MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Good Samaritan Society Waconia
333 Fifth Street West
Waconia, MN 55387
Carver County

Report#: H5234014

Date: September 20, 2016

Date of Visit: March 2, 2016
Time of Visit: 08:30 a.m. – 4:00 p.m.

By: Barbara White, RN, Special Investigator

Type of Facility: ☒ Nursing Home ☐ HHA ☐ Home Care Provider
☐ SLF ☐ ICF/IID
☐ Hospital ☐ Other: _____

☒ Facility Self Report ☐ Complaint

Allegation(s): **It is alleged** that neglect occurred when the facility failed to ensure a resident's wishes were carried out as facility staff failed to follow the resident's Provider Order for Life Sustaining Treatment (POLST) form when he/she became unresponsive. Life saving measures were discontinued against the resident wishes and the resident passed away without being transferred to a hospital.

An unannounced visit was made at this facility and an investigation was conducted under:

☒ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☑ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☒ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☒ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☒ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☒ Federal Regulations for EMTALA (42 CFR Part 489)

☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☑ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
☐ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

Based on a preponderance of evidence, neglect occurred when staff did not provide emergency medical care to a resident, consistent with the resident's advance directive for life-sustaining treatment and cardiopulmonary resuscitation (CPR), and the resident died. CPR was started but discontinued when a staff misunderstood the Provider Order for Life Sustaining Treatment (POLST) form and directed staff to stop CPR.

The resident was admitted to the facility from a hospital after a short stay for respiratory issues, the resident was alert and oriented and made his/her own decisions about medical care. The facility had reviewed the POLST form on admission with the resident, and the form indicated the resident wanted cardiopulmonary resuscitation (CPR) in the event of cardiopulmonary arrest. The form was signed by the resident, a nurse, and the physician.

The resident had a change in condition, a decreased level of consciousness and difficulty breathing. A nurse was monitoring the resident's vital signs and responsiveness, and performing a sternal rub. A second nurse assessed the resident, then left the room to check the electronic medical record to determine the CPR status and the emergency medical system (EMS) was activated. The resident's condition declined and the nurse with the resident determined CPR was indicated, the Licensed Practical Nurse for the next shift came into the room and immediately started CPR. The nursing staff had not brought the emergency equipment of an automated external defibrillator and a back board used to perform CPR to the resident's room, and CPR was initially begun on the bed without a firm surface under the resident.

A nurse and a law enforcement first responder were positioning the resident on a hard surface to continue CPR when another nurse entered the room and directed that CPR should be discontinued based on the POLST form. The resident had no pulse or respirations, and was not sent to a hospital. When other first responders arrived and looked at the POLST form, it was identified that CPR was to be done. The first responders assessed that signs of irreversible death were present and CPR was not restarted.

The nurse who initially read the POLST document was interviewed and stated s/he misunderstood the POLST form and had read the form to the staff performing CPR, and read in error that the POLST form indicated

comfort care and no CPR was to be done.

The physician was interviewed and stated that the resident wished to receive CPR. The resident's death certificate indicated the cause of death was natural causes.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ individual(s) and/or ☒ facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility had policy in place indicating that a POLST form was signed on admission, and that nurses should follow the direction of the POLST form in the event of cardiopulmonary arrest. Multiple staff were involved in the decline of the resident and the care related to CPR.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) – Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No If no, specify: _____
(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met

The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

State Statutes Chapters 144 & 144A – Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"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.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated
"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

☒ Medical Records ☐ Care Guide

☐ Medication Administration Records
☐ Treatment Sheets
☒ Facility Incident Reports
☒ Physician Progress Notes
☐ ADL (Activities of Daily Living) Flow Sheets
☐ Laboratory and X-ray Reports
☒ Physician Orders
☐ Social Service Notes
☒ Nurses Notes
☐ Meal Intake Records
☐ Activities Reports
☐ Weight Records
☐ Therapy and/or Ancillary Services Records
☐ Assessments
☐ Skin Assessments
☒ Care Plan Records
☐ Service Plan
☐ Other, specify: _____

Other pertinent medical records:

☐ Hospital Records ☒ Ambulance/Paramedics ☐ Medical Examiner Records ☒ Death Certificate
☐ Police Report ☐ Other, specify: _____

