Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL23700511M
Compliance #: HL23750012C

Date Concluded: May 7, 2021

Name, Address, and County of Licensee Investigated:
Edgewood Brainerd Senior Living
14890 Beaver Dam Road
Brainerd, MN 56401

Facility Type: Home Care Provider

Investigator's Name: Jeri Gilb, RN, MSN, CNP
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 client was neglected when the facility staff turned away emergency medical services, resulting in a 25-minute delay in the initiation of CPR.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility staff contacted emergency medical services (EMS) when the client became ill. When EMS arrived, facility staff told EMS the client was deceased and no longer needed medical support. Twenty-five minutes later, facility staff determined the client had requested to be a full code (meaning the client wanted CPR) contacted EMS again stating the client was full code and needed EMS. On arrival, EMS found the client pulseless, and the client was receiving CPR from law enforcement. The client was pronounced deceased at the facility.

The investigation included interviews with facility staff members, including nursing, administrative, and unlicensed staff. The clients medical records, facility policies and procedures, staff training, and patient admission agreements were reviewed. Observations were made of the client rooms, medication carts, and staff/ client interactions.

The client's medical record indicated diagnoses of hydrocephalus with shunt and history of trans-ischemic attack with cerebral infarction. The client required assistance with medications, bathing, dressing, and hygiene.

The EMS report indicated the ambulance was dispatched to the facility for a seizure, but on arrival facility staff told EMS the client was deceased and no longer required medical services. Twenty-five minutes later the facility called EMS again for the same client. The EMS report noted dispatch stated the caller was not being cooperative with CPR or airway instructions. The EMS report indicated on the second arrival, the client had no pulse and was receiving CPR from law enforcement. EMS then assumed lifesaving measures for the client and discontinued CPR after almost 40 minutes. The client was not able to be revived and died.

When interviewed the two-facility staff working the evening of the incident stated the client suddenly became very ill and staff called 911. Both staff denied calling 911 or knowing who called 911. Both staff denied telling the EMS crew the client was deceased or knowing who told the EMS crew the client was deceased. Staff stated all clients had a sticker on their door to let staff know what the clients code status is, however, stated the clients code sticker was missing from the client's door. The other staff denied knowing there was a code sticker on the door until that night and believed the code status could only be found in the computer.

When interviewed the administration stated staff contacted her and the client had died. Approximately twenty-five minutes later, staff notified her the client was full code and EMS was called again. Administration stated there is a sticker indicating code status on the back of client doors. She reported new staff learn this in orientation. The administration stated it is possible the client could have removed the sticker. The EMS managers came to the facility the next day to discuss the situation and prevent this from happening again.

During an interview with EMS administration, it was determined EMS followed their policies. EMS administration offered no additional information.

Policies indicated the facility does not train staff in CPR. In an emergency, staff are to contact 911, inform the EMS operator they are not certified in CPR, and then follow EMS instructions.

In conclusion, neglect was substantiated. Facility staff were unaware of the client's request to be a full code resulting in an approximate twenty-five-minute delay in the client receiving CPR.

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

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.
(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:
(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or sections 253B.03 or 524.5-101 to 524.5-502, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:
(i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or
(ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; or
(2) the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult;
(3) the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:
(i) a person including a facility staff person when a consensual sexual personal relationship existed prior to the caregiving relationship; or
(ii) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship; or
(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: No, deceased.
F**amily/Responsible Party interviewed**: Yes.
Alleged Perpetrator interviewed: Not applicable- No specific alleged perpetrator was named.

Action taken by facility: The facility added code status to the assignment sheets for every shift, verified the correct color for code status is in the room for every resident, and on the medication cart for every resident for easy access for staff.

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
Crow Wing County Attorney
Brainerd City Attorney
Brainerd Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H23750	A. BUILDING: _____ B. WING _____	C 05/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD BRAINERD SENIOR LIVING LLC	14890 BEAVER DAM ROAD BRAINERD, MN 56401

(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
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 an investigation. 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 May 7, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL23750012C/#HL23700511M. At the time of the investigation, there were #80 clients receiving services under the comprehensive license. The following correction orders are issued for #HL23750012C/#HL23700511M, tag identification 0265, 0325.	0 000	The Minnesota Department of Health documents 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the investigators' findings is the Time Period for Correction. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for licensing order follow-ups. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
0 265 SS=G	144A.44, Subd. 1(a)(2) Up-To-Date Plan/Accepted Standards Practice Subdivision 1.Statement of rights. (a) A client who	0 265		

