Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: H5350118M
Compliance #: H5350101C

Date Concluded: December 2, 2020

Name, Address, and County of Licensee Investigated:
St. Benedicts Senior Community
1810 Minnesota Blvd SE
St. Cloud, MN 56304
Sherburne County

Facility Type: Nursing Home

Investigator's Name: Christine Bluhm, RN
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.

Allegation:
It is alleged: Neglect occurred when the alleged perpetrator (AP) failed to confirm the resident's code status and initiate cardiopulmonary resuscitation (CPR) when the AP found the resident not breathing and without a pulse.

Investigative Findings and Conclusion:
Neglect was substantiated. The AP failed to immediately check the resident's code status, announce the code to alert other staff, and start CPR on the resident. As a result, CPR efforts were delayed.

The investigation included interviews with facility nursing staff and the medical director. The investigation included a review of policies and procedures as well as staff training records. Employee personnel files were reviewed for appropriate licenses and backgrounds. The resident's record was reviewed.

The resident had a history of traumatic brain injury, vascular disease, diabetes, decubitus ulcers (bed sores), kidney disease, and decreased lung function. The resident used a wheelchair and relied on staff for mobility. The resident had impaired decision making ability.

Review of the resident's advanced directive status form indicated the resident had a full code status (start life saving measures in the event there is no breathing and/or no pulse).

Review of the incident notes indicated that one morning, staff assisted the resident back to his room after breakfast. A short time later, the AP entered the resident's room to administer the resident's insulin and found the resident was not breathing and had no pulse. The AP asked several other nurses what next steps to take after the resident's death. One nurse asked the AP if she had checked the resident's code status, and the AP stated she had not. The resident's chart was checked and it indicated a full code status. Incident notes indicated that CPR was initiated after a delay of approximately between eight and eleven minutes. The medical director who was rounding via video conference at the time, was made aware of the situation and directed staff to discontinue CPR and call the time of death.

During interview, the director of nursing (DON) stated that the AP was expected to know the resident's code status that day. The DON further stated that the AP proceeded to process the resident's death as an expected occurrence and not as an emergency.

During interview, the AP stated that she informed the other nurses that the resident passed away and asked them what needed to be done. It was not until after several nurses were asked, that one nurse asked if she had looked up the residents' code status. The AP stated she knows what she did was wrong and had not meant to deprive him the help he needed.

The medical director was interviewed and stated the resident was not able to make decisions for himself. Due to the COVID pandemic, the opportunity to discuss the code status had not occurred and his code status defaulted to full code.

A facility-provided policy titled, "Code Blue Cardio resuscitation" indicated that when a resident has a cardiac or respiratory arrest, the code status is immediately verified. Residents that have a "full code" will have CPR immediately initiated by staff trained in CPR that are present.

Review of the AP's facility training records revealed the AP was trained in CPR and to respond to a code situation.

The resident's death record indicated the cause of death included atherosclerotic vascular disease and dementia and manner of death as natural.

In conclusion, neglect occurred. The AP did not check the resident's code status and CPR was not immediately initiated. The resident's code status and facility policy indicated that CPR was to be initiated.

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: No, the resident was deceased.
Family interviewed: No, the family did not respond to requests for interview.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility reviewed its policies and procedures for CPR and provided re-education for the AP and all staff. The AP was suspended during the facility investigation.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

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
Minnesota Board of Nursing
Sherburne County Attorney
St. Cloud City Attorney