Additional facility records:

☐ Resident/Family Council Minutes
☒ Personnel Records/Background Check, etc.
☒ Staff Time Sheets, Schedules, etc.
☒ Facility In-service Records
☒ Facility Internal Investigation Reports
☒ Facility Policies and Procedures
☐ Call Light Audits
☐ Other, specify: _____

Number of additional resident(s) reviewed: 2

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ○ Yes ○ No ◉ N/A Specify: _____

If unable to contact complainant, attempts were made on:
Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation: ○ Yes ◉ No ○ N/A Specify: _____

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 5

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 10

Physician interviewed: ◉ Yes ○ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Physician Assistant interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: ○ Yes , date subpoena was issued _____ ○ No

Were contacts made with any of the following:
☒ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify Sheriff Officers

Observations were conducted related to:

☐ Wound Care	☐ Medication Pass	☐ Meals
☐ Personal Care	☐ Dignity/Privacy Issues	☐ Restorative Care
☐ Nursing Services	☒ Safety Issues	☒ Facility Tour
☐ Infection Control	☐ Cleanliness	☐ Injury
☐ Use of Equipment	☐ Transfers	☐ Incontinence
☐ Call Light	☒ Other: Emergency Equipment	

Was any involved equipment inspected: ○ Yes ◉ No ○ N/A Specify: _____

Was equipment being operated in safe manner: ○ Yes ◉ No ○ N/A Specify: _____

Were photographs taken: ○ Yes ◉ No Specify: _____

xc: Health Regulation Division - Licensing & Certification
Minnesota Board of Examiners for Nursing Home Administrators
The Office of Ombudsman for Long Term Care
Minnesota Board of Nursing
Carver County Medical Examiners
Carver County Sheriff Department
Carver County Attorney

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	245234	A. BUILDING _____ B. WING _____	C 04/11/2016

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GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5234014. As a result, the following deficiency is issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure emergency medical care, cardiopulmonary resuscitation (CPR) was provided in accordance with the resident's directives for 1 of 1 residents (R1), stopped breathing, and had no pulse. Staff started CPR but discontinued it when the resident's advanced directives were read incorrectly by a staff. The resident died at the facility. Findings include: R1's medical record was reviewed and indicated R1 was admitted to the facility's transitional care unit for short term rehabilitation on 02/10/2016 after being hospitalized for three days. The	F 309		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	Continued From page 1 hospital history and physical indicated that R1 had an upper respiratory infection and an exacerbation of chronic obstructive pulmonary disease (COPD). The facility policy dated September 2015 title "Cardiopulmonary Resuscitation" (CPR) indicated that the facility had staff on duty at all times to provide CPR, that CPR was offered unless a do not resuscitate order was in place, or there were no obvious signs of clinical death. The policy indicated staff was certified by the American Heart Association and the American Red Cross and CPR was guidelines. An automatic external defibrillator (AED) and a backboard were observed 3/2/16 at 9 a.m. stored in an office on the same floor, on the long term care side. The admission nurse note dated 2/10/16 at 1:20 p.m. indicated that R1 was alert, oriented, and made her own decisions. The Provider Orders for Life Sustaining Treatment (POLST) was signed on admission by R1 and indicated R1 wanted staff to perform CPR. The POLST form dated 2/10/2016 included R1's signature, the nurse, and the physician's signature. The goals of treatment sections (sections B and C) of the form were not completed to limit care when not in cardiopulmonary arrest. The electronic face sheet and medication administration record (MAR) indicated "MN POLST (A) CPR/Attempt Resuscitation. When not in cardiac arrest, follow orders in B and C".	F 309		

