Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 16, 2024

Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, MN 56431

RE: CCN: 245119
Cycle Start Date: July 10, 2024

Dear Administrator:

On July 23, 2024, we notified you a remedy was imposed. On August 8, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 5, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 7, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 23, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 7, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 5, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 16, 2024

Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, MN 56431

Re: Reinspection Results
Event ID: JNNX12

Dear Administrator:

On August 8, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 10, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 23, 2024

Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, MN 56431

RE: CCN: 245119
Cycle Start Date: July 10, 2024

Dear Administrator:

On July 10, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 7, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 7, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 7, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 7, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Aitkin Health Services will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 7, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

A Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 10, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate

formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900

St. Paul, Minnesota 55164-0900

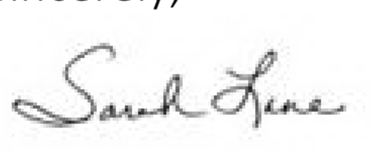
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://forms.web.health.state.mn.us/form/NHDisputeResolution

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 23, 2024

Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, MN 56431

Re: State Nursing Home Licensing Orders
Event ID: JNNX11

Dear Administrator:

The above facility was surveyed on July 8, 2024 through July 10, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using 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 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 that are in violation of the state statute or rule after the statement, "This MN Requirement is not met 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 NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

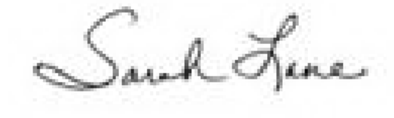
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	C 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

(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 On 7/8/24, through 7/10/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H51195214C (MN00104620) with deficiencies issued at F580 and F684. As a result of the investigation, deficiencies were also issued at F609, F610, and F625. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F 580		8/5/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/01/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	C 07/10/2024

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F 580	Continued From page 1 (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	C 07/10/2024

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AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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F 580	Continued From page 2 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interviews and document review, the facility failed to notify the resident's physician timely with a change in condition for 1 of 3 residents (R1) when staff inserted an indwelling catheter three times, resulted in bleeding, blood clots, pain, discomfort, low urine output, and low blood pressure, sent to emergency room via ambulance, and developed sepsis, and admitted to intensive care unit. Findings include: R1's quarterly Minimum Data Set (MDS) dated 5/30/24, identified severely impaired cognition and no behaviors noted. MDS indicated R1 had an indwelling catheter, always incontinent of bowel, and neurogenic bladder (interference of the relationship between the nervous system and bladder function and affects the way bladder functions due to injury or disease). MDS also indicated R1 had impairment on one side of his upper and lower body and was dependent upon staff for all cares, transfers, and repositioning. R1's health conditions form dated 6/2/24, to 7/2/24, were identified as anemia, benign prostatic hyperplasia (enlargement of the prostate) (BPH) with lower urinary tract symptoms, hemiplegia and hemiparesis (weakness and/or paralysis on one side of the body) following cerebral infarction (stroke) affected left non-dominant side, neuromuscular dysfunction of bladder (the nerves and muscles don't work together very well. As a result, the bladder may not fill or empty correctly), and dementia.	F 580	Aitkin Health Services', Notification of Significant Change policy ensures the resident's physician is notified in a timely manner with any resident change in condition in accordance with the professional standards of practice. Nursing completed a catheter/urinary assessment on R1. Nursing documentation (alter charting) was implemented for each shift to identify any issues with catheter and urinary status. Provider will be notified of any catheter size/placement issues, bleeding, blood clots, pain, discomfort, low urine output, and vital sign changes. All residents have the potential to be affected by this deficient practice. The Notification of Significant Change Policy was reviewed with no revisions. All nursing staff are being re-educated on Notification of Significant Change policy, when to inform the Provider of a significant change in condition that results in a negative outcome due to treatment provided by the facility. Nurse training will take place for all nursing staff by 8/5/2024 or prior to next scheduled shift. DON/designee will perform Notification of Change audits 2 x week for 4 weeks, weekly for 4 weeks, then monthly x 2. The findings will be brought to QAPI team for review and for further recommendations.	

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
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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F 580	Continued From page 3 R1's care plan (CP) dated 7/10/24, identified risk for bleeding due to anticoagulant (blood thinner) use, directed staff to monitor vitals and for bleeding, and contact provider with changes and update as needed. CP identified R1 was at risk for urinary tract infection (UTI) due to indwelling catheter and directed staff to observe and monitor for signs of infection and urine quality changes (change in urine color/sediment). R1 had an indwelling Foley catheter 14 F (French) 10 cc (cubic centimeters), and to document urine output at the end of every shift. R1's physician order dated 6/21/24, identified change 14 F catheter with 10 cc every 28 days at evening 2 p.m. to 10:30 p.m. once a month and change the bag at the same time. R1's physician order dated 6/21/24, identified empty catheter bag and document output three times day (morning 6:00 a.m. to 2:30 p.m., evening 2:00 p.m. to 10:30 p.m., night 10:00 p.m. to 6:30 a.m.). R1's House Standing Orders signed and dated 2/29/24, identified may irrigate catheter with 30 to 60 ml (milliliters) of sterile normal saline with signs of blockage (clots, no urine flow or bypassing around catheter). Change indwelling catheter PRN (as needed) if becomes obstructed or comes out of bladder. R1's progress notes from 6/28/24, through 7/5/24, identified: -6/28/24, at 12:07 a.m. to 7/2/24, at 12:15 a.m. no documentation noted in R1's medical record (over four days).	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	C 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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F 580	Continued From page 4 -7/2/24, at 12:15 a.m. 14 F was inserted at 9:20 p.m. and tolerated well. Later at 11:15 p.m. resident woke up screaming ouch and in pain. Irrigation, repositioning, and massage of bladder done but no urine output and still in a lot of pain. Small amount of thick blood and clots in bag and bloody urine bypassing. On call notified and she said to call on call provider if pain increased. -7/2/24, at 12:15 p.m. from report the evening nurse changed resident catheter with a 14 F (per interview with LPN-A this was a 16 F, see below) and then a 16 F with blood output. At 8:30 p.m. writer was called to R1's room, screaming in pain, and guarded his groin area whenever staff tried to reach for that area. R1 refused to have brief closed due to increased pain, bladder scanned for 216 cc. On call nurse was notified and suggested flush/irrigate catheter, push fluids and change catheter to 14 F. When catheter was gushed there was increased pain and no output. Removed 16 F and noted continuous gross hematuria (bleeding) with some blood clots from penis. On call was notified and she said to let him drain for 15 minutes then insert a 14 F. After 15 minutes the gross hematuria was minimum and R1 felt better with less pain. -7/2/24, at 5:09 a.m. R1 was screaming, reported a lot of pain (10 out of 10) when his brief was changed around 3:30 a.m. R1's vitals blood pressure (BP) 90/53, respirations 18, and oxygen saturation 92%. Bladder scan completed and resulted in 249 cc with no urine in output in bag. On call provider notified and gave order to send to emergency room (ER) at 4:30 a.m. -7/2/24, at 10:01 a.m. received call from local	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	C 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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F 580	Continued From page 5 hospital, R1 had been admitted with diagnosis of sepsis. R1's family updated and placed on LOA (leave of absence). -7/4/24, at 5:53 p.m. called hospital for update. R1 was moved out of ICU (intensive care unit) and downgraded to medical unit, off drip and BP was ok, and placed on two antibiotics. Possibly be there for two more days. -7/5/24, at 2:13 p.m. was re-admitted back to facility from hospital at 1:30 p.m. R1 had indwelling catheter in place that was free flowing, patent, urine was light yellow in color, without sediment, no blood no unusual odor. R1's catheter was to be changed every 28 days, if anticipated difficulty with catheter contact urology. Continued to be treated with antibiotics for UTI every 12 hours for 11 more days. R1's hospital admission notes dated 7/2/24, indicated indwelling catheter change completed at nursing home facility last evening resulted in significant bleeding and no urine output. An attempted catheter placement in ER resulted in ongoing bleeding and no urine output. CT (computerized tomography) scan was completed and showed catheter balloon inflated in the urethra. Urology was contacted and replaced the catheter over a guidewire with cystoscopy (a hollow tube equipped with a lens inserted into urethra and slowly advanced into the bladder). Principle problems identified: urinary tract infection associated to indwelling catheter, sepsis (life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), with acute renal failure and septic shock, and anemia with acute blood loss from urethra resulting from Foley catheter	F 580		

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F 580	Continued From page 6 placement. During an interview on 7/8/24, at 4:00 p.m. licensed practical nurse (LPN)-A stated R1 was due for a catheter change on July 1, 2024. LPN-A stated she had gathered supplies: catheter size 16 F, catheter bag, catheter change kit, and an extra syringe. LPN-A indicated pulled out R1's catheter 14 F after deflating balloon and noted urine was dark amber, cloudy, and sediment in the tubing without odor. LPN-A stated emptied 450 cc of urine from collection bag. LPN-A stated when she inserted the 16 F catheter bright red blood was seen, panicked, and pulled out the catheter. LPN-A stated talked with floor manager LPN-B and informed was normal for R1 to bleed a bit and instructed to insert another catheter. LPN-A stated went back and inserted 16 F catheter and bloody return was noted with a small amount of urine. LPN-A stated she had went to the EMAR and noted the order indicated 14 F, it was then she realized she had inserted the wrong size catheter twice. LPN-A stated she reported to LPN-B and DON and was told it was fine and instructed to let things settle down/stop bleeding before the catheter was changed again. LPN-A stated checked on R1 prior to end of shift and no pain, no urine was flowing out of the tube and offered to flush but RN-A said no it was ok and left for the day. LPN-A stated a provider should have been notified about the wrong size catheter (2 times) and blood returned with little to no urine but did not due to LPN-B and DON indicated it was normal for R1 to bleed some. LPN-A stated they did not document this and should have. During a telephone interview on 7/9/24, at 2:00 a.m. registered nurse (RN)-A stated she started her night shift at 6:00 p.m. RN-A indicted she had	F 580		

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F 580	Continued From page 7 received report from the LPN-A regarding R1's Foley catheter change. RN-A stated LPN-A indicated she she inserted a 14 F and got blood so removed it, placed another catheter this time a 16 F and was still bleeding when she realized she had used the wrong size catheter. RN-A indicted LPN-A reported to DON and floor manager LPN-B and they both came to conclusion the urethra was already irritated, so it was ok to leave it in until morning, monitor for bleeding, and replace it the next day with a 14 F catheter. RN-A stated she had never seen blood in R1's catheter prior to this day. RN-A stated she peaked in on R1 at 6:30 p.m. prior to a medication pass that evening and there was approximately 100 cc of bloody drainage in the collection bag and in the catheter tubing and R1 reported no pain at that time. RN-A stated she had been told in the past when the catheter was not placed properly due to the BPH and neurogenic bladder a small amount of blood was normal for R1. RN-A stated when she had placed R1's catheter in the past, she had never seen any bleeding. RN-A stated later, a staff nursing assistant came and got her and indicated R1 was in pain. RN-A went to R1's room and he complained of pain and said, "ouch ouch". RN-A stated she tried to close his brief, but he would not allow and yelled out. RN-A checked urinary output which had remained the same as earlier (6:30 p.m.) then called the on-call nurse (DON) and was directed to massage the bladder area, push fluids, and then flush the catheter tubing. RN-A stated a provider should have been notified when R1 started to have no urine output with bleeding but she relied on DON for direction instead. RN-A stated DON instructed her the provider did not have to be called because there was nothing he could do and would round the next day. RN-A indicated she was unable to flush	F 580		

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F 580	Continued From page 8 the catheter tubing, R1 complained of more pain, then she contacted DON again. RN-A stated DON indicated R1's 16 F catheter should be removed and replaced with a 14 F. RN-A stated she removed the 16 F catheter and R1 had gross hematuria from the penis and replaced it with a 14 F with approximately 80 cc of bloody drainage in bag and allowed more time to see when urine would drain and what color. RN-A stated she had bladder scanned R1 prior to the insertion of the catheter and noted 216 cc. RN-A verified at 11:00 p.m. R1 complained of pain again, but was unable to give more Tylenol. RN-A texted DON and instructed to reposition R1, massage the bladder area and if in one hour still in pain call the on call provider and ask for order to use emergency kit to give a different analgesic. RN-A stated R1 indicated he was ok and then checked on him again at 3:00 a.m. bloody output had remained the same in bag at 50 ml and no urine noted and R1 had started to complain about pain again. RN-A called on call provider and informed them R1 had no urinary output and bladder pain then received order, and sent R1 into the hospital. During an interview on 7/9/24, at 11:00 a.m. hospital physician assistant (PA)-A (provided urological care to patients) verified she was notified about R1's admission to ER and asked to provide assistance with insertion of a catheter. PA-A stated R1 had a large prostate and obstructive urinary symptoms and required the use of a guide wire and cystoscopy (a hollow tube equipped with a lens to view the urethra and bladder) as she inserted the indwelling catheter. PA-A indicated was unable to see if there was a false tract (a false passage in the urethra is formation of an epithelialized tract created when	F 580		

