Electronically Submitted
July 22, 2019

Administrator
Johnson Memorial Hospital & Home
1290 Locust Street
Dawson, MN 56232

RE: Project Number H5485006

Dear Administrator:

On July 1, 2019, an extended survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted past non-complaince, immediate jeopardy (Level J). The Statement of Deficiencies (CMS-2567) is being electronically delivered. Past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On June 25, 2019, the situation of immediate jeopardy to potential health and safety cited at F678 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department is recommending the following enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty. (42 CFR 488.430 through 488.444).

If the Centers for Medicare and Medicaid Services (CMS) decides to impose this recommended remedy they will send you a notice of imposition of the remedy and appeal rights.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits

approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 1, 2019. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Johnson Memorial Hosp & Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 1, 2019. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing

request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245485	A. BUILDING _____ B. WING _____	C 07/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MEMORIAL HOSP & HOME	1290 LOCUST STREET DAWSON, MN 56232

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F 000	INITIAL COMMENTS On 6/28/19 through 7/1/19, an abbreviated survey to review complaint H5485006C, was completed by a surveyor from the Minnesota Department of Health (MDH) to determine compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. Complaint H5485006C was substantiated with a deficiency issued at past non-compliance Immediate Jeopardy (IJ) identified at F678. The IJ began on 6/1/19 when the facility failed to ensure a resident's request for cardio-pulmonary resuscitation (CPR) was immediately implemented. The immediate jeopardy was removed on 6/25/19 when the facility had implemented appropriate corrective action to prevent the situation from recurring. In addition, an extended survey was completed on 6/28 - 7/1/19 as a result of the past non-compliance IJ identified at F678. While the facility receives a CMS 2567 documenting the findings, past non-compliance does not require a plan of correction.	F 000		
F 678 SS=J	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:	F 678		7/30/19

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

Electronically Signed | 07/30/2019

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F 678	Continued From page 1 Based on interview and document review, the facility failed to implement their policy to initiate cardio-pulmonary resuscitation (CPR) for 1 of 16 residents (R1) who had requested to be a full code status, meaning the resident wanted life-saving interventions implemented. The deficiency was identified as past non compliance and issued at Immediate Jeopardy (IJ). The IJ began on 6/1/19, when the facility failed to provide CPR for R1 after R1 became unresponsive during care and her heart stopped. However, the facility had implemented corrective action to prevent recurrence by 6/25/18. The facility had conducted a root cause analysis with the resident's physician, corrective action was proivded to the licensed nurse involved, each resident's chart was reviewed to verify code status. In addition, facility policies had been reviewed for adequacy. Staff education had also been implemented to ensure each shift of staff understood the facility's policies, and drills were established for staff to verify appropriate response. Findings include: The American Heart Association's 2015 guidelines for cardio-pulmonary resuscitation indicated while the general rule is to provide emergency treatment to a victim of cardiac arrest (lack of pulse), there were a few exceptions where withholding CPR would be considered appropriate: -Situations where attempts to perform CPR would place the rescuer at risk of serious injury or mortal peril. -"Obvious clinical signs of irreversible death (e.g., rigor mortis [stiffening of muscles], dependent	F 678	Past noncompliance: no plan of correction required.	

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lividity [pooling of blood in the lowest lying part of the body due to gravity], decapitation [separation of the head from the body], transection [cut across body causing body separation], decomposition [decay of the body]."
-a valid advanced directive, Provider Orders for Life-Sustaining Treatment (POLST), or order indicating do not attempt resuscitation

R1's admission Minimum Data Set (MDS) assessment dated 5/2/19 indicated R1 had no cognitive impairment, required extensive assistance with activities of daily living (ADLs), and received physical therapy to help regain strength and mobility. R1's discharge goal was identified to return to an independent living center.

R1's diagnoses included in the initial MDS assessment, and 5/2/19 Face Sheet included: Closed fracture of left fibula, subsequent encounter for routine healing, hyperlipidemia, major depressive disorder, anxiety disorder, an inner ear disease causing dizziness, high blood pressure, and other chronic blood clots in her lower limbs.

R1's 5/2/19, physician orders identified R1 was a "Full Code (CPR)".

Review of R1's 5/2/19, POLST (physician orders for life sustaining treatment) identified R1 wished to have CPR. "Follow these orders until order changes. These medical orders are based on the patient's current medical condition and preferences..." The POLST was signed by R1 and her primary physician 5/2/19.