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F 309	Continued From page 2 The progress note dated 2/29/16 documented a late entry for 2/26/16 by Licensed Practical Nurse (LPN- H), and indicated on arrival for the night shift LPN-H was told by LPN- J that R1 was going into cardiac arrest. LPN- H documented R1 was not breathing, had a rapid pulse, and CPR was initiated. A law enforcement officer arrived, and R1 was placed on the floor to continue CPR. The progress note indicated that LPN- J entered with papers and stated to "stop CPR, that R1 did not need it". CPR was discontinued and R1 had no pulse or respirations, the emergency medical system (EMS) call was canceled. A second officer arrived and reviewed the POLST form and told staff CPR had been indicated. LPN-J did not have progress note documented for 2/26/2016 for the change in condition. The investigative log (undated) filed by LPN-J indicated that R1 was unresponsive but breathing. She began a sternal rub and left the room to activate the emergency medical system (EMS) by calling 911. LPN-J was interviewed on 3/18/2016 at 9:00 a.m. and stated that R1 had a fall at the beginning of the shift and she had monitored R1 several times during the shift for vital signs and injury from the fall. Late in the shift she had been called to R1's room by Registered Nurse (RN-G) because R1 was unresponsive. LPN-J assessed the vital signs and applied a sternal rub, R1 had gasping breathing and had a pulse at that time. LPN-J stated she left the room to call 911 and check the POLST status because she did not know if R1 wanted CPR done. LPN-J stated she did not send someone to get the automated external defibrillator (AED) and backboard to be used if CPR was initiated. She called 911 to activate the	F 309		

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F 309	Continued From page 3 EMS. LPN-J stated she looked at the medication administration record (EMAR) in the electronic record and it said CPR, follow B and C. She was not sure about this and was looking in the electronic record for the POLST form when LPN-H arrived for the next shift and asked about a beeping noise, LPN-H went to R1's room. LPN-J stated she continued to get the POLST form, copied it, and stated she looked at the form and understood the form to note "follow comfort cares written in section B and C". She stated she interpreted the POLST form to mean that R1 wanted comfort cares and CPR was not indicated. She said she went to R1's room and the staff were around R1 on the floor, she read the POLST to them and directed them not to do CPR. LPN-J said she did not know that CPR had been started and did not know why R1 was on the floor. She stated the officer and nurses looked at the POLST form and did not say anything. She stated she did not have training about the POLST form and had not used one before. She said she was told CPR had been started several minutes later by another officer that arrived. RN-G was interviewed 3/16/2016 at 11:30 a.m. and stated that she had been with R1 on 2/26/16 at 11:00 p.m. when R1's level of consciousness changed and R1 was unresponsive and respirations were gasping. She notified LPN-J because she was a trainee and was not assigned resident care. She stated LPN-J assessed R1, increased the oxygen level being given, then left the room to activate the EMS by calling 911. She stated that LPN-J came back to the room and was asked if CPR was indicated and said "refer to section B and C of POLST", RN-G said she was confused by this direction. A few minutes later RN-G felt CPR was indicated, she left the	F 309		

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F 309	Continued From page 4 room for further direction, and LPN-H came down the hall went to R1 and began CPR. R1 was placed on the floor when an officer arrived to continue CPR. RN-G stated that LPN-J came into the room and said stop CPR, RN-G was handed the POLST but did not read the form and gave it to the officer. LPN-H was interviewed 3/16/16 at 1:20 p.m. and stated that she arrived on the unit for the night shift after receiving report on the long term care unit. She said the nurse on the long term care unit was not aware of a medical emergency on the transitional care unit. LPN-H stated that LPN-J was in the office at approximately 11 p.m. and did not initially report a medical emergency to LPN-H until asked what the beeping sounds were by LPN-H. LPN-H was told that R1 was going into cardiac arrest, and she was checking the POLST. LPN-H stated she was surprised she had not been told immediately and the long term care nurse had not been notified. LPN-H stated she went to R1's room, assessed that R1 was not breathing and the pulse had dropped, she laid the bed flat and started CPR. She said that a law enforcement officer had responded, R1 was placed on the floor to continue CPR on a hard surface, R1 was assessed and had no pulse or breathing and CPR was to continue. She stated that LPN-J came into the room with the POLST form at that time and said CPR was not indicated. She stated CPR was discontinued at that time. The POLST form was not seen by her at that time. LPN-H stated that the usual process would be to immediately activate the EMS with a change in level of consciousness and breathing, to stay with	F 309		

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F 309	Continued From page 5	F 309		

the resident to assess and provide care, and have other staff get emergency equipment and AED. LPN-H stated the POLST information was available on the electronic medical record on the E-MAR, E-TAR, and face sheet. LPN-H stated R1's POLST form was very clear that CPR was indicated. LPN-H stated that the nurse should remain with the resident and direct the staff in the medical emergency process.

