



Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name: Bethel Care Center			Report Number: H5295125	Date of Visit: July 24 & 25, 2017
Facility Address: 420 Marshall Avenue			Time of Visit: 8:30 a.m. to 4:35 p.m. & 9:00 a.m. to 10:45 a.m.	Date Concluded: December 19, 2017
Facility City: St Paul			Investigator's Name and Title: Deborah Neuberger, RN, Special Investigator	
State: Minnesota	ZIP: 55102	County: Ramsey		

Nursing Home

Allegation(s):

It is alleged that a resident was neglected when facility staff failed to provide adequate supervision during an activity and the resident's ventilator became disconnected resulting in the resident's death.

- Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence neglect occurred. The resident's ventilator tubing became detached and alarmed which indicated it was detached. No ventilator trained facility staff were available to respond to the alarm, and the detached ventilator tubing was not discovered until approximately one hour at which time, the resident was dead.

The resident was a long term resident of the facility. The resident was ventilator dependent 24 hours a day, 7 days a week due to acute and chronic respiratory failure and in a persistent vegetative state. Facility staff were required to anticipate all of the resident's needs. The resident had a do not resuscitate (DNR) order.

Staff members brought the resident to the church service at about 2:00 p.m. The resident's ventilator was functioning properly at that time. During the church service, the resident's ventilator alarm sounded, but no ventilator trained staff were present. Pastoral staff stated s/he heard the alarm, but had been previously instructed by a nursing staff member to ignore the alarm, so s/he ignored the alarm. At about 3:00 p.m. Pastoral staff observed the resident had poor color, and called for help. Nursing staff responded to the Pastor's request for assistance and found the resident with no vital signs. Nursing staff observed the

resident's ventilator tubing disconnected and reconnected the ventilator tubing. Once staff reconnected the tubing, the alarm stopped and the resident's chest began to rise and fall. Staff called 911 and initiated emergency respiratory breaths manually to the resident, but the resident had a DNR order, so staff did not initiate cardiopulmonary resuscitation (CPR). Staff were never able to obtain any vital signs on the resident, and the resident was pronounced deceased at 3:36 p.m. by emergency medical services (EMS) and the on-call physician staff. The facility had no policies related to supervision of ventilator dependent residents by ventilator trained staff at activities.

A review of the ventilator log revealed the resident's ventilator alarmed at 2:02 p.m., which indicated the ventilator tubing was disconnected. This meant the ventilator did not function normally and the resident did not get adequate ventilation.

A review of ventilator monthly vent check documents at the time of the onsite investigation, revealed the ventilator was recently checked for functionality, and found in working order.

During an interview, the resident's physician stated s/he recently evaluated the resident and the resident was in stable condition. The resident's physician stated it was not likely the resident would have died that day if the ventilator tubing had remained connected.

Contact with law enforcement revealed police responded to the 911 call at the facility. The investigation was ongoing.

The document titled Documentation of Death revealed the resident's cause of death was listed as Asphyxia due to disconnection of the ventilator tubing.

In response to the incident, the facility initiated a new policy that ventilator trained staff are available at all activities that are attended by residents who are ventilator dependent.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

- | | | |
|---|---|---|
| <input type="checkbox"/> Abuse | <input checked="" type="checkbox"/> Neglect | <input type="checkbox"/> Financial Exploitation |
| <input checked="" type="checkbox"/> Substantiated | <input type="checkbox"/> Not Substantiated | <input type="checkbox"/> Inconclusive based on the following information: |

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 no policies related to supervision of ventilator dependent residents during activities, and no ventilator trained staff was available to respond to the resident's ventilator alarm for about one hour.

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

(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

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: Yes No

(State licensing orders will be available on the MDH website.)

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

State licensing orders were issued: Yes No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

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.

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

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
- Nurses Notes
- Assessments
- Physician Orders
- Treatment Sheets
- Physician Progress Notes
- Care Plan Records

Other pertinent medical records:

- Police Report

Additional facility records:

- Staff Time Sheets, Schedules, etc.
- Facility Internal Investigation Reports
- Personnel Records/Background Check, etc.
- Facility Policies and Procedures

Number of additional resident(s) reviewed: 3 _____

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: The resident was deceased. _____

Interviews: The following interviews were conducted during the investigation:

Interview with reporter(s) Yes No N/A

Specify: _____

If unable to contact reporter, 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: The resident was deceased. _____

