Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
St. Benedicts Senior Community
1810 Minnesota Boulevard SE
St. Cloud, MN 56304
Sherburne County

Report #: H5350053

Date: November 5, 2013

Date of Visit: July 3, 2013
Time of Visit: 8:30 a.m. – 4:00 p.m.

By: Diane Wallner, R.N., Special Investigator

Type of Facility: ☒ Nursing Home ☐ SLF ☐ Hospital ☐ HHA ☐ ICF/IID ☐ Other: ____ ☐ Home Care Provider/Assisted Living ☐ Home Care

☒ Facility Self Report ☐ Complaint

Allegation(s): It is alleged that neglect occurred when a resident was not provided with care based on her advanced directive. The resident became unresponsive in the dining room and staff brought the resident to her room. No CPR was initiated although the resident had a full code resuscitation status.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☑ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☑ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)

- [ ] State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
- [ ] State Licensing Rules for Home Care (MN Rules Chapter 4668)
- [ ] State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
- [x] State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- [x] State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

[ ] Abuse [x] Neglect [ ] Financial Exploitation was:

(•) Substantiated ( ) Not Substantiated ( ) Inconclusive based on the following information:

A preponderance of evidence reveals neglect is substantiated when the facility staff failed to provide emergency care, including cardiopulmonary resuscitation (CPR) after a resident became pulseless. The resident's resuscitation code status was full code. Nurses were in attendance with the resident from the time s/he became unresponsive until the nurses noted the resident no longer had a pulse.

The resident was admitted to the facility for short term stay following a pacemaker insertion due to atrial fibrillation (rapid irregular heartbeat). The resident signed an advanced direction consent form to have resuscitation attempted in the event s/he stopped breathing and/or her/his heart stopped. The resident had been at the facility for 10 days when s/he complained of dizziness and became unresponsive after s/he walked to the dining room for lunch. Staff assessed the resident and determined s/he had a pulse and transported the resident back to his/her room. The resident continued to have a pulse during transport. Staff checked the resident again after s/he was back to his/her room then noted the resident had no pulse. Staff failed to call a code according to facility practice for additional staff to come and assist the resident and unit staff when the resident became distressed or deceased.

Nurses were interviewed and stated the resident was a full code status and had a pulse when s/he was in the dining room. Nursing staff transported the resident to his/her room, although not told to do so by the RN in charge. At least one nurse was with the resident the entire time from when s/he became unresponsive in the dining room until when s/he was found to have no pulse in his/her room. When a nurse realized the resident had not pulse and was not breathing, s/he went to the nursing station to get the crash cart and informed the charge nurse the resident had no pulse. The nurse stated the charge nurse told them not to initiate CPR as the nurses did not witness the resident's arrest and too much time had gone by. The charge nurse verified s/he told the other nurse this. Nurses caring for the resident verified at least one of them was with the resident the entire time from when s/he became unresponsive with a pulse until they had transported the resident to his/her room and noted the resident no longer had a pulse. The nurses who checked for a pulse said the resident's death was within about 10 minutes of the unresponsive episode. These nurses felt CPR should have been initiated for the resident but followed the charge nurse direction.

The physician was interviewed and stated the staff should have initiated CPR according to the orders for full resuscitation. This was the resident's preference, the time frame was appropriate for initiation of CPR, and staff

were with the resident.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ individual(s) and/or ☒ facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

Three facility licensed nurses failed to initiate CPR to the resident when they were present when the resident arrested. The resident died. The nurses failed to follow the standard practice for CPR as recommended by the American Heart Association. The facility policy and procedure did not follow the American Heart Association recommendations as a standard of practice for when to perform or not perform CPR.

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.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) – Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No If no, specify: ____________
(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: ____________
(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: ___________
(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: ___________
(State licensing orders will be available on the MDH website.)

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"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;

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

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

☒ Medical Records

☒ Care Guide

☒ Medication Administration Records

☒ Treatment Sheets

☒ Facility Incident Reports

☒ Physician Progress Notes

☒ ADL (Activities of Daily Living) Flow Sheets

☐ Laboratory and X-ray Reports

☒ Physician Orders

☐ Social Service Notes

☒ Nurses Notes

☐ Meal Intake Records

☐ Activities Reports

☐ Weight Records

☐ Therapy and/or Ancillary Services Records

☒ Assessments

☒ Skin Assessments

☒ Care Plan Records

Other pertinent medical records:

☐ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☒ Death Certificate

☐ Police Report

Additional facility records:

☐ Resident/Family Council Minutes

☒ Personnel Records/Background Check, etc.

☒ Staff Time Sheets, Schedules, etc.

☒ Facility In-service Records

☒ Facility Internal Investigation Reports

☒ Facility Policies and Procedures

☐ Call Light Audits

☐ Other, specify: ________

Number of additional resident(s) reviewed: 4

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A Specify: ________

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A Specify: deceased

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ○ Yes ○ No ◉ N/A Specify: ________

If unable to contact complainant, attempts were made on:
Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: ◉ Yes ○ No ○ N/A Specify: ________

Did you interview the resident(s) identified in allegation: ○ Yes ◉ No ○ N/A Specify: deceased

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 10

Interview with staff: ◉ Yes ○ No ○ N/A Specify: 10 additional staff were spoken with during the onsite facility tour and observations

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 7

Physician interviewed: ◉ Yes ○ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: ________

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: ○ Yes , date subpoena was issued ________ ○ No

Were contacts made with any of the following:
☒ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify no record of a call for emergency responders was found

Observations were conducted related to:

☐ Wound Care	☐ Medication Pass	☐ Meals
☐ Personal Care	☒ Dignity/Privacy Issues	☐ Restorative Care
☒ Nursing Services	☒ Safety Issues	☒ Facility Tour

☐ Infection Control ☒ Cleanliness ☐ Injury

☐ Use of Equipment ☐ Transfers ☐ Incontinence

☐ Call Light ☐ Other: ________

Was any involved equipment inspected: ○ Yes ○ No ● N/A

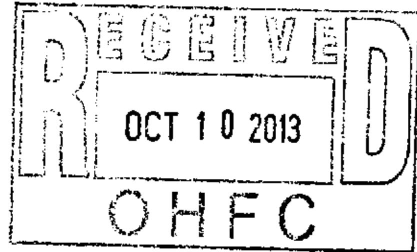
Was equipment being operated in safe manner: ○ Yes ○ No ● N/A

Were photographs taken: ○ Yes ● No Specify: ________

xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Board of Examiners for Nursing Home Administrators
Minnesota Board of Nursing
Sherburne County Medical Examiners
St. Cloud City Police Department
Sherburne County Attorney
St. Cloud City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING ______ B. WING ______	C 09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

