Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL20265009M
Compliance #: HL20265010C

Date Concluded: June 1, 2021

Name, Address, and County of Licensee Investigated:
Mother of Mercy Senior Living
230 Church Avenue
Albany, MN 56307
Stearns County

Facility Type: Home Care Provider

Investigator's Name:
Jana Wegener, RN 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 unlicensed facility staff, alleged perpetrator (AP), neglected the client when they failed to identify a change of condition or call 911 when the client became unresponsive. As a result, the client died.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. Facility staff failed to identify a change in the client's condition or notify the provider. Then, when the client became unresponsive and without pulse or respirations, staff failed to contact 911 and implement cardiopulmonary resuscitation (CPR) according to the client's directive.

The investigation included interviews with facility staff members, including leadership staff, nursing staff, and unlicensed staff. The investigator reviewed the clients medical record, staff training, and facility policies and procedures. In addition, law enforcement was contacted.

The clients medical record indicated the client had diagnoses including congestive heart failure and stage three chronic kidney disease. The client was independent with activities of daily living and was cognitively intact and able to make her own decisions.

The client's signed Physician Order for Life Sustaining Treatment (POLST) indicated the client was full code, and wanted CPR initiated if she should be without a pulse and respirations.

The client's most recent "Health Certification Plan of Care" indicated the clients advanced directive wishes were full code status and provided parameters for when to contact the provider including a pulse less than 50 or greater than 110, blood pressure systolic and/or diastolic less than 90/50, and oxygen level less than 90%. The visit summary indicated the client was recently hospitalized with difficulty breathing and low oxygen saturation related to heart failure, utilized home oxygen as needed, and was on a fluid restriction.

Two days prior to the client's death the medical record indicated she had panting respirations, increased difficulty breathing, cold shaking shivers, fluctuating low oxygen levels down to 77% requiring oxygen up to five liters, increased pulse rate up to 212 beats per minute, and low blood pressure down to 87/53. There was no indication the facility notified the provider of the clients change in condition.

A facility incident report indicated on the night of the client's death she pushed her pendant for help after falling when going to the bathroom. The client's vital signs report at the time of the fall indicated she required three staff for assistance with mobility, could barely sit up in bed, had abnormal vital signs, was very shaky, and was breathing very heavy.

One and a half hours after the client fell, the client pushed her pendant again and requested assistance to use the bathroom. While assisting the client back to bed, she was trying to say something to the AP then abruptly stopped talking. The AP noted at that moment the client looked deceased and reported the client's condition to the on-call nurse, who instructed her to call the non-emergency police phone line.

The police report indicated the unlicensed staff stated she did not initiate "life saving measures" (CPR) or call 911. The report indicated the registered nurse (RN) manager confirmed the client did not have a do not resuscitate (to revive someone from unconsciousness or apparent death) order, and the clients wishes were to receive CPR.

During an interview, the AP stated she was not aware of the client's code status and did not know what to do, so she called the on-call nurse who instructed her to call law enforcement.

During an interview, the on-call nurse stated the AP reported she thought the client had died and did not have a way to look up the client's code status. The on-call nurse stated she was able to look up the code status from home but did not think of it at the time because it was the middle of the night. The on-call nurse stated she called the RN manager for guidance who instructed her to tell the AP to call law enforcement.

During an interview, the RN manager stated when the on-call nurse called for guidance he was not clear with his instructions and had assumed the clients code status had been checked and appropriate actions were taken, but 911 was not called. The RN manager stated at the time of the incident the client was full code status, and the AP witnessed the client become unresponsive and stop breathing. The RN manager stated the client's code status should have been checked, and 911 should have been called.

In conclusion, neglect was substantiated.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No, deceased.

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility implemented code status files in the client's rooms on the doorways and/or refrigerator. The facility updated their emergency/CPR policy and procedure, educated staff on facility policy to call 911 for clients with full code status.