Review of R1's progress notes dated 6/1/19,

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F 678	Continued From page 3 included (1) Shortly before 4:00 a.m., nursing assistant (NA)- A answered R1's call light. R1 was assisted to the bathroom. While voiding, her speech became garbled. NA-A identified R1's speech returned to normal moments later. R1 then stood up and walked towards her bed and stated, "I am so sorry". R1 became limp and NA-A lowered her to the floor. NA-A called for help. When licensed practical nurse (LPN)-A arrived R1's lips were blue and she was foaming at the mouth, was totally limp and unresponsive. R1 was not breathing and had no pulse. (2) No activation of the emergency medical services (EMS) was initiated, and no resuscitative measures were attempted. R1 was pronounced dead at 4:05 a.m. when an unidentified RN, who was working at the adjacent hospital, came from the hospital and verified R1 was pulseless and without breath. (3) Family, the director of nursing (DON) and the physician on call were notified and R1's body was released to the funeral home. Family member (FM)-B was interviewed on 6/27/19, at 1:33 p.m. with regard to the incident on 6/1/19, at 4:00 a.m.. She indicated she had received a telephone call at 4:40 a.m. from FM-A of the death of R1. FM-B denied any knowledge of R1 having any history of cardiac issues. At the time of admission to the facility she was having some shortness of breath, (SOB) but her physician felt it was due to her anxiety. R1 was not having difficulty with her health and was progressing with her therapies and gaining strength. R1 made her wishes previously known to family, and advised them she hade wanted CPR in an emergency. FM-B had arrived at the facility that a.m., shortly after R1 passed away.	F 678		

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LPN-A entered R1's room stating she was sorry for their loss, revealing "We did not perform CPR on [R1]... we didn't even attempt it". In addition, FM-B stated an unknown resident, who knew R1 well, had reported to FM-B he had visited with R1 the night before and she was doing very well. FM-B also said the resident had told FM-B, he had been awake when the incident occurred and had seen NA-A walking with R1 from the bathroom. He reported R1 fell to the floor with her back against the bed and had heard staff say, "She is coding". FM-B said the resident had told FM-B he saw no CPR performed.

RN-A was interviewed on 6/27/19, at 2:55 p.m. and stated she works primarily evenings and nights with the usual staffing pattern consisting of 1 licensed charge nurse for the building and four NAs. RN-A stated she was aware of R1's CPR status. A resident's CPR status is able to be identified by the listing at the top of the resident profile, and outside every resident door based on the sticker beside each resident's nameplate. RN-A stated she was not aware there was a POLST' placed in the closet in each individual resident's room.

RN-B was interviewed on 6/27/19, at 3:11 p.m. and stated she attended monthly care conferences. RN-B stated Advance Directives/POLST documentation was reviewed at every care conference to ensure it remained accurate. RN-B stated in the circumstance where a resident is not cognitively able to voice choices with regard to resuscitative measures, the paperwork is sent to the responsible party for review and signature. Upon receipt, CPR status was documented in the electronic medical record (EMR), resident profile, and on the outside of the

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room nameplate via a red or green colored sticker. In an emergency, staff would quickly check the name plate on the door frame, or the computer if it was close to the room. In addition, RN-B verified only licensed staff were certified in CPR.

NA-C and NA-D were interviewed on 6/27/19, at 3:32 p.m. and confirmed they were not certified in CPR at the facility, but that only licensed nursing staff were certified. They stated, if a resident became unresponsive they would immediately notify the nurse and stay with the patient until the licensed staff arrived. Both NAs stated residents' "code" status is listed in the Kardex which is available via the communication phones that staff carry. The NAs stated they could also ask the nurse what the resident's status was and in the instance of a new resident, or a change, it would be communicated verbally at the time of shift report.

LPN-B was interviewed on 6/27/19, at 3:40 p.m. and verified she primarily worked charge for 12 hour day shifts. LPN-B said if a resident became unresponsive, she would lower to the floor, check for breathing, initiate CPR based on assessment and code status, and activate EMS. If the resident had a no code status (DNR/DNI) she would assess the patient, notify the MD, family and determine their wishes. When asked how she would determine a resident's code status, LPN-B stated a colored "Star" are located on door and green= CPR and Red = No CPR. In addition they also include code status on PCC profile and in paper chart. LPN-B said she would first check the identified sticker on the door in an emergency. The POLST is competed with admission and the code status is also in the physician's orders.

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The director of nursing (DON) was interviewed on 6/27/19, at 3:54 p.m. and verified only licensed staff were certified for CPR and use of the AED (automated external defibrillator) located in the main entrance/lobby of the facility. The DON verified signage on use of the device is clearly posted on the wall beside the AED. Her expectation was staff were to follow facility policies and procedures in the event of an emergency. In the instance of the absence of breathing and pulse, if the resident was listed as wanting CPR, staff would activate the EMS system and initiate CPR. In addition the occurrence of an incident requiring activation of the EMS should have had an incident report completed and submitted according to facility policy.