Did you interview additional residents? Yes No

Total number of resident interviews: 6 _____

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

Tennessee Warnings

Tennessee Warning given as required: Yes No

Total number of staff interviews: 14 _____

Physician Interviewed: Yes No

Nurse Practitioner Interviewed: Yes No

Physician Assistant Interviewed: Yes No

Interview with Alleged Perpetrator(s): Yes No N/A Specify: None identified. _____

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 _____

Observations were conducted related to:

- Nursing Services
- Use of Equipment
- Cleanliness
- Dignity/Privacy Issues
- Safety Issues

Was any involved equipment inspected: Yes No N/A

Was equipment being operated in safe manner: Yes No N/A

Were photographs taken: Yes No Specify: Photo's of the ventilator and where it was detached

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Ramsey County Medical Examiners

St Paul Police Department

Ramsey County Attorney

St Paul City Attorney



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 5, 2017

Mr. Cory Glad, Administrator
Bethel Care Center
420 Marshall Avenue
Saint Paul, MN 55102

RE: Project Number H5295125

Dear Mr. Glad:

On October 27, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 1, 2017. (42 CFR 488.422)

Also on October 27, 2017, this Department informed you that the following enforcement remedies were being recommended to the the Centers for Medicare and Medicaid Services (CMS), they concurred, and imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 27, 2017. (42 CFR 488.417 (b))

Furthermore on October 27, 2017, we recommended to the the Centers for Medicare and Medicaid Services (CMS) the following action:

- Civil Money Penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on September 27, 2017. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On November 29, 2017, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on September 27, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 22, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our abbreviated standard survey, completed on September 27, 2017, as of November 22, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state

Bethel Care Center
December 5, 2017
Page 2

monitoring effective November 22, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of October 27, 2017:


- Civil Money Penalty for the deficiency cited at F323 remain in effect. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 27, 2017 be rescinded as of November 22, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,



Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

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

PRINTED: 01/11/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 11/29/2017
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NAME OF PROVIDER OR SUPPLIER BETHEL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE SAINT PAUL, MN 55102
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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) COMPLETION DATE
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{F 000}	<p>INITIAL COMMENTS</p> <p>A Post Certification revisit was conducted on 11/29/2017, to follow up on deficiencies issued related to complaint H5295125. Bethel Care Center is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities.</p> <p>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. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 12/07/2017
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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.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 27, 2017

Mr. Cory Glad, Administrator
Bethel Care Center
420 Marshall Avenue
Saint Paul, MN 55102

RE: Project Number H5295125

Dear Mr. Glad:

On September 27, 2017, an abbreviated standard survey was completed at your facility by the Minnesota Departments of Health, Office of Health Facility Complaints to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Annette Winters, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: annette.m.winters@state.mn.us
Phone: (651) 201-4204
Fax: (651) 281-9796

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; **OR**
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; **OR**
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; **OR**
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey **OR** deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; **OR**
- A facility is classified as a Special Focus Facility (SFF) **AND** has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective Nov 1, 2017. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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, Licensing and Certification Program 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 revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 27, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 March 27, 2018 (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 Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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:

Bethel Care Center
October 27, 2017
Page 5

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm>

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,



Kate JohnSTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

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

PRINTED: 09/05/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/08/2017
NAME OF PROVIDER OR SUPPLIER BETHEL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE SAINT PAUL, MN 55102		
(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	F 000			
F 323 SS=G	<p>An abbreviated standard survey was conducted to investigate case #H5295125. As a result, the following deficiencies are 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.</p> <p>483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>(d) Accidents. The facility must ensure that -</p> <p>(1) The resident environment remains as free from accident hazards as is possible; and</p> <p>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:</p>	F 323			

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.

