Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H56263026M
Compliance #: H56264676C

Date Concluded: June 30, 2023

Name, Address, and County of Licensee Investigated:
Rochester Rehab and Living Center
1900 Ballington Boulevard NW
Rochester MN 55901
Olmsted County

Facility Type: Nursing Home

Evaluator's Name: Christine Bluhm, RN
Special Investigator

Finding: Inconclusive

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:
The alleged perpetrator (AP) neglected a resident when the AP failed to assess a change in condition and provide sufficient supervision during an emergency situation when the resident had a choking episode during mealtime.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident had difficulty with oral secretions (excess mucous) and breathing during a meal, and the AP gave the medication used to treat the symptoms to the family member to give to the resident. The resident was not in crisis at that time and the AP left the unit for break. The resident's condition worsened. The family member could not find help to assist the resident and had to leave the unit to find staff help on another unit. The AP and other staff arrived to help but the resident continued to have difficulty with breathing and consequently passed away.

The investigator reviewed incident documents and interviews that were completed with facility staff members after the incident. The investigation included review of the resident's medical records, facility policies and procedures and the AP's employee file.

The resident resided in a skilled nursing facility (nursing home). The resident's diagnoses included heart disease, kidney disease, cognitive impairment related to Alzheimer's disease, and anxiety. The resident's care plan included assistance with all activities of daily living and could feed herself with meal setup assistance. The care plan also indicated the resident could become very anxious. Interventions included encouraging relaxation techniques, provide a peaceful and comfortable environment, provide support to family, and notify provider for changes in condition.

The resident's care plan indicated she also received hospice services. Review of hospice nursing notes indicated the resident had ongoing dysphagia (swallowing problems), edema and shortness of breath with mild activity.

Review of the nursing progress note indicated a family member approached the AP, who was a nurse, with concerns of increased secretions while the resident was eating her meal. The AP gave the medication along with directions on how to give it to help with the secretions to the family member to give to the resident. The AP then left the unit and went on a break. While the AP was on break, other staff informed him that the resident had difficulty breathing. The AP returned and the resident was unresponsive. With help of the family member, they attempted to reposition the resident in the chair. 911 was called and emergency dispatchers directed them to place the resident in the bed on her side. When emergency responders arrived, the resident had no pulse. Responders acknowledged the "do not resuscitate order," and no further resuscitation efforts were made. The resident passed away.

Review of the AP's statement after the incident and during interview, the AP stated he gave the family the medication to give to the resident because a similar event occurred about a month prior, and it resolved with the medication. The nurse stated the family member did not express there was a crisis at the time and planned to give warmed up cookies to the resident.

During an interview, the family member stated shortly after he arrived that evening, the resident told him she was having difficulty breathing related to problems clearing her secretions. He stated she had a similar episode previously and a nurse came in with the medication and was able to help. This time, the AP gave the family member the medication to give to the resident. The family member stated he gave the medication, but the resident continued to have with difficulty breathing. He could not find anyone on the unit to assist for approximately 15 to 20 minutes. The call light was pressed but not right away. The family member stated there was no one around to do anything for her during that time and he had to leave the resident and the unit to find staff to help.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted a full house audit of residents that received as needed medications. The audit included how the medication was monitored for actions, interventions, and effectiveness before and after the medication was administered. The nurse involved in the incident completed mandatory education and training on medication documentation, as needed and self-administration of medications, and facility policy and procedures on responding to resident changes in condition.

Action taken by the Minnesota Department of Health:
The facility was found to be in 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

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29822	A. BUILDING: _____ B. WING _____	C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER REHABILITATION AND LIVING CI	1900 BALLINGTON BOULEVARD NW 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 initiated an investigation, an allegation of maltreatment, complaint H56263026M in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557.	2 000		

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2 000	Continued From page 1 The following correction order is issued for H56263026M, 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	21850		

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21850	Continued From page 2 others. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual alleged perpetrator 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.	