FM-A was interviewed on 6/27/19, at 7:44 p.m.. FM-A indicated R1 had been admitted for strengthening and mobility following a leg fracture. FM-A said prior to her leg fracture, R1 lived in a home setting and was independent with her activities of daily living. FM-A stated R1 had progressed from requiring 1 person standby assist for ambulation, and had graduated with therapies to the ability to be independent in her room and standby assist for ambulation in the hall, was alert and oriented, able to make her own decisions and directed her care. FM-A said R1's goal was to be discharged back to her residence within the month of June. FM-A said she had received a telephone call on 6/1/19, at 4:39 a.m. from LPN-A who informed her R1 had been assisted to the bathroom by a NA and had started speaking incoherently, but her garbled speech resolved quickly and staff escorted R2 back to bed. LPN-A advised FM-A they had lowered R1

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to the floor. R1's lips turned blue and she was dead. FM-A stated LPN-A had offered condolences and told her the DON had been notified.

FM-A further reported that family members had gone to the facility on 6/3/19 to collect R1's belongings. FM-A was shown a document that FM-C had retrieved from the closet door. That document was a "POLST" which indicated R1 wanted CPR-and/or full medical treatment. FM-A said she had not been informed that CPR hadn't been initiated. FM-A said she'd returned to the facility on 6/10/19, where she was approached by LPN-A who had said she was sorry. LPN-A confirmed to FM-A, R1's lips turned blue. FM-A said LPN-A had told her she hadn't initiated CPR because she didn't feel it would do any good. FM-A knew her mother wanted CPR and asked LPN-A if that had changed. LPN-A replied. LPN-A reported to FM-A, R1 was in fact still CPR status but it wouldn't have saved her in LPN-A's opinion.

FM-A stated on 6/17/19, at approximately 11:00 a.m. she had requested a meeting with the DON to discuss questions she had related to R1's death. FM-A proceeded to repeat the information LPN-B had told her on 6/10/19, with regard to the sequence of events which had taken place on 6/1/19. FM-A stated she told the DON, LPN-A told her she had not initiated CPR because she hadn't felt it would do any good. FM-A stated she had then asked if the DON if she had been aware of the rational that LPN-A stated as the reason for not initiating resuscitative measures for R1, to which the DON replied, yes. FM-A said she had then asked why no one had said anything to her or anyone in the family about this. FM-A said the

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DON had told her the medical director (MD) had reviewed R1's medical record following the incident. Per FM-A's request a meeting was arranged for 6/19/19, at 12:00 noon. At the time of the meeting, FM-A said she'd requested FM-C be included in the meeting via telephone. FM-A reported FM-C had asked why CPR was not administered and the medical director had replied he was sorry, and stated "maybe the nurse froze". FM-A said the MD also reported having reviewed R1's medical record, and had reported R1 had experienced previous episodes of unresponsiveness while at the nursing home. MD then asked if either FM was aware of R1 having any of these (syncopal) episodes while at home, to which both FM-A and FM-C had responded their mom would get dizzy, but they had no recollection of any spells of unresponsiveness.

LPN-A was interviewed on 6/28/19, at 10:37 a.m. and verified she had worked at the faciltiy 5 years on the over night shift. LPN-A said she had a current CPR certification which included use of the AED, but she had not ever had to perform CPR or attempt to utilize the AED. LPN-A then described the location of the AED in the main lobby area which included directions on the use of the device posted on the wall beside the unit. LPN-A was asked to review the sequence of events with regard to R1. On the night of 6/1/19:
(1) Staffing on the night of 6/1/19 was herself as the charge nurse and 2 NAs.
2.) Around 4:00 a.m. she was toileting another resident when she received a text from NA-A that R1 was on the floor. She messaged the NA back she would come when finished toileting the resident she was with. There was no sense of urgency in the text message she received.
3.) LPN-A proceeded to R1's room and observed