Nursing Assistant (NA- E) was interviewed 3/2/16 at 2:00 p.m. and stated she was in the room with RN-G at 10:50 p.m. on 2/26/16 to care for R1. She stated R1 was not responsive that RN-G was doing a sternal rub and monitoring vital signs for R1. She stated that LPN-J left the room to call 911 and RN-G was not sure about the CPR status. She observed LPN-H come into the room and begin CPR chest compressions on the bed. R1 was lowered to the floor when an officer arrived, then LPN-J came into the room and told the others to stop CPR and waved the POLST form. NA-E stated that there did not seem to be anyone in charge of the medical emergency and communication was poor.

The RN Nurse Manager (RN-B) was interviewed 3/2/16 at 11:15 a.m. and stated that the nurses are expected to have CPR certification, to direct emergency situations and to begin CPR when indicated. She said that the CPR status was documented on readily available computers and the nurse should ask other staff to help get the AED or assist with tasks, while they directed the CPR and have another nurse check the CPR status.

The Director of Nursing (DON) was interviewed 3/2/16 at 3 p.m. and stated that the usual

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F 309	Continued From page 6 procedure for nurses in a CPR medical emergency was to bring the AED and back board to the room and to access the EMS by calling 911. He stated that the POLST information for CPR or do not resuscitate (DNR) were available to nurses and it was important to honor the choice of the resident. Review of the employee records indicated that LPN-J, LPN-H, and RN-G had current certification from the American Heart Association for CPR. Review of the American Heart Association training for healthcare professionals for basic life support dated 2015 indicated " It is expected that Healthcare Professionals (HCPs) are trained in CPR and can effectively perform both compressions and ventilation. However, the priority for the provider, especially if acting alone, should still be to activate the emergency response system and to provide chest compressions. There may be circumstances that warrant a change of sequence, such as the availability of an AED that the provider can quickly retrieve and use. For witnessed adult cardiac arrest when an AED is immediately available, it is reasonable that the defibrillator be used as soon as possible."	F 309		

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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: A complaint investigation was conducted to investigate complaint #H5234014. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at	2 000		

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(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) COMPLETE DATE
2 000	Continued From page 1 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure emergency medical care, cardiopulmonary resuscitation (CPR) was provided in accordance with the resident's directives for 1 of 1 residents (R1), stopped breathing, and had no pulse. Staff started CPR	2 830		

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2 830	Continued From page 2 but discontinued it when the resident's advanced directives were read incorrectly by a staff. The resident died at the facility. Findings include: R1's medical record was reviewed and indicated R1 was admitted to the facility's transitional care unit for short term rehabilitation on 02/10/2016 after being hospitalized for three days. The hospital history and physical indicated that R1 had an upper respiratory infection and an exacerbation of chronic obstructive pulmonary disease (COPD). The facility policy dated September 2015 title "Cardiopulmonary Resuscitation" (CPR) indicated that the facility had staff on duty at all times to provide CPR, that CPR was offered unless a do not resuscitate order was in place, or there were no obvious signs of clinical death. The policy indicated staff was certified by the American Heart Association and the American Red Cross and CPR was guidelines. An automatic external defibrillator (AED) and a backboard were observed 3/2/16 at 9 a.m. stored in an office on the same floor, on the long term care side. The admission nurse note dated 2/10/16 at 1:20 p.m. indicated that R1 was alert, oriented, and made her own decisions. The Provider Orders for Life Sustaining Treatment (POLST) was signed on admission by R1 and indicated R1 wanted staff to perform CPR. The POLST form dated 2/10/2016 included R1's signature, the nurse, and the physician's signature. The goals of treatment	2 830		

