Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL30406002M **Date Concluded:** November 29, 2021
Compliance #: HL30406003C

Name, Address, and County of Licensee Investigated:
Sunrise Village of Milaca
115th-9th Street NW STE 120
Milaca, MN 56353
Mille Lacs County

Facility Type: Assisted Living Facility (ALF) **Evaluator's Name:** Lori Pokela, 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 facility neglected the resident when a staff member did not switch the resident's oxygen tubing from a portable oxygen tank to a stationary tank per the resident's service plan. This allegedly caused the resident's portable oxygen tank to run empty and the resident's oxygen saturation levels to drop, causing the resident to call 911.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. Facility staff did not switch the resident's oxygen tubing from a portable oxygen tank to a stationary tank per the resident's service plan. This caused the resident's oxygen saturation levels to drop, and staff did not respond to the resident's call for help for over an hour and until after the resident had already called 911. Although the resident received necessary care and returned to baseline, the facility also failed to investigate, document, or report the incident.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included an interview with the resident. In addition, the investigator contacted law enforcement. Resident medical records were reviewed,

facility communication and call light records were reviewed. Facility personnel, training records and relevant facility policies were reviewed.

The resident's diagnoses included chronic obstructive pulmonary disease (COPD), cor pulmonale (a condition that causes the right side of the heart to fail), and congestive heart failure (CHF) with dependence on oxygen. The resident's nursing assessment indicated the resident needed assistance of staff to ensure the resident's portable oxygen tubing was switched to the stationary tank while the resident is in bed.

One evening, the police and an ambulance responded to a 911 call made by the resident. The police report indicated when the resident made the call, she was having difficulty breathing and stated she had called staff and no one had responded for an hour. When police arrived, the report stated the resident appeared afraid and was breathing heavy. The resident told the police that staff brought her to her room as usual but forgot to unhook her oxygen tubing from the portable oxygen tank to the stationary tank in her room and her portable tank had run out of oxygen. The resident told the police that she thought she was going to die. Before police and ambulance left the facility, the resident's oxygen level was in the ninety-percentile range.

A message, completed by an unlicensed direct care staff member after the incident and sent out to other staff members as a reminder, indicated the resident was put to bed and ran out of oxygen which caused emergency medical services to be called to the facility. The message indicated when the police and ambulance arrived, the oxygen was already switched from the portable tank to the stationary tank and the resident was stabilized. The ULP had not included the facility administrator or director of nursing when the message was sent to other staff.

The resident's medication administration record (MAR) at the time of the incident indicated the resident needed oxygen at three liters per minute daily. It also indicated that if the resident's oxygen level fell below ninety percent, the resident would need the oxygen level increased to four liters per minute.

The resident's service plan and vulnerability assessment at the time of the incident indicated the resident needed assistance from staff to switch oxygen tubing from the portable tank to the stationary tank when the resident was in bed.

The resident's nurse notes indicated the resident was recently hospitalized and discharged back to the facility, due to respiratory failure, CHF exacerbation, and COPD.

During an interview with the investigator, the resident stated she remembered the incident and feeling like she could not breathe. The resident remembered that the ambulance came but could not remember the staff who cared for her that evening. The resident stated it took too long for staff to answer the call light that evening. The resident stated since the incident she had run out of oxygen again in her large tank when staff had forgotten to check it.

During an interview with the investigator, the unlicensed personnel who switched the oxygen tubing from the portable tank to the stationary tank on the evening of the incident stated she remembered the resident being already in bed when this incident occurred. This staff member checked the resident because she heard her screaming from her room. The unlicensed personnel stated the resident was already on the phone with 911 when she arrived at the resident's room. The unlicensed personnel stated when police and ambulance arrived the resident's oxygen level was back up in the ninety percent range, as opposed to the sixty percent range when she arrived in the room and found the resident screaming.

During an interview, another unlicensed personnel who worked the evening of the incident, did not remember the incident, or whether she assisted the resident to bed.

During an interview, the director of nursing stated she was not aware of the incident, so an internal investigation was not conducted, and she had not reported the incident to the Minnesota Adult Abuse Reporting Center (MAARC). The director of nursing had no knowledge of why the incident was not communicated to her.