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

The responsible party will be notified of their right to appeal the maltreatment finding.

cc:
The Office of Ombudsman for Long-Term Care

Minnesota Board of Nursing
Stearns County Attorney
Albany Police Department
Albany City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20265	A. BUILDING: _____ B. WING _____	C 06/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY CAMPUS CARE	230 CHURCH AVENUE PO BOX 676 ALBANY, MN 56307

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0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On June 1, 2021, the Minnesota Department of Health initiated an investigation of complaint HL20265009M, and HL20265010C . At the time of the survey, there were 42 clients receiving services under the comprehensive license. The following correction orders were issued, for HL20265009M and HL20265010C, tag identification 0265, 0325, 0805, 1045, and 1190.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.	
0 265 SS=J	144A.44, Subd. 1(a)(2) Up-To-Date Plan/Accepted Standards Practice Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (2) receive care and services according to a suitable and up-to-date plan, and subject to	0 265		

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0 265	Continued From page 1 accepted health care, medical or nursing standards and person-centered care, to take an active part in developing, modifying, and evaluating the plan and services; This MN Requirement is not met as evidenced by: Based on observation, document review and interview the licensee failed to provide services according to accepted medical, nursing, and health care practices when facility staff failed to implement one of one client's (C1) "Physicians Order for Life Sustaining Treatment" (POLST) after observing the client become unresponsive and without a pulse or respirations. The facility staff failed to contact 911 and implement cardiopulmonary resuscitation (CPR), as a result the client died. In addition, facility staff failed to identify a change in C1's condition or notify the provider in the days leading up to the clients death. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: The American Heart Association document titled "2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care- Part Three Ethics", dated November 2, 2010, section "Withholding and Withdrawing CPR - Termination of Resuscitative	0 265		

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0 265	Continued From page 2 Efforts Related to Out-of Hospital Cardiac Arrest (OHCA)" indicated in all OHCA settings emergency treatment to a victim of cardiac arrest should be provided, and indicated there are a few exceptions where withholding CPR might be appropriate, as follows: - Situations where attempts to perform CPR would place the rescuer at risk of serious injury or mortal peril. - Obvious clinical signs of irreversible death (e.g., rigormortis, dependent lividity, decapitation, transection, or decomposition). - A valid, signed, and dated advance directive indicating that resuscitation is not desired, or a valid, signed, and dated Do Not Resuscitate (DNR) order. C1 was admitted to the facility on January 17, 2017, and had diagnoses including, Diverticullitis (inflammation of small bulging pouches in the lining of your digestive system), Osteoarthritis, Heart Failure (a chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs), and Stage Three Chronic Kidney Disease (a disease when the kidneys have been moderately damaged over time and are not working optimally). C1's Provider Orders for Life Sustaining Treatment (POLST) dated January 17, 2017, indicated if the client had no pulse or respirations she wanted Cardiopulmonary Resuscitation (process of reviving someone from unconsciousness or apparent death) (CPR) initiated. C1's Emergency discharge instructions dated December 29, 2020 included orders for oxygen at two liters via nasal cannula for shortness of breath, or oxygen saturations less than 90	0 265		

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0 265	Continued From page 3 percent. C1's provider communication note dated January 5, 2021, indicated facility staff notified the provider C1 had a new diagnosis of congestive heart failure, with two recent emergency room visits for shortness of breath symptoms. The note indicated C1 was using oxygen at two liters but staff notes C1's oxygen saturations were dropping below 85 percent with exertion requiring staff to increase the oxygen flow rate beyond the two liters ordered. The provider responded with signed orders to use oxygen at five liters via nasal cannula with activity to maintain oxygen saturations greater than 90 percent with activity. C1's Medication Administration Record (MAR) for the month of January included orders for oxygen at two liters via nasal cannula as needed, and instructed staff to put the nasal cannula on the client and hook that and her tubing to the concentrator and set at two liters. The MAR failed to include additional orders for oxygen at five liters with activity. C1's Care Plan dated January 13, 2021, indicated she was full code, independent with activities of daily living, and could make her needs known and make her own decisions. The care plan indicated C1 needed assistance from staff to apply oxygen if her saturations were less than 89 percent on room air, and instructed facility staff to utilize oxygen at five liters by nasal cannula with activity to maintain oxygen saturations greater then 90 percent. The care plan indicated the facility staff would monitor C1's vitals, but failed to include the order for two liters via nasal cannula, or five liters with activity, frequency of monitoring or parameters for when to notify the nurse.	0 265		

