Electronically delivered
May 15, 2020

Administrator
St Benedicts Senior Community
1810 Minnesota Boulevard Southeast
Saint Cloud, MN 56304

SUBJECT: SURVEY RESULTS
CCN: 245350
Cycle Start Date: April 30, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On April 30, 2020, the Minnesota Department of Health completed a complaint investigation at St Benedicts Senior Community to determine if your facility was in compliance with Federal requirements related to the complaint. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567. Because corrective actions were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the April 30, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are

disputing those deficiencies, and (4) supporting documentation by fax or email to:

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kathleen.lucas@state.mn.us
Fax: (320) 223-7348

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

St Benedicts Senior Community may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING _____ B. WING _____	C 04/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

(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 On 4/29/20 through 4/30/20, an abbreviated survey was completed at your facility by the Minnesota Department of Health (MDH). The facility was found not to be in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F678 began on 4/24/20, when resident (R1) had died. The facility failed to ensure timely cardiopulmonary resuscitation (CPR) was delivered upon identifying R1 had absent pulse and respirations. The administrator and director of nursing (DON) were notified of the IJ for R1 on 4/30/20, at 1:00 p.m. The facility corrected the IJ on 4/29/20 prior to surveyors entering, and F678 is being issued at past non-compliance. In addition, an extended survey was completed 4/30/20, related to the substandard quality of care findings. The following complaints were found to be substantiated: H5450101C was substantiated at F678. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the correction. Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents.	F 000		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3)	F 678		5/22/20

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

Electronically Signed | 05/22/2020

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F 678	Continued From page 1 §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 interview and document review, the facility failed to initiate timely cardio-pulmonary resuscitation (CPR) in accordance with resident wishes and physician orders for 1 of 3 residents (R1) reviewed for CPR. This deficient practice resulted in an immediate jeopardy (IJ) when R1 was found with absent pulse and respirations, timely CPR was not initiated, and R1 died. The IJ began on 4/24/20, when R1 was found with an absent pulse and respirations, timely CPR was not initiated, and R1 died. The administrator and director of nursing (DON) were made aware of the incident on 4/24/20, and immediately initiated corrective actions. The administrator and director of nursing (DON) were notified of the IJ on 4/30/20, at 1:00 p.m. The facility implemented corrective action on 4/29/20, prior to the onsite investigation, and the deficiency is being issued at past non-compliance. Findings include: R1's Admission Record printed 4/30/20, indicated R1's diagnoses included compromised pulmonary function, diabetes, blindness, chronic kidney disease, and traumatic brain injury.	F 678	Past noncompliance: no plan of correction required.	

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F 678	Continued From page 2	F 678		

R1's admission Care Area Assessment (CAA) dated 3/29/20, indicated R1 had moderately impaired cognition.

R1's Advance Directive Consent Form dated 3/23/20, directed staff to perform CPR if R1 went into cardiac arrest or respiratory arrest. The document was signed by R1.

The Facility Investigation of alleged neglect dated 4/24/20, indicated registered nurse (RN)-B found R1 with no pulse, no breathing, and eyes open with no response. RN-B notified licensed practical nurse (LPN)-A and RN-A of R1's passing. RN-A asked if RN-B had checked R1's code status. RN-B revealed she had not checked R1's code status. R1's code status was confirmed as full code. CPR was then initiated. The medical director was notified and an order to discontinue efforts and call the time of death was received. Although CPR was initiated, there was a delay of approximately eight minutes. The facility interviewed staff regarding the incident. RN-B was interviewed and placed on suspension for the investigation. The facility initiated education for all staff regarding the Code Blue Response.