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F 580	Continued From page 9 the catheter was inserted aggressively against the urethral wall and/or a weak part of the urethra rather than guided through the urethra lumen, into the bladder, and may occur more often in men due to an enlarge prostate) due to excessive bleeding in the urethra. PA-A stated reinsertion of a catheter had the potential to cause more damage and/or bleeding. PA verified when staff nurse inserted the catheter, got blood return a provider should have been notified right away and not waited. PA-A stated additionally, no urine output for up to 12 hours can cause increased risk for infection due to stagnate urine and possibly go into the kidneys which can be serious. During an interview on 7/9/24, at 11:37 a.m. primary provider/physician assistant (PA)-B stated R1 had no urine output from 9 p.m. until sent to ER (7 hours). PA-B verified it would have been a good idea to have updated provider after the second time the wrong size catheter was inserted and bleeding continued. PA-B also stated when nurse had contacted the DON 4 to 6 times in a matter of 6 hours she was in over her head, clearly struggled, and required direction from the provider especially when R1 yelled out in pain, increased bleeding, and low urine output. PA-B stated she would have not recommended to change 16 F catheter a 14 F catheter, provider should have been contacted much sooner and R1 most likely sent into hospital earlier. During an interview on 7/9/24, at 2:05 p.m. floor manager registered nurse (RN)-C stated repeated insertion of a catheter risked irritation to the lining of the urethra, increased an entry of bacteria which increased risk for infection. RN-C stated it was basic nursing education/practice to not inflate balloon until you get urine back. R1's	F 580		

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F 580	Continued From page 10 change in condition occurred when he had less than 50 cc of urine out for more than two to three hours and a provider should have been contacted especially when the bleeding should have subsided much sooner. During a telephone interview on 7/10/24, at 8:45 a.m. medical director (MD) stated staff nurses attempted to insert three catheters and the trauma to the urethra most likely was started with the first insertion, when the wrong sized catheter 16 F was used. MD stated a catheter balloon should never be inflated until you get a flow of urine. MD stated would have been important with blood return and no urine a provider should have been notified right away, sent to ER so an evaluation could have been completed at another facility. MD verified when a resident had ongoing bleeding, on an anticoagulant, and bled for more than two hours, would be alarming and something else was going on. MD stated he would have expected more documentation from the nursing especially with low urine output and bleeding, in the medical record, to establish a time-line, and what interventions were tried. During a telephone interview on 7/10/24, at 12:48 p.m. ER supervisor RN-D verified R1 arrived in ER with a 16 F catheter with no urine output and blood in bag. During an interview on 7/10/24, at 1:10 p.m. DON stated she had many conversations with both staff nurses starting from 7/1/24, at approximately 4:00 p.m. through 7/5/24, at 11:32 p.m. regarding R1. DON stated last time she had heard from RN-A was at 11:32 p.m. DON stated she arrived at the facility early the next morning on 7/2/24, asked RN-A how R1 was doing and was informed	F 580		

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F 580	Continued From page 11 she had sent him to Emergency Room via ambulance. DON stated she would have expected to be notified R1 was sent to hospital but was not. DON stated repeated catheter insertion could have raised the risk of complications such as infection and urethral damage/bleeding. During a telephone interview on 7/11/24, at 12:00 p.m. emergency care provider, osteopathic doctor (DO) (look at patients as a whole person consisting of a mind, body, and spirit, and tend to focus on preventative medicine) stated the facility inserted a Foley catheter more than once, no urine output and bleeding occurred, clearly it was placed in the wrong spot and not in the bladder. DO stated at that time most likely that was when they started the false tract. DO indicated no urine output was not due to a blood clot because they tried to flush the catheter at the facility, no urine output and only blood. DO stated we removed the Foley catheter once he arrived at ED and inserted a 3 -way catheter without resistance and only a small return of urine. DO stated this indicted there was a false tract prior to his arrival at ED. DO verified the CT scan confirmed the Foley balloon was in the penile urethra therefore suspected R1 had a false tract. DO indicted numerous insertions of a Foley catheter within 10 hours would have caused damage and a false tract when not inserted properly. DO stated the facility continued to re-insert catheters, with no urine out put and bleeding, caused urethra trauma, provider was not contacted right away and should have been, which delayed care and R1 became septic with bacteria in catheter. DO indicated she believed this cause R1 harm. Facility policy titled Notification of Significant	F 580		

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F 580	Continued From page 12 Changes dated 5/2/22, identified policy provided guidance to staff when and who to notify of a significant change in a resident's status. Definition of a significant change meant a change in resident's status, a need to alter treatment, and accident results in injury, or a decision to transfer or discharge the individual receiving services from care center. The charge nurse will immediately (as indicated by the change of condition) informed the resident, consult with the physician, and notify the resident representative for the following significant change: an accident that involved the resident which results in injury and has the potential for required physician intervention, a deterioration in health, in either lift-threatening conditions or clinical complications, and decision to transfer to another provider from the care center without primary physician involvement. Review of facility policy titled Foley Catheter Insertion, Male Resident dated 2001 identified the purpose of the Foley catheter was to provide for and maintain constant urinary drainage. Verification that there was a physician order was required to identify what size Foley catheter was specified. After preparation insert the catheter gently into the meatus (end of penis) approximately five to seven inches until urine began to flow from the bladder then advance the catheter another two inches and inflate balloon with 5 cc (cubic centimeters) and removed syringe. If resistance met do not force the entry, stop the procedure, and notify supervisor. The physician would be expected to be notified of any abnormalities (i.e. bleeding, obstruction).	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		8/5/24

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F 609	Continued From page 13 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report to the State Agency (SA) for 1 of 1 resident (R1) whose indwelling catheter was incorrectly placed three times resulting in bleeding, blood clots, pain, discomfort, low urine output, prolonged provider notification, sepsis, sent to emergency room via ambulance, and admitted to intensive care unit (ICU).	F 609	All residents have the potential to be affected by this deficient practice. Notification of Significant Change, Maltreatment Reporting Guidelines, and SNF Maltreatment Investigation & Reporting policies were reviewed with no revisions necessary.	

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F 609	Continued From page 14 Findings include: R1's quarterly Minimum Data Set (MDS) dated 5/30/24, identified severely impaired cognition and no behaviors noted. R1 had an indwelling catheter and always incontinent of bowel. R1 had a neurogenic bladder (interference of the relationship between the nervous system and bladder function and affects the way bladder functions due to injury or disease). R 1 had impairment on one side of his upper and lower body and was dependent upon staff for all cares, transfers, and repositioning. R1's hospital admission notes dated 7/2/24, indicated indwelling catheter change completed at nursing home facility last evening resulted in significant bleeding and no urine output. An attempted catheter placement in ER resulted in ongoing bleeding and no urine output. CT scan was completed and showed catheter balloon inflated in the urethra. Urology was contacted and replaced the catheter over a guidewire with cystoscopy (a hollow tube equipped with a lens inserted into urethra and slowly advanced into the bladder). Principle problems identified: urinary tract infection associated to indwelling catheter, sepsis with acute renal failure and septic shock, and anemia with acute blood loss from urethra (a muscular tube that conveys urine from the urinary bladder to the exterior at the end of the penis). resulting from Foley catheter placement. During an interview on 7/9/24, at 12:44 p.m. floor manager licensed practical nurse (LPN)-B stated R1 has had a history of difficult indwelling catheter attempts with scant amount of blood but would have expected the bleeding to stop within	F 609	The facility will educate staff on vulnerable adult, maltreatment, and abuse reporting. This includes the reporting of any significant change in condition that results in a negative outcome due to treatment provided by the facility. All nursing staff will be educated on timely Notification of Significant Change, Maltreatment Reporting Guidelines, and SNF Maltreatment Investigation & Reporting policies. Nurse training will take place for all nursing staff by 8/5/2024 or prior to next scheduled shift. DON and/or designee will complete audits on all incidents/vulnerable adult reports to determine if reportable in a timely manner. Audits will be conducted 2 x week for 4 weeks, weekly for 4 weeks, then monthly x 2. The findings will be brought to QAPI team for review and for further recommendations.	

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F 609	Continued From page 15 an hour. LPN-B stated on 7/1/24, LPN-A attempted to insert the wrong size catheter 16 French (F) (order was for a 14 F), larger than it should have been, and blood came through the tubing. LPN-B stated the bleeding was caused by insertion of a catheter too large and scraped his urethra. LPN-B stated along with the director of nursing (DON) we had chosen to wait to re-insert another catheter due to urethra being raw, could have caused more damage and discomfort, and allowed that area to recover. LPN-B stated there had been some harm done here, there had been damage to the urethra and he bled, required medical intervention, sent to hospital and admitted. LPN-B confirmed a vulnerable report (VA) probably should have been filed along with a facility incident report to review the entire situation and avoid it from happening again. During an interview on 7/9/24, at 2:05 p.m. floor manager registered nurse (RN)-C stated bleeding was not typical for any insertion of an indwelling catheter no matter what size it was. RN-C stated a change in condition would have been identified as less than 50 cubic centimeters (cc) of urine output an hour for more than two to three hours, blood in the urine should have subsided a lot sooner than it did, and a provider should have been contacted from the get-go. RN-C verified no facility incident report or VA report were filed. During a telephone interview on 7/10/24, at 12:48 p.m. ER supervisor RN-D verified R1 arrived in ER with a 16 F catheter with no urine output and blood in bag. During an interview with on 7/10/24, at 1:10 p.m. director of nursing (DON) stated A vulnerable adult (VA) report was not filed with the state, the	F 609		

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F 609	Continued From page 16 nurses followed the facility policy, processes, and procedures, except for the wrong catheter size. DON stated an incident report should have been filed under medication error. DON stated she was not aware until Monday morning (7/6/24), R1 came back from hospital and CT (computerized tomography) scan showed R1 had a catheter balloon inflated in the urethra rather than the bladder. Review of facility policy titled Maltreatment Reporting Guidelines reviewed last on 10/18/21, identified any alleged maltreatment involving neglect must be reported by the supervising employee of the building to the administrator of the care center immediately and to the Minnesota Department of Health (MDH) and other officials according to the following timelines based on severity of alleged maltreatment. Review of facility policy titled SNF (Skilled Nursing Facility) Maltreatment Investigation and Reporting dated 10/18/21, identified an initial investigation must be conducted immediately to determine what happened and whether the incident requires reporting to the Office of Health Facility Complaints (OHFC) or the Minnesota Adult Abuse Reporting Center (MAARC). A report to OHFC must be initiated as soon as the incident is determined to be reportable.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged	F 610		8/5/24

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F 610	Continued From page 17 violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate and take steps to correct neglect of care for 1 of 1 resident (R1) who did not receive the necessary care and monitoring when facility staff inserted an indwelling catheter incorrectly three times, resulted in bleeding, blood clots, pain, discomfort, low urine output, prolonged provider notification, and low blood pressure, sent to emergency room via ambulance, and developed sepsis, and admitted to intensive care unit (ICU). Findings include: R1's quarterly Minimum Data Set (MDS) dated 5/30/24, identified severely impaired cognition and no behaviors noted. R1 had an indwelling catheter and always incontinent of bowel. R1 had a neurogenic bladder (interference of the relationship between the nervous system and bladder function and affects the way bladder functions due to injury or disease). R 1 had impairment on one side of his upper and lower body and was dependent upon staff for all cares,	F 610	All residents have the potential to be affected by this deficient practice. Notification of Significant Change, Maltreatment Reporting Guidelines, and SNF Maltreatment Investigation & Reporting policies were reviewed with no revisions necessary. The facility will educate nursing staff on vulnerable adult, maltreatment, and abuse reporting. This includes the reporting of any significant change in condition that results in a negative outcome due to treatment provided by the facility. All nursing staff will be educated on timely Notification of Significant Change, Maltreatment Reporting Guidelines, and SNF Maltreatment Investigation & Reporting policies. Nurse training will take place for all nursing staff by 8/5/2024 or prior to next scheduled shift. DON and/or designee will complete audits on all investigations, incidents, and VA	

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	245119	A. BUILDING _____ B. WING _____	C 07/10/2024

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F 610	Continued From page 18 transfers, and repositioning. R1's hospital admission notes dated 7/2/24, indicated indwelling catheter change completed at nursing home facility last evening resulted in significant bleeding and no urine output. An attempted catheter placement in ER resulted in ongoing bleeding and no urine output. CT scan was completed and showed catheter balloon inflated in the urethra. Urology was contacted and replaced the catheter over a guidewire with cystoscopy (a hollow tube equipped with a lens inserted into urethra and slowly advanced into the bladder). Principle problems identified: urinary tract infection associated to indwelling catheter, sepsis with acute renal failure and septic shock, and anemia with acute blood loss from urethra (a muscular tube that conveys urine from the urinary bladder to the exterior at the end of the penis). resulting from Foley catheter placement. During a telephone interview on 7/10/24, at 12:48 p.m. ER supervisor RN-D verified R1 arrived in ER with a 16 F catheter with no urine output and blood in bag. During an interview on 7/8/24, at 4:00 p.m. licensed practical nurse (LPN)-A stated R1 was due for a catheter change on July 1, 2024. LPN-A stated she had gathered supplies: catheter size 16 F, catheter bag, catheter change kit, and an extra syringe. LPN-A indicated pulled out R1's catheter 14 F after deflating balloon and noted urine was dark amber, cloudy, and sediment in the tubing without odor. LPN-A stated emptied 450 cc of urine from collection bag. LPN-A stated when she inserted the 16 F catheter bright red blood was seen, panicked, and pulled out the catheter. LPN-A stated talked with floor manager	F 610	reports to determine if reportable in a timely manner. Audits will be conducted 2 x week for 4 weeks, weekly for 4 weeks, then monthly x 2. The findings will be brought to QAPI team for review and for further recommendations.	