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0 265	Continued From page 4 C1's Health Certification Plan of Care dated January 29, 2021, indicated C1 required assistance with medication administration including oxygen administration. C1's plan had parameters for when to contact the provider including a pulse less than 50 or greater than 110, blood pressure systolic and/or diastolic less than 90/50, or greater than 180/110, and oxygen saturations less than 90 percent. C1's vital sign report notes reviewed from January 1, 2021 to January 31, 2021, indicated the client received assistance from staff with applying prescribed oxygen. No issues were noted by staff until the following: - On January 29, 2021 at 2:00 a.m. staff indicated the clients oxygen saturation was 77 percent on room air, then increased to 91 percent when staff applied oxygen. - On January 29, 2021, at 10:00 a.m. staff noted C1's oxygen saturations were low. At 6:00 p.m. staff noted C1 was having trouble breathing with her oxygen on, and was 81 percent. The note indicated Licensed Practical Nurse (LPN)-B was notified and instructed staff to turn the oxygen flow rate up to 5 liters. Staff documented C1's oxygen saturations increased to 96 percent after 5 minutes, then LPN-B instructed staff to turn C1's flow rate down to 3 liters via nasal cannula. In addition to C1 having low oxygen saturation staff documented the client had cold shivers and panting respirations. - On January 30, 2021, at 2:00 a.m. staff documented the clients oxygen saturations were fluctuating, her pulse was 85 to 212 beats per minute, and C1 was shaking cold. - At 10:30 a.m. staff documented the clients oxygen saturations were 97 percent on 5 liters via nasal cannula.	0 265		

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0 265	Continued From page 5 - On January 31, 2021, at 2:00 a.m. staff documented the clients oxygen saturations were fluctuating between 88 and 96 percent. The note indicated C1's hands were shaky, and she was very thirsty drinking three cups of water in 15 minutes. Staff noted C1 was very weak requiring three staff assist her off the floor after she had fallen. The note indicated C1 was dependant of staff for mobility due to weakness because she was unable to adjust herself in bed or sit up. - At 2:49 a.m. staff noted the clients pulse was bounding from 112 to 116 beats per minute, she was very shaky, her blood pressure was 87/53, and oxygen saturations were 88 to 96 percent while on oxygen. The note indicated C1 was breathing heavily. - At 3:15 a.m. the client was deceased with no apical pulse , no blood pressure, no respirations, with signs of lividity in hands and distal arms, Albany police were present. C1's progress notes lacked any indication nursing had identified or notified the provider of C1's change in condition beginning on January 29, 2021. The undated document titled "Time Line of Events" indicated C1 pushed her pendant on January 31, 2021, at 1:38 a.m. after she fell going to the bathroom due to weakness, three staff assisted C1 back to bed. At 2:00 a.m. Care Attendant (CA)-A notified LPN-B of the fall. The client was assisted back to bed. At 2:52 a.m. C1 pushed her pendant again and requested assistance to use the bathroom. The documentation indicated while assisting the client back into bed the client was saying something then abruptly stopped. The document indicated the unlicensed staff thought at that moment the client looked deceased. The staff reported the	0 265		

