Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL23249001M
Compliance #: HL23249002C

Date Concluded: July 25, 2022

Name, Address, and County of Licensee Investigated:
Ridgeway on 23rd
720 23rd Street North
New Ulm, MN 56073
Brown County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

Finding: Inconclusive

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
Facility staff neglected a resident when staff failed to follow physician orders and cardiopulmonary resuscitation (CPR) was initiated on a resident with a do not resuscitate (DNR) order.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The status of the resident at the time of the initial assessment could not be confirmed. In addition, the facility had conflicting polices related to the provision of cardiopulmonary resuscitation (CPR). The RN initiated CPR per dispatch instructions. However, upon learning of the resident's code status resuscitation efforts were ceased.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigation included review of resident and employee records, hospital records and observation of video surveillance of the incident.

The resident resided in an assisted living facility with current diagnoses which included history of heart valve replacement, small vessel disease, and high blood pressure. The resident's service plan included for staff to assist with showers, medication management and complete three safety checks during the night.

The resident's face sheet identified the resident code status as Do Not Resuscitate (DNR)/Do not intubate (DNI). Signed physician orders from two months prior to the incident included the code status: DNR/DNI.

The day the incident occurred facility staff found the resident on the floor in the hallway outside of his room. Staff immediately called for a nurse to assess the resident. The nurse assessed the resident and found the resident to have a weak, thready pulse and labored, gasping breaths. The nurse contacted emergency medical services (EMS) and followed dispatch instructions to position the resident on his side to prevent aspiration and obtain the automated external defibrillator (AED). While on the phone, the nurse directed another staff member to get the AED while she stayed with the resident. Following continued direction from dispatch, the nurse applied the AED to the resident and followed the prompts provided by the AED. The AED indicated an electric shock was advised and the AED provided an electric shock to the resident. The AED then prompted the nurse to initiate cardiopulmonary resuscitation (CPR). The nurse began chest compressions on the resident. Police were the first to respond and upon arrival took over resuscitation efforts. During this time another staff member contacted the Director of Nursing (DON) who directed the staff member to obtain the resident's emergency information to provide to EMS upon their arrival. Facility staff provided the ambulance crew with the resident's emergency information upon arrival. Upon review of this information, it was discovered the resident had a DNR/DNI code status and resuscitation efforts were ceased. The ambulance crew then transferred the resident to the hospital.

Hospital records indicated the resident was unresponsive, had flaccid paralysis and declining vital signs upon arrival. The resident was placed on comfort cares and passed away two days later.

The Uniform Disclosure of Assisted Living Services and Amenities (a required document to describe services provided by the facility) indicated the facility had limited use of an automated external defibrillator (AED) and staff did not provide cardiopulmonary resuscitation (CPR).

The resident handbook indicated staff were not qualified for emergency assistance such as CPR; not obligated to provide such assistance and would not attempt to administer it.

Facility policies related to emergency care directed staff to contact emergency medical services (EMS), stay with the resident, answer questions of the dispatch and stay on the phone until help arrived. The policies directed staff to locate resident emergency information to provide to EMS upon arrival. A policy stated the emergency information was to include the emergency

information record, Provider Orders for Life Sustaining Treatment (POLST) and/or Advanced Directives, if available, and a list of current medications.

Review of the resident's medical record and staff interviews indicated conflicting information on the resident's responsiveness and whether the resident and a pulse and/or was breathing prior to initiation of CPR.

During an interview, the facility nurse working the day of the incident stated when she arrived to assist the resident, she noted a weak pulse and abnormal breathing. The nurse indicated the resident did not stop breathing throughout the course of the incident. The nurse stated she called 911 and followed the dispatchers' instructions which included turning the resident to his side, applying the AED, and starting compressions (CPR). The police took over resuscitation efforts upon arrival to the facility. Upon learning of the resident's DNR/DNI code status, resuscitation efforts were ceased, and the resident was transferred to the hospital.

During an interview with the administrative nurse, she stated it was a "kind of a gray area" about what staff can and cannot do in emergency situations, however indicated facility policies directed staff to contact EMS and follow dispatch instructions. The administrative nurse stated she was unaware of the conflicting information provided in the resident handbook which indicated staff were not qualified, obligated, and would not attempt to provide CPR.

During an interview, the resident's family member stated the facility staff resuscitated the resident against his wishes and as a result the resident had to endure additional and unnecessary pain and suffering. The family member expressed concerns with the staff's ability to respond to emergency situations and lack of awareness of resident code status and facility policies and procedures.

As a result of this investigation, state licensing orders were issued related to appropriate care and services.