During an interview with the investigator, the administrator stated a MAARC Report was not filed regarding the incident because she had no knowledge of the incident. She did not know why the incident was not communicated to her.

In conclusion, the facility was responsible for neglect.

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.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: No, not able to be reached

Alleged Perpetrator interviewed: Not applicable, no AP identified

Action taken by facility:
The unlicensed personnel documented a message to staff to remind them that the resident must have the oxygen tubing switched from the portable oxygen tank to the stationary oxygen tank while in bed.

Action taken by the Minnesota Department of Health:
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
Mille Lacs County Attorney
Mille Lacs Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30406	A. BUILDING: ____ B. WING ____	C 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE VILLAGE OF MILACA	**115 9TH STREET NW #120 MILACA, MN 56353**

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint 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: HL30406002M/ #HL30406003C On November 24, 2021, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 34 residents receiving services under the provider's assisted living license. The following correction orders are issued for #HL30406003C/#HL30406002M, tag identification: 0510, 0620, 1640, 2360 and 3000.	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 Assisted Living Facilities. 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 evaluators ' 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 144G.31 SUBDIVISION 1-3.	
0 510 SS=I	144G.41 Subd. 3 Infection control program	0 510		

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(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.
(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.
(c) The facility must maintain written evidence of compliance with this subdivision.

This MN Requirement is not met as evidenced by:
Based on observation, document review, and interview, the licensee failed to develop and implement an infection control protocol that followed CDC Guidelines for quarantine of residents, screening of staff, and testing. The licensee failed to ensure staff completed the COVID symptom screen upon entrance into the licensee, and as a result, a nurse came to work with symptoms and tested COVID-positive. One of the other staff, whom the nurse was in contact with, subsequently tested positive, and that staff had contact with two residents. The licensee failed to initiate facility-wide COVID testing on staff and residents immediately after this. Once COVID testing was conducted, over half of the residents tested positive. Even after this COVID outbreak, the licensee failed to ensure all staff followed their policy regarding personal protective equipment (PPE) and failed to ensure safe disposal of used PPE.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,

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or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

The Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes for Nursing Homes and Long-Term Care Facilities, dated September 10, 2021, indicated fully vaccinated residents who have had close contact with someone with SARS-CoV-2 infection should be tested. The same document indicated all HCP (Healthcare personnel) who have had a higher-risk exposure and residents who have had close contacts, regardless of vaccination status, should be tested immediately. The document also indicated eye protection that covers the front and sides of the face should be worn by health care workers during all patient care encounters.

The CDC website updated September 18, 2021, titled Quarantine and Isolation, indicated fully vaccinated people should get tested 3-5 days after their exposure and should quarantine until a negative test result or for 10 days without testing.

On November 16, 2021, a licensee provided document indicated the licensee had 18 COVID-Positive residents on quarantine out of 34 residents total residing in the licensee. This same document indicated the licensee had one COVID positive staff member on October 25, 2021. This same document also indicated facility-wide COVID testing was to start on November 4, 2021.

Minnesota Department of Health

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0 510	Continued From page 3 On November 16, 2021, it was observed that two used PPE waste receptacles were located in a licensee community hallway next to isolation rooms. One of the receptacles had a lid and there was used PPE hanging out from under the lid; another receptacle did not have a lid. On November 16, 2021, one staff member was observed wearing eyewear that did not provide side protection. On November 18. 2021 at 10:18 a.m., the licensee provided an email that indicated that licensee COVID contact tracing was not completed when one staff member, Registered Nurse (RN)-K, reported a positive COVID test result to licensee on October 25, 2021. On November 18, 2021, the licensee provided documentation of a corrective action for RN-K, regarding failure to complete the daily employee COVID screen prior to starting work every day. During an interview on November 18, 2021 at 1:41p.m., the director of nursing, (DON)-I stated RN-K arrived to work on October 25, 2021 with a scratchy throat, runny nose, and was afebrile. DON-I stated RN-K had not indicated on the COVID symptom screen any symptoms upon arriving to work on this date. DON-I stated RN-K proceeded to test herself for COVID at work that day and the COVID test result was positive. DON-I stated RN-K had been primarily in the office this date and came in contact with DON-I and an unlicensed personnel (ULP)-F. DON-I stated it is unknown if RN-K came in contact with any residents this day. DON-I stated on October 30, 2021, she had COVID symptoms and a positive COVID test result and went on	0 510		