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

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NAME OF PROVIDER OR SUPPLIER BETHEL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE SAINT PAUL, MN 55102		
(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 323	<p>Continued From page 1</p> <p>Based on interview and document review the facility failed to adequately supervise one of four resident's reviewed, (R1), when R1, who is ventilator dependent, was taken to an activity off the unit without the supervision by a ventilator trained staff. R1's was harmed when R1's ventilator disconnected, alarmed, no ventilator trained staff were available to respond to the alarm, and R1 died.</p> <p>Findings include:</p> <p>R1's medical record was reviewed. R1 was admitted with a diagnosis of acute and chronic respiratory failure.</p> <p>R1's care plan dated initiated 6/6/2014 indicated R1 was vulnerable and needed all his needs anticipated by staff due to his persistent vegetative state, had a Do Not Resuscitate (DNR) order, and was ventilator and tracheostomy dependent due to chronic respiratory failure.</p> <p>The document titled Monthly Vent Check Sheet, dated 7/10/2017 indicated the ventilator company checked R1's ventilator for functionality, and R1's ventilator was operating correctly.</p> <p>R1's Nurse Practitioner visit note, dated 7/11/2017 indicated R1 had unlabored respirations, was dependent on the ventilator 24-hours a day, 7 days a week, and staff must anticipate all of R1's needs.</p> <p>Nursing note dated 7/16/2017, written by Registered Nurse (RN)-G, indicated R1 was in church service at 2:00 p.m. on 7/16/2017 and R1's ventilator became disconnected. After the church service, the disconnected ventilator tube</p>	F 323		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/08/2017
NAME OF PROVIDER OR SUPPLIER BETHEL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE SAINT PAUL, MN 55102		
(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 323	<p>Continued From page 2</p> <p>was observed after the reverend called for help. RN-G reconnected the ventilator tube, and R1's chest began to rise and fall. No blood pressure, pulse or pulse oxygen was detected by staff. Staff Ambu-bagged R1, called 911, and continued to bag R1 until emergency medical services (EMS) arrived. R1 was pronounced dead at 3:36 p.m. after EMS arrived and after discussion with the on-call doctor.</p> <p>An untitled document identified by staff as the ventilator log, indicated on 7/16/2017 at 2:02 p.m. the ventilator circuit disconnected.</p> <p>A review of R1's death certificate indicated R1 died on 7/16/2017 and R1's cause of death was listed as asphyxia due to disconnection of the ventilator tube.</p> <p>During an interview on 7/24/2017 at 3:45 p.m., RN-J stated she cared for R1 on 7/16/2017 on the day shift. Just before R1 left the unit for church, which was scheduled for 2:00 p.m. in the dining room. RN-J checked R1's condition. R1's vital signs were stable, his ventilator was functioning, the tubing was connected properly, and the ventilator was not alarming.</p> <p>During an interview on 7/24/2017 at 2:45 p.m., Nursing Assistant (NA)-H stated she cared for R1 on the day shift on 7/16/2017. R1's condition was stable a when he left the unit for church in the dining room. At about 2:05 p.m. she brought R1 downstairs for church. At that time, R1's ventilator was functioning and was not alarming. NA-H stated she checked him again at about 2:10 p.m. and his ventilator was functioning normally and not alarming. The facility had no policy for ventilator trained staff to stay with ventilator</p>	F 323		

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

PRINTED: 09/05/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/08/2017
NAME OF PROVIDER OR SUPPLIER BETHEL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE SAINT PAUL, MN 55102		
(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 323	<p>Continued From page 3</p> <p>dependent residents when they are at activities off the unit, and she left R1 in the dining room for church service.</p> <p>During an interview on 7/24/2017 at 4:10 p.m., the reverend stated on 7/16/2016 he gathered residents for church services in the dining room as he normally did. The reverend stated the process included nursing staff bringing residents to the dining room for services as well as he assists residents to the services. He stated all residents (including ventilator dependent residents) are alone in the dining room as he gathers residents from the units for the service that started at 2:00 p.m. At about 2:00 p.m. the service started. He brought R1 into the room from the elevator where NA-H had brought him. At that time, R1's alarm was not sounding. At sometime during the service, R1's ventilator started to beep. The sound was the same as one he had heard previously, and he had been told by a nursing staff member (name unknown) that the beep he heard was not important and he could ignore it. The reverend stated since it was the same sound he had heard previously and he had been told to ignore it then, he thought it was okay and did not seek help. The reverend stated he had never been formally trained on ventilator issues, but had just learned by watching staff and didn't know what the alarms meant. He stated the facility had no policy or practice related to having ventilator trained staff in activities when ventilator dependent residents were attending the activities, and no ventilator trained staff were in the activity. The reverend stated at the end of the service, at about 3:00 p.m. he realized R1's color was bad and he had a problem, so he called for help.</p> <p>During an interview on 7/24/2017 at 2:30 p.m.,</p>	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 323	<p>Continued From page 4</p> <p>RN-G stated she was called to the lobby area on 7/16/2017 for another resident problem at about 3:00 p.m. When RN-G got the the lobby area, right outside the dining room, the area was in chaos with a lot of loud noise and residents in the area due to the other incident she was called down there for. RN-G stated she did not hear R1's ventilator alarm. When the Reverend called for assistance she was one of the staff who responded. When she got close she could hear his ventilator was disconnected somewhere by the sounds it was making. She saw that the ventilator tubing was completely detached at the humidifier port. When she reconnected the tubing the alarm stopped sounding and R1's chest started to rise and fall. RN-G brought R1 upstairs to his room. Staff members attached him to the vitals tower to check his vital signs and his vital signs did not register. A check of his pulse oxygen revealed no reading. R1 was DNR so staff did not initiate CPR, but staff Ambu-bagged him and called 911. EMS paramedics arrived quickly and were unable to get any vital signs. R1's on-call doctor was called and EMS told staff to stop bagging him. RN-G stated the facility had no policy related to having ventilator trained staff in activities when ventilator dependent residents were at the activity, and there were no ventilator trained staff in the church service that day.</p> <p>During an interview on 7/25/2017 at 9:00 a.m., Director of Nursing (DON)-B stated the facility had no policy related to ensuring ventilator trained staff were at activities when ventilator dependent residents were at the activity prior to this incident. DON-B stated the facility took action related to this event to ensure nothing like this ever happens again. DON-B stated the facility staff checked all ventilators to ensure they were</p>	F 323			

