional support. [Nurse #1] directed staff to obtain crash cart. [Nurse #1] did not initiate CPR immediately. Additional staff were called to room, [Nurse #2] initiated CPR immediately upon arrival. Resident left facility with active CPR in progress with EMS staff. Provider and family updated at time of incident. 9. How do you plan to protect all residents during the time you are investigating this allegation? Immediately post incident all staff involved were interviewed. Education on CPR policy was completed on all licensed nurses. . . . Results of Investigation: Nurse [#1] educated on CPR policy and counseled per administration and human resources. Final Action Taken: Nurse [#1] verbalized understanding of immediately performing CPR per policy indicators. . . ."

Review of the facility's investigation identified the following timeline of events on 11/09/22 per the unit camera footage:
* 12:23 p.m. - "[CNA #3] enters room with meal" and "comes out of room to call for help"
* 12:24 p.m. - "[CNA #4] enters room" and "[CNA #4] exits room and [CNA #3] waits in doorway"
* 12:24 p.m. - "[Nurse #1] enters room"

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F 678	Continued From page 4 * 12:25 p.m. - "[CNA #4] brings crash cart" * 12:27 p.m. - "[Nurse #1] peaks out of bubble [plastic covering for isolation purposes over Resident #1's room door] and appears to be calling someone for help." * 12:27 p.m. - "[Nurse #2] enters the room and initiates CPR" * 12:28 p.m. - "[Nurse #1] grabs [back] board off crash cart." * 12:29 p.m. - "[CNA #3] pushes crash cart into resident room." * 12:31 p.m. - "[Administrative staff member #5] take AED into room" * 12:36 p.m. - "EMS arrives in building [exits building after 11 minutes]" The facility's investigation included the following staff interviews completed on 11/09/22: * CNA #3 - ". . . [CNA #3] went to [Resident #1's] room walkied [walkie talkie] for nurse as [Resident #1] was not responsive. [Nurse #1] told [CNA #3] that resident had passed after checking pulse. [Nurse #1] did not give any instructions to [CNA #3]. [CNA #3] called [Nurse #2] for assistance." * CNA #4 - "[CNA #3] and [CNA #4] were taking resident food trays to those Covid positive residents when [CNA #3] found [Resident #1] unresponsive. [CNA #3] called [Nurse #1] on the walkie to request assistance. [Nurse #1] came to resident room within two minutes. [Nurse #1] did not start compressions. [Nurse #1] told [CNA #4] to grab crash cart. Compressions were started as soon as [Nurse #2] arrived a few minutes later." * Nurse #1 - "[CNA #3] called [Nurse #1] in to [Resident #1's] room. [Nurse #1] responded to	F 678		

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request within two minutes. [CNA #3] said she thinks [Resident #1] had died. Before [Nurse #1] went in, asked [CNA #4] to get the [crash] cart. [Nurse #1] knew she was a full code. [Nurse #1] did not start compressions initially. [Nurse #1] called 911 as [Nurse #2] started compressions. [Nurse #2] did compressions, followed by [CNA #3] followed by [Nurse #1]. [Nurse #1] stated her mind froze when it came to doing CPR."

* Nurse #2 - "Responded to a call to room [Resident #1's room number]. When [Nurse #2] got to room, nurse on duty [Nurse #1] told [Nurse #2] this resident was a full code. [Nurse #2] initiated CPR and instructed [Nurse #1] to call 911. [Nurse #2 was assisted by [CNA #3] and [Nurse #1] with the code."

During an interview on 11/16/22 at 9:30 a.m., an administrative nurse (#6) stated Resident #1 tested positive for COVID-19 in the week prior to the incident, and the facility placed the resident and her room in an isolation bubble with plastic sheeting with a zipper opening over her door. Once the nurse (#1) donned personal protective equipment (PPE) and entered the room, she assessed Resident #1 and determined the resident lacked a pulse and respirations and her extremities felt cold. The administrative nurse (#6) stated the nurse (#1) froze and didn't know what to do immediately as she felt the resident had been expired for a while and CPR would be futile. During this time, the nurse (#1) actively sought and called on the walkie for help and the crash cart and activated the EMS protocol. Once the crash cart arrived, the nurse (#1) retrieved the ambu (artificial manual breathing unit) bag and got things ready to start CPR. The

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administrative nurse (#6) stated when the second nurse (#2) arrived, the nurse (#2) started CPR even though the nurse's (#2) initial assessment and impression was Resident #1 had been deceased for some time.

During an interview on 11/16/22 at 11:34 a.m., an administrative staff member (#5) verified the nurse (#1) checked Resident #1's pulse several times between 12:24 and 12:25 p.m. on 11/09/22, retrieved items from the crash cart outside the isolation wall, and called for the second nurse and EMS. Staff removed the barrier wall to take the crash cart inside Resident #1's room. The administrative staff member (#5) stated the second nurse (#2) stated during the investigation that starting CPR two or three minutes earlier would not have changed the outcome as the resident was already gone. She stated the nurse (#1) realized afterwards she should have started CPR immediately.

At 1:57 p.m., an administrative staff member (#5) stated the camera time stamp included a second hand and showed the nurse (#1) entered Resident #1's room at 12:24:59 p.m., peaked out of bubble to call for help at 12:27:14, and the other nurse (#2) entered and started CPR at 12:27:48 p.m.

Review of personnel records on 11/16/22 identified:
* All licensed nurses held current CPR certification, including Nurse #1.
* All staff completed annual advance directive education in the past year.
* All licensed nurses completed "Mock Code Education" between May and August 2022.

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F 678	Continued From page 7 * The administrator, CNAs, medication assistants, and activities assistants completed "Response to an Unconscious Person" between April and August 2022. * Nurse #1's orientation in 2021 included oxygen and supplies, code status, death & dying process, orientation to crash cart, AED, and how to reach EMS services. Based on the following information, non-compliance at F678 is considered past non-compliance. The facility implemented the corrective action for the resident affected by the deficient practice by: * Completing an investigation with interviews of staff who assisted Resident #1 during the incident on 11/16/22. * Determining the investigation showed Nurse #1 failed to follow the CPR policy which may have contributed to Resident #1's death. * Providing one-on-one education with Nurse #1 on the CPR policy immediately after the incident. The facility addressed measures put in place and implemented systemic changes to ensure the deficient practice does not recur by: * Providing all nurses with face-to-face education on the policy for Advance Directives/CPR following the incident on 11/09/22. * Continuing with evaluation of all code situations and/or conducting mock codes a minimum of twice yearly, a practice started in 2020. The facility provided additional training based on outcomes of the mock and real codes (one mock code and four actual codes in the past 12 months). The survey team determined a deficient practice	F 678		

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F 678	Continued From page 8 existed on 11/09/22. The facility implemented corrective action on 11/09/22 and completed nursing education on 11/11/22.	F 678		