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quarantine. On November 2, 2021, ULP-F had COVID symptoms and a positive COVID test result which caused her to go on quarantine. DON-I stated two residents were placed on quarantine on November 2, 2021, after contact tracing indicated ULP-F came in contact with them. DON-I stated the licensee did not think COVID testing was warranted or placing residents in quarantine after RN-K tested positive at work on October 25, 2021 because it was unknown if she was in contact with any residents on this date. DON-I stated testing was not conducted facility-wide because there was not a nurse available to conduct the testing. DON-I stated a hospice agency agreed to conduct facility-wide testing for residents and staff on November 4, 2021. DON-I indicated staff should be wearing protective PPE, eyewear in isolation rooms, and prescription eyeglasses, goggles, or face shield in isolation rooms.

The licensee provided, as their policy, COVID-19 Centers for Medicare and Medicaid (CMS) Guidelines dated March 17, 2021, that had indicated screening of all who enter the facility will be conducted and denial of entry for any persons who have signs or symptoms of COVID-19. This policy also indicated the staff to be wearing face masks and other PPE. The policy indicated swift detection of COVID-19 is completed through routine testing and when a staff member or resident is identified as COVID positive, the licensee should immediately begin outbreak COVID-19 testing.

TIME PERIOD FOR CORRECTION: Two days

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0 620	Continued From page 5	0 620		
0 620 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma	0 620		

144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan.
(a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility 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 licensee failed to comply with the requirements for reporting suspected maltreatment within 24 hours for one of five (R1) reviewed. R1 called 911 after the staff did not switch her oxygen tubing from a portable tank to her stationary tank while R1 was in bed. The licensee was aware of the incident but did not report the incident to the Minnesota Adult Abuse Reporting Agency (MAARC).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

Findings Include:

R1's medical record was reviewed. R1 was admitted to the licenesee on September 29, 2012. R1's diagnoses included: schizo-affective

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disorder, diabetes, venous ulcer and congestive heart failure (CHF). The resident's nursing assessment indicated the resident needed assistance of staff to ensure the resident's portable oxygen tubing is switched to the stationary tank while the resident is in bed.

R1's vulnerability assessment dated October 19, 2021 indicated R1 needed daily assistance of staff to switch portable oxygen tank to stationary unit while R1 is in bed. This same document indicated R1 needed assistance of two staff and a mechanical lift for all transfers.

R1's October 2021, medication administration record (MAR) indicated R1 received oxygen daily on the evening shift three liters per minute, continuous flow per nasal cannula. This same document indicated R1 oxygen levels to be checked twice daily and if the oxygen levels fall below 90 percent, the oxygen liter flow is to increase to four liters per minute continuous flow per nasal cannula.

On October 6, 2021, a police report indicated police arrived at the licensee at 9:45 p.m. and R1 appeared to be scared and breathing heavy. This same document indicated a licensee employee placed R1 in the room and forgot to switch the oxygen tubing from a portable tank to a stationary tank. The report indicated R1 ran out of oxygen and did not get a response from staff for nearly an hour. This same document indicated R1 told the police that she thought she was going to die. The report indicated that prior to police and ambulance leaving, R1's oxygen level was back in the 90%s.

The licensee provided a note written on October 6, 2021 at 10:03 p.m., by an unlicensed

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personnel (ULP-E), and messaged to other staff members, not including the administrator (Adm-A) and director of nursing (DON-I). The note indicated R1 was put to bed and ran out of oxygen, which caused 911 to be called out to the licensee. This same document indicated when the police and ambulance arrived the oxygen was switched from the portable tank to the stationary tank and R1 was stable.

During an interview with the investigator on November 16, 2021 at 1:10 p.m., R1 stated she remembered the incident and not being able to breathe. In this same interview, R1 stated she also remembered the ambulance coming out, but could not remember the staff who cared for her the night of the incident. R1 stated it took too long for staff to answer the call light. During this interview, R1 stated since the incident she has run out of oxygen in her large, stationary tank, and it had been forgotten to get switched.