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0 265	Continued From page 6 client's condition to LPN-B at 3:15 a.m. who instructed her to call the police department. A review of the police report indicated after being assisted to the bathroom C1 became unresponsive and died. The report indicated CA-A stated she did not initiate life saving measures or call 911. The report indicated the registered nurse (RN)-C arrived to confirm the client's death verified the client did not have a DNR order. During an interview on May 17, 2021, at 12:11 p.m. RN-C stated CPR was not initiated and 911 was not called when C1 became unresponsive. RN-C stated CA-A or LPN-B should have checked C1's code status and call 911. RN-C stated he was not clear with instructions, and had assumed the clients code status had been checked and appropriate action was taken. RN-C stated C1 was full code status and when the client become unresponsive and stop breathing 911 should have been called. During an interview on May 17, 2021, at 12:37 p.m. LPN-B stated she was the nurse on call the night C1 died. LPN-B stated CA-A did not have her i-pad to tell me what C1's code status was. LPN-B stated she had the ability to look up C1's code status on her phone at home, but didn't think to look it up for her because it was the middle of the night. LPN-B stated after she talked to RN-C she called CA-A back and told her to call the non-emergent law enforcement number. During a follow up interview on May 26, 2021, at 2:40 p.m. RN-C stated the documentation on C1's MAR for oxygen use was not an accurate and lacked documentation of her increased	0 265		

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0 265	Continued From page 7 oxygen demand leading up to her death. RN-C stated staff should have documented any time they applied C1's oxygen, and indicated they had not. RN-C indicated he was not aware of staffs documentation of C1's change in condition starting on January 29, 2021, indicated he was also unaware the MAR lacked the orders for the oxygen rate of five liters. RN-C stated C1's change in condition and increase in oxygen demand prior to her death should have been reported to nursing staff, and the provider should have been notified. RN-C verified staff had documented C1's best oxygen saturation in the vital column which bypassed the report for monitoring out of range vital signs. RN-C stated the facility did not have a policy to provide guidance for when to notify or report things to the nurse other than falls or an emergency, but indicated he would expect staff to call the nurse for any abnormal vitals including low oxygen saturations. RN-C stated the policy and procedure for a client with full code unwitnessed arrest staff would not perform CPR or call 911 because we do not know how long they have been with out a pulse. RN-C stated on the night of the incident a report should have been filed to the Minnesota Adult Abuse Reporting Center (MAARC) then, an incident report should have been completed and an investigation should have been done. RN-C stated the policy used to have language about withholding CPR for signs of obvious death, but indicated it felt like unnecessary language and was removed from the policy. The facility policy and procedure titled "CPR Policy for Assisted Living Employees", dated February 19, 2021,Section 2. indicated if a tenant arrests (no breathing/no pulse) and it was witnessed by staff or others, staff should check	0 265		

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0 265	Continued From page 8 for the client's code status, or the file of life pocket located on the fridge or by the door. Anyone without CPR/DNR documentation will be presumed to request CPR. Alert staff to help, call 911, call Dr. Dash for full code tenant, begin CPR if willing and follow CPR instructions from dispatch. The undated Procedure titled "Regarding Medical Emergencies, CPR, and/or Death", indicated if a tenant appears to die or be in severe distress (can't breathe, stops breathing, doesn't respond) Section 1. Instructed staff to check the code status on RTasks, or POLST book. Section 2. Indicated if the clients code status was CPR they were to call for help using Dr. DASH, and start CPR if they are comfortable/willing. Section 3. Indicated staff should call 911 for emergency personnel assitance. No additional information was provided TIME PERIOD TO CORRECT-Two (2) days.	0 265		
0 325 SS=D	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced	0 325		

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0 325	Continued From page 9 by: Based on observation, interviews, and document review, the facility failed to ensure client one, (C1) was free from maltreatment. Findings include: On June 1, 2021, the Minnesota Department of Health (MDH) issued a determination that maltreatment by neglect occurred, and the facility was responsible for the maltreatment.	0 325	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of tag 0325.	
0 805 SS=D	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors Subd. 6.Reporting maltreatment of vulnerable adults and minors. (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in section 626.556 and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Each home care provider must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility staff failed to report suspected neglect for one of one clients (C1) reviewed for allegations of neglect regarding implementing the client's (C1) "Physicians Order for Life Sustaining Treatment" (POLST) after the client became unresponsive and without a pulse or respirations. In addition, facility staff failed to contact 911 and implement cardiopulmonary resuscitation (CPR), as a result the client died.	0 805		