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F 610	Continued From page 19 LPN-B and informed was normal for R1 to bleed a bit and instructed to insert another catheter. LPN-A stated went back and inserted 16 F catheter and bloody return was noted with a small amount of urine. LPN-A stated she had went to the EMAR and noted the order indicated 14 F, it was then she realized she had inserted the wrong size catheter twice. LPN-A stated she reported to LPN-B and DON and was told it was fine and instructed to let things settle down/stop bleeding before the catheter was changed again. LPN-A stated checked on R1 prior to end of shift and no pain, no urine was flowing out of the tube and offered to flush but RN-A said no it was ok and left for the day. LPN-A stated a provider should have been notified about the wrong size catheter (2 times) and blood returned with little to no urine but LPN-B and DON indicated it was normal for R1 to bleed some. LPN-A stated no one talked to me about this again after I left for the day nor was there education provided to me. LPN-A stated did not document this and should have. During an interview on 7/9/24, at 11:00 a.m. physician assistant (PA)-A (provided urological care to patients) verified she was notified about R1's admission to ER and asked to provide assistance with insertion of a catheter. PA stated R1 had a large prostate and obstructive urinary symptoms and required the use of a guide wire and cystoscopy (a hollow tube equipped with a lens to view the urethra and bladder) as she inserted the indwelling catheter. PA-A indicated was unable to see if there was a false tract (a false passage in the urethra is formation of an epithelialized tract created when the catheter was inserted aggressively against the urethral wall and/or a weak part of the urethra rather than guided through the urethra lumen, into the	F 610		

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F 610	Continued From page 20 bladder, and may occur more often in men due to an enlarge prostate) due to excessive bleeding in the urethra. PA-A stated reinsertion of a catheter had the potential to cause more damage and/or bleeding. PA-A verified when staff nurse inserted the catheter, got blood return a provider should have been notified right away and not waited. PA-A stated additionally, no urine output for up to 12 hours can cause increased risk for infection due to stagnate urine and possibly go into the kidneys which can be serious. During an interview on 7/9/24, at 11:37 a.m. primary provider physician assistant (PA)-B stated R1 had no urine output from 9 p.m. until sent to ER (7 hours). PA-B indicated when a nurse lacked skill for catheter insertion they may butt up to the inside of the urethra and felt like it was in the bladder, but no urine appeared. PA-B stated lack of urine would be the most thing to worry about but when catheter was placed incorrectly and in the wrong spot and/or a clot blocked off urine flow that would have been concerning. PA-B stated when R1 was catheterized improperly more than once that increased his risk for urethral damage and increased bleeding. PA-B stated R1's gross hematuria was caused by trauma from catheterization that was for sure and the only thing that made sense. During an interview on 7/9/24, at 12:44 p.m. floor manager licensed practical nurse (LPN)-B stated R1 has had a history of difficult indwelling catheter attempts with scant amount of blood but would have expected that to stop within an hour. LPN-B stated on 7/1/24, LPN-A informed him she attempted to insert the wrong size catheter 16 F(should have been a 14 F), larger than it should have been, and blood came through the tubing.	F 610		

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F 610	Continued From page 21 LPN-B stated the bleeding was caused by insertion of a catheter too large and scraped his urethra (a muscular tube that conveys urine from the urinary bladder to the exterior at the end of the penis). LPN-B stated along with the director of nursing (DON) we had chosen to wait to re-insert another catheter due to urethra being raw, could have caused more damage and discomfort, and allowed that area to recover. LPN-B stated there had been some harm done here, there had been damage to the urethra, R1 bled, required medical intervention, sent to hospital and admitted. During an interview on 7/10/24, at 1:10 p.m. DON stated no incident report was filed. DON also verified no investigation was started prior to 7/8/24, when surveyor arrived at their facility and at that time she started reviewing the documents such as medical record and hospital visit notes. DON indicated she had talked to LPN-A on 7/8/24, in the morning after surveyor had already interviewed her and education was completed briefly about lack of documentation, checking doctor's orders more thoroughly prior to changing out of the catheter to ensure the correct size was used. DON stated she had not visited and /or provided RN-A with education since incident. DON also verified there was no internal investigation or root/cause analysis completed within the facility. Review of facility policy titled SNF (Skilled Nursing Facility) Maltreatment Investigation and Reporting dated 10/18/21, identified Our care center will investigate all incidents and allegations of maltreatment to determine the cause (if able), and to determine if the incident needs to be reported to the appropriate authorities. An initial investigation must be conducted immediately to	F 610		

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F 610	Continued From page 22 determine what happened and whether the incident requires reporting to the Office of Health Facility Complaints (OHFC) or the Minnesota Adult Abuse Reporting Center (MAARC). Once the incident is initially assessed by the person in charge and immediate interventions are initiated to prevent any further occurrences, the incident report will be further assessed by the Interdisciplinary Team (IDT) or responsible person(s) to evaluate the effectiveness of the current interventions and/or implementation of any further interventions.	F 610		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for	F 625		8/5/24

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F 625	Continued From page 23 hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident or resident's representative was informed of the bed hold policy at the time of hospitalization for 1 of 3 residents (R1) reviewed for hospitalization. Findings include: R1's quarterly Minimum Data Set (MDS) dated 5/30/24, identified severely impaired cognition and no behaviors noted. R1 had an indwelling catheter and always incontinent of bowel. R1 had a neurogenic bladder (interference of the relationship between the nervous system and bladder function and affects the way your bladder function due to injury or disease). R1 had impairment on one side of his upper and lower body and was dependent upon staff for all cares, transfers, and repositioning. Review of R1's progress notes from 7/2/24, through 7/5/24, identified: - On 7/2/24, at 5:09 a.m. R1 screaming, reported a lot of pain rated 10 out of 10, blood pressure 90/53, bladder scanned 249 milliliters (ml), no urine in bag. On call provider notified and gave order to send to emergency room for evaluation due to low urine output for more than six hours. EMT (emergency medical technicians) were called, and R1 left for ER (emergency room) at 4:30 a.m.	F 625	R1 has returned to the facility. R1's representative will be educated on the bed hold policy, consent, and process for future transfers out of the building by 8/2/2024. All residents have the potential to be affected by this deficient practice. The Bed Hold Election and Hospital Transfer policy and the Bed Hold Election and Hospital Transfer form have been reviewed with no revisions necessary. All nursing staff are being re-educated on the policy, form, and how to obtain consent at time of transfer out of facility. Process put in place for clinical leadership team to follow up after residents are transferred out of facility to ensure consent was obtained and form completed. Nurse training will take place for all nursing staff by 8/5/2024 or prior to next scheduled shift. DON and/or designee will complete audits on transfers out of facility that require a bed hold consent. Audits will be conducted on all transfers x 3 months. The findings will be brought to QAPI team for review and for further recommendations.	

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F 625	Continued From page 24 -On 7/2/24, at 10:01 a.m. received call from local hospital, R1 was admitted with diagnosis of sepsis. Resident's family updated and resident placed on LOA (leave of absence). -On 7/4/24, at 5:53 p.m. writer called local hospital for an update on R1. Out of ICU (intensive care unit) and downgrade to medical unit, might be there for another two days. -On 7/5/24, at 2:13 p.m. R1 re-admitted to facility at 1:30 p.m. Further review of R28's medical record lacked documentation that R1 or family/legal representative had been provided information on the facility's bed hold policy at the time of the hospital transfer. During an interview on 7/9/24, at 4:37 p.m. floor manager registered nurse (RN)-C stated reviewed R1's chart and confirmed on 7/2/24, R1's LOA started and ended on 7/5/24. RN-C confirmed R1/family/legal representative were not provided a bed hold policy/information prior to his discharge to the hospital. During an interview on 7/9/24, at 4:29 p.m. social service designee (SSD) stated reviewed R1's chart and a bed hold was not provided to R1/family/legal representative or documented a bed hold was issued. SSD verified she had never done a bed hold before should have been done prior to R1's discharge to hospital. Review of facility policy titled Bed Hold Election and Hospital Transfer dated 11/16/23, identified the care center will assure each resident,	F 625		

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F 625	Continued From page 25 responsible person or legal representative is provided the option to hold their bed during a hospitalization or a therapeutic leave.	F 625		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure treatment and care in accordance with professional standards of practice for 1 of 3 residents (R1) reviewed who did not receive the necessary care and monitoring related to multiple incorrect insertion attempts of an indwelling catheter which resulted in bleeding, blood clots, pain, discomfort, low urine output, and low blood pressure, leading to a diagnosis of sepsis and admission to the Intensive Care Unit (ICU) via ambulance. This resulted in actual harm for R1. Findings include: R1's quarterly Minimum Data Set (MDS) dated 5/30/24, identified severely impaired cognition and no behaviors noted. MDS indicated R1 had an indwelling catheter, always incontinent of bowel, and neurogenic bladder (interference of the relationship between the nervous system and	F 684	R1 has returned to the facility. Nursing completed a catheter and urinary assessment on R1. Nursing documentation (progress note order) was implemented daily to identify any issues with catheter placement, catheter size per order, blood clots, pain, discomfort, low urine output, and vital sign changes. Care Plan was reviewed and revised. Any significant changes in condition will be acted upon immediately, treatment, and/or interventions will be implemented to ensure resident health and well-being. All residents with a urinary catheter have the potential to be affected by the deficient practice. Facility does not have any other current residents with catheters. Upon admission into the facility any residents with catheters will be assessed to identify any issues with catheter placement, blood	8/5/24

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F 684	Continued From page 26 bladder function and affects the way bladder functions due to injury or disease). MDS also indicated R1 had impairment on one side of his upper and lower body and was dependent upon staff for all cares, transfers, and repositioning. R1's health conditions form dated 6/2/24, to 7/2/24, were identified as anemia, benign prostatic hyperplasia (enlargement of the prostate) (BPH) with lower urinary tract symptoms, hemiplegia and hemiparesis (weakness and/or paralysis on one side of the body) following cerebral infarction (stroke) affected left non-dominant side, neuromuscular dysfunction of bladder (the nerves and muscles don't work together very well. As a result, the bladder may not fill or empty correctly), and dementia. R1's care plan (CP) dated 7/10/24, identified risk for bleeding due to anticoagulant (blood thinner) use, directed staff to monitor vitals and for bleeding, and contact provider with changes and update as needed. CP identified R1 was at risk for urinary tract infection (UTI) due to indwelling catheter and directed staff to observe and monitor for signs of infection and urine quality changes (change in urine color/sediment). R1 had an indwelling Foley catheter 14 F (French) 10 cc (cubic centimeters), and directed staff to document urine output at the end of every shift. R1's physician order dated 6/21/24, identified change 14 F catheter with 10 cc every 28 days at evening 2 p.m. to 10:30 p.m. once a month and change the bag at the same time. R1's physician order dated 6/21/24, identified empty catheter bag and document output three	F 684	clots, pain, discomfort, low urine output, and vital sign changes. Nursing documentation (progress note order) will be implemented daily to identify catheter/urinary issues and/or any significant change in condition. Care plans will identify catheter/urinary assessment findings. Any significant changes in condition will be acted upon immediately, treatment, and/or interventions will be implemented to ensure resident health and well-being. All nursing staff will be re-educated on how to identify the correct catheter size per order, catheter placement, assess/evaluate for signs and symptoms of catheter/urinary changes that may result in infection and/or sepsis, and implementation of nursing documentation (progress note order) to identify significant changes in condition. Nurse training will take place for all nursing staff by 8/5/2024 or prior to next scheduled shift. DON and/or designee will complete audits to ensure residents have the correct catheter placement and size, nursing documentation completed, and treatment/interventions implemented. Audits will be conducted 2 x week for 4 weeks, weekly for 4 weeks, then monthly x 2. The findings will be brought to QAPI team for review and for further recommendations.	