During an interview with the investigator on November 16, 2021 at 3:18 p.m., ULP- E stated she rememberd R1 being already in bed when the incident occurred and checked on R1 because she heard her screaming. ULP-E stated R1 was already on the phone with 911 when she arrived at R1's room. In this same interview, ULP-E stated when police and ambulance arrived R1's oxygen level was back up in the 90 percentile and that prior to attaching the oxygen tubing to the stationary oxygen tank, R1s oxygen level was in the 60 percentile.

During an interview with the investigator on November 16, 2021 at 3:30 p.m., DON-I stated she was not aware of the incident, thus an internal investigation was not conducted and a MAARC Report was not completed by the

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0 620	Continued From page 8 licensee. During an interview with the investigator on November 16, 2021 at 4:12 p.m., the Adm-A stated a MAARC Report was not filed regarding the incident because she had no knowledge of the incident. The licensee Oxygen Policy dated August 1, 2021, indicated it is the licensee's responsibility to administer oxygen to a resident per physician's orders. The license's On Call Procedure dated July 9, 2021, indicated the nursing department is to call the on-call nurse for any emergency medical call (EMS) calls. The sunrise provided a policy/training documented dated, 2020, indicated staff instructions regarding the use of oxygen and oxygen equipment. The licensee's Maltreatment, Communication, Prevention and Reporting Policy, dated February 2021, under: Procedures, section 6: All staff are provided training regarding obligations to report suspected maltreatment to MAARC- who will assign the allegation and investigations to a lead investigative agency. TIME PERIOD TO CORRECT: Seven (7) days.	0 620		
01640 SS=E	144G.70 Subd. 4 Service plan, implementation, and revisions t (a) No later than 14 calendar days after the date	01640		

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that services are first provided, an assisted living facility shall finalize a current written service plan.
(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care.
(c) The facility must implement and provide all services required by the current service plan.
(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.
(e) Staff providing services must be informed of the current written service plan.

This MN Requirement is not met as evidenced by:
Based on record review, the licensee failed to ensure service plans included signatures or other authentication by the residents and the licensee to document agreement on the services to be provided for four out of five residents, (R1, R2, R3 and R4's) reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

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Findings Include:

R1's medical record was reviewed. R1 was admitted to the licensee on September 29, 2012. R1's diagnoses included: schizo-affective disorder, diabetes, venous ulcer and congestive heart failure (CHF).

R1's service plan, dated August 1, 2021, indicated R1 required assistance with personal cares, transfers, and medication management. R1 used a wheelchair for ambulation. R1's service plan lacked a signature or other authentication by R1 or the licensee documenting agreement on the services to be provided.

R2's medical record was reviewed. R2 was admitted to the licensee on October 28, 2021. R2's diagnoses included: lupus, decubitus ulcer and neurogenic bladder.

R2's service plan, dated August 1, 2021, indicated R2 required assistance with personal cares, transfers, and medication management. R2 used a wheelchair for ambulation. R2's service plan lacked a signature or other authentication by R2 or the licensee documenting agreement on the services to be provided.

R3's medical record was reviewed. R3 was admitted to the licensee on September 29, 2020. R3's diagnoses included: severe obesity, major depressive disorder, hypertension and colitis.

R3's service plan, dated August 1, 2021, indicated R3 required assistance with personal cares, transfers, and medication management. R3 required stand by assist of one staff as needed for ambulation. R3's service plan lacked a signature or other authentication by R3 or the

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01640	Continued From page 11 licensee documenting agreement on the services to be provided. R4's medical record was reviewed. R4 was admitted to the licensee on February 3, 2020. R4's diagnoses included: right sided hemiparesis, diabetes mellitus II, bipolar disorder and dysphagia. R4's service plan, dated August 1, 2021, indicated R4 required assistance with personal cares, transfers, and medication management. R3 required stand by assist of one staff as needed for ambulation. R4's service plan lacked a signature or other authentication by R4 or the licensee documenting agreement on the services to be provided. TIME PERIOD TO CORRECT: Seven (7) days.	01640		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews and document review, the licensee failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On November 29, 2021, the Minnesota Department of Health (MDH) issued a	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

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02360	Continued From page 12 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.	02360		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.	03000		