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2 830	Continued From page 3 sections (sections B and C) of the form were not completed to limit care when not in cardiopulmonary arrest. The electronic face sheet and medication administration record (MAR) indicated "MN POLST (A) CPR/Attempt Resuscitation. When not in cardiac arrest, follow orders in B and C". The progress note dated 2/29/16 documented a late entry for 2/26/16 by Licensed Practical Nurse (LPN- H), and indicated on arrival for the night shift LPN-H was told by LPN- J that R1 was going into cardiac arrest. LPN- H documented R1 was not breathing, had a rapid pulse, and CPR was initiated. A law enforcement officer arrived, and R1 was placed on the floor to continue CPR. The progress note indicated that LPN- J entered with papers and stated to "stop CPR, that R1 did not need it". CPR was discontinued and R1 had no pulse or respirations, the emergency medical system (EMS) call was canceled. A second officer arrived and reviewed the POLST form and told staff CPR had been indicated. LPN-J did not have progress note documented for 2/26/2016 for the change in condition. The investigative log (undated) filed by LPN-J indicated that R1 was unresponsive but breathing. She began a sternal rub and left the room to activate the emergency medical system (EMS) by calling 911. LPN-J was interviewed on 3/18/2016 at 9:00 a.m. and stated that R1 had a fall at the beginning of the shift and she had monitored R1 several times during the shift for vital signs and injury from the fall. Late in the shift she had been called to R1's room by Registered Nurse (RN-G) because R1 was unresponsive. LPN-J assessed the vital	2 830		

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2 830	Continued From page 4 signs and applied a sternal rub, R1 had gasping breathing and had a pulse at that time. LPN-J stated she left the room to call 911 and check the POLST status because she did not know if R1 wanted CPR done. LPN-J stated she did not send someone to get the automated external defibrillator (AED) and backboard to be used if CPR was initiated. She called 911 to activate the EMS. LPN-J stated she looked at the medication administration record (EMAR) in the electronic record and it said CPR, follow B and C. She was not sure about this and was looking in the electronic record for the POLST form when LPN-H arrived for the next shift and asked about a beeping noise, LPN-H went to R1's room. LPN-J stated she continued to get the POLST form, copied it, and stated she looked at the form and understood the form to note "follow comfort cares written in section B and C". She stated she interpreted the POLST form to mean that R1 wanted comfort cares and CPR was not indicated. She said she went to R1's room and the staff were around R1 on the floor, she read the POLST to them and directed them not to do CPR. LPN-J said she did not know that CPR had been started and did not know why R1 was on the floor. She stated the officer and nurses looked at the POLST form and did not say anything. She stated she did not have training about the POLST form and had not used one before. She said she was told CPR had been started several minutes later by another officer that arrived. RN-G was interviewed 3/16/2016 at 11:30 a.m. and stated that she had been with R1 on 2/26/16 at 11:00 p.m. when R1's level of consciousness changed and R1 was unresponsive and respirations were gasping. She notified LPN-J because she was a trainee and was not assigned resident care. She stated LPN-J assessed R1,	2 830		

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2 830	Continued From page 5 increased the oxygen level being given, then left the room to activate the EMS by calling 911. She stated that LPN-J came back to the room and was asked if CPR was indicated and said "refer to section B and C of POLST", RN-G said she was confused by this direction. A few minutes later RN-G felt CPR was indicated, she left the room for further direction, and LPN-H came down the hall went to R1 and began CPR. R1 was placed on the floor when an officer arrived to continue CPR. RN-G stated that LPN-J came into the room and said stop CPR, RN-G was handed the POLST but did not read the form and gave it to the officer. LPN-H was interviewed 3/16/16 at 1:20 p.m. and stated that she arrived on the unit for the night shift after receiving report on the long term care unit. She said the nurse on the long term care unit was not aware of a medical emergency on the transitional care unit. LPN-H stated that LPN-J was in the office at approximately 11 p.m. and did not initially report a medical emergency to LPN-H until asked what the beeping sounds were by LPN-H. LPN-H was told that R1 was going into cardiac arrest, and she was checking the POLST. LPN-H stated she was surprised she had not been told immediately and the long term care nurse had not been notified. LPN-H stated she went to R1's room, assessed that R1 was not breathing and the pulse had dropped, she laid the bed flat and started CPR. She said that a law enforcement officer had responded, R1 was placed on the floor to continue CPR on a hard surface, R1 was assessed and had no pulse or breathing and CPR was to continue. She stated that LPN-J came into the room with the POLST form at that time and said CPR was not indicated. She stated	2 830		