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F 684	Continued From page 27 times day (morning 6:00 a.m. to 2:30 p.m., evening 2:00 p.m. to 10:30 p.m., night 10:00 p.m. to 6:30 a.m.). R1's House Standing Orders signed and dated 2/29/24, identified may irrigate catheter with 30 to 60 ml (milliliters) of sterile normal saline with signs of blockage (clots, no urine flow or bypassing around catheter). Change indwelling catheter PRN (as needed) if becomes obstructed or comes out of bladder. R1's electronic medication administration record (EMAR) from 6/29/24, through 7/2/24, identified: -6/29/34, urine output evening shift 2:00 p.m. to 10:30 p.m. 150 ml; EMAR lacked documentation for morning or night shift output. -6/30/23, urine output evening shift 2:00 p.m. to 10:30 p.m. 600 ml; EMAR lacked documentation for morning or night shift output. -7/1/24, urine output 6:00 a.m. to 2:35 p.m. 450 ml, 2:00 p.m. to 10:30 p.m. 300 ml, and 10:00 p.m. to 6:30 am. 0 ml. -7/1/24, Acetaminophen oral tablet 500 mg (milligrams) 2 tablets by mouth as needed one time per day was documented as administered at 9:30 p.m., not effective. -7/1/24, 2:00 p.m. to 10:30 p.m. blood pressure (BP) 97/57 mmHg (millimeters of mercury) and the only blood pressure documented in R1's EMAR. -7/1/24, evening shift 2:00 p.m. to 10:30 p.m. change 14 F catheter with 10 cc balloon every 28	F 684		

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F 684	Continued From page 28 days (once a month). R1's progress notes from 6/28/24, through 7/5/24, identified: -6/28/24, at 12:07 a.m. to 7/2/24, at 12:15 a.m. no documentation noted in R1's medical record (four days). -7/2/24, at 12:15 a.m. 14 F was inserted at 9:20 p.m. and tolerated well. Later at 11:15 p.m. resident woke up screaming ouch and in pain. Irrigation, repositioning, and massage of bladder done but no urine output and still in a lot of pain. Small amount of thick blood and clots in bag and bloody urine bypassing. On call notified and she said to call on call provider if pain increased. -7/2/24, at 12:15 p.m. From report the evening nurse changed resident catheter with a 14 F (per interview with LPN-A this was a 16 F see below) and then a 16 F with blood output. At 8:30 p.m. writer was called to R1's room, screaming in pain, and guarded his groin area whenever staff tried to reach for that area. R1 refused to have brief closed due to increased pain, bladder scanned for 216 cc. On call nurse was notified and suggested flush/irrigate catheter, push fluids and change catheter to 14 F. When catheter was flushed there was increased pain and no output. Removed 16 F and noted continuous gross hematuria (bleeding) with some blood clots from penis. On call was notified and she said to let him drain for 15 minutes then insert a 14 F. After 15 minutes the gross hematuria was minimum and R1 felt better with less pain. -7/2/24, at 5:09 a.m. R1 was screaming, reported a lot of pain (10 out of 10) when his brief was	F 684		

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	245119	A. BUILDING _____ B. WING _____	C 07/10/2024

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F 684	Continued From page 29 changed around 3:30 a.m. R1's vitals blood pressure (BP) 90/53, respirations 18, and oxygen saturation 92%. Bladder scan completed and resulted in 249 cc with no urine in output in bag. On call provider notified and gave order to send to emergency room (ER) at 4:30 a.m. -7/2/24, at 10:01 a.m. received call from local hospital, R1 had been admitted with diagnosis of sepsis. R1's family updated and placed on LOA (leave of absence). -7/4/24, at 5:53 p.m. called hospital for update. R1 was moved out of ICU (intensive care unit) and downgraded to medical unit, off drip and BP was ok, and placed on two antibiotics. Possibly be there for two more days. -7/5/24, at 2:13 p.m. was re-admitted back to facility from hospital at 1:30 p.m. R1 had indwelling catheter in place that was free flowing, patent, urine was light yellow in color, without sediment, no blood no unusual odor. R1's catheter was to be changed every 28 days, if anticipated difficulty with catheter contact urology. Continued to be treated with antibiotics for UTI every 12 hours for 11 more days. R1's hospital admission notes dated 7/2/24, indicated indwelling catheter change completed at nursing home facility last evening resulted in significant bleeding and no urine output. An attempted catheter placement in ER resulted in ongoing bleeding and no urine output. CT (computerized tomography) scan was completed and showed catheter balloon inflated in the urethra. Urology was contacted and replaced the catheter over a guidewire with cystoscopy (a hollow tube equipped with a lens inserted into	F 684		

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F 684	Continued From page 30 urethra and slowly advanced into the bladder). Principle problems identified: urinary tract infection associated to indwelling catheter, sepsis (life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), with acute renal failure and septic shock, and anemia with acute blood loss from urethra resulting from Foley catheter placement. R1's lab results dated 7/2/24, urine collected at 9:14 a.m. revealed: urine was amber colored, turbid (cloudy), trace of ketones, large amount of blood, severely increased protein levels (indicates problems with the kidneys), positive nitrate (most likely indicates a bacterial infection in the bladder), and a small number of leukocytes (white blood cells). R1's Complete Blood Count (CBC) dated 7/2/24, identified hemoglobin low 10.7 g/dl (grams/Deciliter) (normal range 13.5 to 17.5. g/dl). R1's CT scan of abdomen pelvis dated 7/2/24, at 6:32 a.m. identified indication: gross hematuria and decreased urine output, sepsis. Impression: malposition Foley catheter with balloon inflated with in the penile urethra. Only mild urinary bladder distension. During an interview on 7/8/24, at 4:00 p.m. licensed practical nurse (LPN)-A stated R1 was due for a catheter change on July 1, 2024. LPN-A stated she had gathered supplies: catheter size 16 F, catheter bag, catheter change kit, and an extra syringe. LPN-A indicated pulled out R1's catheter 14 F after deflating balloon and noted urine was dark amber, cloudy, and sediment in	F 684		

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F 684	Continued From page 31 the tubing without odor. LPN-A stated emptied 450 cc of urine from collection bag. LPN-A stated when she inserted the 16 F catheter bright red blood was seen, panicked, and pulled out the catheter. LPN-A stated talked with floor manager LPN-B and informed was normal for R1 to bleed a bit and instructed to insert another catheter. LPN-A stated went back and inserted 16 F catheter and bloody return was noted with a small amount of urine. LPN-A stated she had went to the EMAR and noted the order indicated 14 F, it was then she realized she had inserted the wrong size catheter twice. LPN-A stated she reported to LPN-B and DON and was told it was fine and instructed to let things settle down/stop bleeding before the catheter was changed again. LPN-A stated checked on R1 prior to end of shift and no pain, no urine was flowing out of the tube and offered to flush but RN-A said no it was ok and left for the day. LPN-A stated a provider should have been notified about the wrong size catheter (2 times) and blood returned with little to no urine but did not due to LPN-B and DON indicated it was normal for R1 to bleed some. LPN-A stated they did not document this and should have. During a telephone interview on 7/9/24, at 2:00 a.m. registered nurse (RN)-A stated she started her night shift at 6:00 p.m. RN-A indicted she had received report from the LPN-A regarding R1's Foley catheter change. RN-A stated LPN-A indicated she she inserted a 14 F and got blood so removed it, placed another catheter this time a 16 F and was still bleeding when she realized she had used the wrong size catheter. RN-A indicted LPN-A reported to DON and floor manager LPN-B and they both came to conclusion the urethra was already irritated, so it was ok to leave it in until morning, monitor for bleeding, and	F 684		

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F 684	Continued From page 32 replace it the next day with a 14 F catheter. RN-A stated she had never seen blood in R1's catheter prior to this day. RN-A stated she peaked in on R1 at 6:30 p.m. prior to a medication pass that evening and there was approximately 100 cc of bloody drainage in the collection bag and in the catheter tubing and R1 reported no pain at that time. RN-A stated she had been told in the past when the catheter was not placed properly due to the BPH and neurogenic bladder a small amount of blood was normal for R1. RN-A stated when she had placed R1's catheter in the past, she had never seen any bleeding. RN-A stated later, a staff nursing assistant came and got her and indicated R1 was in pain. RN-A went to R1's room and he complained of pain and said, "ouch ouch". RN-A stated she tried to close his brief, but he would not allow and yelled out. RN-A checked urinary output which had remained the same as earlier (6:30 p.m.) then called the on-call nurse (DON) and was directed to massage the bladder area, push fluids, and then flush the catheter tubing. RN-A stated a provider should have been notified when R1 started to have no urine output with bleeding but she relied on DON for direction instead. RN-A stated DON instructed her the provider did not have to be called because there was nothing he could do and would round the next day. RN-A indicated she was unable to flush the catheter tubing, R1 complained of more pain, then she contacted DON again. RN-A stated DON indicated R1's 16 F catheter should be removed and replaced with a 14 F. RN-A stated she removed the 16 F catheter and R1 had gross hematuria from the penis and replaced it with a 14 F with approximately 80 cc of bloody drainage in bag and allowed more time to see when urine would drain and what color. RN-A stated she had bladder scanned R1 prior to the insertion of the	F 684		

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F 684	Continued From page 33 catheter and noted 216 cc. RN-A verified at 11:00 p.m. R1 complained of pain again, but was unable to give more Tylenol. RN-A texted DON and instructed to reposition R1, massage the bladder area and if in one hour still in pain call the on call provider and ask for order to use emergency kit to give a different analgesic. RN-A stated R1 indicated he was ok and then checked on him again at 3:00 a.m. bloody output had remained the same in bag at 50 ml and no urine noted and R1 had started to complain about pain again. RN-A called on call provider and informed them R1 had no urinary output and bladder pain then received order, and sent R1 into the hospital. During an interview on 7/9/24, at 11:00 a.m. hospital physician assistant (PA)-A (provided urological care to patients) verified she was notified about R1's admission to ER and asked to provide assistance with insertion of a catheter. PA-A stated R1 had a large prostate and obstructive urinary symptoms and required the use of a guide wire and cystoscopy (a hollow tube equipped with a lens to view the urethra and bladder) as she inserted the indwelling catheter. PA-A indicated was unable to see if there was a false tract (a false passage in the urethra is formation of an epithelialized tract created when the catheter was inserted aggressively against the urethral wall and/or a weak part of the urethra rather than guided through the urethra lumen, into the bladder, and may occur more often in men due to an enlarge prostate) due to excessive bleeding in the urethra. PA-A stated reinsertion of a catheter had the potential to cause more damage and/or bleeding. PA verified when staff nurse inserted the catheter, got blood return a provider should have been notified right away and	F 684		

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F 684	Continued From page 34 not waited. PA-A stated additionally, no urine output for up to 12 hours can cause increased risk for infection due to stagnate urine and possibly go into the kidneys which can be serious. During an interview on 7/9/24, at 11:37 a.m. primary provider/physician assistant (PA)-B stated R1 had no urine output from 9 p.m. until sent to ER (7 hours). PA-B indicated when a nurse lacked skill for catheter insertion they may butt up to the inside of the urethra and felt like it was in the bladder, but no urine appeared. PA-B stated lack of urine would be the most thing to worry about but when catheter was placed incorrectly and in the wrong spot and/or a clot blocked off urine flow that would have been concerning. PA-B stated when R1 was catheterization improperly more than once that increased his risk for urethral damage and increased bleeding. PA-B stated R1's gross hematuria was caused by trauma from cauterization that was for sure and the only thing that made sense. PA-B verified it would have been a good idea to have updated provider after the second time the wrong size catheter was inserted and bleeding continued. PA-B also stated when nurse had contacted the DON 4 to 6 times in a matter of 6 hours she was in over her head, clearly struggled, and required direction from the provider especially when R1 yelled out in pain, increased bleeding, and low urine output. PA-B stated she would have not recommended to change 16 F catheter a 14 F catheter, provider should have been contacted much sooner and R1 most likely sent into hospital earlier. During an interview on 7/9/24, at 12:44 p.m. floor manager (LPN)-B stated R1 has had a history of difficult indwelling catheter attempts with scant amount of blood but would have expected that to	F 684		

