STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355050	A. BUILDING _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR CARE CENTER	**1116 9TH AVE LANGDON, ND 58249**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite investigation survey regarding a facility reported incident was completed on November 15, 2022. The concerns identified by the report were substantiated.	F 000		
F 678 SS=G	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility reported incident investigation, review of facility policies, review of personnel records, and staff interview, the facility failed to perform Cardiopulmonary Resuscitation (CPR) on 1 of 1 resident (Resident #1) who requested CPR in the event of absence of pulse or respirations. Failure to perform CPR contributed to Resident #1's death. This citation is considered past non-compliance based on review of the corrective action the facility implemented immediately following the incident. Findings include: Review of the facility policy titled "Emergency Procedure-Cardiopulmonary Resuscitation" occurred on 11/15/22. This policy, revised April 2022, stated, " . . . Personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR) and basic life support (BLS), including defibrillation, for victims of sudden	F 678	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 11/29/2022

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F 678	Continued From page 1 cardiac arrest. . . . If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiate CPR unless: a. It is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual; or b. there are obvious signs of irreversible death (e.g., rigor mortis, decapitation or decomposition). . . . Emergency Procedure-Cardiopulmonary Resuscitation . . . If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR: Instruct a staff member to activate the emergency response system (code) and call 911. Instruct a staff member to retrieve the automatic external defibrillator. Verify or instruct a staff member to verify the DNR or code status of the individual. Initiate the basic life support (BLS) sequence of events. . . ." Review of Resident #1's medical record occurred on 11/15/22 and identified medical diagnoses of atherosclerotic heart disease, coronary artery disease, heart failure, and hypertension. Resident #1's DO NOT RESUSCITATE (DNR) REQUEST FORM signed by Resident #1 and Resident #1's physician on 05/10/22 stated, "I understand the 'Do Not Resuscitate' order. (Check one)." The resident placed a check mark by "I want to be resuscitated." Physician's rounds/orders review, dated 09/28/22, showed, "FULL CODE . . . order status active, order date 05/10/2022 . . ." Resident #1's most recent care plan stated ". . . Advanced Directives Full Code . . ."	F 678		

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F 678	Continued From page 2 Review of progress notes identified the following: * 10/06/22 at 2:23 p.m. ". . . Care conference was held. Those in attendance was Interdisciplinary Team [IDT] and [resident name]. Family declined invite. Advanced directives were discussed and will remain as full code. . . ." * 10/14/22 at 4:20 a.m. ". . . Resident was found at this time to have cold lips, blue, eyes fixed and no reaction to light, no pulse, no heartbeat or respirations, [name] power of attorney [POA] was contacted and gave the ok to release the body to [name of funeral home] upon medical doctor [MD's] order. . . ." * 10/14/22 at 5:00 a.m. ". . . [family] arrived to see resident and did have priest come and deliver residents last rights. . . ." * 10/14/22 at 6:41 a.m. " . . . Signed fax back [from physician] at this time in regards to residents time of death and ok to release body to [name of funeral home]. . . ." The facility's investigation report dated 10/18/22 included the following documentation: * Staff #2 interview "10/14/22 I received an for your information [FYI] call from [Nurse #3] during the night shift notifying me that she had found an unresponsive resident with no pulse. [Nurse #3] stated that the resident was cold, lips were blue, eyes fixed, and she wasn't sure how long he had been like this. [Nurse #3] stated that she was going to call the resident's POA and the funeral home. Upon hanging up the phone with [Nurse #3] I became worried that the resident she had called about was a full code. I immediately texted and call her back, which she did not immediately answer as she was on the phone with the POA. She quickly returned my call. I stated that I	F 678		

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F 678	Continued From page 3 thought the resident was a full code, so I asked if they started CPR and called 911. She confirmed that he was a full code but stated that the resident was cold, blue, and pupils were fixed. I stated that I still thought that CPR needed to be started and 911 called. [Nurse #3] stated to me again that he looked like he had been gone for some time and the body was cold. She repeated that he was blue/pale and pupils were fixed with no pulse or breath sounds. She also stated that the POA had already been called for permission to release the body. I stated that she needed to call the on-call physician for more guidance as I was under the impression that we needed to start CPR. I instructed [Nurse #3] to call me back when she found out. Shortly thereafter, [Nurse #3] called me back and reported that the physician told her that she did not have to do CPR since the POA gave approval to release the body." During an interview on 11/15/22 at 4:35 p.m., two administrative staff members (#1 and #2) stated they expected staff to initiate CPR on Resident #1. Based on the following information, non-compliance at F678 is considered past non-compliance. The facility implemented corrective actions for the deficient practice by: *Completing an investigation with interviews of staff who were present on 10/14/22. *Determining the investigation showed staff failed to follow CPR policy and resulted in a resident's death. *Providing 1 on 1 education immediately after the incident with involved staff regarding the facility's emergency procedure for cardiopulmonary	F 678		

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F 678	Continued From page 4 resuscitation. *Suspending (Nurse #3) for three days pending investigation and notifying the appropriate state agency. The facility addressed measures put in place and implemented systemic changes to ensure the deficient practice does not recur by: *Providing education to all nursing staff on the facility's emergency procedure for cardiopulmonary resuscitation and providing staff with copies of the policy beginning on 10/14/22 through the weekend of 10/17/22. *Informing the Quality Assurance committee on 11/08/22 and determining what audits will be implemented. The surveyor determined a deficient practice existed on 10/14/22. The facility implemented corrective action on 10/14/22 and completed nursing education by 10/17/22.	F 678		