Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H53043447M
Compliance #: H53045246C

Date Concluded: August 1, 2023

Name, Address, and County of Licensee Investigated:
Terrace Cannon Falls LLC
300 Dow Street North
Cannon Falls, MN 55009
Goodhue County

Facility Type: Nursing Home

Evaluator's Name: Brandon Martfeld, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Investigation:
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), licensed facility staff, neglected a resident when the AP failed to initiate cardiopulmonary resuscitation (CPR) when the resident was found unresponsive with no pulse and not breathing. The resident died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to initiate CPR, according to the resident's Provider Orders for Life-Sustaining Treatment (POLST) indicating the resident requested CPR, if the resident was found unresponsive, not breathing, and without a pulse.

The investigator conducted interviews with nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of federal compliance surveyor notes, medical records, and policies and procedures.

The resident resided in a skilled nursing facility. The resident's diagnoses included sepsis (life-threatening response to infection), long term use of blood thinning medication, and bleeding of the esophagus. The resident was mildly cognitively impaired due to a diagnosis of autism. The resident required assistance with grooming, hygiene, repositioning in bed, dressing, toileting, and walking. The resident was independent using the wheelchair.

The resident's Provider Orders for Life-Sustaining Treatment (POLST) and signed by the resident's responsible party indicated the resident requested CPR with full treatment (intubation for an airway, mechanical ventilation, and transfer to a hospital) if the resident had no pulse and not breathing.

The facility's progress note indicated one early morning; a nursing assistant (NA) told the AP the resident was not responding to staff. The AP assessed the resident who did not respond to touch or verbal commands and was without a pulse and respirations. Following the assessment, the AP notified the residents family, the resident's provider, and the facility director of nursing of the resident's death. Later, the facility released the resident's body to a funeral home.

During an interview, a NA stated when checking on the resident that night, the resident was unresponsive. The NA's co-worker reported the resident's status to the AP. When the AP came into the room, she assessed the resident and said the resident was gone. The AP did not perform CPR.

During an interview with the federal surveyor, the AP stated she did not check the resident's code status after it was determined the resident was without a pulse and respirations. The AP stated CPR should have been started when the resident was found without a pulse and respirations. The AP was aware of the location of the resident's code status in the electronic medical record. The AP stated she realized the resident was full code later when filling out the death paperwork and realized she should have done CPR. The AP provided no additional information for not initiating CPR for the resident.

During an interview, the AP stated the previous shift nurse reported the resident was not himself and did not eat well that day. When checking on the resident, a NA reported to the AP that the resident was not doing well. When the AP entered the resident's room, the resident was not breathing, had no pulse, and was warm to the touch. The AP told the NA to clean up the resident and went back to the nurse's station. The AP called the family member to notify them of the passing of the resident. After approximately a 40-minute phone call with the resident's family member, the AP notified the doctor on call and the director of nursing. At the end of the notifications and when documenting the resident's death to release the resident' body to the funeral home, the AP realized the resident requested CPR if found without a pulse and respirations. The AP provided no additional information for not initiating CPR for the resident when the resident was found without respirations and a pulse.

Review of the certificate of death indicated the resident died from natural causes.

During an interview, a family member stated the AP called and said the resident had passed away. The family member stated the resident was to have CPR performed. The family member did not recall the AP saying CPR was performed.

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 neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means 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 was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility provided all staff education on code status. The AP was no longer employed by the facility. The nursing home is no longer in operation.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term Care Facilities, and substantiated facility 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

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies. You may also call 651-201-4200 to receive a copy via mail or email.

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
The Office of Ombudsman for Mental Health and Developmental Disabilities
Goodhue County Attorney
Cannon Falls City Attorney
Cannon Falls 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
	00758	A. BUILDING: _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT CANNON FALLS	300 NORTH DOW STREET CANNON FALLS, MN 55009

(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, complaints #H53043447M, #H53043083M and #H53043084M in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No	2 000		

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2 000	Continued From page 1 state orders were written because the facility was closed at the time the investigation was completed	2 000		