(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) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey was initiated to investigate case #H5350053. As a result, the following deficiency is issued.	F 000		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and documentation review, the facility failed to provide emergency care, including resuscitation attempts, for 1 of 1 resident (R1). When R1 became unresponsive and his/her pulse stopped, staff did not initiate emergency care even though staff were attending to R1 from the time s/he had a pulse to when s/he no longer had a pulse. R1 died. No cardiopulmonary resuscitation (CPR) was initiated in accordance with R1's advance directives. Findings include: During the facility entrance on 7/3/13 at 8:31 a.m., Employee B/administration stated part of the admission process is to discuss and complete the Advanced Directive consent form with the resident. The facility tour was conducted on 7/3/13 at 8:41 a.m. with Employee A/administrator and revealed the facility has two short stay units where residents receive nursing care and	F 309		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christine Bakke
TITLE: Administrator
(X6) DATE: 10/3/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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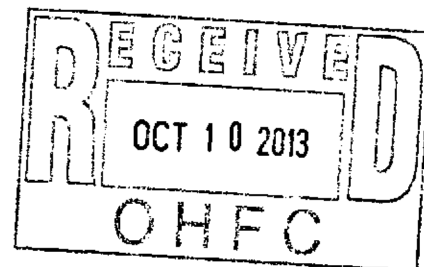
F 309	Continued From page 1	F 309		

rehabilitative services to return home to the community. The short stay units are equipped with emergency care crash carts. The north short stay unit has 24 beds. The south short stay unit has 20 beds.

The medical records for R1 was reviewed. The physician orders and care plan dated 6/13 for R1 with an admission date of 6/19/13 revealed R1 was admitted to the north short stay unit following hospitalization for a pacemaker placement. The Advanced Directive Consent Form, signed by R1 and dated 6/18/13 was signed by the physician on 6/20/13, indicated R1's preference was to be resuscitated in the event his/her heart or breathing stopped. Review of the Clinical Monitoring Record dated 6/13 revealed R1 complained of dizziness at least six times during a 10 day facility stay. The physician documentation dated 6/27/13 noted the patient had some lightheadedness and was admitted to the facility following pacemaker implantation for rapid atrial fibrillation. Progress notes dated 6/29/13 at 12:42 p.m. revealed the patient was going to the dining room at 12 noon, became dizzy and had a pulse present. R1 died. Staff verified the time of R1's death was 12:10 p.m.

An interview with registered nurse (RN)-G was conducted on 7/8/2013 at 3:16 p.m. RN-G said on 6/29/13 at lunchtime R1 came into the dining room and told RN-G s/he was dizzy and sat in a dining room chair. RN-G said R1 became unresponsive but had a pulse and was breathing when she began to immediately assess R1. RN-G called licensed practical nurse (LPN)/E to take over care for R1. RN-G left the dining room to begin calling the physician, emergency transport, and family. LPN-E, licensed practical



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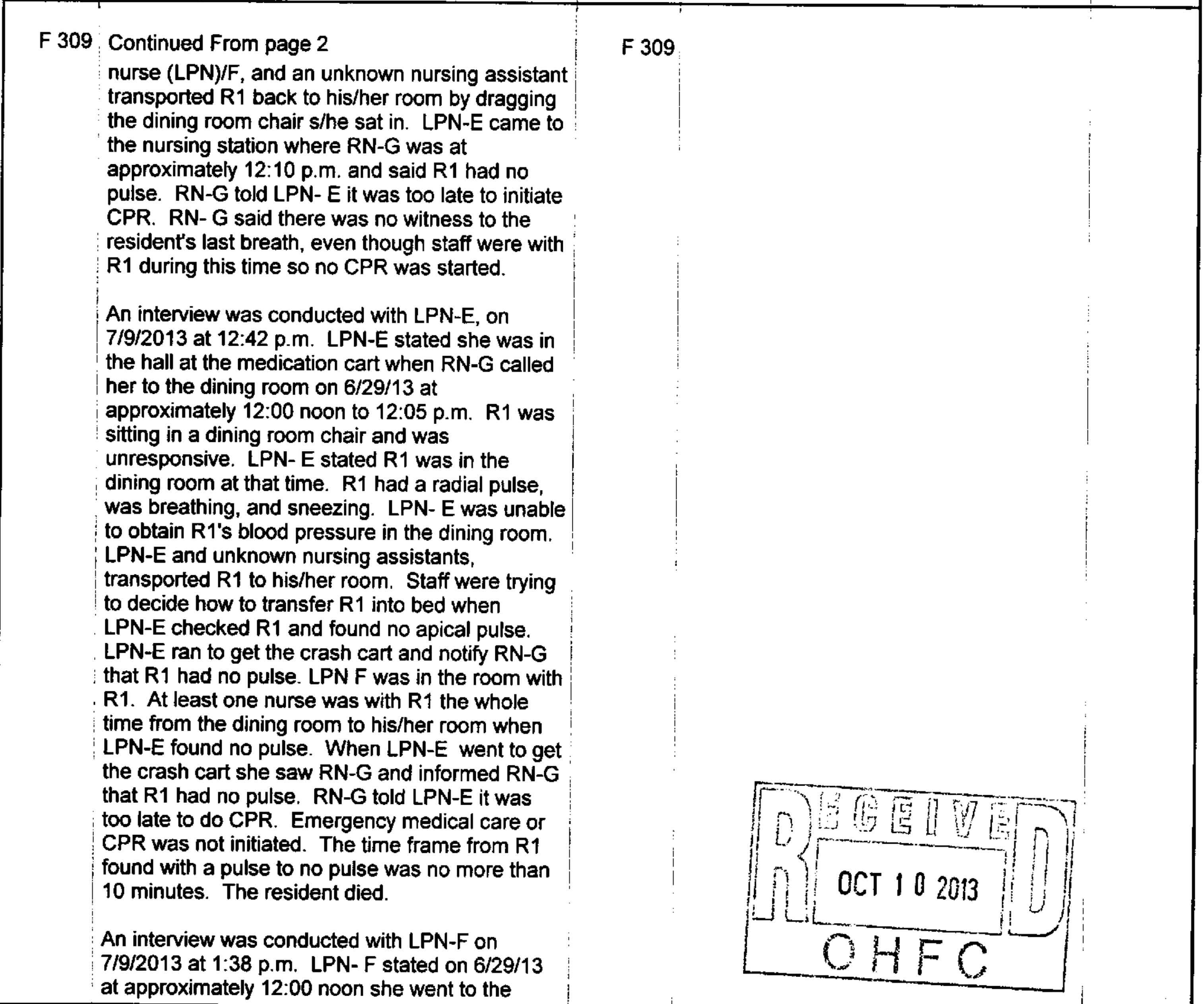