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

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F 323	<p>Continued From page 5</p> <p>functioning properly and were alarming properly and changed facility policy to ensure that a ventilator trained staff member is at all activities that ventilator dependent residents attend. The facility staff meet each morning to review the activities and assign a ventilator trained staff member to attend all activities that ventilator dependent resident attend. The new policy, titled Bethel Care Center Vent Patient Activities had already been implemented.</p> <p>During an interview on 7/25/2017 at 1:40 p.m., R1's family member stated he saw R1 about 1 week prior to 7/16/2017 and R1 was stable. R1's family member questioned how this incident happened.</p> <p>During an interview on 7/26/2017 at 11:25 a.m., R1's physician stated she saw R1 regularly and his condition did not change much from visit to visit. During the last visit there were no symptoms of any medical concerns. R1's physician further stated that it is not likely R1 would have died on 7/16/2017 if his ventilator tubing had not become detached.</p> <p>The policy titled Monitoring the Ventilator Dependent Resident, dated June 2015 and provided by facility staff revealed: Care of the ventilator dependent resident will be performed under the supervision of the assigned nurse or respiratory care practitioner and under the direction of the resident's physician. Licensed nurses and respiratory care practitioners must be trained in ventilator care with demonstrated ability to complete the following: summon appropriate resources as needed to determine or remedy equipment or resident problem, respond quickly to emergencies including, but not limited to</p>	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 323	Continued From page 6 accidental ventilator disconnection. The new policy dated July 2017 and titled Bethel Care Center Vent Patient Activities revealed under Procedures. 2. Larger group activities such as music or church, which are too highly attended to be held on the vent unit will be held in the facility dining room and supervised by a vent trained staff.	F 323			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 5, 2017

Mr. Cory Glad, Administrator
Bethel Care Center
420 Marshall Avenue
Saint Paul, MN 55102

Re: Enclosed Reinspection Results - Complaint Number H5295125

Dear Mr. Glad:

On November 29, 2017 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on September 27, 2017. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the president of your facility's governing body.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Kate Johnston'.

Kate Johnston, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00913	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 11/29/2017
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NAME OF PROVIDER OR SUPPLIER BETHEL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE SAINT PAUL, MN 55102
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{2 000}	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: A licensing order follow-up was completed to follow up on correction orders issued related to complaint H5295125. Bethel Care Center was found in compliance with state regulations.</p> <p>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first</p>	{2 000}		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 12/07/17
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00913	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 11/29/2017
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NAME OF PROVIDER OR SUPPLIER BETHEL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE SAINT PAUL, MN 55102
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{2 000}	Continued From page 1 page of the State form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{2 000}		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 27, 2017

Mr. Cory Glad, Administrator
Bethel Care Center
420 Marshall Avenue
Saint Paul, MN 55102

Re: Enclosed State Nursing Home Licensing Orders - Complaint Number H5295125

Dear Mr. Glad:

A complaint investigation was completed on August 8, 2017. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the licensing order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited violation. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the violation within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the enclosed Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing 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 number and the corresponding text of 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 that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following investigator's findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

Bethel Care Center
October 27, 2017
Page 2

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Annette Winters, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: annette.m.winters@state.mn.us
Phone: (651) 201-4204
Fax: (651) 281-9796

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

If you have questions or concerns you may call me at the number below.