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R1 lying on the floor on her left side with a pillow beneath her head. NA-A and NA-B were standing in the room looking at R1. LPN-A stated the NAs thought R1 was having a "behavioral episode".
4.) LPN-A stated she'd bent over R1 and attempted a sternal rub, to which R1 usually responded by regaining orientation with her past history of syncopal episodes at the facility. R1 opened her eyes and was breathing through her mouth. R1 was not verbally responsive and her skin color was pale. LPN-A noted R1 had some foam around her mouth.
5.) LPN-A attempted to sit R1 upright, and her head fell forward and she had no muscle tone. LPN-A looked at the 2 NA's and stated, "she's dead".
6.) LPN-A checked for a heart rate and didn't find a pulse, so she went to retrieve a stethoscope and contacted the RN on duty at the hospital. LPN-A failed to begin CPR as outlined in the policy. She returned to R1's room, listened for a heart beat, and did not find one.
7.) The hospital RN was called. When she arrived, she verified there were no signs of life for R1.
8.) LPN-A began the appropriate notifications to family, physician and management.
Further interview with LPN-A identified she was aware of R1's code status, but stated it had been approximately 4-5 minutes from the time she was notified via text message to the time she arrived at R1's side. When asked why she hadn't initiated CPR or initiated EMS when R1 had a full code status, LPN-A stated "she was gone too long". LPN-A was aware of the faciltiy policy which included the signs of irreversible death which included rigor mortis and coldness. She confirmed neither of these conditions were present when she'd arrived at R1's bedside.

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NA-B was interviewed on 6/28/19, at 12:11 p.m. and indicated she had been employed since October 2018, and commonly worked the night shift. NA-B had been on duty the night of 6/1/19 and was assisting a resident in a different room when she received a page that help was needed in R1's room. Upon her arrival at R1's room, she observed R1 on the floor and NA-A was telling her to get up. There was no response from R1. She had foam around her mouth. NA-B instructed NA-A to call the nurse and had proceeded to turn R1 onto her side to assist with opening her airway. LPN-A responded to the room, and turned R1 onto her back, LPN-A was rubbing R1's sternal area NA-B had been advised to call the adjoining hospital and "get a nurse over here". NA-B said LPN-A left the room and went to call the hospital nurse. NA-A and NA-B were left in attendance with R1 and no resuscitative measures were implemented as only licensed staff were allowed to perform CPR. NA-B stated the hospital RN responded, assessed R1 and stated she "was gone." NA-B stated she was not currently certified in CPR, but had asked NA-A what R1's code status was. NA-A responded she was unaware. NA-B instructed NA-A to go look on the door. NA-A did and reported to NA-B CPR was indicated. LPN-A then entered the room, looked at R1 lying on the floor and commented she is a "full code". Neither the EMS or CPR were initiated following R1's emergency by any staff.

The facility Administrator was interviewed on 6/28/19, at 12:45 p.m.. She indicated she had been notified of R1's death via text at 9:54 a.m. by the DON. R1 was to have been a full code. On 6/3/19 she received a phone call with a follow up email notifying her of a plan for a family meeting.

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The administrator stated her expectation was that care and services would be provided according to the facility policies and standards of nursing practice. The EMS system should have been activated at the time of the incident. Following discussion with the DON it was decided the incident should be reported. The incident which occurred on 6/1/19, was first reported to the State Agency 6/24/19.

The medical director (MD) was interviewed on 6/28/19 at 1:00 p.m,. and confirmed his expectation a resident whose POLST/Advance Directive indicated a "full code" status should receive necessary lifesaving treatment. MD stated following this incident, there had been discussion with staff, the best chance scenario would have been to initate CPR, and obtain and utilize the AED. The MD indicated without those measures, there would be no chance of survival. The MD was aware of some syncopal episodes fro R1, but there was nothing in her medical history that would indicate R1 was at risk for sudden death. He said he had not learned about the incident until the following day and it had been disappointing to hear. MD stated, "If CPR had been initiated, it would have been [R1's] best chance." He had told R1's family there was no excuse for what had happened. "It was a mistake, and we are doing our best to insure it never happens again."

Review of the facility's July 2018, CPR/CODE Status policy , the facility policy included: To 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 advanced directives. Further, the

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policy indicated the care center was to have at least one staff member on duty at all times, who is trained in single rescuer adult CPR and who has completed the initial training, or a refresher course, within the previous two years. The policy indicated CPR certification would be obtained through training that included hands-on practice and in-person skills assessment. "A staff member, properly trained in CPR, will be available immediately to provide basic life support to residents requiring emergency, prior to the arrival of EMS and subject to accepted professional guidelines, the resident's advance directives, and physician orders."

Review of the facility's professional guidelines from The American Heart Association (AHA)included: If a resident experiences a cardiac or respiratory arrest and the resident does not show obvious clinical signs of death (e.g. rigor mortis, dependent lividity, decapitation, transection, or decomposition), facility staff must provide basic life support, including CPR, prior to the arrival of EMS in accordance with the resident's advance directives and any related physician order, such as code status, or in the absence of advance directives or a DNR order.