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F 309	Continued From page 2 nurse (LPN)/F, and an unknown nursing assistant transported R1 back to his/her room by dragging the dining room chair s/he sat in. LPN-E came to the nursing station where RN-G was at approximately 12:10 p.m. and said R1 had no pulse. RN-G told LPN- E it was too late to initiate CPR. RN- G said there was no witness to the resident's last breath, even though staff were with R1 during this time so no CPR was started. An interview was conducted with LPN-E, on 7/9/2013 at 12:42 p.m. LPN-E stated she was in the hall at the medication cart when RN-G called her to the dining room on 6/29/13 at approximately 12:00 noon to 12:05 p.m. R1 was sitting in a dining room chair and was unresponsive. LPN- E stated R1 was in the dining room at that time. R1 had a radial pulse, was breathing, and sneezing. LPN- E was unable to obtain R1's blood pressure in the dining room. LPN-E and unknown nursing assistants, transported R1 to his/her room. Staff were trying to decide how to transfer R1 into bed when LPN-E checked R1 and found no apical pulse. LPN-E ran to get the crash cart and notify RN-G that R1 had no pulse. LPN F was in the room with R1. At least one nurse was with R1 the whole time from the dining room to his/her room when LPN-E found no pulse. When LPN-E went to get the crash cart she saw RN-G and informed RN-G that R1 had no pulse. RN-G told LPN-E it was too late to do CPR. Emergency medical care or CPR was not initiated. The time frame from R1 found with a pulse to no pulse was no more than 10 minutes. The resident died. An interview was conducted with LPN-F on 7/9/2013 at 1:38 p.m. LPN- F stated on 6/29/13 at approximately 12:00 noon she went to the	F 309	RECEIVED OCT 10 2013 OHFC	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/29/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING ______ B. WING ______	C 09/12/2013

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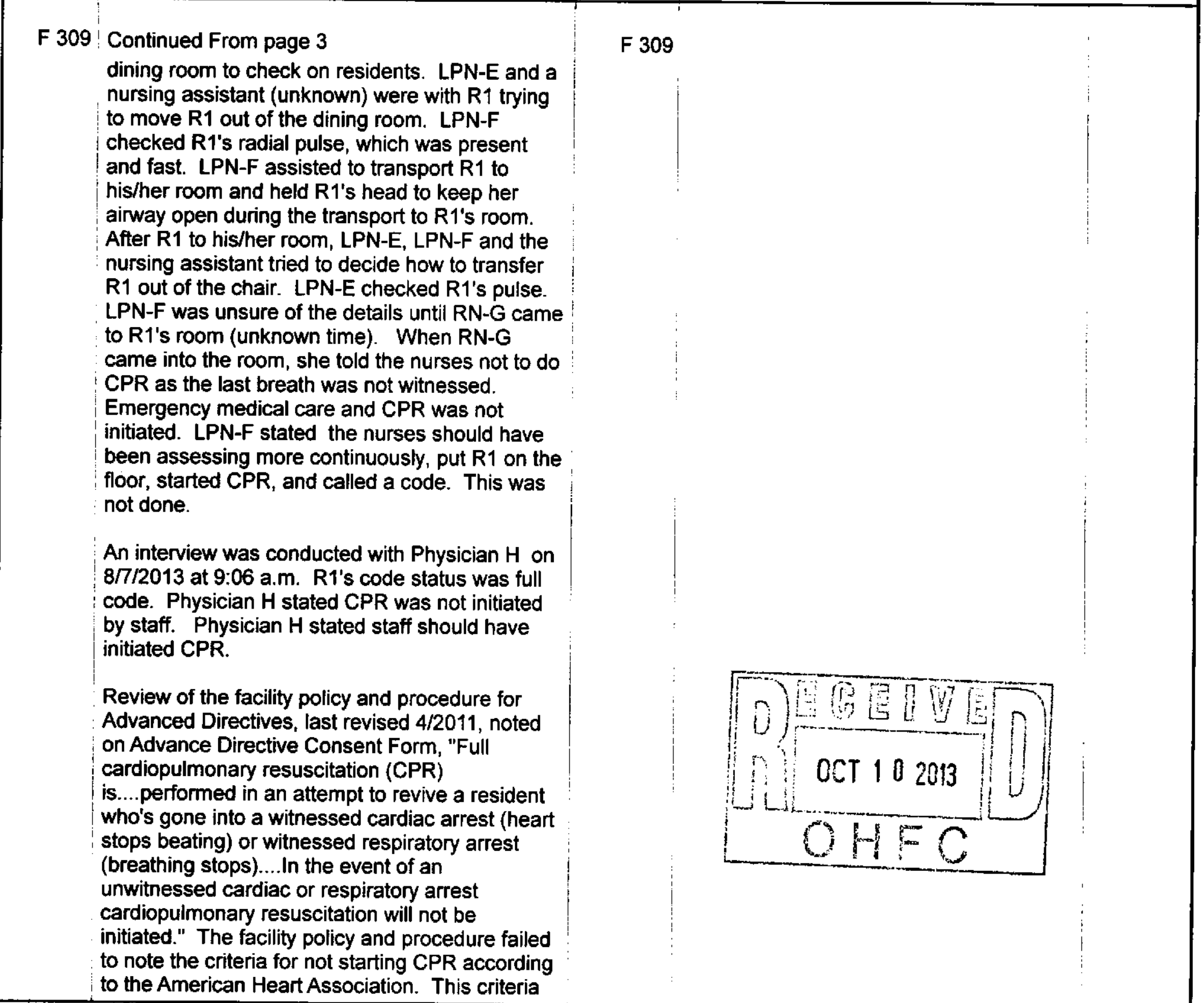

F 309 Continued From page 3 F 309

dining room to check on residents. LPN-E and a nursing assistant (unknown) were with R1 trying to move R1 out of the dining room. LPN-F checked R1's radial pulse, which was present and fast. LPN-F assisted to transport R1 to his/her room and held R1's head to keep her airway open during the transport to R1's room. After R1 to his/her room, LPN-E, LPN-F and the nursing assistant tried to decide how to transfer R1 out of the chair. LPN-E checked R1's pulse. LPN-F was unsure of the details until RN-G came to R1's room (unknown time). When RN-G came into the room, she told the nurses not to do CPR as the last breath was not witnessed. Emergency medical care and CPR was not initiated. LPN-F stated the nurses should have been assessing more continuously, put R1 on the floor, started CPR, and called a code. This was not done.

An interview was conducted with Physician H on 8/7/2013 at 9:06 a.m. R1's code status was full code. Physician H stated CPR was not initiated by staff. Physician H stated staff should have initiated CPR.