In conclusion, neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No, deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility placed emergency binders on all floors of the facility and re-educated staff on emergency response and current policies and procedures.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html,

or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23249	A. BUILDING: _____ B. WING _____	C 05/19/2022

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL23249002C/#HL23249001M On May 19, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 54 residents receiving services under the Assisted Living with Dementia Care license. The following correction orders are issued for #HL23249002C/#HL23249001M, tag identification 0800 and 2310.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is 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. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 1 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation as required by MN Statute 144G.45, subd.2(a)(4). This has the potential to affect 36 out 54 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 19, 2022, at 2:20 p.m., unlicensed personnel (ULP)-B, stated the carpet on second floor had ripples in it. ULP-B stated a resident's family member had complained of the rippled carpet due to it being a tripping hazard. ULP-B stated the resident had passed away. On May 19, 2022, at 2:40 p.m., the surveyor observed the second floor. The hallway floor to the left of the stairway was plywood. To the right of the stairway after the communal area, the carpet had rippled areas or bumps in the	0 800		

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0 800	Continued From page 2 carpeting and was a tripping hazard. On May 19, 2022, at 1:00 p.m., owner (O)-A stated there were ripples in the carpet on the second floor. O-A stated replacing the carpet had been in the works for many months. On May 19. 2022, at 5:54 p.m., the maintenance director (M)-E stated the installation of carpet has been a long process and is going on almost a year. M-E stated the carpet installer kept delaying for various personal reasons. The installer also said there was a problem getting the correct material. On May 19, 2022, at 6:15 p.m., the surveyor and O-A went to the second floor to observe the rippled carpet. While walking to the right of the communal area toward there was a seam from one carpet to another with a large hole, which a foot could get stuck in. O-A took a rug and put it over the seam to prevent anyone from tripping. O-A verified the carpet should be replaced and it was taking far too long for their installer to replace the carpet in the facility. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
02310 SS=G	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced	02310		

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02310	Continued From page 3 by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one resident (R1). R1 had a signed do not resuscitate (DNR) order, however, when R1 was found unresponsive, licensee staff were initially not aware of or did not check for this order. In addition, licensee staff provided conflicting information on whether the resident was still breathing. The licensee did not have consistent policies related to emergency situations, including contradictory directions on whether or when to initiate CPR, which had the potential to affect all 54 residents residing in the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The April 7, 2020 Minnesota Medical Association Provider Orders for Life Sustaining Treatment (POLST) Guide indicated the POLST form is a portable medical order that can give patients with advanced serious illness the option to exercise increased control over the treatment they do and do not want to receive at the end of life. The POLST helps to ensure the patient's wishes are conveyed to emergency services and other medical providers. The POLST form is used and recognized by hospital systems, long-term care	02310		

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02310	Continued From page 4 facilities, medical professionals, and emergency medical services throughout Minnesota. R1 resided in an assisted living facility with current diagnoses of valve replacement, small vessel disease, and high blood pressure. R1's service plan dated August 18, 2021, indicated R1 required assistance with showers, medication management and three safety checks during the night. R1's POLST dated July 19, 2019, under section A indicated R1 did not want resuscitation if found with no pulse and not breathing. The POLST form, under section B (medical treatments) noted to check one of the following: full treatment, selective treatment, or comfort-focused treatment (allow natural death) if the resident had a pulse and/or is breathing. This section of the form was not completed and was left blank. The form was signed by R1's power of attorney and by R1's medical doctor. R1's current face sheet indicated R1 was a Do Not Resuscitate (DNR)/Do not intubate (DNI). R1's physician orders dated August 17, 2021, also included a code status of DNR/DNI. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated July 28, 2021, indicated the licensee provided limited use of an automated external defibrillator (AED) and did not provide cardiopulmonary resuscitation (CPR). The licensee's resident handbook dated September 5, 2017, indicated facility staff were not qualified for emergency assistance such as CPR, not obligated to provide such assistance and will not attempt to administer it.	02310		