During interview on 4/29/20, at 1:38 p.m RN-A was interviewed regarding R1's passing and stated at approximately 9:30 a.m. on 4/24/20, RN-B came to RN-A and stated R1 had passed away. RN-A asked what R1's code status was and RN-B did not know what R1's code status was. RN-A and RN-B went to the area where the paper charts were and found R1 was a full code (will allow all interventions needed to get their heart started). The physician was on speaker

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F 678	Continued From page 3	F 678		

phone with LPN-A doing a telehealth rounding session and the physician directed to do ten compressions for R1 and check for a pulse, and if no response do not continue. RN-A stated about 9:45 a.m. they went to R1's room and performed ten compressions, R1 had no pulse, and efforts were halted. RN-A stated there was no code blue (an emergency situation announced in an institution in which a patient is in cardiopulmonary arrest, requiring a team of providers to rush to the specific location and begin immediate resuscitative efforts) called for R1. RN-A stated RN-B was taken off the floor, talked to by the director of nursing (DON), and has not been back to the unit. RN-A stated the facility started asking staff what they would do if they found an unresponsive person on 4/24/20. RN-A stated staff from the day shift received education and as the evening shift came in to work they received education on what to do when you would find an unresponsive person in the facility. RN-A stated you check the resident's code status in the paper chart or have someone look for you. RN-A stated staff had to sign a sheet that indicated they had read the policy and what the expectation of the facility was for an unresponsive person.

During interview on 4/29/20, at 3:20 p.m. nursing assistant (NA)-A was interviewed regarding the passing of R1. NA-A stated that morning R1 was up for breakfast at 8:00 a.m. in the dining room. R1 ate breakfast and did not mention any discomfort. NA-A stated R1 was assisted to bed after breakfast, about 9:00 a.m. NA-A further stated later in the morning, unsure of the time, RN-B called over the walkie talkie that help was needed in R1's room. NA-A stated R1 was laying

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F 678	Continued From page 4 on right side with a pillow behind the back. NA-A stated RN-B thought R1 had passed away. RN-B went to get the vital machine and there was no blood pressure, no oximetry (measure the oxygen level of the blood). NA-A stated R1 was grayish in color. NA-A stated NA-A went to get RN-A and RN-A was on a telephone conference. RN-B went to get someone else. NA-A never went back into R1's room until R1 was prepared for viewing by the family. On 4/29/20, at 3:59 p.m. the DON was interviewed and stated RN-A had come to see her after she had a missed call from RN-A. The DON went on to state that RN-A told her there was a problem, that R1 had coded, was a full code and CPR was not immediately initiated. The DON stated the administrator was also informed of the incident at this time. The DON stated they started the investigation immediately, obtained written statements from those involved, and that following interview and obtaining a written statement, RN-B was suspended. The DON stated they had initiated "whole house" education on how to response to an unresponsive resident, what they would do when a resident is found unresponsive, and what the expectation is. The DON stated staff working during the day shift on 4/24/20, were asked to read and sign they understood the facility process for a resident that is found unresponsive that included the following, to call for assistance and have someone check the code status for the resident and if a full code, staff would call a code blue and proceed with CPR. If the resident was DNR (do not resuscitate) then staff were to follow the process of expiration. The DON stated a code blue is called to get more staff to the	F 678		

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F 678	Continued From page 5	F 678		

location quickly and for assistance. The DON stated the evening shift on 4/24/20, was educated on this same process as they came in to work and the rest of the staff continued to be educated when they came for their shift. The DON stated this education was completed by the nurse managers on the unit when the staff entered the facility. The DON stated, on the day of the incident, a code blue was not called for R1 and CPR should have been initiated.

On 4/29/20, at 4:10 p.m. LPN-A was interviewed and stated on the day of the incident of 4/24/20, she was talking with the physician when RN-B came into the area and stated R1 was cool to the touch and had passed away. RN-B left the area to find RN-A. Then RN-A and RN-B came to the area and checked on R1's code status. R1's code status was listed as full code. LPN-A stated the physician told them to try CPR. LPN-A was not sure of the exact time. When asked about what she would do if a resident was found unresponsive, LPN-A stated it does not matter if the resident is cold you do CPR until called (time of death) by the physician. LPN-A stated our policy indicates if unresponsive, check the paper chart for code status, if full code, call code blue and start CPR. LPN-A stated others could call 911 while CPR compressions are started until emergency management system (EMS) would come and take over the compressions.