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0 265	Continued From page 1 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 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 interview and document review, the licensee failed to provide services according to accepted medical or nursing standards for one of one client, C1, reviewed for CPR (cardiopulmanary resusitation). Although C1 was a full code (CPR completed if required), the facility lacked a clear system for staff to idenify client code status resulting in a 25 minute delay of CPR being inititiated for C1 according to the clients wishes. The client was not able to be revived and died. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: C1's medical record indicated diagnoses of hydrocephalus with shunt and history of	0 265		

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0 265	Continued From page 2 trans-ischemic attack with cerebral infarction. C1's service plan dated January 13, 2021 indicated she required medication management, assistance with bathing, dressing, hygiene, and escort to dining. C1's code status is listed on the service plan as Cardio Pulmonary Resuscitation (CPR). C1's Death Certificate dated March 1, 2021 listed date of death February 20, 2021 at 21:39 of natural causes. The EMS report dated February 20, 2021indicated the facility called EMS for a seizure at 20:43, but on ambulance arrival at 20:48, facility staff reported the client was deceased and no longer required medical services. The EMS report indicated at 21:12, the facility contacted EMS again reporting a seizure for C1, who was not breathing. The EMS report noted the caller was not cooperative with CPR or airway instructions from EMS dispatch. The report also noted the facility determined C1 was full code status. The EMS report indicated on second arrival at 21:16, C1 was pulseless and law enforcement were administering CPR. EMS then assumed lifesaving measures for C1. EMS discontinued CPR at 21:39. During interview on March 12, 2021 at 3:08 p.m., Unlicensed Personnel (ULP)-A stated C1 seemed well earlier in the shift, but then she cried out at about 8:40 p.m. and did not look well. ULP-A looked on the back of C1's door for her code sticker but it was not there. ULP-A then went to the computer to look it up. ULP-A is unsure who called the ambulance or who told the ambulance C1 was deceased and did not need medical services. ULP-A stated the code status sticker is	0 265		

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0 265	Continued From page 3 usually on the back of each resident door. ULP-A reported she administered medications that night, so she went back to her duties. ULP-A stated the facility has resident code statuses on the assignment sheets now, as well as the medication cart and the back of the resident door. During interview on March 12, 2021 at 3:20 p.m., ULP-B stated when she returned from break approximately 8:40 p.m., C1 was very suddenly ill. ULP-B stated other staff asked her to check C1's pulse because ULP-B had recently gone through vitals class. None of the staff could find C1's pulse. ULP-B is unsure who called 911 or who sent the ambulance away. ULP-B stated she thought the code status was only in the computer until that night. ULP-B denied receiving training about code stickers on resident doors. ULP-B denied knowing C1's code status that day. ULP-B stated since that night, the facility has put the code status of all residents on the shift sheets and was able to show me her shift sheet with the code statuses of the residents. During interview on March 12, 2021 at 3:45 p.m., the Clinical Director (CD)-C stated staff contacted her to say the client had died on February 20, 2021 at approximately 8:40 p.m. Staff called the on-call RN first, but then notified CD-C. CD-C stated C1's pulse was in the 40's and her oxygen saturation level was low initially. CD-C stated she is unsure who called EMS or who sent EMS away. CD-C stated after staff determined C1 was full code, staff contacted EMS again and then on EMS return, they performed CPR on C1 for almost an hour. CD-C stated each resident's code status is on the back of their door and all staff learn this in new employee training. When asked if it is possible C1 removed the sticker from the door or staff forgot to place the sticker,	0 265		

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0 265	Continued From page 4 CD-C stated, "That is possible." CD-C stated since the loss of C1, the facility placed code statuses of all residents on the medication cart, on the assignment sheets, and on the back of each resident's door, for easy access for staff. The facility conducted a meeting with staff to train on where to find a resident's code status to prevent this from happening again. This training is documented. The facility CPR policy dated August 2020 indicated staff are not certified in CPR, however will accommodate resident's wishes according to a valid advanced directive. All staff should be educated at general orientation to call 911 in the event of cardiac or respiratory arrest. They should inform the EMS operator whether or not they are certified in CPR and should then follow the EMS operator's instructions. The facility Resuscitation/Code Status Protocol dated December 2011indicated the code status should be appropriately and prominently signified in the resident's room in an approved and standardized location (ie- on the back of the resident's door, etc.). TIME PERIOD FOR CORRECTION: One (1) day	0 265		
0 325	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;	0 325		

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0 325	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. C1 was neglected when the facility staff turned away emergency medical services, resulting in a 25-minute delay in the initiation of CPR. Findings include: On May 7, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred. There was a preponderance of evidence that maltreatment occurred and the facility was responsible for maltreatment.	0 325	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (sent separately) for details of tag 0325.	