The past non-compliance that began on 6/1/19, was verified during the 6/28-7/1/19 onsite visit to have been corrected by 6/25/19. Verification of corrective action was confirmed by interview with a variety of nursing staff, interview with the medical director, review of progress notes, and documentation of staff training. In addition, facility policies were reviewed and audits had been scheduled.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

July 22, 2019

Administrator
Johnson Memorial Hospital & Home
1290 Locust Street
Dawson, MN 56232

RE: Project Number H5485006C

Dear Administrator:

On July 1, 2019, an abbreviated standard survey was conducted to investigate complaint # at your facility by the Minnesota Department of Health, Office of Health Facility Complaints to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

The investigation resulted in no deficiencies being issued. Electronically attached is your copy of the Federal Form CMS-2567. 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. Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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F 000	INITIAL COMMENTS On 6/28/19 through 7/1/19, an abbreviated survey to review complaint H5485006C, was completed by a surveyor from the Minnesota Department of Health (MDH) to determine compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. Complaint H5485006C was substantiated with a deficiency issued at past non-compliance Immediate Jeopardy (IJ) identified at F678. The IJ began on 6/1/19 when the facility failed to ensure a resident's request for cardio-pulmonary resuscitation (CPR) was immediately implemented. The immediate jeopardy was removed on 6/25/19 when the facility had implemented appropriate corrective action to prevent the situation from recurring. In addition, an extended survey was completed on 6/28 - 7/1/19 as a result of the past non-compliance IJ identified at F678. While the facility receives a CMS 2567 documenting the findings, past non-compliance does not require a plan of correction.	F 000		
F 678 SS=J	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:	F 678		7/30/19

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

Electronically Signed | 07/30/2019

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F 678	Continued From page 1 Based on interview and document review, the facility failed to implement their policy to initiate cardio-pulmonary resuscitation (CPR) for 1 of 16 residents (R1) who had requested to be a full code status, meaning the resident wanted life-saving interventions implemented. The deficiency was identified as past non compliance and issued at Immediate Jeopardy (IJ). The IJ began on 6/1/19, when the facility failed to provide CPR for R1 after R1 became unresponsive during care and her heart stopped. However, the facility had implemented corrective action to prevent recurrence by 6/25/18. The facility had conducted a root cause analysis with the resident's physician, corrective action was proivded to the licensed nurse involved, each resident's chart was reviewed to verify code status. In addition, facility policies had been reviewed for adequacy. Staff education had also been implemented to ensure each shift of staff understood the facility's policies, and drills were established for staff to verify appropriate response. Findings include: The American Heart Association's 2015 guidelines for cardio-pulmonary resuscitation indicated while the general rule is to provide emergency treatment to a victim of cardiac arrest (lack of pulse), there were a few exceptions where withholding CPR would be considered appropriate: -Situations where attempts to perform CPR would place the rescuer at risk of serious injury or mortal peril. -"Obvious clinical signs of irreversible death (e.g., rigor mortis [stiffening of muscles], dependent	F 678	Past noncompliance: no plan of correction required.	

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lividity [pooling of blood in the lowest lying part of the body due to gravity], decapitation [separation of the head from the body], transection [cut across body causing body separation], decomposition [decay of the body]."
-a valid advanced directive, Provider Orders for Life-Sustaining Treatment (POLST), or order indicating do not attempt resuscitation

R1's admission Minimum Data Set (MDS) assessment dated 5/2/19 indicated R1 had no cognitive impairment, required extensive assistance with activities of daily living (ADLs), and received physical therapy to help regain strength and mobility. R1's discharge goal was identified to return to an independent living center.

R1's diagnoses included in the initial MDS assessment, and 5/2/19 Face Sheet included: Closed fracture of left fibula, subsequent encounter for routine healing, hyperlipidemia, major depressive disorder, anxiety disorder, an inner ear disease causing dizziness, high blood pressure, and other chronic blood clots in her lower limbs.

R1's 5/2/19, physician orders identified R1 was a "Full Code (CPR)".

Review of R1's 5/2/19, POLST (physician orders for life sustaining treatment) identified R1 wished to have CPR. "Follow these orders until order changes. These medical orders are based on the patient's current medical condition and preferences..." The POLST was signed by R1 and her primary physician 5/2/19.

