Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52821421M **Date Concluded:** December 22, 2022

Name, Address, and County of Licensee Investigated:
Charter House
211 2nd Street NW
Rochester, MN 55901
Olmstead County

Facility Type: Nursing Home **Evaluator's Name:** Michele R. Larson
Special Investigator

Finding: Substantiated, individual 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.

Initial Investigation Allegation(s):
The alleged perpetrator (AP) neglected a resident when they failed to assess the resident throughout her shift after the resident experienced a change in his condition. The resident was found deceased in his bed at the end of her shift.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP was told during shift change report the resident had severely low oxygen saturation reading (79%) and was placed on oxygen, yet the AP never assessed the resident during her shift and never called the on-call provider to update them on the resident's change-in-condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The resident's providers were interviewed. The AP was interviewed. The investigation included review of the resident's records, and facility records,

including their policies and procedures. Documents were reviewed from a previous compliance investigation.

The resident resided in the short-term rehabilitation center (STRC) for eight days until his unexpected death. The resident's diagnoses included severe central sleep apnea with congestive heart failure, hypoxia, and chronic kidney disease.

The resident's care plan indicated the resident required assistance with toileting, transfers, and mobility while in and out of bed. The resident's care plan indicated nursing staff would reposition the resident every two to three hours and as needed while the resident was in his bed or chair. His care plan indicated the resident was expected to return to independent living in the facility's assisted living section after his brief stay in STRC.

The resident's care plan did not include interventions for the resident's assessed breathing issues or use of a nightly CPAP machine to help him breathe at night.

The resident's assessment indicated he was alert and oriented to person, place, and time. The resident was assessed as having diminished lung sounds in the mid and lower lobes. The resident experienced shortness of breath with exertion and lying flat. The resident used a continuous positive airway pressure (CPAP) breathing device machine every night due to his diagnosis of severe sleep apnea. The resident's assessment indicated the resident required extensive assistance of two staff persons with bed mobility.

The resident's physician orders indicated the resident was prescribed as needed (PRN) aerosolized inhalation (nebulizer) machine for his shortness of breath, in addition to using his CPAP device at night.

On day three at 12:44 p.m., a nurse progress note indicated the resident's oxygen saturation was 86% on room air. The resident was given a scheduled nebulizer treatment. The resident's oxygen saturation increased to 94% after the treatment. No shortness of breath was noted. An email was sent to the resident's provider requesting PRN oxygen. The nurse indicated he would continue to monitor the resident.

The resident's record lacked evidence the resident's provider was notified regarding the resident's decrease in his oxygen saturation.

On day four at 3:50 a.m., a nurse progress note indicated the resident took his CPAP mask off throughout the night. The nurse noted the resident's oxygen saturation was 90-91% on room air and 95% wearing his CPAP mask. The resident denied any shortness of breath or difficulty breathing (dyspnea). The nurse indicated she would continue to monitor the resident.

The resident's record lacked evidence the resident's provider or on-call provider were notified regarding the resident's removal of his CPAP mask.

On day five at 4:00 a.m., a nurse progress note indicated the resident's lung sounds were diminished and he had a persistent productive cough with whitish secretions. The resident received a nebulizer treatment. The nurse advised the resident to use his incentive spirometer (lung expansion device) every one to two hours while awake. The nurse's note indicated the resident slept well using wearing his CPAP mask. The nurse indicated she would continue to monitor the resident.

On day six at 4:46 p.m., a nurse progress note indicated the resident experienced shortness of breath (SOB) when changing positions and doing activities. The resident had fine crackle sounds in his right lobe and diminished lung sounds in the left lobes. The resident's oxygen saturation was documented at 91-93% room air. The resident was pleasant and cooperative. The nurse indicated she would continue to monitor the resident.

The progress note lacked evidence his provider was notified regarding his increased SOB, crackles in his lungs, and diminished lung sounds.

On day seven at 9:36 p.m., a nurse progress note written by nurse #1, indicated the resident's oxygen saturation was 79% at room air. Nurse #1 indicated the resident experienced shortness of breath during rest. Nurse #1 placed the resident on 2 liters per minute (lpm) of oxygen via nasal cannula per facility standing orders. Nurse #1 sent an in-basket message to the resident's provider.

On day eight at 5:07 a.m., a nurse progress note written by the AP, indicated the resident passed away peacefully in his sleep. The AP indicated there were no signs of life. The resident's wife, nurse manager, chaplain, and provider were notified.

On day eight at 7:55 a.m., the AP documented the resident refused to wear his CPAP mask. The AP documented the progress note two hours after the resident died. The AP wrote the resident refused the CPAP mask when she offered it to him.

Review of the nurse progress notes indicated the AP never documented she assessed the resident during her shift nor monitored the resident's oxygen saturation.

Review of the resident's vital sign document indicated the resident's oxygen saturation or other vital signs were never checked during the AP's overnight shift.