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F 684	Continued From page 35 stop within an hour. LPN-B stated on 7/1/24, LPN-A informed him she attempted to insert the wrong size catheter 16 French (F) (should have been a 14 F), larger than it should have been, and blood came through the tubing. LPN-B stated the bleeding was caused by insertion of a catheter too large and scraped his urethra (a muscular tube that conveys urine from the urinary bladder to the exterior at the end of the penis). LPN-B stated along with the director of nursing (DON) we had chosen to wait to re-insert another catheter due to urethra being raw, could have caused more damage and discomfort, and allowed that area to recover. LPN-B stated there had been some harm done here, there had been damage to the urethra and R1 bled, required medical intervention, sent to hospital, and admitted. During an interview on 7/9/24, at 2:05 p.m. floor manager registered nurse (RN)-C stated staff had difficulty with catheter placement with R1 in the past with flank blood upon insertion then subsided. RN-C indicated she would have been concerned from the word go when there was more blood than urine that would not be a typical finding after placement of a urinary catheter. RN-C also stated if there was flank blood after insertion of the catheter would have expected it to dissipate and see clean urine within in four hours with at least 50 cc an hour while fluids were pushed also. RN-C stated R1 had an extremely enlarge prostate and therefore made it a more difficult insertion and caused irritation of the urethra which caused bleeding. RN-C verified repeated insertion of a catheter risked irritation to the lining of the urethra, creased an entry of bacteria which increased risk for infection. RN-C stated it was basic nursing education/practice to	F 684		

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F 684	Continued From page 36 not inflate balloon until you get urine back. R1's change in condition occurred when he had less than 50 cc of urine out for more than two to three hours and a provider should have been contacted especially when the bleeding should have subsided much sooner. RN-C stated LPN-A placed a larger sized catheter (16 F) rather than 14 F that was ordered and bleeding occurred. RN-C stated LPN-C would be expected to document in the progress notes what transpired from the insertion of the catheters and what was going on during shift change. RN-C stated no follow up had been completed since the incident, no root cause analysis, and had been done or education with the nurses involved. During a telephone interview on 7/10/24, at 8:45 a.m. medical director (MD) stated staff nurses attempted to insert three catheters and the trauma to the urethra most likely was started with the first insertion, when the wrong sized catheter 16 F was used. MD stated a catheter balloon should never be inflated until you get a flow of urine. MD stated would have been important with blood return and no urine a provider should have been notified right away, sent to ER so an evaluation could have been completed at another facility. MD verified when a resident had ongoing bleeding, on an anticoagulant, and bled for more than two hours, would be alarming and something else was going on. MD stated he would have expected more documentation from the nursing especially with low urine output and bleeding, in the medical record, to establish a time-line, and what interventions were tried. During a telephone interview on 7/10/24, at 12:48 p.m. ER supervisor RN-D verified R1 arrived in ER with a 16 F catheter with no urine output and	F 684		

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F 684	Continued From page 37 blood in bag. RN-D stated the 16 F was removed and a 5:45 a.m. another catheter was placed by the ER staff with no resistance and into a suspected false tract. RN-D stated if the false tract would have not been there previously before R1 came to ER would have most likely met up with resistance due to R1's BPH but would have then inserted directly into the bladder. RN-D stated urology PA-C was contacted and a catheter was placed with a scope and guide wire into the bladder. During an interview on 7/10/24, at 1:10 p.m. DON stated she had many conversations with both staff nurses starting from 7/1/24, at approximately 4:00 p.m. through 7/5/24, at 11:32 p.m. regarding R1. DON stated last time she had heard from RN-A was at 11:32 p.m. DON stated she arrived at the facility early the next morning on 7/2/24, asked RN-A how R1 was doing and was informed she had sent him to Emergency Room via ambulance. DON stated she would have expected to be notified R1 was sent to hospital but was not. A vulnerable adult (VA) report was not filed with the State Agency, because the nurses did follow the facility policy, processes, and procedures, except for inserting the wrong catheter size. DON stated because of the long holiday weekend she was not aware until Monday morning (7/6/24), when R1 came back from hospital, and the cat scan (CT) (computer tomography scan) showed R1 had a catheter balloon inflated in the urethra rather than the bladder. DON stated repeated catheter insertion could have raised the risk of complications such as infection and urethral damage/bleeding. DON stated an incident report should have been filed under medication error. DON verified no incident report was filed. DON also verified no	F 684		

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F 684	Continued From page 38 investigation was started prior to 7/8/24, when surveyor arrived at their facility and at that time she started reviewing the documents such as medical record and hospital visit notes. DON indicated she had talked to LPN-A on 7/8/24, in the morning after surveyor had already interviewed her and education was completed briefly about lack of documentation, checking doctor's orders more thoroughly prior to changing out of the catheter to ensure the correct size was used. DON stated she had not visited and /or provided RN-A with education since incident. DON also verified there was no internal investigation or root/cause analysis completed within the facility. During a telephone interview on 7/11/24, at 12:00 p.m. emergency care provider, osteopathic doctor (DO) (look at patients as a whole person consisting of a mind, body, and spirit, and tend to focus on preventative medicine) stated the facility inserted a Foley catheter more than once, no urine output and bleeding occurred, clearly it was placed in the wrong spot and not in the bladder. DO stated at that time most likely that was when they started the false tract. DO indicated no urine output was not due to a blood clot because they tried to flush the catheter at the facility, no urine output and only blood. DO stated we removed the Foley catheter once he arrived at ED and inserted a 3 -way catheter without resistance and only a small return of urine. DO stated this indicted there was a false tract prior to his arrival at ED. DO verified the CT scan confirmed the Foley balloon was in the penile urethra therefore suspected R1 had a false tract. DO indicted numerous insertions of a Foley catheter within 10 hours would have caused damage and a false tract when not inserted properly. DO stated the facility	F 684		

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F 684	Continued From page 39 continued to re-insert catheters, with no urine out put and bleeding, caused urethra trauma, provider was not contacted right away and should have been, which delayed care and R1 became septic with bacteria in catheter. DO indicated she believed this cause R1 harm. Review of facility policy titled Foley Catheter Insertion, Male Resident dated 2001 identified the purpose of the Foley catheter was to provide for and maintain constant urinary drainage. Verification that there was a physician order was required to identify what size Foley catheter was specified. After preparation insert the catheter gently into the meatus (end of penis) approximately five to seven inches until urine began to flow from the bladder then advance the catheter another two inches and inflate balloon with 5 cc (cubic centimeters) and removed syringe. If resistance met do not force the entry, stop the procedure, and notify supervisor. The physician would be expected to be notified of any abnormalities (i.e. bleeding, obstruction). The following information should be recorded in the resident's medical record: -date and time of procedure -name, title of individual who preformed procedure -all assessment data (e.g. character, color, clarity) obtained during the procedure -the size of the Foley catheter inserted and amount of fluid used to inflate the balloon -how resident tolerated procedure -signature and title of person recording data Facility policy titled Notification of Significant Changes dated 5/2/22, identified policy provided guidance to staff when and who to notify of a	F 684		

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F 684	Continued From page 40 significant change in a resident's status. Definition of a significant change meant a change in resident's status, a need to alter treatment, and accident results in injury, or a decision to transfer or discharge the individual receiving services from care center. The charge nurse will immediately (as indicated by the change of condition) informed the resident, consult with the physician, and notify the resident representative for the following significant change: an accident that involved the resident which results in injury and has the potential for required physician intervention, a deterioration in health, in either lift-threatening conditions or clinical complications, and decision to transfer to another provider from the care center without primary physician involvement.	F 684		

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	00002	A. BUILDING: _____ B. WING _____	C 07/10/2024

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AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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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: On 7/8/24, through 7/10/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed H51195214C (MN00104620) with a licensing order issued at 0830 and 0265. As a result of the investigation, a licensing order was also issued at 1995. Minnesota Department of Health is documenting the State Licensing Correction Orders using 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 entitled "ID Prefix Tag." 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 met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the	2 000		

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2 000	Continued From page 2 heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications;	2 265		8/5/24

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2 265	Continued From page 3 C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to notify the resident's physician timely with a change in condition for 1 of 3 residents (R1) when staff inserted an indwelling catheter three times, resulted in bleeding, blood clots, pain, discomfort, low urine output, and low blood pressure, sent to emergency room via ambulance, and developed sepsis, and admitted to intensive care unit. Findings include: R1's quarterly Minimum Data Set (MDS) dated 5/30/24, identified severely impaired cognition and no behaviors noted. MDS indicated R1 had an indwelling catheter, always incontinent of bowel, and neurogenic bladder (interference of the relationship between the nervous system and bladder function and affects the way bladder functions due to injury or disease). MDS also indicated R1 had impairment on one side of his upper and lower body and was dependent upon staff for all cares, transfers, and repositioning. R1's health conditions form dated 6/2/24, to 7/2/24, were identified as anemia, benign	2 265	Corrected by 8/5/2024	

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2 265	Continued From page 4 prostatic hyperplasia (enlargement of the prostate) (BPH) with lower urinary tract symptoms, hemiplegia and hemiparesis (weakness and/or paralysis on one side of the body) following cerebral infarction (stroke) affected left non-dominant side, neuromuscular dysfunction of bladder (the nerves and muscles don't work together very well. As a result, the bladder may not fill or empty correctly), and dementia. R1's care plan (CP) dated 7/10/24, identified risk for bleeding due to anticoagulant (blood thinner) use, directed staff to monitor vitals and for bleeding, and contact provider with changes and update as needed. CP identified R1 was at risk for urinary tract infection (UTI) due to indwelling catheter and directed staff to observe and monitor for signs of infection and urine quality changes (change in urine color/sediment). R1 had an indwelling Foley catheter 14 F (French) 10 cc (cubic centimeters), and to document urine output at the end of every shift. R1's physician order dated 6/21/24, identified change 14 F catheter with 10 cc every 28 days at evening 2 p.m. to 10:30 p.m. once a month and change the bag at the same time. R1's physician order dated 6/21/24, identified empty catheter bag and document output three times day (morning 6:00 a.m. to 2:30 p.m., evening 2:00 p.m. to 10:30 p.m., night 10:00 p.m. to 6:30 a.m.). R1's House Standing Orders signed and dated 2/29/24, identified may irrigate catheter with 30 to 60 ml (milliliters) of sterile normal saline with signs of blockage (clots, no urine flow or bypassing around catheter). Change indwelling	2 265		

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2 265	Continued From page 5 catheter PRN (as needed) if becomes obstructed or comes out of bladder. R1's progress notes from 6/28/24, through 7/5/24, identified: -6/28/24, at 12:07 a.m. to 7/2/24, at 12:15 a.m. no documentation noted in R1's medical record (over four days). -7/2/24, at 12:15 a.m. 14 F was inserted at 9:20 p.m. and tolerated well. Later at 11:15 p.m. resident woke up screaming ouch and in pain. Irrigation, repositioning, and massage of bladder done but no urine output and still in a lot of pain. Small amount of thick blood and clots in bag and bloody urine bypassing. On call notified and she said to call on call provider if pain increased. -7/2/24, at 12:15 p.m. from report the evening nurse changed resident catheter with a 14 F (per interview with LPN-A this was a 16 F, see below) and then a 16 F with blood output. At 8:30 p.m. writer was called to R1's room, screaming in pain, and guarded his groin area whenever staff tried to reach for that area. R1 refused to have brief closed due to increased pain, bladder scanned for 216 cc. On call nurse was notified and suggested flush/irrigate catheter, push fluids and change catheter to 14 F. When catheter was gushed there was increased pain and no output. Removed 16 F and noted continuous gross hematuria (bleeding) with some blood clots from penis. On call was notified and she said to let him drain for 15 minutes then insert a 14 F. After 15 minutes the gross hematuria was minimum and R1 felt better with less pain. -7/2/24, at 5:09 a.m. R1 was screaming, reported a lot of pain (10 out of 10) when his brief was	2 265		