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2 830	Continued From page 6 CPR was discontinued at that time. The POLST form was not seen by her at that time. LPN-H stated that the usual process would be to immediately activate the EMS with a change in level of consciousness and breathing, to stay with the resident to assess and provide care, and have other staff get emergency equipment and AED. LPN-H stated the POLST information was available on the electronic medical record on the E-MAR, E-TAR, and face sheet. LPN-H stated R1's POLST form was very clear that CPR was indicated. LPN-H stated that the nurse should remain with the resident and direct the staff in the medical emergency process. Nursing Assistant (NA- E) was interviewed 3/2/16 at 2:00 p.m. and stated she was in the room with RN-G at 10:50 p.m. on 2/26/16 to care for R1. She stated R1 was not responsive that RN-G was doing a sternal rub and monitoring vital signs for R1. She stated that LPN-J left the room to call 911 and RN-G was not sure about the CPR status. She observed LPN-H come into the room and begin CPR chest compressions on the bed. R1 was lowered to the floor when an officer arrived, then LPN-J came into the room and told the others to stop CPR and waved the POLST form. NA-E stated that there did not seem to be anyone in charge of the medical emergency and communication was poor. The RN Nurse Manager (RN-B) was interviewed 3/2/16 at 11:15 a.m. and stated that the nurses are expected to have CPR certification, to direct emergency situations and to begin CPR when indicated. She said that the CPR status was documented on readily available computers and the nurse should ask other staff to help get the AED or assist with tasks, while they directed the	2 830		

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2 830	Continued From page 7 CPR and have another nurse check the CPR status. The Director of Nursing (DON) was interviewed 3/2/16 at 3 p.m. and stated that the usual procedure for nurses in a CPR medical emergency was to bring the AED and back board to the room and to access the EMS by calling 911. He stated that the POLST information for CPR or do not resuscitate (DNR) were available to nurses and it was important to honor the choice of the resident. Review of the employee records indicated that LPN-J, LPN-H, and RN-G had current certification from the American Heart Association for CPR. Review of the American Heart Association training for healthcare professionals for basic life support dated 2015 indicated " It is expected that Healthcare Professionals (HCPs) are trained in CPR and can effectively perform both compressions and ventilation. However, the priority for the provider, especially if acting alone, should still be to activate the emergency response system and to provide chest compressions. There may be circumstances that warrant a change of sequence, such as the availability of an AED that the provider can quickly retrieve and use. For witnessed adult cardiac arrest when an AED is immediately available, it is reasonable that the defibrillator be used as soon as possible." A Suggested Method of Correction: (1) Develop and implement a system which	2 830		

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2 830	Continued From page 8 ensures that the residents' current advance directive is clearly indicated and followed by staff; educate all licensed nurses. (2) Conduct routine audits of residents' EMRs to ensure compliance. (3) Document all corrective action taken. Time Period for Correction: Thirty (30) days.	2 830		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure one of one (R1) residents were free from maltreatment. R1 was neglected when staff failed to provide emergency care (life-sustaining treatment and cardiopulmonary resuscitation(CPR)) when (R1) had a change in condition, stopped breathing, had no pulse, and died. Staff started CPR, but discontinued CPR	21850		

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21850	Continued From page 9 when the resident's advanced directives were read incorrectly by a staff. The resident died at the facility. Findings include: R1's medical record was reviewed and indicated R1 was admitted to the facility's transitional care unit for short term rehabilitation on 02/10/2016 after being hospitalized for three days. The hospital history and physical indicated that R1 had an upper respiratory infection and an exacerbation of chronic obstructive pulmonary disease (COPD). The facility policy dated September 2015 title "Cardiopulmonary Resuscitation" (CPR) indicated that the facility had staff on duty at all times to provide CPR, that CPR was offered unless a do not resuscitate order was in place, or there were no obvious signs of clinical death. The policy indicated staff was certified by the American Heart Association and the American Red Cross and CPR was guidelines. An automatic external defibrillator (AED) and a backboard were observed 3/2/16 at 9 a.m. stored in an office on the same floor, on the long term care side. The admission nurse note dated 2/10/16 at 1:20 p.m. indicated that R1 was alert, oriented, and made her own decisions. The Provider Orders for Life Sustaining Treatment (POLST) was signed on admission by R1 and indicated R1 wanted staff to perform CPR. The POLST form dated 2/10/2016 included R1's signature, the nurse, and the physician's signature. The goals of treatment	21850		