Review of the facility policy and procedure for Advanced Directives, last revised 4/2011, noted on Advance Directive Consent Form, "Full cardiopulmonary resuscitation (CPR) is....performed in an attempt to revive a resident who's gone into a witnessed cardiac arrest (heart stops beating) or witnessed respiratory arrest (breathing stops)....In the event of an unwitnessed cardiac or respiratory arrest cardiopulmonary resuscitation will not be initiated." The facility policy and procedure failed to note the criteria for not starting CPR according to the American Heart Association. This criteria

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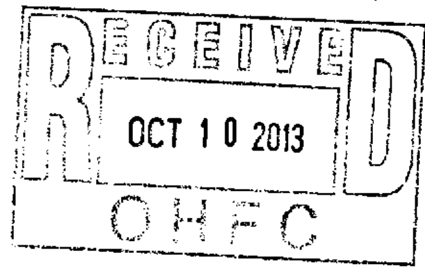
F 309	Continued From page 4 states: " ....Therefore, it is recommended that all patients in cardiac arrest receive resuscitation unless The patient has a valid DNAR order. The patient has signs of irreversible death: rigor mortis, decapitation, or dependent lividity. No physiological benefit can be expected because the vital functions have deteriorated despite maximal therapy for such conditions as progressive septic or cardiogenic shock. Withholding attempts to resuscitate in the delivery room is appropriate for newly born infants with....." R1 met none of the exceptions listed above.	F 309		



The facility objects to the allegations on non-compliance in this statement of deficiency and disagrees with both the findings of non-compliance and the level of deficiency cited. Submission of this response and Plan of Correction is not a legal admission that deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission against the interest of the facility, the administrator, of any employees, agents or other individual who draft or may be discussed in the Response of Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or an agreement of any kind by the facility of the truth or any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Accordingly, the facility has prepared and submitted this Plan of Correction solely because of the requirements under State and Federal law that mandate submission of a Plan of Correction within ten days of the survey as a Condition of Participation in Title 18 and Title 19 programs. The submission of the Plan of correction within this time frame should in no way be considered or construed as agreement with allegations of non-compliance or admission by the facility.

F 309

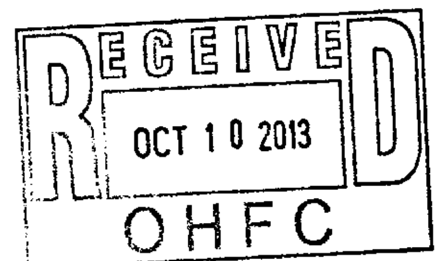
1. The two LPN's that were in the room and failed to initiate CPR when R1 arrested: both successfully completed/renewed their cognitive and skill evaluations in accordance with the curriculum of the American Heart Association BLS (Basic Life Support or CPR) for Health Care Providers on 04/03/13 and 04/19/12, received education on the facility "code blue" policy on orientation (11/04/08 & 11/12/12) and at their annual education (both on 05/07/13), were immediately suspended on 06/29/13 pending investigation and on 07/01/13 were terminated from employment. RN-G was counseled and provided re-education on the facility "code blue" policy and procedure and is auditing the facility "code blue" drills under the guidance of the Director of Education.

2. The facility "code blue" policy was updated to direct staff to resuscitate all residents requesting resuscitation (references in the policy to witnessed and unwitnessed were removed). The facility has implemented periodic "code blue" drills. The clinical nurse managers provided their staff with education on the changes in the "code blue" policy. Licensed personnel will continue to receive education on the facility "code blue" policy at their orientation and annually, and be required to successfully renew their cognitive and skill evaluations in accordance with the curriculum of the American Heart Association BLS (Basic Life Support or CPR) for Health Care Providers .

3. The Director of Education will audit the "code blue" drills.

4. The Director of Nursing and Director of Educations and/or designee will present to the "Quality Assurance Committee" at their next meeting, the audit findings related to "code blue" drills and determine the need for periodic auditing.

Dated Corrected: 09/30/13



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00774	A. BUILDING: ______ B. WING ______	C 09/12/2013

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2 000	Initial Comments	2 000		

*****ATTENTION******

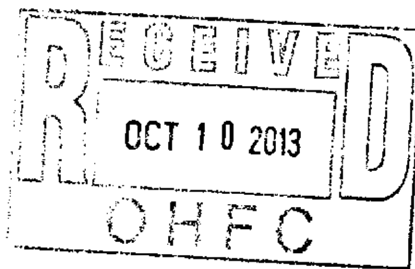
NH LICENSING CORRECTION ORDER

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:
A complaint investigation was initiated to investigate complaint #H5350053. The following correction orders are issued.