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02310	Continued From page 5 R1's progress note, dated October 22, 2021, written by registered nurse (RN)-A indicated an unlicensed personnel (ULP) found R1 on the floor in the hallway. RN-A noted the resident was face down, dark purple/blue in the face and was agonal breathing (abnormal breathing pattern of gasping breaths) at least 45 seconds apart and R1 was not responding to verbal commands. R1's pulse was weak and thready and RN-A called 911. Dispatch instructed RN-A to turn R1 on his side to prevent aspiration. Dispatch then advised RN-A to get the automated external defibrillator (AED). RN-A applied the AED and an electric shock was provided to R1 via the AED. RN-A then began chest compressions following dispatch orders and direction from the AED. Emergency medical services (EMS) arrived and delivered rescue breaths while RN-A continued chest compressions. During this time, another staff member contacted the Director of Nursing (DON) and was advised to locate R1's POLST form in the emergency binder to provide to EMS. Upon their arrival, EMS directed all life-saving efforts should be stopped due to the resident's code status (DNR/DNI) indicated on the POLST form. EMS records, dated October 22, 2021, indicated the resident was unresponsive upon initial assessment and was in full cardiac arrest. The resident was shocked by the AED one time prior to their arrival and cardiopulmonary resuscitation (CPR) had been initiated. EMS was informed upon their arrival the resident had a DNR/DNI order. The AED was charging to deliver a second shock when EMS instructed the AED to be turned off in accordance with the resident's wishes. The resident's agonal breathing then returned to a regular rate. The initial electrocardiogram (EKG),	02310		

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02310	Continued From page 6	02310		

a test used to measure electrical activity of the heart, showed ventricular fibrillation (an abnormal heart rhythm). The EKG further demonstrated R1 converted from ventricular fibrillation to sinus bradycardia (a slow, normal heart rhythm) independently prior to transport to the hospital.

The resident's hospital records dated October 22, 2021, indicated the resident's admission diagnoses were cardiac arrest and acute respiratory failure with hypoxia. The resident was placed on comfort cares and passed away two days later.

On May 19, 2022, at 5:00 p.m., Registered Nurse (RN)-A was interviewed and stated when she arrived to assist R1, he was not breathing normal but was still breathing. RN-A stated R1 never stopped breathing throughout the incident. RN-A stated she called 911 and followed the dispatchers' instructions which included turning the resident to his side, applying the AED and starting compressions (CPR). RN-A confirmed she was unaware of R1's code status at the time and said she should have checked the residents' code status prior to applying the AED or starting chest compressions.

On June 8, 2022, at 1:00 p.m., the Corporate Clinical Nurse Supervisor was interviewed and stated she received a call from an unlicensed personnel (ULP) regarding this incident and directed the ULP to obtain R1's POLST form to provide to the ambulance crew. The Cooperate Clinical Nurse Supervisor stated their policy indicated, if possible, to check the residents code status in emergency situations. The Corporate Clinical Nurse Supervisor went on to say facility staff were directed by facility policy's to contact 911 in emergency situations and should follow the

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02310	Continued From page 7 directions of the dispatcher. The Corporate Clinical Nurse Supervisor confirmed this is what RN-A did in this situation. The Corporate Clinical Nurse Supervisor stated she did not "deal" with the resident hand book and the information was reviewed with the residents by the licensed assisted living director (LALD). The Corporate Clinical Nurse Supervisor was unaware the UDALSA indicated facility staff would not perform CPR. She went on to say it [CPR] "gets to be hairy, because we are taught to call 911, and follow their instruction; it is kind of a "gray area", are we supposed to go against what dispatch is telling us on the phone?" On May 27, 2022, at 2:00 p.m., family member (FM)-B stated RN-A resuscitated R1 against his wishes. FM-B was concerned with how staff responded to the emergency and stated it was clear staff did not know how to respond in an emergency. FM-B indicated it took over seven minutes for RN-A to respond to R1 and attach the AED to R1. FM-B further stated the resident handbook indicated facility staff members do not do CPR and questioned the facility's understanding of their policies and how to respond in emergency situations. FM-B stated facility policies should match the handbook, staff should be aware of resident code status and know how to respond appropriately in emergencies.. FM-B was concerned R1 had to endure additional pain and suffering due to facility staff not following the resident's wishes. The licensee's undated, Summoning Help Policy, indicated if a resident is in need of medical help, facility staff will call the ambulance, stay with the resident until help arrives, remove the information form the 3-ring binder located in the office and give to ambulance personnel. The information	02310		

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02310	Continued From page 8 forms in the 3-ring binder should include: emergency information record, POLST and or advanced directives. Facility staff should then contact family or a responsible person and a registered nurse (RN). The licensee's undated, Resident Collapses or is Found Unresponsive Policy indicated staff will seek appropriate help according to the resident's documented wishes and DNR status and will notify the resident's emergency contacts. If a staff member finds a resident who is unresponsive or witnesses a collapse, the staff should: check for evidence of breathing and pulse, stay with the person and call 911, the RN or other staff on duty. The policy further indicated if possible, immediately check the resident's DNR status located in the office, tell dispatch the condition of the resident, and call the RN. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		