Sincerely,



Kate Johnston, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File
Home Care & Assisted Living File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00913	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/08/2017
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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5295125. 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</p>	2 000	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID</p>	
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00913	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/08/2017
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2 000	Continued From page 1 http://www.health.state.mn.us/divs/fpc/profinfo/info/obul.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	Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 1441.474 subd. 11 (b) (1) (2)	
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	2 830		

Minnesota Department of Health

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2 830	<p>Continued From page 2</p> <p>written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to adequately supervise one of four resident's reviewed, (R1), when R1, who is ventilator dependent, was taken to an activity off the unit without the supervision by a ventilator trained staff. R1's was harmed when R1's ventilator disconnected, alarmed, no ventilator trained staff were available to respond to the alarm, and R1 died.</p> <p>Findings include:</p> <p>R1's medical record was reviewed. R1 was admitted with a diagnosis of acute and chronic respiratory failure.</p> <p>R1's care plan dated initiated 6/6/2014 indicated R1 was vulnerable and needed all his needs anticipated by staff due to his persistent vegetative state, had a Do Not Resuscitate (DNR) order, and was ventilator and tracheostomy dependent due to chronic respiratory failure.</p> <p>The document titled Monthly Vent Check Sheet, dated 7/10/2017 indicated the ventilator company checked R1's ventilator for functionality, and R1's ventilator was operating correctly.</p> <p>R1's Nurse Practitioner visit note, dated 7/11/2017 indicated R1 had unlabored respirations, was dependent on the ventilator</p>	2 830		

Minnesota Department of Health

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2 830	<p>Continued From page 3</p> <p>24-hours a day, 7 days a week, and staff must anticipate all of R1's needs.</p> <p>Nursing note dated 7/16/2017, written by Registered Nurse (RN)-G, indicated R1 was in church service at 2:00 p.m. on 7/16/2017 and R1's ventilator became disconnected. After the church service, the disconnected ventilator tube was observed after the reverend called for help. RN-G reconnected the ventilator tube, and R1's chest began to rise and fall. No blood pressure, pulse or pulse oxygen was detected by staff. Staff Ambu-bagged R1, called 911, and continued to bag R1 until emergency medical services (EMS) arrived. R1 was pronounced dead at 3:36 p.m. after EMS arrived and after discussion with the on-call doctor.</p> <p>An untitled document identified by staff as the ventilator log, indicated on 7/16/2017 at 2:02 p.m. the ventilator circuit disconnected.</p> <p>A review of R1's death certificate indicated R1 died on 7/16/2017 and R1's cause of death was listed as asphyxia due to disconnection of the ventilator tube.</p> <p>During an interview on 7/24/2017 at 3:45 p.m., RN-J stated she cared for R1 on 7/16/2017 on the day shift. Just before R1 left the unit for church, which was scheduled for 2:00 p.m. in the dining room. RN-J checked R1's condition. R1's vital signs were stable, his ventilator was functioning, the tubing was connected properly, and the ventilator was not alarming.</p> <p>During an interview on 7/24/2017 at 2:45 p.m., Nursing Assistant (NA)-H stated she cared for R1 on the day shift on 7/16/2017. R1's condition was stable a when he left the unit for church in the</p>	2 830		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER BETHEL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE SAINT PAUL, MN 55102
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2 830	<p>Continued From page 4</p> <p>dining room. At about 2:05 p.m. she brought R1 downstairs for church. At that time, R1's ventilator was functioning and was not alarming. NA-H stated she checked him again at about 2:10 p.m. and his ventilator was functioning normally and not alarming. The facility had no policy for ventilator trained staff to stay with ventilator dependent residents when they are at activities off the unit, and she left R1 in the dining room for church service.</p> <p>During an interview on 7/24/2017 at 4:10 p.m., the reverend stated on 7/16/2016 he gathered residents for church services in the dining room as he normally did. The reverend stated the process included nursing staff bringing residents to the dining room for services as well as he assists residents to the services. He stated all residents (including ventilator dependent residents) are alone in the dining room as he gathers residents from the units for the service that started at 2:00 p.m. At about 2:00 p.m. the service started. He brought R1 into the room from the elevator where NA-H had brought him. At that time, R1's alarm was not sounding. At sometime during the service, R1's ventilator started to beep. The sound was the same as one he had heard previously, and he had been told by a nursing staff member (name unknown) that the beep he heard was not important and he could ignore it. The reverend stated since it was the same sound he had heard previously and he had been told to ignore it then, he thought it was okay and did not seek help. The reverend stated he had never been formally trained on ventilator issues, but had just learned by watching staff and didn't know what the alarms meant. He stated the facility had no policy or practice related to having ventilator trained staff in activities when ventilator dependent residents were attending the activities,</p>	2 830		

