DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 15, 2022

Administrator
Charter House
211 Northwest Second Street
Rochester, MN 55901

RE: CCN: 245282
Cycle Start Date: April 7, 2022

Dear Administrator:

On June 3, 2022, we notified you a remedy was imposed. On July 13, 2022 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 30, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 18, 2022 be discontinued as of June 30, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of June 3, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 20, 2022. This does not apply to or affect any previously imposed NATCEP loss.
The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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June 3, 2022

Administrator
Charter House
211 Northwest Second Street
Rochester, MN 55901

RE: CCN: 245282
Cycle Start Date: April 7, 2022

Dear Administrator:

On April 29, 2022, we informed you that we may impose enforcement remedies.

On May 20, 2022, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. 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. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On May 12, 2022, the situation of immediate jeopardy to potential health and safety cited at F684 was removed. This deficient practice was corrected prior to the start of the survey and was therefore Past Noncompliance.

On May 20, 2022, the situation of immediate jeopardy to potential health and safety cited at F678 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 18, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 18, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 18, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires 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. <u>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.</u>

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 § 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, Charter House is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 20, 2022. 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.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 7, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to 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
(202) 565-9462

A request for a hearing should identify the specific issues, 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. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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 electronic 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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245282	A. BUILDING _____ B. WING _____	C 05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER HOUSE	211 NORTHWEST SECOND STREET ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/17/22 through 5/20/22, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT in compliance with requirements of 42 CFR Part 483, Subpart B, the requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H52821180C (MN00083128) with a deficiency cited an F678. The survey resulted in an immediate jeopardy (IJ), cardiopulmonary resuscitation (CPR) at F678. The IJ began on 5/1/22, at 5:03 a.m. when the facility did not perform CPR, against R1's wishes for resuscitation and physician's order. The administrator was notified of the IJ on 5/18/22, at 4:40 p.m. The IJ was removed on 5/20/22, at 1:50 p.m. when the facility successfully implemented a removal plan. An extended survey was completed. The survey also resulted in a finding of immediate jeopardy PAST NON-COMPLIANCE at F684 when the facility failed to provide onoging assessments of a resident (R1) who was having shortness of breath and low oxygen saturation levels. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the correction. NO plan of correction is required for a finding of past non-compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

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

Electronically Signed | 06/10/2022

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 000	Continued From page 1 Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	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: Based on interview and document review, the facility failed to follow the Provider Orders for Life Sustaining Treatment (POLST), did not initiate cardiopulmonary resuscitation (CPR) as per the residents wishes or follow the American Heart Association guidelines for CPR for 1 of 1 residents (R1). R1 was found without a pulse or respirations and staff did not initiate CPR and expired. This resulted in an Immediate Jeopardy (IJ) for R1. The IJ began on 5/02/22, at approximately 4:45 a.m. when R1 had no respirations or pulse, and CPR was not initiated. The administrator and	F 678	Plan of Correction: Charter House is wholly owned and operated by Mayo Clinic. Charter House staff are trained on and follow Mayo Clinic Policies and Procedures, as well as specific policies identified for the unique population at the Charter House. At the time of the incident, Charter House staff relied upon existing Mayo Clinic Code Blue Policy and existing Lippincott Code Blue procedure for medical emergency response as applicable to Charter House staff. To support further compliance and staff training, Charter House developed	6/10/22