Review of the facility's internal investigation report indicated nurse #1 reported at 9:36 p.m., she placed the resident on 2 lpm of oxygen via nasal cannula after she discovered the resident's oxygen was at 79% room air. Nurse #1 sent an in-basket message (email) to the resident's provider updating them on the resident's status. The investigation report indicated nurse #1 reported the resident's change-in-condition to the AP during shift change report at 10:00 p.m. During the internal investigation, the AP indicated nurse #1 updated her on the resident's

change in condition. The report indicated the AP did not perform cardiopulmonary resuscitation (CPR) because the resident was “dead.”

During an interview, nurse #1 stated she gave report to the AP during shift change regarding the resident’s change-in-condition. Nurse #1 stated the AP told her she would call the on-call provider to update them. Nurse #1 stated she was concerned about the resident’s drastic change-in-condition and stated the resident should have been admitted to a hospital. Nurse #1 stated the resident was breathing and wearing his CPAP mask when she left work for that evening.

During an interview, nurse #2 stated resident’s oxygen should have been rechecked during the shift. Nurse #2 stated nurses were supposed to notify either the resident’s provider or on-call provider whenever a resident experienced a notable change-in-condition.

During an interview, unlicensed personnel (ULP) #4 stated the AP never told her to check the resident’s oxygen and vital signs during the overnight shift. ULP #3 stated ULP obtained vital signs for the first three days in STRC but stated, “after that the nurses do it.”

During an interview ULP #5 stated she and ULP #4 performed rounds (safety checks) at the beginning of their shift, 2:00 a.m. and 4:00 a.m. ULP #5 stated the resident was breathing during those times. ULP #5 stated she thought the AP did rounds at 11:00 p.m. but was unsure and stated she could not recall the AP entering the resident’s room until 5:00 a.m. when the three of them entered the resident’s room and found him dead. ULP #5 stated the AP tried to blame her and another ULP for not checking on the resident during the shift. ULP #5 stated she and the other ULP were not nurses and it was the AP’s responsibility to assess and check on the resident. ULP #5 stated it was uncomfortable working with the AP because she complained about everything, stating, “I did not want to work with her.” ULP #5 stated she was unsure if the resident had his CPAP mask on that night.

During an interview, a licensed health professional stated the resident had severe central sleep apnea and used a CPAP every night. The licensed health professional stated would expect to see that the AP assessed the resident during the night which included a set of vitals and a physical exam given the resident’s low 02 reading and shortness of breath during the previous shift.

During an interview, the AP stated nurse #1 told her the resident was fine during shift change report. The AP stated nurse #1 told her the resident had oxygen saturation in the 80’s during the previous shift so nurse #1 administered 2 lpm oxygen via nasal cannula but stated nurse #1 told her the resident’s oxygen saturation was in the low 90’s. The AP stated she trusted nurse #1’s report. The AP stated she was under the assumption the resident was okay. The AP stated she did not notify the on-call provider since she was not the one who assessed the resident to have low oxygen saturation readings, stating “that’s not how I roll. I don’t call it if I don’t see it.” The AP stated she does not document on another nurse’s assessments and stated she only documented what she took. The AP stated she assumed the ULP’s were checking vitals and

“we” should not upset the resident when she was told he was okay, stating nurse #1 told her the resident was “fine.” The AP stated the facility was short one ULP since ULP #5 was being oriented by ULP #4. The AP stated she did not have time to read the previous shift’s progress notes or review the resident’s vital sign document, stating, “I don’t have time for that.” The AP stated she was unsure ULP #4 obtained any vital signs on the resident during the overnight shift. The AP stated she did “peek” on the resident around 12:00 a.m., making sure he had his oxygen on, but stated she did not document her assessment and did not write a nurse progress note stating, “I forgot.” The AP stated she kept asking ULP #4 and ULP #5 if the resident was okay but admitted she should have asked more specific questions. The AP stated she did not perform CPR since he was “dead.”

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

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.

Vulnerable Adult interviewed: No. The resident is deceased.
Family/Responsible Party interviewed: No.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility implemented colored stickers (green, red) to place on the outside edge of resident charts indicating whether a resident was full code (green) or a do not resuscitate or intubate (DNR/DNI) (red) status.

Action taken by the Minnesota Department of Health:
The facility was found to be in non-compliance during a previous onsite investigation by another division within MDH.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Olmstead County Attorney

Rochester City Attorney
Rochester Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00193	A. BUILDING: _____ B. WING _____	C 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER HOUSE	211 NORTHWEST SECOND STREET ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H52821421M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for	2 000		

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2 000	Continued From page 1 #H52821421M, tag identification 1850. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.	21850		

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21850	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure one resident (R1) with records reviewed, was free from maltreatment. R1 was neglected. The Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that individual staff persons were responsible for the maltreatment, in connection with the incident which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	21850	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	