Review of R1's progress notes dated 6/1/19,

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F 678	Continued From page 3 included (1) Shortly before 4:00 a.m., nursing assistant (NA)- A answered R1's call light. R1 was assisted to the bathroom. While voiding, her speech became garbled. NA-A identified R1's speech returned to normal moments later. R1 then stood up and walked towards her bed and stated, "I am so sorry". R1 became limp and NA-A lowered her to the floor. NA-A called for help. When licensed practical nurse (LPN)-A arrived R1's lips were blue and she was foaming at the mouth, was totally limp and unresponsive. R1 was not breathing and had no pulse. (2) No activation of the emergency medical services (EMS) was initiated, and no resuscitative measures were attempted. R1 was pronounced dead at 4:05 a.m. when an unidentified RN, who was working at the adjacent hospital, came from the hospital and verified R1 was pulseless and without breath. (3) Family, the director of nursing (DON) and the physician on call were notified and R1's body was released to the funeral home. Family member (FM)-B was interviewed on 6/27/19, at 1:33 p.m. with regard to the incident on 6/1/19, at 4:00 a.m.. She indicated she had received a telephone call at 4:40 a.m. from FM-A of the death of R1. FM-B denied any knowledge of R1 having any history of cardiac issues. At the time of admission to the facility she was having some shortness of breath, (SOB) but her physician felt it was due to her anxiety. R1 was not having difficulty with her health and was progressing with her therapies and gaining strength. R1 made her wishes previously known to family, and advised them she hade wanted CPR in an emergency. FM-B had arrived at the facility that a.m., shortly after R1 passed away.	F 678		

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LPN-A entered R1's room stating she was sorry for their loss, revealing "We did not perform CPR on [R1]... we didn't even attempt it". In addition, FM-B stated an unknown resident, who knew R1 well, had reported to FM-B he had visited with R1 the night before and she was doing very well. FM-B also said the resident had told FM-B, he had been awake when the incident occurred and had seen NA-A walking with R1 from the bathroom. He reported R1 fell to the floor with her back against the bed and had heard staff say, "She is coding". FM-B said the resident had told FM-B he saw no CPR performed.

RN-A was interviewed on 6/27/19, at 2:55 p.m. and stated she works primarily evenings and nights with the usual staffing pattern consisting of 1 licensed charge nurse for the building and four NAs. RN-A stated she was aware of R1's CPR status. A resident's CPR status is able to be identified by the listing at the top of the resident profile, and outside every resident door based on the sticker beside each resident's nameplate. RN-A stated she was not aware there was a POLST' placed in the closet in each individual resident's room.

RN-B was interviewed on 6/27/19, at 3:11 p.m. and stated she attended monthly care conferences. RN-B stated Advance Directives/POLST documentation was reviewed at every care conference to ensure it remained accurate. RN-B stated in the circumstance where a resident is not cognitively able to voice choices with regard to resuscitative measures, the paperwork is sent to the responsible party for review and signature. Upon receipt, CPR status was documented in the electronic medical record (EMR), resident profile, and on the outside of the

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room nameplate via a red or green colored sticker. In an emergency, staff would quickly check the name plate on the door frame, or the computer if it was close to the room. In addition, RN-B verified only licensed staff were certified in CPR.

NA-C and NA-D were interviewed on 6/27/19, at 3:32 p.m. and confirmed they were not certified in CPR at the facility, but that only licensed nursing staff were certified. They stated, if a resident became unresponsive they would immediately notify the nurse and stay with the patient until the licensed staff arrived. Both NAs stated residents' "code" status is listed in the Kardex which is available via the communication phones that staff carry. The NAs stated they could also ask the nurse what the resident's status was and in the instance of a new resident, or a change, it would be communicated verbally at the time of shift report.

LPN-B was interviewed on 6/27/19, at 3:40 p.m. and verified she primarily worked charge for 12 hour day shifts. LPN-B said if a resident became unresponsive, she would lower to the floor, check for breathing, initiate CPR based on assessment and code status, and activate EMS. If the resident had a no code status (DNR/DNI) she would assess the patient, notify the MD, family and determine their wishes. When asked how she would determine a resident's code status, LPN-B stated a colored "Star" are located on door and green= CPR and Red = No CPR. In addition they also include code status on PCC profile and in paper chart. LPN-B said she would first check the identified sticker on the door in an emergency. The POLST is competed with admission and the code status is also in the physician's orders.

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The director of nursing (DON) was interviewed on 6/27/19, at 3:54 p.m. and verified only licensed staff were certified for CPR and use of the AED (automated external defibrillator) located in the main entrance/lobby of the facility. The DON verified signage on use of the device is clearly posted on the wall beside the AED. Her expectation was staff were to follow facility policies and procedures in the event of an emergency. In the instance of the absence of breathing and pulse, if the resident was listed as wanting CPR, staff would activate the EMS system and initiate CPR. In addition the occurrence of an incident requiring activation of the EMS should have had an incident report completed and submitted according to facility policy.