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0 805	Continued From page 10 This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1 was admitted to the facility on January 17, 2017, with diagnoses including, Diverticulitis (inflammation of small bulging pouches in the lining of your digestive system), Left Hip Fracture, and Osteoarthritis. Recently C1 was also diagnosed with congestive heart failure, and had diagnoses including stage 3 chronic kidney disease. C1's Provider Orders for Life Sustaining Treatment dated January 17, 2017, indicated if the client had no pulse or respirations she wanted Cardiopulmonary Resuscitation initiated (CPR). The undated document titled "Time Line of Events" indicated C1 pushed her pendant on January 31, 2021, at 1:38 a.m. after she fell going to the bathroom due to weakness, three staff assisted C1 back to bed. At 2:00 a.m. CA-A notified Licensed Practical Nurse (LPN)-B of the fall. The client was assisted back to bed. At 2:52 a.m. C1 pushed her pendant again and requested assistance to use the bathroom. The documentation indicated while assisting the client back to bed the client was saying something then abruptly stopped. The document indicated the unlicensed staff thought at that moment the client looked deceased. The staff reported the client's	0 805		

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	H20265	A. BUILDING: _____ B. WING _____	C 06/01/2021

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0 805	Continued From page 11 condition to LPN-B at 3:15 a.m. who instructed her to call the police department. A review of the police report indicated after being assisted to the bathroom C1 became unresponsive and died. The report indicated CA-A stated she did not initiate life saving measures or call 911. The report indicated the registered nurse (RN)-C arrived to confirm the client's death verified the client did not have a do not resuscitate order. On May 26, 2021, at 2:40 p.m. Registered Nurse (RN)-C stated there was no internal investigation done following the incident, and it was not reported to the Minnesota Adult Abuse Reporting Center (MAARC). RN-C stated the police were aware and he did not think about it because the police were doing an active investigation. RN-C stated he was under the assumption it was going to be reported. The facility policy and procedure titled "Vulnerable Adult Reporting and Investigation Policy", dated January 2014, indicated in accordance with state and federal vulnerable adult laws the facility would investigate and report suspected abuse, neglect, or financial exploitation. Section d. Immediate Report to MAARC Required indicated upon hearing description of the incident, if the incident appears to be suspected abuse neglect or financial exploitation the RN shall immediately make and oral written report tot MAARC, immediately means as soon as possible, but no later than 24 hours from the time the RN received knowledge the incident occurred. TIME PERIOD TO CORRECT- fourteen (14) days	0 805		

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01045	Continued From page 12	01045		
01045 SS=D	144A.4793, Subd. 5 Documentation of Treatment/Therapy Subd. 5.Documentation of administration of treatments and therapies. Each treatment or therapy administered by a comprehensive home care provider must be documented in the client's record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the client's needs. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to document administration of treatments and therapies for one of one client (C1) with record review. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1's Emergency discharge instructions dated December 29, 2020 included orders for oxygen at	01045		