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21850	Continued From page 10 sections (sections B and C) of the form were not completed to limit care when not in cardiopulmonary arrest. The electronic face sheet and medication administration record (MAR) indicated "MN POLST (A) CPR/Attempt Resuscitation. When not in cardiac arrest, follow orders in B and C". The progress note dated 2/29/16 documented a late entry for 2/26/16 by Licensed Practical Nurse (LPN- H), and indicated on arrival for the night shift LPN-H was told by LPN- J that R1 was going into cardiac arrest. LPN- H documented R1 was not breathing, had a rapid pulse, and CPR was initiated. A law enforcement officer arrived, and R1 was placed on the floor to continue CPR. The progress note indicated that LPN- J entered with papers and stated to "stop CPR, that R1 did not need it". CPR was discontinued and R1 had no pulse or respirations, the emergency medical system (EMS) call was canceled. A second officer arrived and reviewed the POLST form and told staff CPR had been indicated. LPN-J did not have progress note documented for 2/26/2016 for the change in condition. The investigative log (undated) filed by LPN-J indicated that R1 was unresponsive but breathing. She began a sternal rub and left the room to activate the emergency medical system (EMS) by calling 911. LPN-J was interviewed on 3/18/2016 at 9:00 a.m. and stated that R1 had a fall at the beginning of the shift and she had monitored R1 several times during the shift for vital signs and injury from the fall. Late in the shift she had been called to R1's room by Registered Nurse (RN-G) because R1 was unresponsive. LPN-J assessed the vital	21850		

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21850	Continued From page 11	21850		

signs and applied a sternal rub, R1 had gasping breathing and had a pulse at that time. LPN-J stated she left the room to call 911 and check the POLST status because she did not know if R1 wanted CPR done. LPN-J stated she did not send someone to get the automated external defibrillator (AED) and backboard to be used if CPR was initiated. She called 911 to activate the EMS. LPN-J stated she looked at the medication administration record (EMAR) in the electronic record and it said CPR, follow B and C. She was not sure about this and was looking in the electronic record for the POLST form when LPN-H arrived for the next shift and asked about a beeping noise, LPN-H went to R1's room. LPN-J stated she continued to get the POLST form, copied it, and stated she looked at the form and understood the form to note "follow comfort cares written in section B and C". She stated she interpreted the POLST form to mean that R1 wanted comfort cares and CPR was not indicated. She said she went to R1's room and the staff were around R1 on the floor, she read the POLST to them and directed them not to do CPR. LPN-J said she did not know that CPR had been started and did not know why R1 was on the floor. She stated the officer and nurses looked at the POLST form and did not say anything. She stated she did not have training about the POLST form and had not used one before. She said she was told CPR had been started several minutes later by another officer that arrived.

RN-G was interviewed 3/16/2016 at 11:30 a.m. and stated that she had been with R1 on 2/26/16 at 11:00 p.m. when R1's level of consciousness changed and R1 was unresponsive and respirations were gasping. She notified LPN-J because she was a trainee and was not assigned resident care. She stated LPN-J assessed R1,

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21850	Continued From page 12	21850		

increased the oxygen level being given, then left the room to activate the EMS by calling 911. She stated that LPN-J came back to the room and was asked if CPR was indicated and said "refer to section B and C of POLST", RN-G said she was confused by this direction. A few minutes later RN-G felt CPR was indicated, she left the room for further direction, and LPN-H came down the hall went to R1 and began CPR. R1 was placed on the floor when an officer arrived to continue CPR. RN-G stated that LPN-J came into the room and said stop CPR, RN-G was handed the POLST but did not read the form and gave it to the officer.

