*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** H53691921M
**Compliance #:** H53693352C

**Date Concluded:** December 27, 2022

**Name, Address, and County of Licensee Investigated:**
St. Mark's Living
400 15th Avenue Southwest
Austin, MN 55912
Mower County

**Facility Type: Nursing Home**

**Evaluator's Name:**
Katie Germann, 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.

**Initial Investigation Allegation(s):**
The alleged perpetrator (AP), a nurse, neglected a resident when she did not perform cardiovascular resuscitation (CPR) upon finding a resident nonresponsive and not breathing.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. A facility staff notified the AP the resident was unresponsive. The AP assessed the resident who had no pulse, but her skin was warm to the touch. Although the AP was aware the resident's medical records/ physician orders indicated the resident wished to have cardiopulmonary resuscitation (CPR) in case she was found to have cardiac arrest, the AP did not attempt CPR.

The investigator conducted interviews with facility staff members including nursing staff, and unlicensed staff. The investigation included review of the federal investigation findings, medical records, staff training records, and facility policies and procedures.

The resident resided in a skilled nursing facility.  The resident's diagnoses included history of myocardial infarction, and pulmonary hypertension related to left heart disease. The resident's service plan included assistance with activities of daily living, medication administration, bathing assistance, skilled nursing, and meals.

The residents medical record indicated the resident signed a POLST (physician orders for life sustaining treatment) which indicated the resident requested CPR be initiated if the resident was found to have no pulse and/or not breathing.

An investigation of the incident indicated an unlicensed staff member found the resident in her room unresponsive. The unlicensed staff member called the AP to the resident's room. The AP indicated the resident was unresponsive, not breathing, and had no pulse. The AP stated the residents' lips were blue, but the resident was still warm to the touch. The AP indicated she checked the resident's physician orders for life sustaining treatment (POLST) and saw the resident wished to have cardiopulmonary resuscitation (CPR) in case she was found to have cardiac arrest.  The nurse then attempted to contact the director of nursing and a nurse manager to inform them of the findings but was unable to reach them. The nurse made the determination the resident had passed away and it would be too late to preform CPR. The nurse then called the coroner and the police.

When interviewed an unlicensed staff stated he found the resident in bed unresponsive.  The staff member stated he last checked on the resident approximately 2 hours prior and the resident had no signs of distress. The unlicensed staff found the resident unresponsive and called the AP for assistance on the walkie. The AP came to the room and assessed the resident. The unlicensed staff member stated that the AP told him the resident had passed away. The unlicensed staff said he questioned the AP about the resident's code status. The AP did go and check on the resident's code status and told him it was too late to preform CPR.

In an interview, the AP stated the unlicensed staff called her on the walkie to come into the resident's room around 4:30 a.m. When the AP found the resident, the resident was not breathing, she was still warm, her lips were blue, and she had no pulse. The AP went to check on the resident's code status and found the resident was full code (meaning that she requested CPR if she was found to have cardiac arrest). The AP stated she attempted to call the director of nursing and nurse manager, but there were no responses to her calls. The AP determined it was too late to preform CPR and called the police and the coroner. No paramedics were called. The AP stated she should have done CPR as the residents POLST directed, but she thought it was too late [to do CPR].

When interviewed the resident's family member stated the resident was not obviously ill, and death did not appear imminent, but her decline was expected.

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, deceased.
**Family/Responsible Party interviewed**: Yes
**Alleged Perpetrator interviewed**: Yes

**Action taken by facility:**
The facility did re-training with all the nursing staff regarding POLST and implementation.

**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.

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
Mower County Attorney
Austin City Attorney
Austin Police Department

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00394 | A. BUILDING: _____ B. WING _____ | C 11/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST MARKS LIVING | 400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912 |

| (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<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H53691921M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557.<br><br>The following correction order is issued/orders | 2 000 | | |

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| 2 000 | Continued From page 1<br>are issued for #H53691921M, tag identification 1850.<br><br>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<br><br>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<br><br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure 1 of 1 residents reviewed, R1, was free from maltreatment.<br><br>Findings include:<br><br>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. | 21850 | No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag. | |