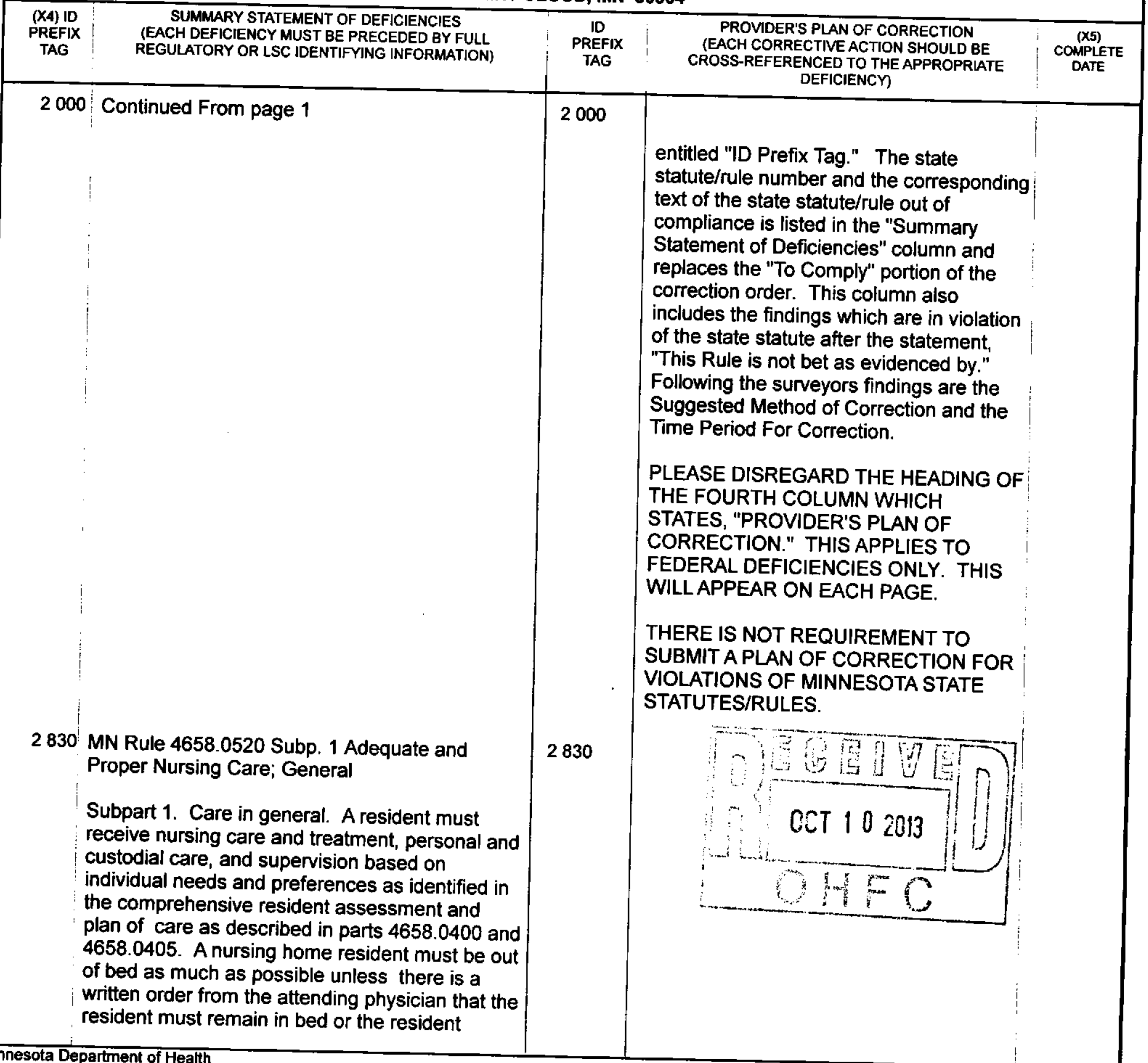


Minnesota Department of Health is documenting the State Licensing Correction Orders using the federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00774	A. BUILDING: ________ B. WING ________	C 09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304



(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	Continued From page 1	2 000	entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not bet as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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 NOT REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident	2 830	RECEIVED OCT 10 2013 OHFC	

PRINTED: 09/29/2013
FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00774	A. BUILDING: ______ B. WING ______	C 09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

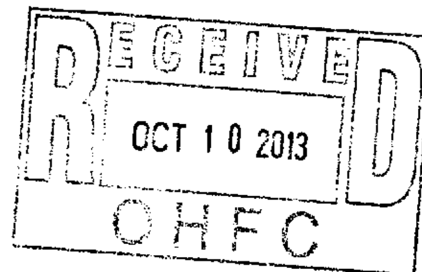
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 2	2 830		

prefers to remain in bed.

This MN Requirement is not met as evidenced by:
Based on observations, interviews, and documentation review, the facility failed to provide emergency care, including resuscitation attempts, for 1 of 1 resident (R1). When R1 became unresponsive and his/her pulse stopped, staff did not initiate emergency care even though staff were attending to R1 from the time s/he had a pulse to when s/he no longer had a pulse. R1 died. No cardiopulmonary resuscitation (CPR) was initiated in accordance with R1's advance directives. Findings include:

During the facility entrance on 7/3/13 at 8:31 a.m., Employee B/administration stated part of the admission process is to discuss and complete the Advanced Directive consent form with the resident. The facility tour was conducted on 7/3/13 at 8:41 a.m. with Employee A/administrator and revealed the facility has two short stay units where residents receive nursing care and rehabilitative services to return home to the community. The short stay units are equipped with emergency care crash carts. The north short stay unit has 24 beds. The south short stay unit has 20 beds.

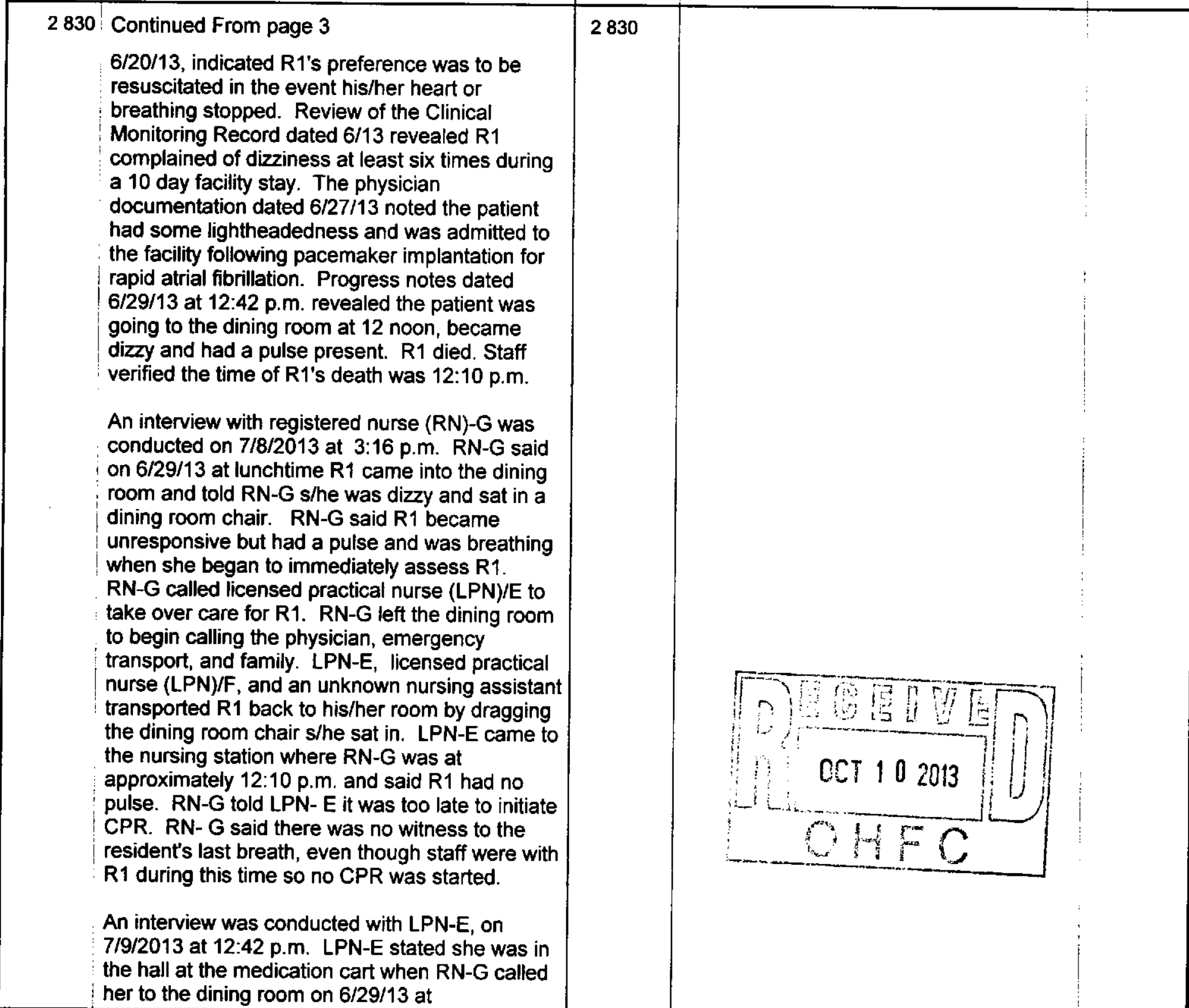
The medical records for R1 was reviewed. The physician orders and care plan dated 6/13 for R1 with an admission date of 6/19/13 revealed R1 was admitted to the north short stay unit following hospitalization for a pacemaker placement. The Advanced Directive Consent Form, signed by R1 and dated 6/18/13 was signed by the physician on