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(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to comply with the requirements for reporting suspected maltreatment within 24 hours for one of five (R1) reviewed. R1 called 911 after the staff did not switch her oxygen tubing from a portable tank to her stationary tank while R1 was in bed. The licensee was aware of the incident but did not report the incident to the Minnesota Adult Abuse Reporting Agency (MAARC).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

Minnesota Department of Health

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03000	Continued From page 14 Findings Include: R1's medical record was reviewed. R1 was admitted to the licensee on September 29, 2012. R1's diagnoses included: schizo-affective disorder, diabetes, venous ulcer and congestive heart failure (CHF). The resident's nursing assessment indicated the resident needed assistance of staff to ensure the resident's portable oxygen tubing is switched to the stationary tank while the resident is in bed. R1's vulnerability assessment dated October 19, 2021 indicated R1 needed daily assistance of staff to switch portable oxygen tank to stationary unit while R1 is in bed. This same document indicated R1 needed assistance of two staff and a mechanical lift for all transfers. R1's October 2021, medication administration record (MAR) indicated R1 received oxygen daily on the evening shift three liters per minute, continuous flow per nasal cannula. This same document indicated R1 oxygen levels to be check twice daily and if the oxygen levels fall below 90 percent, the oxygen liter flow is to increase to four liters per minute continuous flow per nasal cannula. On October 6, 2021, a police report indicated police arrived at the licensee at 9:45 p.m. and R1 appeared to be scared and breathing heavy. This same document indicated a licensee employee placed R1 in the room and forgot to switch the oxygen tubing from a portable tank to a stationary tank. The report indicated R1 ran out of oxygen and did not get a response from staff for nearly an hour. This same document indicated R1 told the police that she thought she was going to die.	03000		

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The report indicated that prior to police and ambulance leaving, R1's oxygen level was back in the 90%s.

The licensee provided a note written on October 6, 2021 at 10:03 p.m., by an unlicensed personnel (ULP-E), and messaged to other staff members, not including the administrator (Adm-A) and director of nursing (DON-I). The note indicated R1 was put to bed and ran out of oxygen which caused 911 to be called out to the licensee. This same document indicated when the police and ambulance arrived the oxygen was switched from the portable tank to the stationary tank and R1 was stable.

During an interview with the investigator on November 16, 2021 at 1:10 p.m., R1 stated she remembered the incident and not being able to breathe. In this same interview, R1 stated she also remembered the ambulance coming out, but could not remember the staff who cared for her the night of the incident. R1 stated it took too long for staff to answer the call light. During this interview, R1 stated since the incident she has run out of oxygen in her large, stationary tank, and it had been forgotten to get switched.

During an interview with the investigator on November 16, 2021 at 3:18 p.m., ULP- E stated she rememberd R1 being already in bed when the incident occurred and checked on R1 because she heard her screaming. ULP-E stated R1 was already on the phone with 911 when she arrived at R1's room. In this same interview, ULP-E stated when police and ambulance arrived R1's oxygen level was back up in the 90 percentile and that prior to attaching the oxygen tubing to the stationary oxygen tank, R1s oxygen level was in the 60 percentile.

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During an interview with the investigator on November 16, 2021 at 3:30 p.m., DON-I stated she was not aware of the incident, thus an internal investigation was not conducted and a MAARC Report was not completed.

During an interview with the investigator on November 16, 2021 at 4:12 p.m., the Adm-A stated a MAARC Report was not filed regarding the incident because she had no knowledge of the incident.

The licensee Oxygen Policy dated August 1, 2021, indicated it is the licensee's responsibility to administer oxygen to a resident per physician's orders.

The licensee's On Call Procedure dated July 9, 2021, indicated the nursing department is to call the on-call nurse for any emergency medical call (EMS) calls.

The licensee provided a policy/training documented dated, 2020, indicated staff instructions regarding the use of oxygen and oxygen equipment.

The licensee's Maltreatment, Communication, Prevention and Reporting Policy, dated February 2021, under: Procedures, section 6: All staff are provided training regarding obligations to report suspected maltreatment to MAARC- who will assign the allegation and investigations to a lead investigative agency.

TIME PERIOD TO CORRECT: Seven (7) days.