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01045	Continued From page 13 two liters via nasal cannula for shortness of breath, or oxygen saturations less than 90 percent. C1's provider communication note dated January 5, 2021, indicated facility staff notified the provider C1 had a new diagnosis of congestive heart failure, with two recent emergency room visits for shortness of breath symptoms. The note indicated C1 was using oxygen at two liters but staff notes C1's oxygen saturations were dropping below 85 percent with exertion requiring staff to increase the oxygen flow rate beyond the two liters ordered. The provider responded with signed orders to use oxygen at five liters via nasal cannula with activity to maintain oxygen saturations greater than 90 percent with activity. C1's Medication Administration Record (MAR) for the month of January, 2021, included orders for oxygen at two liters via nasal cannula as needed, and instructed staff to put the nasal cannula on the client and hook that and her tubing to the concentrator and set at two liters. The MAR lacked documentation of oxygen utilization and included documentation for only three days of oxygen utilized on January 1, 6, and 9th. The MAR failed to include additional orders for oxygen at five liters with activity. C1's vital sign report notes reviewed from January 1, 2021 to January 31, 2021, indicated the client received assistance from staff with applying prescribed oxygen. No issues were noted by staff until January 29, 2021 at 2:00 a.m. when staff indicated the clients oxygen saturation was 77 percent on room air, then increased to 91 percent when staff applied oxygen. - On January 29, 2021, at 10:00 a.m. staff noted C1's oxygen saturations were low. At 6:00 p.m.	01045		

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01045	Continued From page 14 staff noted C1 was having trouble breathing with her oxygen on, and was 81 percent. The note indicated Licensed Practical Nurse (LPN)-B was notified and instructed staff to turn the oxygen flow rate up to 5 liters. Staff documented C1's oxygen saturations increased to 96 percent after 5 minutes, then LPN-B instructed staff to turn C1's flow rate down to 3 liters via nasal cannula. In addition to C1 having low oxygen saturation staff documented the client had cold shivers and panting respirations. - On January 30, 2021, at 2:00 a.m. staff documented the clients oxygen saturations were fluctuating. - At 10:30 a.m. staff documented the clients oxygen saturations were 97 percent on 5 liters via nasal cannula. - On January 31, 2021, at 2:00 a.m. staff documented the clients oxygen saturations were fluctuating between 88 and 96 percent. - At 2:49 a.m. staff noted C1's oxygen saturations were 88 to 96 percent while on oxygen, and was breathing heavily. C1's progress notes lacked any indication nursing had identified or notified the provider of C1's increase in oxygen demand beginning on January 29, 2021. During a interview on May 26, 2021, at 2:40 p.m. RN-C stated C1 was using oxygen daily and the documentation on the MAR for C1's oxygen use was not accurate, and did not reflect C1's increase in oxygen demand. RN-C stated staff should have documented every time they applied C1's oxygen, and indicated they had not. RN-C indicated he was unaware the MAR lacked the orders for the oxygen rate of five liters with physical activity. RN-C stated the facility did not have a policy for when to notify or report changes	01045		

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01045	Continued From page 15 or concerns to the nurse other than falls or emergencies, but indicated he would expect staff to call the nurse for any abnormal vitals including low oxygen saturations. Policy and procedures were requested, no additional information was provided. TIME PERIOD TO CORRECT- fourteen (14) days	01045		
01190 SS=D	144A.4796, Subd. 6 Required Annual Training Subd. 6.Required annual training. (a) All staff that perform direct home care services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the home care provider or another source and must include topics relevant to the provision of home care services. The annual training must include: (1) training on reporting of maltreatment of minors under section 626.556 and maltreatment of vulnerable adults under section 626.557, whichever is applicable to the services provided; (2) review of the home care bill of rights in section 144A.44; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand-washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and	01190		

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01190	Continued From page 16 reporting of communicable diseases; and (4) review of the provider's policies and procedures relating to the provision of home care services and how to implement those policies and procedures. (b) In addition to the topics listed in paragraph (a), annual training may also contain training on providing services to clients with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research-based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure required annual training included a review of the provider's policies and procedures related to the provision of home care	01190		