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00774	A. BUILDING: ______ B. WING ______	C 09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

(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
2 830	Continued From page 3	2 830		



6/20/13, indicated R1's preference was to be resuscitated in the event his/her heart or breathing stopped. Review of the Clinical Monitoring Record dated 6/13 revealed R1 complained of dizziness at least six times during a 10 day facility stay. The physician documentation dated 6/27/13 noted the patient had some lightheadedness and was admitted to the facility following pacemaker implantation for rapid atrial fibrillation. Progress notes dated 6/29/13 at 12:42 p.m. revealed the patient was going to the dining room at 12 noon, became dizzy and had a pulse present. R1 died. Staff verified the time of R1's death was 12:10 p.m.

An interview with registered nurse (RN)-G was conducted on 7/8/2013 at 3:16 p.m. RN-G said on 6/29/13 at lunchtime R1 came into the dining room and told RN-G s/he was dizzy and sat in a dining room chair. RN-G said R1 became unresponsive but had a pulse and was breathing when she began to immediately assess R1. RN-G called licensed practical nurse (LPN)/E to take over care for R1. RN-G left the dining room to begin calling the physician, emergency transport, and family. LPN-E, licensed practical nurse (LPN)/F, and an unknown nursing assistant transported R1 back to his/her room by dragging the dining room chair s/he sat in. LPN-E came to the nursing station where RN-G was at approximately 12:10 p.m. and said R1 had no pulse. RN-G told LPN- E it was too late to initiate CPR. RN- G said there was no witness to the resident's last breath, even though staff were with R1 during this time so no CPR was started.

An interview was conducted with LPN-E, on 7/9/2013 at 12:42 p.m. LPN-E stated she was in the hall at the medication cart when RN-G called her to the dining room on 6/29/13 at

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00774	A. BUILDING: ______ B. WING ______	C 09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

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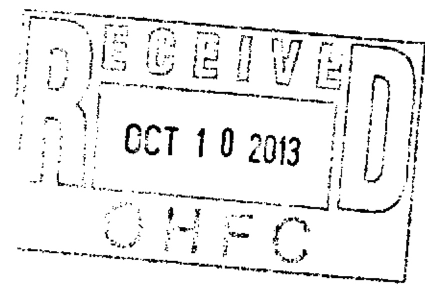
2 830	Continued From page 4 approximately 12:00 noon to 12:05 p.m. R1 was sitting in a dining room chair and was unresponsive. LPN- E stated R1 was in the dining room at that time. R1 had a radial pulse, was breathing, and sneezing. LPN- E was unable to obtain R1's blood pressure in the dining room. LPN-E and unknown nursing assistants, transported R1 to his/her room. Staff were trying to decide how to transfer R1 into bed when LPN-E checked R1 and found no apical pulse. LPN-E ran to get the crash cart and notify RN-G that R1 had no pulse. LPN F was in the room with R1. At least one nurse was with R1 the whole time from the dining room to his/her room when LPN-E found no pulse. When LPN-E went to get the crash cart she saw RN-G and informed RN-G that R1 had no pulse. RN-G told LPN-E it was too late to do CPR. Emergency medical care or CPR was not initiated. The time frame from R1 found with a pulse to no pulse was no more than 10 minutes. The resident died. An interview was conducted with LPN-F on 7/9/2013 at 1:38 p.m. LPN- F stated on 6/29/13 at approximately 12:00 noon she went to the dining room to check on residents. LPN-E and a nursing assistant (unknown) were with R1 trying to move R1 out of the dining room. LPN-F checked R1's radial pulse, which was present and fast. LPN-F assisted to transport R1 to his/her room and held R1's head to keep her airway open during the transport to R1's room. After R1 to his/her room, LPN-E, LPN-F and the nursing assistant tried to decide how to transfer R1 out of the chair. LPN-E checked R1's pulse. LPN-F was unsure of the details until RN-G came to R1's room (unknown time). When RN-G came into the room, she told the nurses not to do CPR as the last breath was not witnessed. Emergency medical care and CPR was not	2 830		