FM-A was interviewed on 6/27/19, at 7:44 p.m.. FM-A indicated R1 had been admitted for strengthening and mobility following a leg fracture. FM-A said prior to her leg fracture, R1 lived in a home setting and was independent with her activities of daily living. FM-A stated R1 had progressed from requiring 1 person standby assist for ambulation, and had graduated with therapies to the ability to be independent in her room and standby assist for ambulation in the hall, was alert and oriented, able to make her own decisions and directed her care. FM-A said R1's goal was to be discharged back to her residence within the month of June. FM-A said she had received a telephone call on 6/1/19, at 4:39 a.m. from LPN-A who informed her R1 had been assisted to the bathroom by a NA and had started speaking incoherently, but her garbled speech resolved quickly and staff escorted R2 back to bed. LPN-A advised FM-A they had lowered R1

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to the floor. R1's lips turned blue and she was dead. FM-A stated LPN-A had offered condolences and told her the DON had been notified.

FM-A further reported that family members had gone to the facility on 6/3/19 to collect R1's belongings. FM-A was shown a document that FM-C had retrieved from the closet door. That document was a "POLST" which indicated R1 wanted CPR-and/or full medical treatment. FM-A said she had not been informed that CPR hadn't been initiated. FM-A said she'd returned to the facility on 6/10/19, where she was approached by LPN-A who had said she was sorry. LPN-A confirmed to FM-A, R1's lips turned blue. FM-A said LPN-A had told her she hadn't initiated CPR because she didn't feel it would do any good. FM-A knew her mother wanted CPR and asked LPN-A if that had changed. LPN-A replied. LPN-A reported to FM-A, R1 was in fact still CPR status but it wouldn't have saved her in LPN-A's opinion.

FM-A stated on 6/17/19, at approximately 11:00 a.m. she had requested a meeting with the DON to discuss questions she had related to R1's death. FM-A proceeded to repeat the information LPN-B had told her on 6/10/19, with regard to the sequence of events which had taken place on 6/1/19. FM-A stated she told the DON, LPN-A told her she had not initiated CPR because she hadn't felt it would do any good. FM-A stated she had then asked if the DON if she had been aware of the rational that LPN-A stated as the reason for not initiating resuscitative measures for R1, to which the DON replied, yes. FM-A said she had then asked why no one had said anything to her or anyone in the family about this. FM-A said the

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DON had told her the medical director (MD) had reviewed R1's medical record following the incident. Per FM-A's request a meeting was arranged for 6/19/19, at 12:00 noon. At the time of the meeting, FM-A said she'd requested FM-C be included in the meeting via telephone. FM-A reported FM-C had asked why CPR was not administered and the medical director had replied he was sorry, and stated "maybe the nurse froze". FM-A said the MD also reported having reviewed R1's medical record, and had reported R1 had experienced previous episodes of unresponsiveness while at the nursing home. MD then asked if either FM was aware of R1 having any of these (syncopal) episodes while at home, to which both FM-A and FM-C had responded their mom would get dizzy, but they had no recollection of any spells of unresponsiveness.

LPN-A was interviewed on 6/28/19, at 10:37 a.m. and verified she had worked at the faciltiy 5 years on the over night shift. LPN-A said she had a current CPR certification which included use of the AED, but she had not ever had to perform CPR or attempt to utilize the AED. LPN-A then described the location of the AED in the main lobby area which included directions on the use of the device posted on the wall beside the unit. LPN-A was asked to review the sequence of events with regard to R1. On the night of 6/1/19:
(1) Staffing on the night of 6/1/19 was herself as the charge nurse and 2 NAs.
2.) Around 4:00 a.m. she was toileting another resident when she received a text from NA-A that R1 was on the floor. She messaged the NA back she would come when finished toileting the resident she was with. There was no sense of urgency in the text message she received.
3.) LPN-A proceeded to R1's room and observed

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R1 lying on the floor on her left side with a pillow beneath her head. NA-A and NA-B were standing in the room looking at R1. LPN-A stated the NAs thought R1 was having a "behavioral episode".
4.) LPN-A stated she'd bent over R1 and attempted a sternal rub, to which R1 usually responded by regaining orientation with her past history of syncopal episodes at the facility. R1 opened her eyes and was breathing through her mouth. R1 was not verbally responsive and her skin color was pale. LPN-A noted R1 had some foam around her mouth.
5.) LPN-A attempted to sit R1 upright, and her head fell forward and she had no muscle tone. LPN-A looked at the 2 NA's and stated, "she's dead".
6.) LPN-A checked for a heart rate and didn't find a pulse, so she went to retrieve a stethoscope and contacted the RN on duty at the hospital. LPN-A failed to begin CPR as outlined in the policy. She returned to R1's room, listened for a heart beat, and did not find one.
7.) The hospital RN was called. When she arrived, she verified there were no signs of life for R1.
8.) LPN-A began the appropriate notifications to family, physician and management.
Further interview with LPN-A identified she was aware of R1's code status, but stated it had been approximately 4-5 minutes from the time she was notified via text message to the time she arrived at R1's side. When asked why she hadn't initiated CPR or initiated EMS when R1 had a full code status, LPN-A stated "she was gone too long". LPN-A was aware of the faciltiy policy which included the signs of irreversible death which included rigor mortis and coldness. She confirmed neither of these conditions were present when she'd arrived at R1's bedside.