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01190	Continued From page 17 services and how to implement those policies and procedures for 3 of 3 employees (CA-A, LPN-B, and RN-C) reviewed for failure to implement a clients (C1) full code status when she became unresponsive and without a pulse or respirations, as a result C1 died. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1 was admitted to the facility on January 17, 2017, with diagnoses including, Diverticulitis (inflammation of small bulging pouches in the lining of your digestive system), Left Hip Fracture, and Osteoarthritis. Recently C1 was also diagnosed with congestive heart failure, and had diagnoses including stage 3 chronic kidney disease. C1's Provider Orders for Life Sustaining Treatment dated January 17, 2017, indicated if the client had no pulse or respirations she wanted Cardiopulmonary Resuscitation initiated (CPR). The undated document titled "Time Line of Events" indicated C1 pushed her pendant on January 31, 2021, at 1:38 a.m. after she fell going to the bathroom due to weakness, three staff assisted C1 back to bed. At 2:00 a.m. CA-A notified Licensed Practical Nurse (LPN)-B of the fall. The client was assisted back to bed. At 2:52	01190		

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01190	Continued From page 18 a.m. C1 pushed her pendant again and requested assistance to use the bathroom. The documentation indicated while assisting the client back to bed the client was saying something then abruptly stopped. The document indicated the unlicensed staff thought at that moment the client looked deceased. The staff reported the client's condition to LPN-B at 3:15 a.m. who instructed her to call the police department. A review of the police report indicated after being assisted to the bathroom C1 became unresponsive and died. The report indicated CA-A stated she did not initiate life saving measures or call 911. The report indicated the registered nurse (RN)-C arrived to confirm the client's death verified the client did not have a do not resuscitate order. A review of CA-A personnel file indicated she was hired in 2014. CA-A's education transcripts lacked evidence of review of facility policy and procedures for medical emergencies, including CPR, or death being completed. Document titled "Employee Coaching Form", dated January 31, 2021, indicated the CA-A did not follow facility policy regarding medical emergency and need for CPR. CA-A was coached to immediately check the clients code status, and call 911 if the tenant is not on hospice with a review of the policy and procedure done. On May 24, 2021, at 1:54 a.m. CA-A stated she had not received training on what to do if someone stopped breathing since she was hired. CA-A indicated she did not have her tablet with her when C1 became unresponsive and was unable to look up her code status. CA-A stated she did not know what to do so she called LPN-B	01190		

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01190	Continued From page 19 who instructed her to call the non-emergency police number. CA-A stated LPN-B did not check the code status, CPR was not initiated and 911 was not called. On May 17, 2021 at 12:37 p.m. LPN-B stated CA-A reported they thought C1 had died and she did not have a way to look up the C1's code status. LPN-B stated she was able to look up the code status from home, but did not think of it at the time because it was the middle of the night. LPN-B stated she called RN-C for guidance who instructed her to tell the CA-A to call law enforcement which she had done. On May 17, 2021, at 12:11 p.m. RN-C stated he was in charge of staff education and training and indicated CA-A was hired prior to his employment. RN-C indicated he did not know what training CA-A had received prior to the incident. RN-C stated when LPN-B called for guidance he was not clear with his instructions assumed the clients code status was checked and appropriate actions were taken. RN-C stated the client's code status should have been checked, and 911 should have been called. RN-C stated policy does not require staff to be trained in CPR, but they should call 911. Facility policy and procedure titled "CPR Policy for Assisted Living Employees", dated February 19, 2021,Section 2. indicated if a tenant arrests (no breathing/no pulse) and it was witnessed by staff or others, staff should check for the client's code status, or the file of life pocket located on the fridge or by the door. Anyone without CPR/DNR documentation will be presumed to request CPR. Alert staff to help, call 911, call Dr. Dash for full code tenant, begin CPR if willing and follow CPR instructions from dispatch.	01190		

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01190	Continued From page 20 The undated Procedure titled "Regarding Medical Emergencies, CPR, and/or Death", indicated if a tenant appears to die or be in severe distress (can't breathe, stops breathing, doesn't respond) Section 1. Instructed staff to check the code status on RTasks, or POLST book. Section 2. Indicated if the clients code status was CPR they were to call for help using Dr. DASH, and start CPR if they are comfortable/willing. Section 3. Indicated staff should call 911 for emergency personnel assitance. TIME PERIOD TO CORRECT- Fourteen (14) days	01190		