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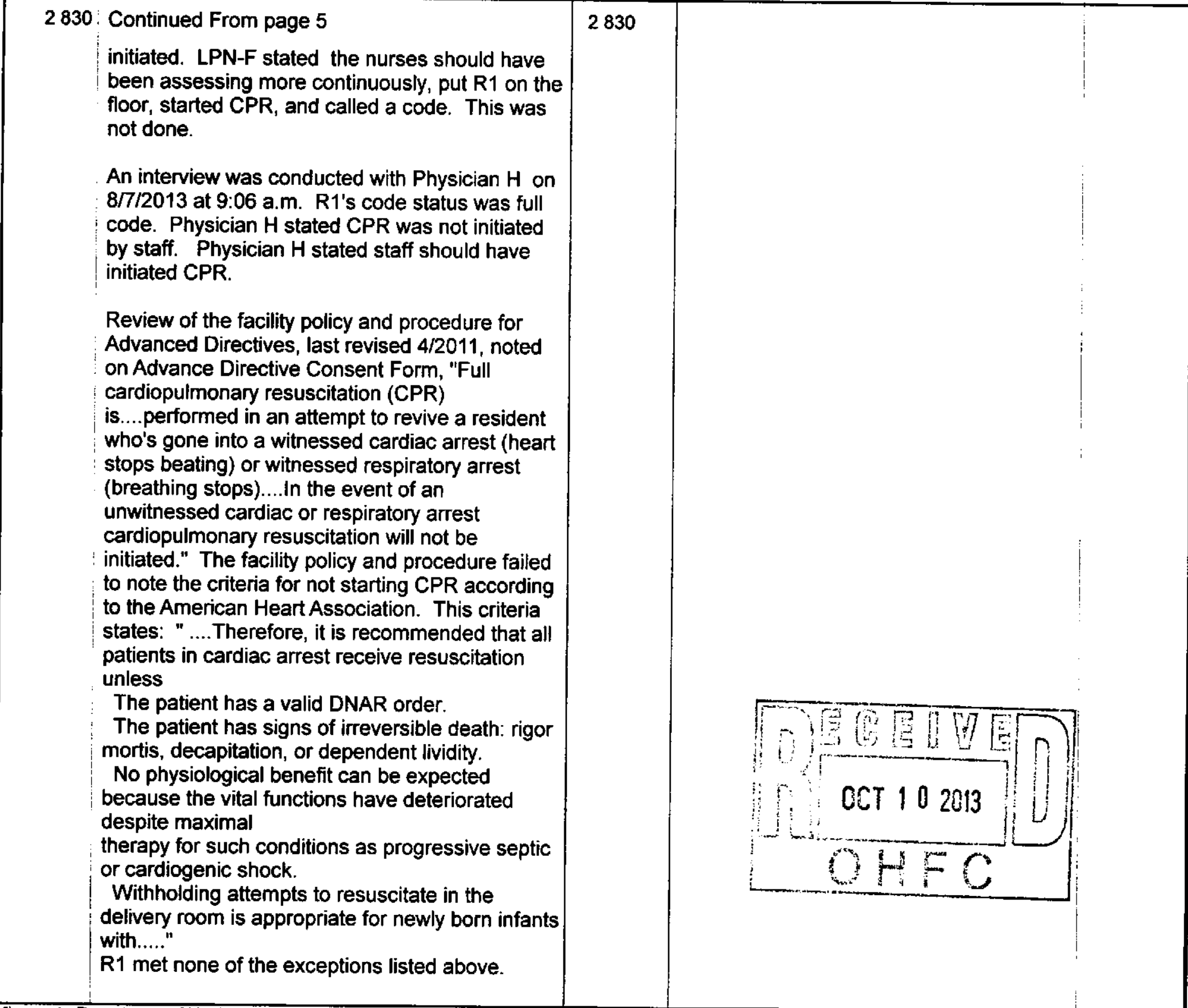
Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00774	A. BUILDING: ____ B. WING ____	C 09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304



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2 830	Continued From page 5 initiated. LPN-F stated the nurses should have been assessing more continuously, put R1 on the floor, started CPR, and called a code. This was not done. An interview was conducted with Physician H on 8/7/2013 at 9:06 a.m. R1's code status was full code. Physician H stated CPR was not initiated by staff. Physician H stated staff should have initiated CPR. Review of the facility policy and procedure for Advanced Directives, last revised 4/2011, noted on Advance Directive Consent Form, "Full cardiopulmonary resuscitation (CPR) is....performed in an attempt to revive a resident who's gone into a witnessed cardiac arrest (heart stops beating) or witnessed respiratory arrest (breathing stops)....In the event of an unwitnessed cardiac or respiratory arrest cardiopulmonary resuscitation will not be initiated." The facility policy and procedure failed to note the criteria for not starting CPR according to the American Heart Association. This criteria states: " ....Therefore, it is recommended that all patients in cardiac arrest receive resuscitation unless The patient has a valid DNAR order. The patient has signs of irreversible death: rigor mortis, decapitation, or dependent lividity. No physiological benefit can be expected because the vital functions have deteriorated despite maximal therapy for such conditions as progressive septic or cardiogenic shock. Withholding attempts to resuscitate in the delivery room is appropriate for newly born infants with....." R1 met none of the exceptions listed above.	2 830	RECEIVED OCT 10 2013 OHFC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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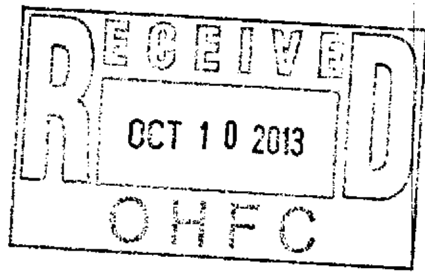
2 830	Continued From page 6 SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could educate staff regarding follow following a resident's plan of care. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 830		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based upon interviews and documentation review, the facility failed to provide medical care for 1 of 1 resident (R1) when nurses failed to provide emergency care and attempt cardiopulmonary resuscitation when R1's breathing and heart stopped. R1's Advanced Directives consent form noted R1's preference was to have resuscitation performed in an attempt to be revived when his/her heart stopped beating or breathing stopped. Findings include: The medical record for R1 was reviewed. The physician orders and care plan dated 6/13 noted R1 was admitted to north short stay unit of the facility on 6/19/13 following a hospital stay where R1 had a pacemaker placement and R1 had a full	21810		

Minnesota Department of Health

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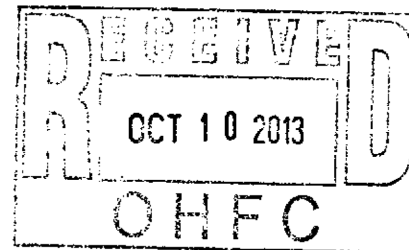
21810	Continued From page 7	21810		

code status. The Advanced Directive Consent Form, signed by R1 and dated 6/18/13 was signed by the physician on 6/20/13. It noted R1's preference was to be resuscitated. Review of the Clinical Monitoring Record dated 6/13 revealed R1 complained of dizziness at least six times during her 10 day facility stay. The physician documentation dated 6/27/13 noted the patient had some lightheadedness and was admitted to the facility following pacemaker implantation for rapid atrial fibrillation. Progress notes dated 6/29/13 at 12:42 p.m. revealed the patient was going to the dining room at 12 noon, became dizzy and had a pulse present. R1 died. Staff verified the time of R1's death was 12:10 p.m.

An interview with registered nurse (RN)/G was conducted on 7/8/2013 at 3:16 p.m. RN-G stated R1 told RN-G she was dizzy when R1 came into the dining room. RN-G began to assess R1 and noted R1 had a pulse. R1 became unresponsive. Staff transported R1 back to her room. Licensed practical nurse (LPN)/E came to the nursing station and said R1 had no pulse. RN-G told LPN-E it was too late to initiate CPR. RN-G said there was no witness to R1's last breath, even though staff were with R1 during this time so no CPR was started. RN-G verified she told LPN-E was too late to do CPR for R1.