LPN-H was interviewed 3/16/16 at 1:20 p.m. and stated that she arrived on the unit for the night shift after receiving report on the long term care unit. She said the nurse on the long term care unit was not aware of a medical emergency on the transitional care unit. LPN-H stated that LPN-J was in the office at approximately 11 p.m. and did not initially report a medical emergency to LPN-H until asked what the beeping sounds were by LPN-H. LPN-H was told that R1 was going into cardiac arrest, and she was checking the POLST. LPN-H stated she was surprised she had not been told immediately and the long term care nurse had not been notified.

LPN-H stated she went to R1's room, assessed that R1 was not breathing and the pulse had dropped, she laid the bed flat and started CPR. She said that a law enforcement officer had responded, R1 was placed on the floor to continue CPR on a hard surface, R1 was assessed and had no pulse or breathing and CPR was to continue. She stated that LPN-J came into the room with the POLST form at that time and said CPR was not indicated. She stated

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21850	Continued From page 13 CPR was discontinued at that time. The POLST form was not seen by her at that time. LPN-H stated that the usual process would be to immediately activate the EMS with a change in level of consciousness and breathing, to stay with the resident to assess and provide care, and have other staff get emergency equipment and AED. LPN-H stated the POLST information was available on the electronic medical record on the E-MAR, E-TAR, and face sheet. LPN-H stated R1's POLST form was very clear that CPR was indicated. LPN-H stated that the nurse should remain with the resident and direct the staff in the medical emergency process. Nursing Assistant (NA- E) was interviewed 3/2/16 at 2:00 p.m. and stated she was in the room with RN-G at 10:50 p.m. on 2/26/16 to care for R1. She stated R1 was not responsive that RN-G was doing a sternal rub and monitoring vital signs for R1. She stated that LPN-J left the room to call 911 and RN-G was not sure about the CPR status. She observed LPN-H come into the room and begin CPR chest compressions on the bed. R1 was lowered to the floor when an officer arrived, then LPN-J came into the room and told the others to stop CPR and waved the POLST form. NA-E stated that there did not seem to be anyone in charge of the medical emergency and communication was poor. The RN Nurse Manager (RN-B) was interviewed 3/2/16 at 11:15 a.m. and stated that the nurses are expected to have CPR certification, to direct emergency situations and to begin CPR when indicated. She said that the CPR status was documented on readily available computers and the nurse should ask other staff to help get the AED or assist with tasks, while they directed the	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00924	A. BUILDING: _____ B. WING _____	C 04/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND	333 FIFTH STREET WEST WACONIA, MN 55387

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21850	Continued From page 14 CPR and have another nurse check the CPR status. The Director of Nursing (DON) was interviewed 3/2/16 at 3 p.m. and stated that the usual procedure for nurses in a CPR medical emergency was to bring the AED and back board to the room and to access the EMS by calling 911. He stated that the POLST information for CPR or do not resuscitate (DNR) were available to nurses and it was important to honor the choice of the resident. Review of the employee records indicated that LPN-J, LPN-H, and RN-G had current certification from the American Heart Association for CPR. Review of the American Heart Association training for healthcare professionals for basic life support dated 2015 indicated " It is expected that Healthcare Professionals (HCPs) are trained in CPR and can effectively perform both compressions and ventilation. However, the priority for the provider, especially if acting alone, should still be to activate the emergency response system and to provide chest compressions. There may be circumstances that warrant a change of sequence, such as the availability of an AED that the provider can quickly retrieve and use. For witnessed adult cardiac arrest when an AED is immediately available, it is reasonable that the defibrillator be used as soon as possible." Suggested Method of Correction: (1) Develop and implement a system which ensures that the residents' current advance directive is clearly indicated and followed by staff;	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21850	Continued From page 15 educate all licensed nurses. (2) Conduct routine audits of residents' EMRs to ensure compliance. (3) Document all corrective action taken. Time Period for Correction: Thirty (30) days.	21850		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245234 Y1	A. Building B. Wing Y2	5/24/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 05/24/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 4/11/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00924 Y1	A. Building B. Wing Y2	5/24/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 05/24/2016	ID Prefix 21850 Reg. # MN St. Statute 144.651 Subd. 14 LSC	Correction Completed 05/24/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
4/11/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: GR1G12