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2 265	Continued From page 6 changed around 3:30 a.m. R1's vitals blood pressure (BP) 90/53, respirations 18, and oxygen saturation 92%. Bladder scan completed and resulted in 249 cc with no urine in output in bag. On call provider notified and gave order to send to emergency room (ER) at 4:30 a.m. -7/2/24, at 10:01 a.m. received call from local hospital, R1 had been admitted with diagnosis of sepsis. R1's family updated and placed on LOA (leave of absence). -7/4/24, at 5:53 p.m. called hospital for update. R1 was moved out of ICU (intensive care unit) and downgraded to medical unit, off drip and BP was ok, and placed on two antibiotics. Possibly be there for two more days. -7/5/24, at 2:13 p.m. was re-admitted back to facility from hospital at 1:30 p.m. R1 had indwelling catheter in place that was free flowing, patent, urine was light yellow in color, without sediment, no blood no unusual odor. R1's catheter was to be changed every 28 days, if anticipated difficulty with catheter contact urology. Continued to be treated with antibiotics for UTI every 12 hours for 11 more days. R1's hospital admission notes dated 7/2/24, indicated indwelling catheter change completed at nursing home facility last evening resulted in significant bleeding and no urine output. An attempted catheter placement in ER resulted in ongoing bleeding and no urine output. CT (computerized tomography) scan was completed and showed catheter balloon inflated in the urethra. Urology was contacted and replaced the catheter over a guidewire with cystoscopy (a hollow tube equipped with a lens inserted into urethra and slowly advanced into the bladder).	2 265		

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2 265	Continued From page 7 Principle problems identified: urinary tract infection associated to indwelling catheter, sepsis (life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), with acute renal failure and septic shock, and anemia with acute blood loss from urethra resulting from Foley catheter placement. During an interview on 7/8/24, at 4:00 p.m. licensed practical nurse (LPN)-A stated R1 was due for a catheter change on July 1, 2024. LPN-A stated she had gathered supplies: catheter size 16 F, catheter bag, catheter change kit, and an extra syringe. LPN-A indicated pulled out R1's catheter 14 F after deflating balloon and noted urine was dark amber, cloudy, and sediment in the tubing without odor. LPN-A stated emptied 450 cc of urine from collection bag. LPN-A stated when she inserted the 16 F catheter bright red blood was seen, panicked, and pulled out the catheter. LPN-A stated talked with floor manager LPN-B and informed was normal for R1 to bleed a bit and instructed to insert another catheter. LPN-A stated went back and inserted 16 F catheter and bloody return was noted with a small amount of urine. LPN-A stated she had went to the EMAR and noted the order indicated 14 F, it was then she realized she had inserted the wrong size catheter twice. LPN-A stated she reported to LPN-B and DON and was told it was fine and instructed to let things settle down/stop bleeding before the catheter was changed again. LPN-A stated checked on R1 prior to end of shift and no pain, no urine was flowing out of the tube and offered to flush but RN-A said no it was ok and left for the day. LPN-A stated a provider should have been notified about the wrong size catheter (2 times) and blood returned with little to no urine but did not due to LPN-B and DON indicated it	2 265		

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2 265	Continued From page 8 was normal for R1 to bleed some. LPN-A stated they did not document this and should have. During a telephone interview on 7/9/24, at 2:00 a.m. registered nurse (RN)-A stated she started her night shift at 6:00 p.m. RN-A indicted she had received report from the LPN-A regarding R1's Foley catheter change. RN-A stated LPN-A indicated she she inserted a 14 F and got blood so removed it, placed another catheter this time a 16 F and was still bleeding when she realized she had used the wrong size catheter. RN-A indicted LPN-A reported to DON and floor manager LPN-B and they both came to conclusion the urethra was already irritated, so it was ok to leave it in until morning, monitor for bleeding, and replace it the next day with a 14 F catheter. RN-A stated she had never seen blood in R1's catheter prior to this day. RN-A stated she peaked in on R1 at 6:30 p.m. prior to a medication pass that evening and there was approximately 100 cc of bloody drainage in the collection bag and in the catheter tubing and R1 reported no pain at that time. RN-A stated she had been told in the past when the catheter was not placed properly due to the BPH and neurogenic bladder a small amount of blood was normal for R1. RN-A stated when she had placed R1's catheter in the past, she had never seen any bleeding. RN-A stated later, a staff nursing assistant came and got her and indicated R1 was in pain. RN-A went to R1's room and he complained of pain and said, "ouch ouch". RN-A stated she tried to close his brief, but he would not allow and yelled out. RN-A checked urinary output which had remained the same as earlier (6:30 p.m.) then called the on-call nurse (DON) and was directed to massage the bladder area, push fluids, and then flush the catheter tubing. RN-A stated a provider should have been notified when R1 started to have no urine output	2 265		

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2 265	Continued From page 9 with bleeding but she relied on DON for direction instead. RN-A stated DON instructed her the provider did not have to be called because there was nothing he could do and would round the next day. RN-A indicated she was unable to flush the catheter tubing, R1 complained of more pain, then she contacted DON again. RN-A stated DON indicated R1's 16 F catheter should be removed and replaced with a 14 F. RN-A stated she removed the 16 F catheter and R1 had gross hematuria from the penis and replaced it with a 14 F with approximately 80 cc of bloody drainage in bag and allowed more time to see when urine would drain and what color. RN-A stated she had bladder scanned R1 prior to the insertion of the catheter and noted 216 cc. RN-A verified at 11:00 p.m. R1 complained of pain again, but was unable to give more Tylenol. RN-A texted DON and instructed to reposition R1, massage the bladder area and if in one hour still in pain call the on call provider and ask for order to use emergency kit to give a different analgesic. RN-A stated R1 indicated he was ok and then checked on him again at 3:00 a.m. bloody output had remained the same in bag at 50 ml and no urine noted and R1 had started to complain about pain again. RN-A called on call provider and informed them R1 had no urinary output and bladder pain then received order, and sent R1 into the hospital. During an interview on 7/9/24, at 11:00 a.m. hospital physician assistant (PA)-A (provided urological care to patients) verified she was notified about R1's admission to ER and asked to provide assistance with insertion of a catheter. PA-A stated R1 had a large prostate and obstructive urinary symptoms and required the use of a guide wire and cystoscopy (a hollow tube equipped with a lens to view the urethra and	2 265		

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2 265	Continued From page 10 bladder) as she inserted the indwelling catheter. PA-A indicated was unable to see if there was a false tract (a false passage in the urethra is formation of an epithelialized tract created when the catheter was inserted aggressively against the urethral wall and/or a weak part of the urethra rather than guided through the urethra lumen, into the bladder, and may occur more often in men due to an enlarge prostate) due to excessive bleeding in the urethra. PA-A stated reinsertion of a catheter had the potential to cause more damage and/or bleeding. PA verified when staff nurse inserted the catheter, got blood return a provider should have been notified right away and not waited. PA-A stated additionally, no urine output for up to 12 hours can cause increased risk for infection due to stagnate urine and possibly go into the kidneys which can be serious. During an interview on 7/9/24, at 11:37 a.m. primary provider/physician assistant (PA)-B stated R1 had no urine output from 9 p.m. until sent to ER (7 hours). PA-B verified it would have been a good idea to have updated provider after the second time the wrong size catheter was inserted and bleeding continued. PA-B also stated when nurse had contacted the DON 4 to 6 times in a matter of 6 hours she was in over her head, clearly struggled, and required direction from the provider especially when R1 yelled out in pain, increased bleeding, and low urine output. PA-B stated she would have not recommended to change 16 F catheter a 14 F catheter, provider should have been contacted much sooner and R1 most likely sent into hospital earlier. During an interview on 7/9/24, at 2:05 p.m. floor manager registered nurse (RN)-C stated repeated insertion of a catheter risked irritation to the lining of the urethra, increased an entry of	2 265		

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2 265	Continued From page 11 bacteria which increased risk for infection. RN-C stated it was basic nursing education/practice to not inflate balloon until you get urine back. R1's change in condition occurred when he had less than 50 cc of urine out for more than two to three hours and a provider should have been contacted especially when the bleeding should have subsided much sooner. During a telephone interview on 7/10/24, at 8:45 a.m. medical director (MD) stated staff nurses attempted to insert three catheters and the trauma to the urethra most likely was started with the first insertion, when the wrong sized catheter 16 F was used. MD stated a catheter balloon should never be inflated until you get a flow of urine. MD stated would have been important with blood return and no urine a provider should have been notified right away, sent to ER so an evaluation could have been completed at another facility. MD verified when a resident had ongoing bleeding, on an anticoagulant, and bled for more than two hours, would be alarming and something else was going on. MD stated he would have expected more documentation from the nursing especially with low urine output and bleeding, in the medical record, to establish a time-line, and what interventions were tried. During a telephone interview on 7/10/24, at 12:48 p.m. ER supervisor RN-D verified R1 arrived in ER with a 16 F catheter with no urine output and blood in bag. During an interview on 7/10/24, at 1:10 p.m. DON stated she had many conversations with both staff nurses starting from 7/1/24, at approximately 4:00 p.m. through 7/5/24, at 11:32 p.m. regarding R1. DON stated last time she had heard from RN-A was at 11:32 p.m. DON stated she arrived	2 265		

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2 265	Continued From page 12 at the facility early the next morning on 7/2/24, asked RN-A how R1 was doing and was informed she had sent him to Emergency Room via ambulance. DON stated she would have expected to be notified R1 was sent to hospital but was not. DON stated repeated catheter insertion could have raised the risk of complications such as infection and urethral damage/bleeding. During a telephone interview on 7/11/24, at 12:00 p.m. emergency care provider, osteopathic doctor (DO) (look at patients as a whole person consisting of a mind, body, and spirit, and tend to focus on preventative medicine) stated the facility inserted a Foley catheter more than once, no urine output and bleeding occurred, clearly it was placed in the wrong spot and not in the bladder. DO stated at that time most likely that was when they started the false tract. DO indicated no urine output was not due to a blood clot because they tried to flush the catheter at the facility, no urine output and only blood. DO stated we removed the Foley catheter once he arrived at ED and inserted a 3 -way catheter without resistance and only a small return of urine. DO stated this indicted there was a false tract prior to his arrival at ED. DO verified the CT scan confirmed the Foley balloon was in the penile urethra therefore suspected R1 had a false tract. DO indicted numerous insertions of a Foley catheter within 10 hours would have caused damage and a false tract when not inserted properly. DO stated the facility continued to re-insert catheters, with no urine out put and bleeding, caused urethra trauma, provider was not contacted right away and should have been, which delayed care and R1 became septic with bacteria in catheter. DO indicated she believed this cause R1 harm.	2 265		

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2 265	Continued From page 13 Facility policy titled Notification of Significant Changes dated 5/2/22, identified policy provided guidance to staff when and who to notify of a significant change in a resident's status. Definition of a significant change meant a change in resident's status, a need to alter treatment, and accident results in injury, or a decision to transfer or discharge the individual receiving services from care center. The charge nurse will immediately (as indicated by the change of condition) informed the resident, consult with the physician, and notify the resident representative for the following significant change: an accident that involved the resident which results in injury and has the potential for required physician intervention, a deterioration in health, in either lift-threatening conditions or clinical complications, and decision to transfer to another provider from the care center without primary physician involvement. Review of facility policy titled Foley Catheter Insertion, Male Resident dated 2001 identified the purpose of the Foley catheter was to provide for and maintain constant urinary drainage. Verification that there was a physician order was required to identify what size Foley catheter was specified. After preparation insert the catheter gently into the meatus (end of penis) approximately five to seven inches until urine began to flow from the bladder then advance the catheter another two inches and inflate balloon with 5 cc (cubic centimeters) and removed syringe. If resistance met do not force the entry, stop the procedure, and notify supervisor. The physician would be expected to be notified of any abnormalities (i.e. bleeding, obstruction). SUGGESTED METHOD OF CORRECTION:	2 265		

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2 265	Continued From page 14 The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure compliance, educate all appropriate staff on the policies and procedures and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 265		
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 prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure treatment and care in accordance with professional standards of practice for 1 of 3 residents (R1) reviewed who did not receive the necessary care and monitoring related to multiple incorrect insertion attempts of an indwelling catheter which resulted in bleeding, blood clots, pain, discomfort, low urine output, and low blood pressure, leading to a	2 830	Corrected by 8/5/2024	8/5/24