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2 830	<p>Continued From page 5</p> <p>and no ventilator trained staff were in the activity. The reverend stated at the end of the service, at about 3:00 p.m. he realized R1's color was bad and he had a problem, so he called for help.</p> <p>During an interview on 7/24/2017 at 2:30 p.m., RN-G stated she was called to the lobby area on 7/16/2017 for another resident problem at about 3:00 p.m. When RN-G got the the lobby area, right outside the dining room, the area was in chaos with a lot of loud noise and residents in the area due to the other incident she was called down there for. RN-G stated she did not hear R1's ventilator alarm. When the Reverend called for assistance she was one of the staff who responded. When she got close she could hear his ventilator was disconnected somewhere by the sounds it was making. She saw that the ventilator tubing was completely detached at the humidifier port. When she reconnected the tubing the alarm stopped sounding and R1's chest started to rise and fall. RN-G brought R1 upstairs to his room. Staff members attached him to the vitals tower to check his vital signs and his vital signs did not register. A check of his pulse oxygen revealed no reading. R1 was DNR so staff did not initiate CPR, but staff Ambu-bagged him and called 911. EMS paramedics arrived quickly and were unable to get any vital signs. R1's on-call doctor was called and EMS told staff to stop bagging him. RN-G stated the facility had no policy related to having ventilator trained staff in activities when ventilator dependent residents were at the activity, and there were no ventilator trained staff in the church service that day.</p> <p>During an interview on 7/25/2017 at 9:00 a.m., Director of Nursing (DON)-B stated the facility had no policy related to ensuring ventilator trained staff were at activities when ventilator dependent</p>	2 830		
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2 830	<p>Continued From page 6</p> <p>residents were at the activity prior to this incident. DON-B stated the facility took action related to this event to ensure nothing like this ever happens again. DON-B stated the facility staff checked all ventilators to ensure they were functioning properly and were alarming properly and changed facility policy to ensure that a ventilator trained staff member is at all activities that ventilator dependent residents attend. The facility staff meet each morning to review the activities and assign a ventilator trained staff member to attend all activities that ventilator dependent resident attend. The new policy, titled Bethel Care Center Vent Patient Activities had already been implemented.</p> <p>During an interview on 7/25/2017 at 1:40 p.m., R1's family member stated he saw R1 about 1 week prior to 7/16/2017 and R1 was stable. R1's family member questioned how this incident happened.</p> <p>During an interview on 7/26/2017 at 11:25 a.m., R1's physician stated she saw R1 regularly and his condition did not change much from visit to visit. During the last visit there were no symptoms of any medical concerns. R1's physician further stated that it is not likely R1 would have died on 7/16/2017 if his ventilator tubing had not become detached.</p> <p>The policy titled Monitoring the Ventilator Dependent Resident, dated June 2015 and provided by facility staff revealed: Care of the ventilator dependent resident will be performed under the supervision of the assigned nurse or respiratory care practitioner and under the direction of the resident's physician. Licensed nurses and respiratory care practitioners must be trained in ventilator care with demonstrated ability</p>	2 830		
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2 830	Continued From page 7 to complete the following: summon appropriate resources as needed to determine or remedy equipment or resident problem, respond quickly to emergencies including, but not limited to accidental ventilator disconnection. The new policy dated July 2017 and titled Bethel Care Center Vent Patient Activities revealed under Procedures. 2. Larger group activities such as music or church, which are too highly attended to be held on the vent unit will be held in the facility dining room and supervised by a vent trained staff. SUGGESTED METHOD OF CORRECTION: The Administrator or designee could update relevant policies, train staff on the updated policies and monitor staff for compliance with the policies. TIME PERIOD FOR CORRECTION: Twenty one (21) 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	21850		