An interview was conducted with LPN-E, on 7/9/2013 at 12:42 p.m. LPN-E stated R1 had a pulse, was breathing, and sneezing when s/he became unresponsive in the dining room of the facility. LPN-E was unable to obtain a blood pressure in the dining room. After nurses, including LPN-E, transported R1 to his/her room, R1 was noted to have no pulse. Staff were in attendance with R1 during this time. Medical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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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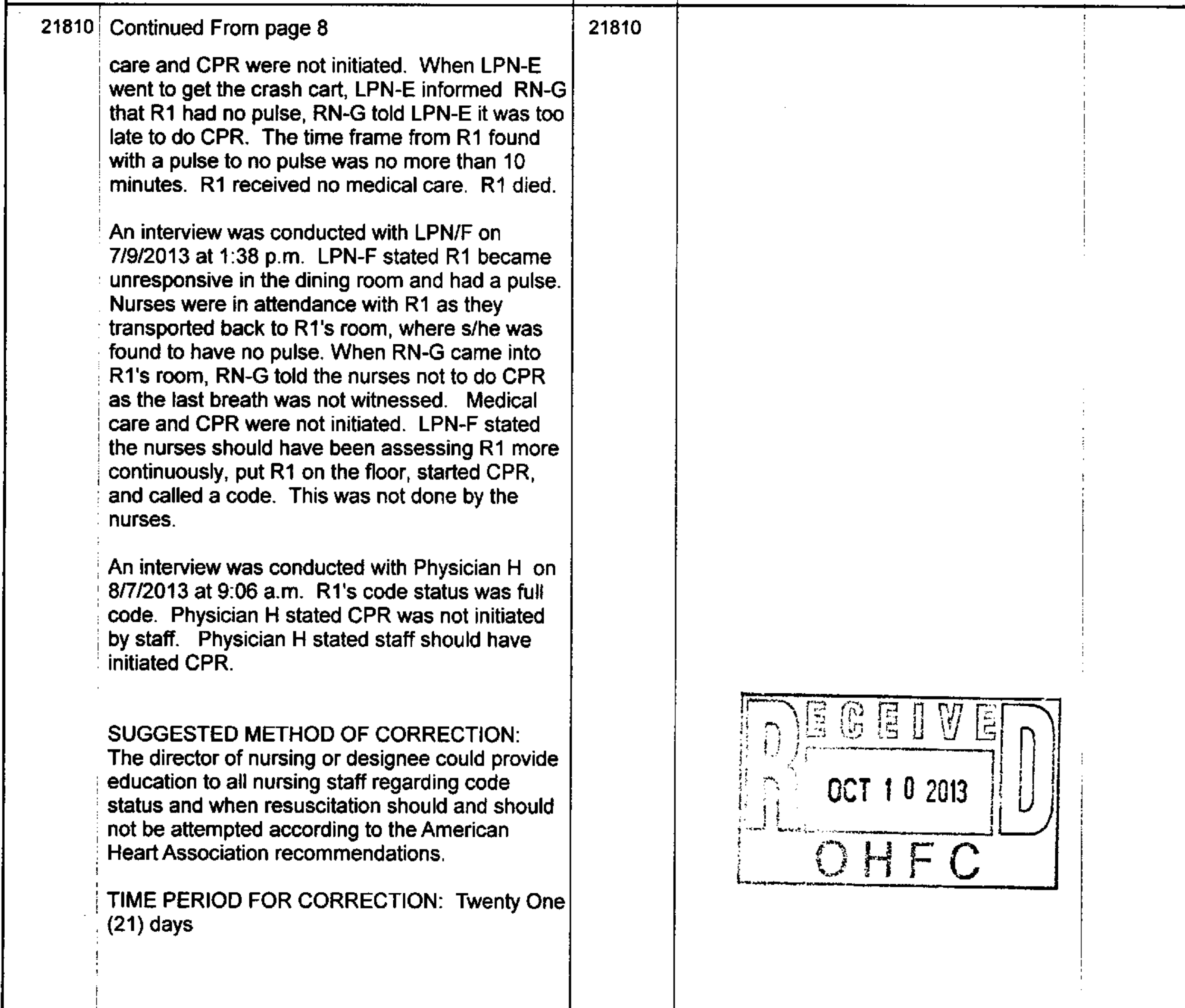

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21810	Continued From page 8	21810		

care and CPR were not initiated. When LPN-E went to get the crash cart, LPN-E informed RN-G that R1 had no pulse, RN-G told LPN-E it was too late to do CPR. The time frame from R1 found with a pulse to no pulse was no more than 10 minutes. R1 received no medical care. R1 died.

An interview was conducted with LPN/F on 7/9/2013 at 1:38 p.m. LPN-F stated R1 became unresponsive in the dining room and had a pulse. Nurses were in attendance with R1 as they transported back to R1's room, where s/he was found to have no pulse. When RN-G came into R1's room, RN-G told the nurses not to do CPR as the last breath was not witnessed. Medical care and CPR were not initiated. LPN-F stated the nurses should have been assessing R1 more continuously, put R1 on the floor, started CPR, and called a code. This was not done by the nurses.

An interview was conducted with Physician H on 8/7/2013 at 9:06 a.m. R1's code status was full code. Physician H stated CPR was not initiated by staff. Physician H stated staff should have initiated CPR.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee could provide education to all nursing staff regarding code status and when resuscitation should and should not be attempted according to the American Heart Association recommendations.

TIME PERIOD FOR CORRECTION: Twenty One (21) days

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Protecting, Maintaining and Improving the Health of Minnesotans

Post Correction Order Follow-Up/Federal Certification Review Report
PUBLIC DATA

Facility:
St Benedicts Senior Community
1810 Minnesota Boulevard Southeast
St. Cloud, MN 56304
Sherburne County

Report #: H5350053

Date: December 2, 2013

Date of Visit: November 22, 2013
Time of Visit: 10:30 a.m.

By: Stephanie Richard, R.N.
Special Investigator

Nature of Visit
An unannounced visit was made in order to follow-up one federal deficiency and two state licensing order which were issued on September 29, 2013, as the result of an investigation which had been completed on September 12, 2013.

The status of the order is as follow:
1 MN Rule 4658.0520 Subp. 1 - Corrected
2 MN St. Statute 144.651 Subd. 6 - Corrected

See Attached 2567B for status of federal deficiency.

xc: Minnesota Department of Health -Licensing & Certification Division

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245350	A. Building B. Wing	11/22/2013

Name of Facility	Street Address, City, State, Zip Code
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0328 Reg. # 483.25(k) LSC	11/22/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
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ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/KL	12/12/2013	31242	11/22/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/10/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00774	A. Building B. Wing	11/22/2013

Name of Facility	Street Address, City, State, Zip Code
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 20835 Reg. # MN Rule 4658.0520 Subp. 2 A LSC	Correction Completed 11/22/2013	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/KL	12/12/2013	31242	11/22/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/10/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO