DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: H5485007M

Date Concluded: January 24, 2020

Name, Address, and County of Licensee Investigated:
Johnson Memorial Hospital and Home
1282 Walnut Street
Dawson, MN 56232
Lac qui Parle County

Facility Type: Nursing Home

Investigator's Name: Jill Hagen, RN, PHN, Special Investigator

Finding: Substantiated, facility responsibility

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

Allegation(s):
It is alleged: The alleged perpetrator (AP) neglected a resident when she failed to initiate cardio-pulmonary resuscitation (CPR) when the resident became unresponsive without a pulse and respirations.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the neglect. The resident's physician's orders for life-sustaining treatment (POLST) form indicated the resident wanted CPR attempted if she was without a pulse and breathing. Because the facility lacked a consistent communication system to alert staff to an emergency, the resident was without a pulse and respirations for at least five minutes before the AP was able to respond to the resident. The resident passed away.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and the resident's physician. The investigation included review of the resident's record, staff schedules, the AP's personnel file, facility's policies, and procedures including their CPR procedure, and interviews with the resident's family members.

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The resident planned a short term stay at the facility for rehabilitation following a leg fracture. The resident's diagnoses included chronic (long term) blood clots of the lower extremities, Meniere's disease (disorder of the inner ear that can cause dizziness), and hypertension (high blood pressure). The resident was able to make her own decisions. The resident used a front wheeled walker with staff supervision and assistance to walk, staff cues and reminders to complete activities of daily living, and staff supervision with toileting. The last 10 days at the facility the resident experienced five unresponsive episodes; two required a sternal rub to get the resident to respond. In all episodes, the resident required oxygen for low oxygen saturations. The resident's primary physician had ordered an echocardiogram (an ultrasound used to show how the heart was pumping).

Early one morning around 4:00 a.m., nursing assistant (NA)-A responded to the resident's call light who requested assistance with toileting. While sitting on the toilet, the resident's speech became unintelligible; however, the resident quickly recovered. When walking back to the resident's bed she became limp and NA-A lowered the resident to the floor. The resident was unresponsive without respirations or heartbeat, with a bluish color around her lips. NA-A paged for the AP, who was assisting another resident. After five minutes, the AP responded to the resident's room. The resident did not respond to a sternal rub. At that time, the AP took the resident's vital signs and determined the resident had passed away. The AP contacted a licensed nurse from the attached hospital. The licensed nurse also confirmed the resident's death.

During an interview, NA-A said she assisted the resident in the bathroom early one morning. While on the toilet the resident slumped backward with garbled speech. The episode lasted approximately one minute. After that, the resident said she was fine and requested to go to bed. NA-A assisted the resident to walk using a walker and a gait belt. NA-A said when walking back to the bed, the resident became limp. NA-A lowered the resident to the floor. NA-A sent a message to NA-B and the AP requesting assistance with the resident. NA-A said despite calling the resident's name, gently padding her face, rubbing her arm, and using a sternal rub, the resident did not respond and was not breathing. NA-B responded to the resident's room first. NA-A was aware the resident requested CPR.

During an interview, NA-B said when she entered the resident's room the resident was on the floor not breathing. NA-B checked the resident's carotid artery and wrist for a pulse. There was no pulse. In addition, NA-B checked for respirations by placing her head on the resident's chest and held her hand above the resident's mouth. NA-B attempted a sternal rub with no response from the resident. Shortly after that, the AP arrived in the resident's room. NA-B was aware the resident requested CPR. The AP checked again for a pulse and respirations and said the resident had passed away.

Neither NA-B nor NA-A were certified and trained to perform CPR.

During an interview, the AP said she was notified by NA-A that the resident was unresponsive and she needed assistance. The AP said she was assisting another resident in the bathroom and not able to leave that resident for their safety. The AP said there was not a sense of urgency in the message. The resident had a history of unresponsive episodes and always responded after stimulation. It took about five minutes for the AP to get to the resident's room. NA-A and NA-B were on either side of the resident. The AP attempted a sternal rub without response. The AP said the resident had no wrist or carotid pulse. The AP repositioned the resident's head without response. The AP used a stethoscope but the resident had no heartbeat. After contacting the hospital the AP and two staff used a mechanical sling lift to transfer the resident to bed. The AP said she did not initiate CPR because it had been too long for the resident to be without a pulse and respirations. The AP was aware the resident requested CPR and the facility policy directed staff to initiate CPR when requested. The licensed staff came immediately from the hospital and confirmed the resident's death.

During an interview, the resident's physician said if the resident was without a pulse and respirations for about five minutes, initiating CPR probably would not have been successful. After five minutes without a pulse and respirations, the chance of successful cardiac resuscitation was very low. The resident may have had serious neurologic damage and a poor quality of life.

During an interview, the director of nursing (DON) said following the incident, she and the medical director reviewed the facilities policies on CPR. The facility provided education to all staff. The facility also developed a policy to ensure rapid staff response. For residents that requested CPR and in emergency situations, one staff would immediately alert the emergency medical services (EMS) (911) with the same message sent to staff. Prior to this incident, the facility required only licensed staff certification in CPR. Since the review, the facility mandated CPR certification for all nursing assistants in addition to the licensed nurses. The facility required staff attend mock resuscitation drills.

The resident's certificate of death documented acute myocardial (heart) dysrhythmia (improper rate or rhythm of the heart) secondary to arteriosclerosis (hardening and narrowing of arteries) as the resident's cause of death.

In conclusion, neglect was substantiated. The facility failed to have a consistent communication system in place to provide staff awareness of an emergency situation ensuring prompt staff response.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

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

Vulnerable Adult interviewed: No. The resident passed away.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility reviewed their current CPR policy and provided education to all staff on the policy. The facility developed a policy to ensure staff immediately activated EMS for all emergent situations and clearly communicated the emergency to all staff. The facility mandated certification in CPR for all nursing assistants and licensed nurses. The facility required all staff attend mock resuscitation drills.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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.

cc: The Office of Ombudsman for Long-Term Care
Lac qui Parle County Attorney
Dawson City Attorney
Dawson City Police Department
Minnesota Board of Examiners for Nursing Home Administrators

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00326	A. BUILDING: ______ B. WING ______	C 01/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MEMORIAL HOSP & HOME	**1290 LOCUST STREET DAWSON, MN 56232**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	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: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H5485007M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for	2 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/28/20

Minnesota Department of Health

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2 000	Continued From page 1 #H5485007M, tag identification 1850. 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000	far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are 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 evidenced by." 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/RULES.	
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	21850		1/28/20

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21850	Continued From page 2 resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On January 24, 2020, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	21850	No plan of correction is required. Please refer to the public maltreatment report for details. Corrected	