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21850	<p>Continued From page 8</p> <p>period of time, and only when necessary to protect the resident from self-injury or injury to others.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure residents were free from maltreatment for one of four residents, (R1), reviewed when R1, who is ventilator dependent, was taken to an activity off the unit without the supervision by a ventilator trained staff. R1's was harmed when R1's ventilator disconnected, alarmed, no ventilator trained staff were available to respond to the alarm, and R1 died.</p> <p>Findings include:</p> <p>The policy titled Abuse Prevention Plan - MN, provided by facility staff and dated, revised 2/2017 indicated: Purpose: All residents have the right to be free from abuse, neglect, involuntary seclusion, exploitation and misappropriation of property. Neglect: The failure of a caregiver to supply a resident with care or services, including but not limited to food, clothing, shelter, healthcare or supervision which is reasonable and necessary to obtain or maintain the resident's physical or mental health or safety.</p> <p>The policy titled Monitoring the Ventilator Dependent Resident, dated June 2-15 and provided by facility staff indicated: Care of the ventilator dependent resident will be performed under the supervision of the assigned nurse or respiratory care practitioner and under the direction of the resident's physician. Licensed nurses and respiratory care practitioners must be trained in ventilator care with demonstrated ability to complete the following: summon appropriate</p>	21850		
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21850	<p>Continued From page 9</p> <p>resources as needed to determine or remedy equipment or resident problem, respond quickly to emergencies including, but not limited to accidental ventilator disconnection.</p> <p>R1's medical record was reviewed. R1 was admitted with a diagnosis of acute and chronic respiratory failure.</p> <p>R1's care plan dated initiated 6/6/2014 indicated R1 was vulnerable and needed all his needs anticipated by staff due to his persistent vegetative state, had a Do Not Resuscitate (DNR) order, and was ventilator and tracheostomy dependent due to chronic respiratory failure.</p> <p>The document titled Monthly Vent Check Sheet, dated 7/10/2017 indicated the ventilator company checked R1's ventilator for functionality, and R1's ventilator was operating correctly.</p> <p>R1's Nurse Practitioner visit note, dated 7/11/2017 indicated R1 had unlabored respirations, was dependent on the ventilator 24-hours a day, 7 days a week, and staff must anticipate all of R1's needs.</p> <p>Nursing note dated 7/16/2017, written by Registered Nurse (RN)-G, indicated R1 was in church service at 2:00 p.m. on 7/16/2017 and R1's ventilator became disconnected. After the church service, the disconnected ventilator tube was observed after the reverend called for help. RN-G reconnected the ventilator tube, and R1's chest began to rise and fall. No blood pressure, pulse or pulse oxygen was detected by staff. Staff Ambu-bagged R1, called 911, and continued to bag R1 until emergency medical services (EMS) arrived. R1 was pronounced dead at 3:36 p.m. after EMS arrived and after discussion with the</p>	21850		
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21850	<p>Continued From page 10</p> <p>on-call doctor.</p> <p>An untitled document identified by staff as the ventilator log, indicated on 7/16/2017 at 2:02 p.m. the ventilator circuit disconnected.</p> <p>A review of R1's death certificate indicated R1 died on 7/16/2017 and R1's cause of death was listed as asphyxia due to disconnection of the ventilator tube.</p> <p>During an interview on 7/24/2017 at 3:45 p.m., RN-J stated she cared for R1 on 7/16/2017 on the day shift. Just before R1 left the unit for church, which was scheduled for 2:00 p.m. in the dining room. RN-J checked R1's condition. R1's vital signs were stable, his ventilator was functioning, the tubing was connected properly, and the ventilator was not alarming.</p> <p>During an interview on 7/24/2017 at 2:45 p.m., Nursing Assistant (NA)-H stated she cared for R1 on the day shift on 7/16/2017. R1's condition was stable a when he left the unit for church in the dining room. At about 2:05 p.m. she brought R1 downstairs for church. At that time, R1's ventilator was functioning and was not alarming. NA-H stated she checked him again at about 2:10 p.m. and his ventilator was functioning normally and not alarming. The facility had no policy for ventilator trained staff to stay with ventilator dependent residents when they are at activities off the unit, and she left R1 in the dining room for church service.</p> <p>During an interview on 7/24/2017 at 4:10 p.m., the reverend stated on 7/16/2016 he gathered residents for church services in the dining room as he normally did. The reverend stated the process included nursing staff bringing residents</p>	21850		

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21850	<p>Continued From page 11</p> <p>to the dining room for services as well as he assists residents to the services. He stated all residents (including ventilator dependent residents) are alone in the dining room as he gathers residents from the units for the service that started at 2:00 p.m. At about 2:00 p.m. the service started. He brought R1 into the room from the elevator where NA-H had brought him. At that time, R1's alarm was not sounding. At sometime during the service, R1's ventilator started to beep. The sound was the same as one he had heard previously, and he had been told by a nursing staff member (name unknown) that the beep he heard was not important and he could ignore it. The reverend stated since it was the same sound he had heard previously and he had been told to ignore it then, he thought it was okay and did not seek help. The reverend stated he had never been formally trained on ventilator issues, but had just learned by watching staff and didn't know what the alarms meant. He stated the facility had no policy or practice related to having ventilator trained staff in activities when ventilator dependent residents were attending the activities, and no ventilator trained staff were in the activity. The reverend stated at the end of the service, at about 3:00 p.m. he realized R1's color was bad and he had a problem, so he called for help.</p> <p>During an interview on 7/24/2017 at 2:30 p.m., RN-G stated she was called to the lobby area on 7/16/2017 for another resident problem at about 3:00 p.m. When RN-G got the the lobby area, right outside the dining room, the area was in chaos with a lot of loud noise and residents in the area due to the other incident she was called down there for. RN-G stated she did not hear R1's ventilator alarm. When the Reverend called for assistance she was one of the staff who responded. When she got close she could hear</p>	21850		

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21850	<p>Continued From page 12</p> <p>his ventilator was disconnected somewhere by the sounds it was making. She saw that the ventilator tubing was completely detached at the humidifier port. When she reconnected the tubing the alarm stopped sounding and R1's chest started to rise and fall. RN-G brought R1 upstairs to his room. Staff members attached him to the vitals tower to check his vital signs and his vital signs did not register. A check of his pulse oxygen revealed no reading. R1 was DNR so staff did not initiate CPR, but staff Ambu-bagged him and called 911. EMS paramedics arrived quickly and were unable to get any vital signs. R1's on-call doctor was called and EMS told staff to stop bagging him. RN-G stated the facility had no policy related to having ventilator trained staff in activities when ventilator dependent residents were at the activity, and there were no ventilator trained staff in the church service that day.</p> <p>During an interview on 7/25/2017 at 9:00 a.m., Director of Nursing (DON)-B stated the facility had no policy related to ensuring ventilator trained staff were at activities when ventilator dependent residents were at the activity prior to this incident. DON-B stated the facility took action related to this event to ensure nothing like this ever happens again. DON-B stated the facility staff checked all ventilators to ensure they were functioning properly and were alarming properly and changed facility policy to ensure that a ventilator trained staff member is at all activities that ventilator dependent residents attend. The facility staff meet each morning to review the activities and assign a ventilator trained staff member to attend all activities that ventilator dependent resident attend. The new policy, titled Bethel Care Center Vent Patient Activities had already been implemented.</p>	21850		

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21850	<p>Continued From page 13</p> <p>During an interview on 7/25/2017 at 1:40 p.m., R1's family member stated he saw R1 about 1 week prior to 7/16/2017 and R1 was stable. R1's family member questioned how this incident happened.</p> <p>During an interview on 7/26/2017 at 11:25 a.m., R1's physician stated she saw R1 regularly and his condition did not change much from visit to visit. During the last visit there were no symptoms of any medical concerns. R1's physician further stated that it is not likely R1 would have died on 7/16/2017 if his ventilator tubing had not become detached.</p> <p>The policy titled Monitoring the Ventilator Dependent Resident, dated June 2015 and provided by facility staff revealed: Care of the ventilator dependent resident will be performed under the supervision of the assigned nurse or respiratory care practitioner and under the direction of the resident's physician. Licensed nurses and respiratory care practitioners must be trained in ventilator care with demonstrated ability to complete the following: summon appropriate resources as needed to determine or remedy equipment or resident problem, respond quickly to emergencies including, but not limited to accidental ventilator disconnection.</p> <p>The new policy dated July 2017 and titled Bethel Care Center Vent Patient Activities revealed under Procedures. 2. Larger group activities such as music or church, which are too highly attended to be held on the vent unit will be held in the facility dining room and supervised by a vent trained staff.</p> <p>SUGGESTED METHOD OF CORRECTION: The Administrator or designee could update relevant</p>	21850		

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21850	Continued From page 14 policies, train staff on the updated policies and monitor staff for compliance with the policies. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21850		