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2 830	Continued From page 15 diagnosis of sepsis and admission to the Intensive Care Unit (ICU) via ambulance. This resulted in actual harm for R1. Findings include: R1's quarterly Minimum Data Set (MDS) dated 5/30/24, identified severely impaired cognition and no behaviors noted. MDS indicated R1 had an indwelling catheter, always incontinent of bowel, and neurogenic bladder (interference of the relationship between the nervous system and bladder function and affects the way bladder functions due to injury or disease). MDS also indicated R1 had impairment on one side of his upper and lower body and was dependent upon staff for all cares, transfers, and repositioning. R1's health conditions form dated 6/2/24, to 7/2/24, were identified as anemia, benign prostatic hyperplasia (enlargement of the prostate) (BPH) with lower urinary tract symptoms, hemiplegia and hemiparesis (weakness and/or paralysis on one side of the body) following cerebral infarction (stroke) affected left non-dominant side, neuromuscular dysfunction of bladder (the nerves and muscles don't work together very well. As a result, the bladder may not fill or empty correctly), and dementia. R1's care plan (CP) dated 7/10/24, identified risk for bleeding due to anticoagulant (blood thinner) use, directed staff to monitor vitals and for bleeding, and contact provider with changes and update as needed. CP identified R1 was at risk for urinary tract infection (UTI) due to indwelling catheter and directed staff to observe and monitor for signs of infection and urine quality changes (change in urine color/sediment). R1	2 830		

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2 830	Continued From page 16 had an indwelling Foley catheter 14 F (French) 10 cc (cubic centimeters), and directed staff to document urine output at the end of every shift. R1's physician order dated 6/21/24, identified change 14 F catheter with 10 cc every 28 days at evening 2 p.m. to 10:30 p.m. once a month and change the bag at the same time. R1's physician order dated 6/21/24, identified empty catheter bag and document output three times day (morning 6:00 a.m. to 2:30 p.m., evening 2:00 p.m. to 10:30 p.m., night 10:00 p.m. to 6:30 a.m.). R1's House Standing Orders signed and dated 2/29/24, identified may irrigate catheter with 30 to 60 ml (milliliters) of sterile normal saline with signs of blockage (clots, no urine flow or bypassing around catheter). Change indwelling catheter PRN (as needed) if becomes obstructed or comes out of bladder. R1's electronic medication administration record (EMAR) from 6/29/24, through 7/2/24, identified: -6/29/34, urine output evening shift 2:00 p.m. to 10:30 p.m. 150 ml; EMAR lacked documentation for morning or night shift output. -6/30/23, urine output evening shift 2:00 p.m. to 10:30 p.m. 600 ml; EMAR lacked documentation for morning or night shift output. -7/1/24, urine output 6:00 a.m. to 2:35 p.m. 450 ml, 2:00 p.m. to 10:30 p.m. 300 ml, and 10:00 p.m. to 6:30 am. 0 ml. -7/1/24, Acetaminophen oral tablet 500 mg (milligrams) 2 tablets by mouth as needed one	2 830		

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2 830	Continued From page 17 time per day was documented as administered at 9:30 p.m., not effective. -7/1/24, 2:00 p.m. to 10:30 p.m. blood pressure (BP) 97/57 mmHg (millimeters of mercury) and the only blood pressure documented in R1's EMAR. -7/1/24, evening shift 2:00 p.m. to 10:30 p.m. change 14 F catheter with 10 cc balloon every 28 days (once a month). R1's progress notes from 6/28/24, through 7/5/24, identified: -6/28/24, at 12:07 a.m. to 7/2/24, at 12:15 a.m. no documentation noted in R1's medical record (four days). -7/2/24, at 12:15 a.m. 14 F was inserted at 9:20 p.m. and tolerated well. Later at 11:15 p.m. resident woke up screaming ouch and in pain. Irrigation, repositioning, and massage of bladder done but no urine output and still in a lot of pain. Small amount of thick blood and clots in bag and bloody urine bypassing. On call notified and she said to call on call provider if pain increased. -7/2/24, at 12:15 p.m. From report the evening nurse changed resident catheter with a 14 F (per interview with LPN-A this was a 16 F see below) and then a 16 F with blood output. At 8:30 p.m. writer was called to R1's room, screaming in pain, and guarded his groin area whenever staff tried to reach for that area. R1 refused to have brief closed due to increased pain, bladder scanned for 216 cc. On call nurse was notified and suggested flush/irrigate catheter, push fluids and change catheter to 14 F. When catheter was flushed there was increased pain and no output.	2 830		

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2 830	Continued From page 18 Removed 16 F and noted continuous gross hematuria (bleeding) with some blood clots from penis. On call was notified and she said to let him drain for 15 minutes then insert a 14 F. After 15 minutes the gross hematuria was minimum and R1 felt better with less pain. -7/2/24, at 5:09 a.m. R1 was screaming, reported a lot of pain (10 out of 10) when his brief was changed around 3:30 a.m. R1's vitals blood pressure (BP) 90/53, respirations 18, and oxygen saturation 92%. Bladder scan completed and resulted in 249 cc with no urine in output in bag. On call provider notified and gave order to send to emergency room (ER) at 4:30 a.m. -7/2/24, at 10:01 a.m. received call from local hospital, R1 had been admitted with diagnosis of sepsis. R1's family updated and placed on LOA (leave of absence). -7/4/24, at 5:53 p.m. called hospital for update. R1 was moved out of ICU (intensive care unit) and downgraded to medical unit, off drip and BP was ok, and placed on two antibiotics. Possibly be there for two more days. -7/5/24, at 2:13 p.m. was re-admitted back to facility from hospital at 1:30 p.m. R1 had indwelling catheter in place that was free flowing, patent, urine was light yellow in color, without sediment, no blood no unusual odor. R1's catheter was to be changed every 28 days, if anticipated difficulty with catheter contact urology. Continued to be treated with antibiotics for UTI every 12 hours for 11 more days. R1's hospital admission notes dated 7/2/24, indicated indwelling catheter change completed at nursing home facility last evening resulted in	2 830		

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2 830	Continued From page 19 significant bleeding and no urine output. An attempted catheter placement in ER resulted in ongoing bleeding and no urine output. CT (computerized tomography) scan was completed and showed catheter balloon inflated in the urethra. Urology was contacted and replaced the catheter over a guidewire with cystoscopy (a hollow tube equipped with a lens inserted into urethra and slowly advanced into the bladder). Principle problems identified: urinary tract infection associated to indwelling catheter, sepsis (life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), with acute renal failure and septic shock, and anemia with acute blood loss from urethra resulting from Foley catheter placement. R1's lab results dated 7/2/24, urine collected at 9:14 a.m. revealed: urine was amber colored, turbid (cloudy), trace of ketones, large amount of blood, severely increased protein levels (indicates problems with the kidneys), positive nitrate (most likely indicates a bacterial infection in the bladder), and a small number of leukocytes (white blood cells). R1's Complete Blood Count (CBC) dated 7/2/24, identified hemoglobin low 10.7 g/dl (grams/Deciliter) (normal range 13.5 to 17.5. g/dl). R1's CT scan of abdomen pelvis dated 7/2/24, at 6:32 a.m. identified indication: gross hematuria and decreased urine output, sepsis. Impression: malposition Foley catheter with balloon inflated with in the penile urethra. Only mild urinary bladder distension. During an interview on 7/8/24, at 4:00 p.m.	2 830		

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2 830	Continued From page 20 licensed practical nurse (LPN)-A stated R1 was due for a catheter change on July 1, 2024. LPN-A stated she had gathered supplies: catheter size 16 F, catheter bag, catheter change kit, and an extra syringe. LPN-A indicated pulled out R1's catheter 14 F after deflating balloon and noted urine was dark amber, cloudy, and sediment in the tubing without odor. LPN-A stated emptied 450 cc of urine from collection bag. LPN-A stated when she inserted the 16 F catheter bright red blood was seen, panicked, and pulled out the catheter. LPN-A stated talked with floor manager LPN-B and informed was normal for R1 to bleed a bit and instructed to insert another catheter. LPN-A stated went back and inserted 16 F catheter and bloody return was noted with a small amount of urine. LPN-A stated she had went to the EMAR and noted the order indicated 14 F, it was then she realized she had inserted the wrong size catheter twice. LPN-A stated she reported to LPN-B and DON and was told it was fine and instructed to let things settle down/stop bleeding before the catheter was changed again. LPN-A stated checked on R1 prior to end of shift and no pain, no urine was flowing out of the tube and offered to flush but RN-A said no it was ok and left for the day. LPN-A stated a provider should have been notified about the wrong size catheter (2 times) and blood returned with little to no urine but did not due to LPN-B and DON indicated it was normal for R1 to bleed some. LPN-A stated they did not document this and should have. During a telephone interview on 7/9/24, at 2:00 a.m. registered nurse (RN)-A stated she started her night shift at 6:00 p.m. RN-A indicted she had received report from the LPN-A regarding R1's Foley catheter change. RN-A stated LPN-A indicated she she inserted a 14 F and got blood so removed it, placed another catheter this time a	2 830		

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2 830	Continued From page 21 16 F and was still bleeding when she realized she had used the wrong size catheter. RN-A indicted LPN-A reported to DON and floor manager LPN-B and they both came to conclusion the urethra was already irritated, so it was ok to leave it in until morning, monitor for bleeding, and replace it the next day with a 14 F catheter. RN-A stated she had never seen blood in R1's catheter prior to this day. RN-A stated she peaked in on R1 at 6:30 p.m. prior to a medication pass that evening and there was approximately 100 cc of bloody drainage in the collection bag and in the catheter tubing and R1 reported no pain at that time. RN-A stated she had been told in the past when the catheter was not placed properly due to the BPH and neurogenic bladder a small amount of blood was normal for R1. RN-A stated when she had placed R1's catheter in the past, she had never seen any bleeding. RN-A stated later, a staff nursing assistant came and got her and indicated R1 was in pain. RN-A went to R1's room and he complained of pain and said, "ouch ouch". RN-A stated she tried to close his brief, but he would not allow and yelled out. RN-A checked urinary output which had remained the same as earlier (6:30 p.m.) then called the on-call nurse (DON) and was directed to massage the bladder area, push fluids, and then flush the catheter tubing. RN-A stated a provider should have been notified when R1 started to have no urine output with bleeding but she relied on DON for direction instead. RN-A stated DON instructed her the provider did not have to be called because there was nothing he could do and would round the next day. RN-A indicated she was unable to flush the catheter tubing, R1 complained of more pain, then she contacted DON again. RN-A stated DON indicated R1's 16 F catheter should be removed and replaced with a 14 F. RN-A stated she removed the 16 F catheter and R1 had gross	2 830		

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2 830	Continued From page 22 hematuria from the penis and replaced it with a 14 F with approximately 80 cc of bloody drainage in bag and allowed more time to see when urine would drain and what color. RN-A stated she had bladder scanned R1 prior to the insertion of the catheter and noted 216 cc. RN-A verified at 11:00 p.m. R1 complained of pain again, but was unable to give more Tylenol. RN-A texted DON and instructed to reposition R1, massage the bladder area and if in one hour still in pain call the on call provider and ask for order to use emergency kit to give a different analgesic. RN-A stated R1 indicated he was ok and then checked on him again at 3:00 a.m. bloody output had remained the same in bag at 50 ml and no urine noted and R1 had started to complain about pain again. RN-A called on call provider and informed them R1 had no urinary output and bladder pain then received order, and sent R1 into the hospital. During an interview on 7/9/24, at 11:00 a.m. hospital physician assistant (PA)-A (provided urological care to patients) verified she was notified about R1's admission to ER and asked to provide assistance with insertion of a catheter. PA-A stated R1 had a large prostate and obstructive urinary symptoms and required the use of a guide wire and cystoscopy (a hollow tube equipped with a lens to view the urethra and bladder) as she inserted the indwelling catheter. PA-A indicated was unable to see if there was a false tract (a false passage in the urethra is formation of an epithelialized tract created when the catheter was inserted aggressively against the urethral wall and/or a weak part of the urethra rather than guided through the urethra lumen, into the bladder, and may occur more often in men due to an enlarge prostate) due to excessive bleeding in the urethra. PA-A stated reinsertion of	2 830		

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2 830	Continued From page 23 a catheter had the potential to cause more damage and/or bleeding. PA verified when staff nurse inserted the catheter, got blood return a provider should have been notified right away and not waited. PA-A stated additionally, no urine output for up to 12 hours can cause increased risk for infection due to stagnate urine and possibly go into the kidneys which can be serious. During an interview on 7/9/24, at 11:37 a.m. primary provider/physician assistant (PA)-B stated R1 had no urine output from 9 p.m. until sent to ER (7 hours). PA-B indicated when a nurse lacked skill for catheter insertion they may butt up to the inside of the urethra and felt like it was in the bladder, but no urine appeared. PA-B stated lack of urine would be the most thing to worry about but when catheter was placed incorrectly and in the wrong spot and/or a clot blocked off urine flow that would have been concerning. PA-B stated when R1 was catheterization improperly more than once that increased his risk for urethral damage and increased bleeding. PA-B stated R1's gross hematuria was caused by trauma from cauterization that was for sure and the only thing that made sense. PA-B verified it would have been a good idea to have updated provider after the second time the wrong size catheter was inserted and bleeding continued. PA-B also stated when nurse had contacted the DON 4 to 6 times in a matter of 6 hours she was in over her head, clearly struggled, and required direction from the provider especially when R1 yelled out in pain, increased bleeding, and low urine output. PA-B stated she would have not recommended to change 16 F catheter a 14 F catheter, provider should have been contacted much sooner and R1 most likely sent into hospital earlier. During an interview on 7/9/24, at 12:44 p.m. floor	2 830		