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NA-B was interviewed on 6/28/19, at 12:11 p.m. and indicated she had been employed since October 2018, and commonly worked the night shift. NA-B had been on duty the night of 6/1/19 and was assisting a resident in a different room when she received a page that help was needed in R1's room. Upon her arrival at R1's room, she observed R1 on the floor and NA-A was telling her to get up. There was no response from R1. She had foam around her mouth. NA-B instructed NA-A to call the nurse and had proceeded to turn R1 onto her side to assist with opening her airway. LPN-A responded to the room, and turned R1 onto her back, LPN-A was rubbing R1's sternal area NA-B had been advised to call the adjoining hospital and "get a nurse over here". NA-B said LPN-A left the room and went to call the hospital nurse. NA-A and NA-B were left in attendance with R1 and no resuscitative measures were implemented as only licensed staff were allowed to perform CPR. NA-B stated the hospital RN responded, assessed R1 and stated she "was gone." NA-B stated she was not currently certified in CPR, but had asked NA-A what R1's code status was. NA-A responded she was unaware. NA-B instructed NA-A to go look on the door. NA-A did and reported to NA-B CPR was indicated. LPN-A then entered the room, looked at R1 lying on the floor and commented she is a "full code". Neither the EMS or CPR were initiated following R1's emergency by any staff.

The facility Administrator was interviewed on 6/28/19, at 12:45 p.m.. She indicated she had been notified of R1's death via text at 9:54 a.m. by the DON. R1 was to have been a full code. On 6/3/19 she received a phone call with a follow up email notifying her of a plan for a family meeting.

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The administrator stated her expectation was that care and services would be provided according to the facility policies and standards of nursing practice. The EMS system should have been activated at the time of the incident. Following discussion with the DON it was decided the incident should be reported. The incident which occurred on 6/1/19, was first reported to the State Agency 6/24/19.

The medical director (MD) was interviewed on 6/28/19 at 1:00 p.m,. and confirmed his expectation a resident whose POLST/Advance Directive indicated a "full code" status should receive necessary lifesaving treatment. MD stated following this incident, there had been discussion with staff, the best chance scenario would have been to initate CPR, and obtain and utilize the AED. The MD indicated without those measures, there would be no chance of survival. The MD was aware of some syncopal episodes fro R1, but there was nothing in her medical history that would indicate R1 was at risk for sudden death. He said he had not learned about the incident until the following day and it had been disappointing to hear. MD stated, "If CPR had been initiated, it would have been [R1's] best chance." He had told R1's family there was no excuse for what had happened. "It was a mistake, and we are doing our best to insure it never happens again."

Review of the facility's July 2018, CPR/CODE Status policy , the facility policy included: To 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 advanced directives. Further, the

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policy indicated the care center was to have at least one staff member on duty at all times, who is trained in single rescuer adult CPR and who has completed the initial training, or a refresher course, within the previous two years. The policy indicated CPR certification would be obtained through training that included hands-on practice and in-person skills assessment. "A staff member, properly trained in CPR, will be available immediately to provide basic life support to residents requiring emergency, prior to the arrival of EMS and subject to accepted professional guidelines, the resident's advance directives, and physician orders."

Review of the facility's professional guidelines from The American Heart Association (AHA)included: If a resident experiences a cardiac or respiratory arrest and the resident does not show obvious clinical signs of death (e.g. rigor mortis, dependent lividity, decapitation, transection, or decomposition), facility staff must provide basic life support, including CPR, prior to the arrival of EMS in accordance with the resident's advance directives and any related physician order, such as code status, or in the absence of advance directives or a DNR order.

The past non-compliance that began on 6/1/19, was verified during the 6/28-7/1/19 onsite visit to have been corrected by 6/25/19. Verification of corrective action was confirmed by interview with a variety of nursing staff, interview with the medical director, review of progress notes, and documentation of staff training. In addition, facility policies were reviewed and audits had been scheduled.