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F 678	Continued From page 2 nurse manager (NM)-A were notified of the immediate jeopardy on 5/18/22, at 2:45 p.m. The facility implemented corrective action and the IJ was removed on 5/20/22, at 2:45 p.m. However, non-compliance remained at the lower scope and severity of a D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's Face Sheet dated 4/25/22, indicated R1 was admitted to the facility for short term care rehabilitation, with diagnoses of cardiovascular disease, heart failure, hypertensive heart, stage 4 chronic kidney disease, leakage of heart valve prosthesis, and aortic valve insufficiency. R1's 5-day Minimum Data Set (MDS) dated 5/2/22, indicated R1 was cognitively intact. R1's care plan printed on 5/18/22, directed R1 anticipates discharging and returning to his independent living venue and resuming home health care. On admission R1 confirmed and provided a copy of his POLST dated 7/28/14, directing that in the event of cardiopulmonary arrest, staff would attempt resuscitation and begin CPR. R1's POLST was confirmed by his primary care physician (PCP) on 4/25/22, indicating R1 confirms his wishes to be full code (perform chest compressions and rescue breathing) today and CPR components and outcomes discussed. A Progress Note dated 5/2/22, at 7:24 a.m. registered nurse (RN)-A documented R1 was observed on 5/2/22, at 5:03 a.m. and that he	F 678	and adopted a Charter House-specific, Code Blue Policy and Procedure, developed in accordance with the American Heart Association guidelines for cardiopulmonary resuscitation (CPR). The Charter House Code Blue Policy and Code Blue Procedure were developed and approved by the Charter House Quality Assurance and Performance Improvement Committee on May 20,2022, and staff were trained and educated and the policy implemented on May 20, 2022. All resident charts were reviewed to ensure the code status was correct in the electronic health record by May 20, 2022. For each new admission beginning on May 20, 2022, the code status is reviewed by the admitting nurse and verified by the provider. Nurses assigned to each resident will document Code Status and per applicable Provider Orders for Life Sustaining Treatment (POLST) Physician Orders. Visual reminders of code status will be implemented by placing colored stickers on each resident's chart binder and a colored magnet placed on the right upper corner of the whiteboard in each resident's room. Residents whose code status is Do Not Resuscitate (DNR) will be noted by a red circle and residents whose code status is full code will be noted by a green circle. This process was fully implemented as of June 7, 2022. Charter House implemented mock code drills across all shifts starting May 11, 2022. Mock code drills will continue twice monthly for six months including all three	

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F 678	Continued From page 3 passed away peacefully in his sleep. There were no signs of life. House supervisor RN-B was paged, and she confirmed no signs of life (no vital signs, no blood pressure, and not breathing). The progress note does not document that CPR was attempted. During an interview on 5/17/22, at 4:45 p.m. NM-A stated R1 was a full code and CPR should have been started, but it was not. NM-A interviewed RN-A and asked her why she did not start CPR and RN-A shared it was the first time she had encountered a resident death and did not know what to do. NM-A provided the Emergency Medical Response (Code Blue and Rapid Response Teams) Policy - Rochester, unknown date, that directed on how to provide a coordinated response to a medical emergency but did not contain components from American Heart Association (AHA) recommendations that directed staff when to initiate basic life support or address how to ensure staff were familiar with facility policies related to CPR. NM-A stated she is unaware of what components of the AHA guidelines should be included in a policy or what assessments indicators would indicate if CPR should be initiated or not. NM-A stated there were no other policies for CPR. During an interview on 5/18/22, at 8:06 a.m. primary care provider (PCP) stated R1 has a lot of comorbidities from his hospitalization and additionally his advanced age. PCP stated his expectations if the facility would follow their protocol for care of residents. PCP further stated if there is no documentation in the chart it is hard to verify what care was provided. During an interview on 5/18/22, at 8:45 a.m.	F 678	shifts (day, evening and night) in varied locations. After six months, drill frequency will decrease to once monthly for six months with random audits thereafter. Mock codes are conducted by the nurse manager and/or staff development coordinator with just in time feedback and correction. Procedure for implementing PoC: Charter House nursing staff and certified nursing assistant staff were reeducated on the new Charter House Code Blue Policy and Procedure in team huddles starting with the first reporting shift at 2 p.m. on May 20, 2022. Email communication of the new policy and procedure was sent to all applicable staff on May 20, 2022. Documentation of receipt and review of the policy and procedure was demonstrated through return-receipt notification on email and a required response to the email indicating review and understanding by each staff member. The email response was printed and available in each staff member's personnel file. Emergency preparedness with Code Blue Policy/Procedure and mock coded integrated into orientation and annual training. All applicable staff will be educated on the policy and procedure by June 10, 2022. All resident charts were reviewed by nurse manager or RN care coordinator to validate code status, and providers and nursing staff were educated on the process to validate code status upon admission and documented by nursing	

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F 678	Continued From page 4 nursing assistant (NA)-D stated she received an end of shift report from NA-A at approximately 10:00 p.m. but there was no mention of R1 having oxygen on. When NA-A rounded on R1 at approximately midnight, R1 was noted to not have oxygen or his C-PAP on. NA-D stated nursing assistants are supposed to check and change R1 every two hours, but he was not observed until approximately 3:00 a.m. by NA-E. NA-D indicated NA-E observed R1 was moving at 3:00 a.m. so she did not check, change, or reposition him. At approximately 4:58 a.m. NA-D went to R1's room and found out that he had passed away. During an interview on 5/19/22, at 1:00 p.m. RN-A stated she had not been assigned to the hallway that R1 resides, usually works the other hallway, so she has limited experience in providing care for R1. RN-A indicated she checked on all the residents at the beginning of her shift and when she observed R1, he appeared to be sleeping and did not seem in distress. RN-A stated she did not wake R1 or complete an assessment. RN-A stated she did not document her observation and does not chart every interaction she has with a resident. RN-A acknowledged she did not assess or chart any interaction with R1 until approximately 4:45 a.m. on 5/2/22, when R1 was found deceased. RN-A stated R1 was cold, and his hands and arms were getting stiff. RN-A stated she knew R1 was a full code and should have started CPR but has not experienced a death of a resident and was not sure of what she should do. RN-A stated she is not familiar if the facility has a code blue policy. RN-A stated she thought the overnight nursing supervisor would tell her what to do but she did not inform RN-B	F 678	staff on the work sheet at the start of each shift. Staff were educated on the new visual alert process of the green and red dots and appropriate placement. Education was performed through one-on-one education and emails to verify and document code status on their work sheet at the start of each shift as noted in Physician Orders for affected staff, including housekeeping staff responsible for whiteboard cleaning and maintenance, and documented understanding recorded via email read-receipt or log signed by staff after verification of understanding by supervisor. All education will be completed as of June 10, 2022. Monitoring: Mock code drills will be completed twice monthly by nurse manager or staff development coordinator (or designee) for 6 months, once monthly for the following 6 months and random audits thereafter. Just in time reeducation and correction will occur with the mock code drills. Emergency preparedness with Code Blue Policy/Procedure and mock coded integrated into orientation and annual training per coordinated efforts of Director of Health Services, nurse manager and staff development coordinator. For the code status and visual alert process compliance, the nurse manager or RN care coordinator will monitor each resident's chart twice a week for 4 weeks, weekly for 2 months, then monthly for 6 months with random audits thereafter.	

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F 678	Continued From page 5 that R1 was a full code. During an interview on 5/18/22, at 9:06 a.m. director of nursing (DON) stated it appeared that nursing did not document any overnight contact with R1 on 5/1/22, until approximately 5:00 a.m. on 5/2/22. DON stated all residents should be assessing after any change in condition and it should be documented in the residents chart. DON further stated there is a nurse assigned to every resident and the vital signs sheet for R1 should have gone directly to that nurse. DON confirmed that Mayo Clinic Health System has their own CPR policy, they follow Lippincott Nursing Procedures and indicated she was unaware of the AHA guidelines. The IJ began on 5/2/22, was removed on 5/20/22, at 2:45 p.m. when the facility implemented one-on-one coaching for RN-A, all staff were required to complete the watch-and-notify reeducation on resident assessment, documentation, oxygen delivery, reporting of abnormal vital signs, attend Mock Code in-service training, and review the Emergency Medical Response Code Blue Procedure - Charter House revision and implementation dated 5/20/22, and Emergency Medical Response Code Blue Policy - Charter House 5/20/22 revision and implementation.	F 678	Person responsible for implementing PoC: Director of Health Services- Charter House	
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		6/10/22

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F 684	Continued From page 6 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide ongoing assessments and monitoring after a respiratory change of condition was identified for 1 of 1 residents (R1) who sustained a medical emergency requiring administration of oxygen. R1 was found without a pulse or respirations, and subsequently died. This resulted in an Immediate Jeopardy (IJ) for R1. The IJ began on 5/1/22, when the facility failed to provide ongoing assessment of R1 who was having shortness of breath and low oxygen saturation levels. R1 was found deceased on 5/2/22. The administrator and nurse manager were notified of the IJ on 5/18/22, at 2:45 p.m. The IJ was removed, and the deficient practice was corrected on 5/12/22, prior to the start of the survey and was therefore Past Noncompliance. Findings include: R1's Face Sheet dated 4/25/22, indicated R1 was admitted to the facility for short term care rehabilitation, with diagnosis's of cardiovascular disease, heart failure, hypertensive heart, stage 4 chronic kidney disease, leakage of heart valve prosthesis, and aortic valve insufficiency. R1's health history and physical exam dated 4/25/22, by R1's primary care physician, documented R1 was being admitted to the facility with acute on chronic diastolic (congestive) heart failure.	F 684	Past noncompliance: no plan of correction required.	

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	245282	A. BUILDING _____ B. WING _____	C 05/20/2022

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F 684	Continued From page 7 R1's 5-day Minimum Data Set (MDS) dated 5/2/22, indicated R1 was cognitively intact, exhibited no signs of delirium (temporary mental state characterized by confusion and anxiety), R1's MDS indentified R1 did not use oxygen. R1's care plan printed on 5/18/22, directed R1 anticipates discharging and returning to his independent living venue and resuming home health care, at risk for fluid imbalance related to diuretic medication, has cardiac and renal disease and placed on a fluid restriction, activities of daily living decreased functional abilities related to recent hospital stay and weakness, nursing staff to provide assistance to reposition and off load at least every two-three hours and as needed in bed and chair and monitor oxygen saturation. R1's admission physician medication order dated 4/25/22, included Ipratropium Bromide (albuterol nebulizer) inhalation nebulization solution as needed for wheezing or shortness of breath. R1's Cardiology Hospital Discharge Summary dated 4/25/22, indicated on 4/12/22, R1 underwent a transcutaneous aortic valve replacement for severe calcific aortic valve stenosis (replacement of calcific heart valve). A Progress Note dated 4/29/22, at 4:00 p.m. by registered nurse (RN)-H documented R1 continues to have a persistent productive cough with whitish sputum. R1 had one dose of albuterol nebulizer with some relief and lung sounds are diminished. A Progress Note dated 5/01/22, at 9:36 p.m.	F 684		

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F 684	Continued From page 8 licensed practical nurse (LPN)-A documented R1's oxygen saturation was 79% (normal saturations are considered to be 95%-100%; 79% reflects severe hypoxia and a medical emergency) on room air and he has shortness of breath while resting. Oxygen (O2) standing orders activated and R1 was placed on 2 liters (lpm) of oxygen per nasal cannula. O2 saturation level improved to 94% on 2 lpm. In-basket notification was faxed to certified nurse practitioner (CNP). LPN-A indicated During non-business hours, the providers In-Basket is monitored by the on-call provider. It is the responsibility of the on-call provider to monitor faxes from the In-Basket and to respond to the facility. It is unknown why the on-call provider did not respond to the facility fax. A Progress Note dated 5/2/22, at 7:24 a.m. RN-A documented R1 was observed at 5:03 a.m. on 5/2/22, and that he passed away peacefully in his sleep. There were no signs of life. House supervisor RN-B was paged, and she confirmed no signs of life (no vital signs, no blood pressure, and not breathing). R1's medical record was reviewed between 5/1/22 to 5/2/22, and no respiratory documentation of R1's level of consciousness, breathing rate, pattern and effort, skin color, chest configuration, or symmetry of chest expansion was documented. During an interview on 5/17/22, at 4:45 p.m. nurse manager (NM)-A stated from her chart review, she did not find documentation by RN-A that she provided any care, assessments and monitoring for R1 during her overnight shift from 5/1/22 - 5/2/22.	F 684		

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F 684	Continued From page 9 During an interview on 5/18/22, at 8:06 a.m. primary care physician (PCP) stated R1 has a lot of comorbidities from his hospitalization and additionally his advanced age. PCP stated his expectations if the facility would follow their protocol for care of residents. PCP further stated if there is no documentation in the chart, it is hard to verify what care was provided. During an interview on 5/18/22, at 8:45 a.m. nursing assistant (NA)-D stated she received an end of shift report from NA-A at approximately 10:00 p.m. but there was no mention of R1 having oxygen on. When NA-A rounded on R1 at approximately midnight, R1 was noted to not have oxygen or his C-PAP on. NA-D stated nursing assistants are supposed to check and change R1 every two hours, but he was not observed until approximately 3 a.m. by NA-E. NA-D explained at 3:00 a.m. NA-E had observed R1 was moving so she did not check or change or reposition him. At approximately 4:58 a.m. NA-D went to R1's room and found out that he had passed away. During an interview on 5/18/22, at 8:57 a.m. LPN-A stated on 5/1/22 she worked the 6 a.m. to 10 p.m. shift and handed off care to RN-A at the end of her shift. LPN-A informed RN-A that NA-A obtained R1's O2 saturation of 84% on 5/1/22, at 7:35 p.m. and placed the Dynmap Vital Signs Machine print out slip on the nurses' desk instead of notifying her. LPN-A stated by the time she assessed R1 on 5/1/22, at approximately 9:30 p.m. R1's O2 saturation had decreased to 79%. Further, R1 was experiencing shortness of breath and a high respiratory rate. LPN-A informed RN-A that she started R1 on oxygen at 2 lpm., per the	F 684		

