Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL337725387M
Compliance #: HL337727389C

Date Concluded: October 17, 2024

Name, Address, and County of Licensee Investigated:
The Sanctuary at Brooklyn Center
6121 Brooklyn Boulevard
Brooklyn Center, MN 55429
Hennepin County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Not Substantiated

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 facility neglected to provide up to date medical information about the resident's wish regarding cardiopulmonary resuscitation (CPR). Staff provided emergency medical service (EMS) providers with a provider order for life-sustaining treatment document (POLST) that indicated do not resuscitate (DNR), so paramedics did not initiate CPR when the resident's heart stopped on the way to the hospital and the resident died. When they arrived at the hospital, the hospital discovered a newer POLST which indicated the resident did wish to receive CPR.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had a POLST on file at the hospital from when she had a surgical procedure earlier in the year. The hospital discharged the resident to a transitional care unit (TCU) for four months. When the resident returned to the facility, she identified that she did not want CPR as reflected on her admission POLST.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator reached out to family and the medical examiner. The investigation included review of the resident records, death record, hospital records, facility internal investigation, staff schedules, ambulance run report, and related facility policy and procedures. Also, the investigator observed the staff offices which contained the" grab and go" binders with resident information envelopes prepared for hand off to EMS.

The resident lived in an assisted living facility for several years. The resident's diagnoses included emphysema, obstructive sleep apnea, and history of gall bladder removal. The resident's service plan included assistance with storage of controlled substances, bathing, compression stockings application and removal, and medication set-up. The service plan indicated the resident was independent with activities of daily living, transfers, mobility, and medication administration/reordering. All the resident's assessments conducted at the facility indicated the resident requested staff do not attempt cardiopulmonary resuscitation in the event of cardiac arrest and breathing stoppage (DNR).

Resident progress notes indicated a speech therapist working with the resident one day noted the resident became unusually tired during the session and requested to lay down. The progress note indicated the speech therapist continued to check on the resident and when the resident became less responsive, asked an emergency medical technician (EMT) (who was in the building for another resident) to assess the resident. The EMT assessed the resident and called for another ambulance to bring the resident to the hospital. The progress note indicated staff provided the EMT with paperwork regarding the resident (face sheet with medical contacts, allergies, diagnoses, and POLST).

Ambulance narrative notes indicated they responded to the facility for a resident in respiratory distress. The notes indicated the EMTs assessed the resident, began monitoring the resident's heart, provided oxygen, loaded the resident into the ambulance, and headed toward the hospital.

The notes indicated the resident's heart rate and respiratory effort decreased on the way to the hospital. The facility paperwork indicated the resident was DNR, so when the resident's heart and respirations stopped, the EMTs did not initiate CPR.

Hospital records indicated the doctor pronounced the resident deceased at the hospital. The hospital records indicated they later found a POLST on file that indicated the resident wished to receive full CPR. (The resident signed the POLST while hospitalized to have her gallbladder removed seven months before the incident.)

During an interview, a nurse stated she had reviewed with the resident her wishes regarding CPR three months before the incident when the resident returned from a nursing home stay after surgical removal of her gallbladder. The nurse verified the resident stated she wanted no CPR (do not resuscitate (DNR)) in the event her heart stopped, and breathing stopped. The

nurse stated since the resident's decision was the same as when she admitted to the facility, the nurse did not fill out a new POLST form but documented the conversation in the resident's assessment.

During an interview, the resident's medical provider stated she spoke with the resident when the resident returned to the facility after gallbladder surgery. The medical provider stated she believed the POLST the resident signed at the hospital was only for the gallbladder surgery and conversations the provider had with the resident confirmed that she did not want CPR while at the facility. The provider stated it was not her practice to create a new POLST form if it was still accurate.

During investigative interviews, multiple staff members stated the resident was independent with most of her cares, loved to watch movies, and was able to express her wants and needs.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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, the resident passed away.
Family/Responsible Party interviewed: No, attempted.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility investigated the incident, reviewed all residents' POLST documents for accuracy, re-educated clinical staff on reviewing code status at all assessments to clarify any discrepancies.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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
	33772	A. BUILDING: _____ B. WING _____	C 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT BROOKLYN CENTER	6121 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55429

(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
0 000	Initial Comments On October 10, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL337727389C/#HL337725387M. No correction orders are issued.	0 000		