During a telephone interview on 4/30/20, at 10:18 a.m. RN-B stated on 4/24/20, the day of the incident, RN-B entered R1's room at 9:35 a.m. to administer medication. R1 was in bed. RN-B stated R1 did not respond to the greeting from RN-B, that R1's eyes were open, no blinking, and

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F 678	Continued From page 6	F 678		

R1's color was gray. RN-B stated the covers were lowered and RN-B placed a hand on R1's chest to see if R1 was breathing and checked R1's right wrist for a pulse. R1's finger tips were a blue, purple color, and that R1's hands and arms were cool to the touch. RN-B stated she called over the walkie talkie for a NA to assist. RN-B went to get the vital machine and did a blood pressure (BP) on the right upper arm and there was no reading obtained. RN-B stated at 9:38 a.m. she went to RN-A's office and they were in a meeting and then talked to LPN-A about what the process was for residents that passed away. At 9:40 a.m. RN-A came out of the office and RN-B stated R1 had passed away. RN-A had asked what R1's code status was. RN-B stated that R1's code status was not checked and they both proceeded to the paper chart where R1 was determined to be a full code. The physician was on the phone and could hear the conversation and told them to do ten chest compressions and check for a pulse and if there was no pulse, to call it. RN-B stated this direction was followed and the time RN-B was 9:42 a.m. RN-B stated following R1's death, she had not done any charting of the incident. RN-B had not called a code blue for R1. RN-B stated, "I did not check [R1's] code status and I do not know why I did not check code status." RN-B stated RN-B had CPR certification and was current. RN-B stated she assumed R1 was a DNR/DNI (do not resuscitate/intubate). RN-B stated she was sent home while the investigation was pending.

On 4/30/20, at 11:33 a.m. family member (FM)-A was interviewed and stated R1 was treated well and had no concerns that were shared about the facility. FM-A stated the facility called and stated

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F 678	Continued From page 7 R1 was found by the nurse and had passed away. FM-A stated the facility did not help R1 and that is why he passed away. The facility implemented corrective action to prevent recurrence by 4/29/20. On 4/24/20, the facility started to educate all licensed nursing staff and unlicensed staff on the Code Blue Response for finding a resident unresponsive. Staff are to immediately check the resident's code status in the paper chart. If DNR, (do not resuscitate) no further action is required. If full code, immediately initiate CPR. 95% of staff were trained prior to survey on 4/29/20, with a plan in place to retrain the remaining staff prior to working. In addition, staff were interviewed and were able to correctly verbalize understanding of the established CPR policy and procedure. The facility policy Code Blue Response, undated, indicated if a resident is witnessed to become unresponsive or is found unresponsive and is without a pulse or respiration, you must immediately call for assistance and check the paper chart to confirm the resident's code status preference. If the resident code status is indicated Do Not Resuscitate (DNR) no further intervention is required. If the resident has indicated a wish for Resuscitate/full code immediately initiate CPR.	F 678		

Electronically delivered
May 15, 2020

Administrator
St Benedicts Senior Community
1810 Minnesota Boulevard Southeast
Saint Cloud, MN 56304

Re: State Nursing Home Licensing Orders
Event ID: TET611

Dear Administrator:

The above facility was surveyed on April 29, 2020 through April 30, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health

Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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	00774	A. BUILDING: _____ B. WING _____	C 04/30/2020

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/29/20, through 4/30/20, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first	2 000		

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2 000	Continued From page 1 page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make	21830		4/30/20

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reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and

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21830	Continued From page 3 the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to initiate timely cardio-pulmonary resuscitation (CPR) in accordance with resident wishes and physician orders for 1 of 3 residents (R1) reviewed for CPR. This deficient practice resulted in an immediate jeopardy (IJ) when R1 was found with absent pulse and respirations, timely CPR was not initiated, and R1 died. The IJ began on 4/24/20, when R1 was found with an absent pulse and respirations, timely CPR was not initiated, and R1 died. The administrator and director of nursing (DON) were made aware of the incident on 4/24/20, and immediately initiated corrective actions. The administrator and director of nursing (DON) were notified of the IJ on 4/30/20, at 1:00 p.m. The facility implemented corrective action on 4/29/20, prior to the onsite investigation, and the deficiency is being issued at past non-compliance.	21830	Corrected.	

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21830	Continued From page 4 Findings include: R1's Admission Record printed 4/30/20, indicated R1's diagnoses included compromised pulmonary function, diabetes, blindness, chronic kidney disease, and traumatic brain injury. R1's admission Care Area Assessment (CAA) dated 3/29/20, indicated R1 had moderately impaired cognition. R1's Advance Directive Consent Form dated 3/23/20, directed staff to perform CPR if R1 went into cardiac arrest or respiratory arrest. The document was signed by R1. The Facility Investigation of alleged neglect dated 4/24/20, indicated registered nurse (RN)-B found R1 with no pulse, no breathing, and eyes open with no response. RN-B notified licensed practical nurse (LPN)-A and RN-A of R1's passing. RN-A asked if RN-B had checked R1's code status. RN-B revealed she had not checked R1's code status. R1's code status was confirmed as full code. CPR was then initiated. The medical director was notified and an order to discontinue efforts and call the time of death was received. Although CPR was initiated, there was a delay of approximately eight minutes. The facility interviewed staff regarding the incident. RN-B was interviewed and placed on suspension for the investigation. The facility initiated education for all staff regarding the Code Blue Response. During interview on 4/29/20, at 1:38 p.m RN-A was interviewed regarding R1's passing and stated at approximately 9:30 a.m. on 4/24/20,	21830		

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21830	Continued From page 5 RN-B came to RN-A and stated R1 had passed away. RN-A asked what R1's code status was and RN-B did not know what R1's code status was. RN-A and RN-B went to the area where the paper charts were and found R1 was a full code (will allow all interventions needed to get their heart started). The physician was on speaker phone with LPN-A doing a telehealth rounding session and the physician directed to do ten compressions for R1 and check for a pulse, and if no response do not continue. RN-A stated about 9:45 a.m. they went to R1's room and performed ten compressions, R1 had no pulse, and efforts were halted. RN-A stated there was no code blue (an emergency situation announced in an institution in which a patient is in cardiopulmonary arrest, requiring a team of providers to rush to the specific location and begin immediate resuscitative efforts) called for R1. RN-A stated RN-B was taken off the floor, talked to by the director of nursing (DON), and has not been back to the unit. RN-A stated the facility started asking staff what they would do if they found an unresponsive person on 4/24/20. RN-A stated staff from the day shift received education and as the evening shift came in to work they received education on what to do when you would find an unresponsive person in the facility. RN-A stated you check the resident's code status in the paper chart or have someone look for you. RN-A stated staff had to sign a sheet that indicated they had read the policy and what the expectation of the facility was for an unresponsive person. During interview on 4/29/20, at 3:20 p.m. nursing assistant (NA)-A was interviewed regarding the passing of R1. NA-A stated that morning R1 was up for breakfast at 8:00 a.m. in the dining room.	21830		

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21830	Continued From page 6 R1 ate breakfast and did not mention any discomfort. NA-A stated R1 was assisted to bed after breakfast, about 9:00 a.m. NA-A further stated later in the morning, unsure of the time, RN-B called over the walkie talkie that help was needed in R1's room. NA-A stated R1 was laying on right side with a pillow behind the back. NA-A stated RN-B thought R1 had passed away. RN-B went to get the vital machine and there was no blood pressure, no oximetry (measure the oxygen level of the blood). NA-A stated R1 was grayish in color. NA-A stated NA-A went to get RN-A and RN-A was on a telephone conference. RN-B went to get someone else. NA-A never went back into R1's room until R1 was prepared for viewing by the family. On 4/29/20, at 3:59 p.m. the DON was interviewed and stated RN-A had come to see her after she had a missed call from RN-A. The DON went on to state that RN-A told her there was a problem, that R1 had coded, was a full code and CPR was not immediately initiated. The DON stated the administrator was also informed of the incident at this time. The DON stated they started the investigation immediately, obtained written statements from those involved, and that following interview and obtaining a written statement, RN-B was suspended. The DON stated they had initiated "whole house" education on how to response to an unresponsive resident, what they would do when a resident is found unresponsive, and what the expectation is. The DON stated staff working during the day shift on 4/24/20, were asked to read and sign they understood the facility process for a resident that is found unresponsive that included the following, to call for assistance and have someone check the code status for the	21830		

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resident and if a full code, staff would call a code blue and proceed with CPR. If the resident was DNR (do not resuscitate) then staff were to follow the process of expiration. The DON stated a code blue is called to get more staff to the location quickly and for assistance. The DON stated the evening shift on 4/24/20, was educated on this same process as they came in to work and the rest of the staff continued to be educated when they came for their shift. The DON stated this education was completed by the nurse managers on the unit when the staff entered the facility. The DON stated, on the day of the incident, a code blue was not called for R1 and CPR should have been initiated.

On 4/29/20, at 4:10 p.m. LPN-A was interviewed and stated on the day of the incident of 4/24/20, she was talking with the physician when RN-B came into the area and stated R1 was cool to the touch and had passed away. RN-B left the area to find RN-A. Then RN-A and RN-B came to the area and checked on R1's code status. R1's code status was listed as full code. LPN-A stated the physician told them to try CPR. LPN-A was not sure of the exact time. When asked about what she would do if a resident was found unresponsive, LPN-A stated it does not matter if the resident is cold you do CPR until called (time of death) by the physician. LPN-A stated our policy indicates if unresponsive, check the paper chart for code status, if full code, call code blue and start CPR. LPN-A stated others could call 911 while CPR compressions are started until emergency management system (EMS) would come and take over the compressions.

During a telephone interview on 4/30/20, at 10:18 a.m. RN-B stated on 4/24/20, the day of the

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incident, RN-B entered R1's room at 9:35 a.m. to administer medication. R1 was in bed. RN-B stated R1 did not respond to the greeting from RN-B, that R1's eyes were open, no blinking, and R1's color was gray. RN-B stated the covers were lowered and RN-B placed a hand on R1's chest to see if R1 was breathing and checked R1's right wrist for a pulse. R1's finger tips were a blue, purple color, and that R1's hands and arms were cool to the touch. RN-B stated she called over the walkie talkie for a NA to assist. RN-B went to get the vital machine and did a blood pressure (BP) on the right upper arm and there was no reading obtained. RN-B stated at 9:38 a.m. she went to RN-A's office and they were in a meeting and then talked to LPN-A about what the process was for residents that passed away. At 9:40 a.m. RN-A came out of the office and RN-B stated R1 had passed away. RN-A had asked what R1's code status was. RN-B stated that R1's code status was not checked and they both proceeded to the paper chart where R1 was determined to be a full code. The physician was on the phone and could hear the conversation and told them to do ten chest compressions and check for a pulse and if there was no pulse, to call it. RN-B stated this direction was followed and the time RN-B was 9:42 a.m. RN-B stated following R1's death, she had not done any charting of the incident. RN-B had not called a code blue for R1. RN-B stated, "I did not check [R1's] code status and I do not know why I did not check code status." RN-B stated RN-B had CPR certification and was current. RN-B stated she assumed R1 was a DNR/DNI (do not resuscitate/intubate). RN-B stated she was sent home while the investigation was pending.

On 4/30/20, at 11:33 a.m. family member (FM)-A

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21830	Continued From page 9 was interviewed and stated R1 was treated well and had no concerns that were shared about the facility. FM-A stated the facility called and stated R1 was found by the nurse and had passed away. FM-A stated the facility did not help R1 and that is why he passed away. The facility implemented corrective action to prevent recurrence by 4/29/20. On 4/24/20, the facility started to educate all licensed nursing staff and unlicensed staff on the Code Blue Response for finding a resident unresponsive. Staff are to immediately check the resident's code status in the paper chart. If DNR, (do not resuscitate) no further action is required. If full code, immediately initiate CPR. 95% of staff were trained prior to survey on 4/29/20, with a plan in place to retrain the remaining staff prior to working. In addition, staff were interviewed and were able to correctly verbalize understanding of the established CPR policy and procedure. The facility policy Code Blue Response, undated, indicated if a resident is witnessed to become unresponsive or is found unresponsive and is without a pulse or respiration, you must immediately call for assistance and check the paper chart to confirm the resident's code status preference. If the resident code status is indicated Do Not Resuscitate (DNR) no further intervention is required. If the resident has indicated a wish for Resuscitate/full code immediately initiate CPR.	21830		