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F 684	Continued From page 10 Standing Order, and sent an in-basket message to CNP. During an interview on 5/18/22, at 9:45 a.m. NA-C stated if an abnormal vital sign is obtained, the nursing assistant (NA) is required to immediately take it to the nurse in charge of the resident. The NA must stop all other activities and report to the nurse. During an interview on 5/19/22, at 1:00 p.m. RN-A stated she had not been assigned to the hallway that R1 resided, usually worked the other hallway, so she had limited experience in providing care for R1. RN-A acknowledged that LPN-A provided an end of shift report on R1's oxygen status. RN-A stated the end of shift report from LPN-A, indicated that R1 appeared to have improved with the 2 lpm oxygen via the nasal cannula. RN-A indicated she checked on all the residents at the beginning of her shift and when she observed R1, he appeared to be sleeping and did not seem in distress. RN-A stated she did not wake R1 or complete an assessment. RN-A stated she did not document her observation and does not chart every interaction she had with a resident. RN-A stated she did not have enough time to chart every observation or interaction she had with a resident. RN-A stated it is the nursing assistants job to check and change and reposition R1 every two hours, but they did not complete that task so they didn't see how R1 was doing and if his condition had further detiorated. RN-A acknowledged she did perform assessments or chart any interaction with R1 until approximately 4:45 a.m. on 5/2/22, when R1 was found deceased. RN-A stated R1 was cold, and his hands and arms were getting stiff.	F 684		

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F 684	Continued From page 11 On 5/18/22, at 8:37 a.m. attempts to contact NA-A were unsuccessful due to NA-A being out of the country. During an interview on 5/18/22, at 10:45 a.m. nurse manager (NM)-A summarized from her investigation that NA-A obtained an oxygen level of 84% but did not immediately notify the nurse in charge of the resident. Further, NA-A continued to obtain other residents vital assigns before she placed the vital sign slip on the nurse desk, again did not notify the nurse. NM-A stated NA-A indicated she did not understand that she should have notified the nurse immediately if an abnormal vital sign is obtained. During an interview on 5/18/22, at 9:06 a.m. director of nursing (DON) stated it appeared that nursing did not document any overnight contact with R1 on 5/1/22, until approximately 5:00 a.m. on 5/2/22, when R1 was found expired. DON stated all residents should be assessed after any change in condition and it should be documented in the residents chart. DON further stated there is a nurse assigned to every resident and the vital signs sheet for R1 should have gone directly to that nurse. During an interview on 5/19/22, 2:30 p.m. RN-B stated on 5/2/22, at approximately 4:45 a.m. she was notified that R1 had passed away. RN-B stated she confirmed that R1 did not have an apical pulse and was not breathing. RN-B indicated she did not inquire about R1's overnight care or code status. The Standing Orders for Post-Acute and Long-Term Care (Adapted for Charter House) policy revised date 5/2019, directed that in a Change of Condition, if the oxygen saturation	F 684		

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F 684	Continued From page 12 level is less than 88% from baseline room air, notify the clinician. No documentation could be found in R1's chart that a clinician responded to R1's low oxygen saturation. The past noncompliance IJ began on 5/1/22. The immediate jeopardy was removed, and the deficient practice corrected on 5/12/22 after the facility implemented one-on-one coaching for RN-A and NA-A, and all staff were required to complete the watch-and-notify reeducation on resident assessment, documentation, oxygen delivery, and reporting of abnormal vital signs.	F 684		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 3, 2022

Administrator
Charter House
211 Northwest Second Street
Rochester, MN 55901

Re: Event ID: KR4C11

Dear Administrator:

The above facility survey was completed on May 20, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/17/22 through 5/20/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders and identify the date when they will be	2 000		

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2 000	Continued From page 1 completed. The following complaint was found to be SUBSTANTIATED: H52821180C (MN00083128), no licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by," Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at	2 000		

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2 000	Continued From page 2 the bottom of the first page of state form. 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.	2 000		