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2 830	Continued From page 24 manager (LPN)-B stated R1 has had a history of difficult indwelling catheter attempts with scant amount of blood but would have expected that to stop within an hour. LPN-B stated on 7/1/24, LPN-A informed him she attempted to insert the wrong size catheter 16 French (F) (should have been a 14 F), larger than it should have been, and blood came through the tubing. LPN-B stated the bleeding was caused by insertion of a catheter too large and scraped his urethra (a muscular tube that conveys urine from the urinary bladder to the exterior at the end of the penis). LPN-B stated along with the director of nursing (DON) we had chosen to wait to re-insert another catheter due to urethra being raw, could have caused more damage and discomfort, and allowed that area to recover. LPN-B stated there had been some harm done here, there had been damage to the urethra and R1 bled, required medical intervention, sent to hospital, and admitted. During an interview on 7/9/24, at 2:05 p.m. floor manager registered nurse (RN)-C stated staff had difficulty with catheter placement with R1 in the past with flank blood upon insertion then subsided. RN-C indicated she would have been concerned from the word go when there was more blood than urine that would not be a typical finding after placement of a urinary catheter. RN-C also stated if there was flank blood after insertion of the catheter would have expected it to dissipate and see clean urine within in four hours with at least 50 cc an hour while fluids were pushed also. RN-C stated R1 had an extremely enlarge prostate and therefore made it a more difficult insertion and caused irritation of the urethra which caused bleeding. RN-C verified repeated insertion of a catheter risked irritation to the lining of the urethra, creased an entry of	2 830		

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2 830	Continued From page 25 bacteria which increased risk for infection. RN-C stated it was basic nursing education/practice to not inflate balloon until you get urine back. R1's change in condition occurred when he had less than 50 cc of urine out for more than two to three hours and a provider should have been contacted especially when the bleeding should have subsided much sooner. RN-C stated LPN-A placed a larger sized catheter (16 F) rather than 14 F that was ordered and bleeding occurred. RN-C stated LPN-C would be expected to document in the progress notes what transpired from the insertion of the catheters and what was going on during shift change. RN-C stated no follow up had been completed since the incident, no root cause analysis, and had been done or education with the nurses involved. During a telephone interview on 7/10/24, at 8:45 a.m. medical director (MD) stated staff nurses attempted to insert three catheters and the trauma to the urethra most likely was started with the first insertion, when the wrong sized catheter 16 F was used. MD stated a catheter balloon should never be inflated until you get a flow of urine. MD stated would have been important with blood return and no urine a provider should have been notified right away, sent to ER so an evaluation could have been completed at another facility. MD verified when a resident had ongoing bleeding, on an anticoagulant, and bled for more than two hours, would be alarming and something else was going on. MD stated he would have expected more documentation from the nursing especially with low urine output and bleeding, in the medical record, to establish a time-line, and what interventions were tried. During a telephone interview on 7/10/24, at 12:48 p.m. ER supervisor RN-D verified R1 arrived in	2 830		

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2 830	Continued From page 26 ER with a 16 F catheter with no urine output and blood in bag. RN-D stated the 16 F was removed and a 5:45 a.m. another catheter was placed by the ER staff with no resistance and into a suspected false tract. RN-D stated if the false tract would have not been there previously before R1 came to ER would have most likely met up with resistance due to R1's BPH but would have then inserted directly into the bladder. RN-D stated urology PA-C was contacted and a catheter was placed with a scope and guide wire into the bladder. During an interview on 7/10/24, at 1:10 p.m. DON stated she had many conversations with both staff nurses starting from 7/1/24, at approximately 4:00 p.m. through 7/5/24, at 11:32 p.m. regarding R1. DON stated last time she had heard from RN-A was at 11:32 p.m. DON stated she arrived at the facility early the next morning on 7/2/24, asked RN-A how R1 was doing and was informed she had sent him to Emergency Room via ambulance. DON stated she would have expected to be notified R1 was sent to hospital but was not. A vulnerable adult (VA) report was not filed with the State Agency, because the nurses did follow the facility policy, processes, and procedures, except for inserting the wrong catheter size. DON stated because of the long holiday weekend she was not aware until Monday morning (7/6/24), when R1 came back from hospital, and the cat scan (CT) (computer tomography scan) showed R1 had a catheter balloon inflated in the urethra rather than the bladder. DON stated repeated catheter insertion could have raised the risk of complications such as infection and urethral damage/bleeding. DON stated an incident report should have been filed under medication error. DON verified no incident report was filed. DON also verified no	2 830		

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2 830	Continued From page 27 investigation was started prior to 7/8/24, when surveyor arrived at their facility and at that time she started reviewing the documents such as medical record and hospital visit notes. DON indicated she had talked to LPN-A on 7/8/24, in the morning after surveyor had already interviewed her and education was completed briefly about lack of documentation, checking doctor's orders more thoroughly prior to changing out of the catheter to ensure the correct size was used. DON stated she had not visited and /or provided RN-A with education since incident. DON also verified there was no internal investigation or root/cause analysis completed within the facility. During a telephone interview on 7/11/24, at 12:00 p.m. emergency care provider, osteopathic doctor (DO) (look at patients as a whole person consisting of a mind, body, and spirit, and tend to focus on preventative medicine) stated the facility inserted a Foley catheter more than once, no urine output and bleeding occurred, clearly it was placed in the wrong spot and not in the bladder. DO stated at that time most likely that was when they started the false tract. DO indicated no urine output was not due to a blood clot because they tried to flush the catheter at the facility, no urine output and only blood. DO stated we removed the Foley catheter once he arrived at ED and inserted a 3 -way catheter without resistance and only a small return of urine. DO stated this indicted there was a false tract prior to his arrival at ED. DO verified the CT scan confirmed the Foley balloon was in the penile urethra therefore suspected R1 had a false tract. DO indicted numerous insertions of a Foley catheter within 10 hours would have caused damage and a false tract when not inserted properly. DO stated the facility continued to re-insert catheters, with no urine out	2 830		

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2 830	Continued From page 28 put and bleeding, caused urethra trauma, provider was not contacted right away and should have been, which delayed care and R1 became septic with bacteria in catheter. DO indicated she believed this cause R1 harm. Review of facility policy titled Foley Catheter Insertion, Male Resident dated 2001 identified the purpose of the Foley catheter was to provide for and maintain constant urinary drainage. Verification that there was a physician order was required to identify what size Foley catheter was specified. After preparation insert the catheter gently into the meatus (end of penis) approximately five to seven inches until urine began to flow from the bladder then advance the catheter another two inches and inflate balloon with 5 cc (cubic centimeters) and removed syringe. If resistance met do not force the entry, stop the procedure, and notify supervisor. The physician would be expected to be notified of any abnormalities (i.e. bleeding, obstruction). The following information should be recorded in the resident's medical record: -date and time of procedure -name, title of individual who preformed procedure -all assessment data (e.g. character, color, clarity) obtained during the procedure -the size of the Foley catheter inserted and amount of fluid used to inflate the balloon -how resident tolerated procedure -signature and title of person recording data Facility policy titled Notification of Significant Changes dated 5/2/22, identified policy provided guidance to staff when and who to notify of a significant change in a resident's status. Definition of a significant change meant a change	2 830		

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2 830	Continued From page 29 in resident's status, a need to alter treatment, and accident results in injury, or a decision to transfer or discharge the individual receiving services from care center. The charge nurse will immediately (as indicated by the change of condition) informed the resident, consult with the physician, and notify the resident representative for the following significant change: an accident that involved the resident which results in injury and has the potential for required physician intervention, a deterioration in health, in either lift-threatening conditions or clinical complications, and decision to transfer to another provider from the care center without primary physician involvement. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could review and re-educate all staff on the policies and procedures to ensure that all residents are provided necessary care and services. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting	21995		8/5/24

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21995	Continued From page 30 internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report to the State Agency (SA) for 1 of 1 resident (R1) whose indwelling catheter was incorrectly placed three times resulting in bleeding, blood clots, pain, discomfort, low urine output, prolonged provider notification, sepsis, sent to emergency room via ambulance, and admitted to intensive care unit (ICU). Findings include: R1's quarterly Minimum Data Set (MDS) dated 5/30/24, identified severely impaired cognition and no behaviors noted. R1 had an indwelling catheter and always incontinent of bowel. R1 had a neurogenic bladder (interference of the relationship between the nervous system and bladder function and affects the way bladder functions due to injury or disease). R 1 had impairment on one side of his upper and lower body and was dependent upon staff for all cares, transfers, and repositioning. R1's hospital admission notes dated 7/2/24, indicated indwelling catheter change completed at nursing home facility last evening resulted in significant bleeding and no urine output. An attempted catheter placement in ER resulted in ongoing bleeding and no urine output. CT scan was completed and showed catheter balloon inflated in the urethra. Urology was contacted and replaced the catheter over a guidewire with cystoscopy (a hollow tube equipped with a lens inserted into urethra and slowly advanced into the	21995	Corrected by 08/05/2024	

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21995	Continued From page 31 bladder). Principle problems identified: urinary tract infection associated to indwelling catheter, sepsis with acute renal failure and septic shock, and anemia with acute blood loss from urethra (a muscular tube that conveys urine from the urinary bladder to the exterior at the end of the penis). resulting from Foley catheter placement. During an interview on 7/9/24, at 12:44 p.m. floor manager licensed practical nurse (LPN)-B stated R1 has had a history of difficult indwelling catheter attempts with scant amount of blood but would have expected the bleeding to stop within an hour. LPN-B stated on 7/1/24, LPN-A attempted to insert the wrong size catheter 16 French (F) (order was for a 14 F), larger than it should have been, and blood came through the tubing. LPN-B stated the bleeding was caused by insertion of a catheter too large and scraped his urethra. LPN-B stated along with the director of nursing (DON) we had chosen to wait to re-insert another catheter due to urethra being raw, could have caused more damage and discomfort, and allowed that area to recover. LPN-B stated there had been some harm done here, there had been damage to the urethra and he bled, required medical intervention, sent to hospital and admitted. LPN-B confirmed a vulnerable report (VA) probably should have been filed along with a facility incident report to review the entire situation and avoid it from happening again. During an interview on 7/9/24, at 2:05 p.m. floor manager registered nurse (RN)-C stated bleeding was not typical for any insertion of an indwelling catheter no matter what size it was. RN-C stated a change in condition would have been identified as less than 50 cubic centimeters (cc) of urine output an hour for more than two to three hours, blood in the urine should have subsided a lot	21995		

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21995	Continued From page 32 sooner than it did, and a provider should have been contacted from the get-go. RN-C verified no facility incident report or VA report were filed. During a telephone interview on 7/10/24, at 12:48 p.m. ER supervisor RN-D verified R1 arrived in ER with a 16 F catheter with no urine output and blood in bag. During an interview with on 7/10/24, at 1:10 p.m. director of nursing (DON) stated A vulnerable adult (VA) report was not filed with the state, the nurses followed the facility policy, processes, and procedures, except for the wrong catheter size. DON stated an incident report should have been filed under medication error. DON stated she was not aware until Monday morning (7/6/24), R1 came back from hospital and CT (computerized tomography) scan showed R1 had a catheter balloon inflated in the urethra rather than the bladder. Review of facility policy titled Maltreatment Reporting Guidelines reviewed last on 10/18/21, identified any alleged maltreatment involving neglect must be reported by the supervising employee of the building to the administrator of the care center immediately and to the Minnesota Department of Health (MDH) and other officials according to the following timelines based on severity of alleged maltreatment. Review of facility policy titled SNF (Skilled Nursing Facility) Maltreatment Investigation and Reporting dated 10/18/21, identified an initial investigation must be conducted immediately to determine what happened and whether the incident requires reporting to the Office of Health Facility Complaints (OHFC) or the Minnesota Adult Abuse Reporting Center (MAARC). A	21995		

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21995	Continued From page 33 report to OHFC must be initiated as soon as the incident is determined to be reportable. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure all staff are aware of the importance of following the facility policy for Abuse/Neglect reporting. They could establish a system to audit to ensure all allegations are properly reported in accordance with facility policy. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21995		