Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 23, 2024

Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

RE: CCN: 245618
Cycle Start Date: September 12, 2024

Dear Administrator:

On October 8, 2024, we notified you a remedy was imposed. On October 22, 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 October 22, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 23, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 8, 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 September 12, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 22, 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 Therefore, the NATCEP prohibition is rescinded.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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 23, 2024

Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

Re: Reinspection Results
Event ID: OXBQ12

Dear Administrator:

On October 22, 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 September 12, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Electronically Submitted
October 8, 2024

Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

RE: CCN: 245618
Cycle Start Date: September 12, 2024

Dear Administrator:

On September 12, 2024, survey was completed at your facility by the Minnesota Department of Health and Public Safety 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On September 7, 2024, the situation of immediate jeopardy to potential health and safety cited at F678 was removed. However, continued non-compliance remains at the lower scope and severity of E.

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 October 23, 2024.

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

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of

payment for new admissions is effective October 23, 2024, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 23, 2024, (42 CFR 488.417 (b)).

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.

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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 12, 2024. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of

alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Walker Methodist Westwood Ridge Ii is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 12, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, 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 "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Regional Operations Supervisor, 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, Licensing and Certification Program 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

Upon receipt of an acceptable ePoC, 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 approved 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 Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 12, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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 DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 8, 2024

Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

Re: State Nursing Home Licensing Orders
Event ID: OXBQ11

Dear Administrator:

The above facility was surveyed on September 4, 2024 through September 12, 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, Regional Operations Supervisor, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27996	A. BUILDING: _____ B. WING _____	C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/4/24, to 9/6/24, and 9/9/24, to 9/12/24, 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	2 000		

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

Electronically Signed | 10/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27996	A. BUILDING: _____ B. WING _____	C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaint was reviewed. H56187782C (MN00106264) As a result of the investigation, licensing orders were issued at 0265, 0830, and 1980. 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27996	A. BUILDING: _____ B. WING _____	C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	**61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	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		10/22/24

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
WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

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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 interview, and document review the facility failed to notify the physician timely for 1 of 1 resident (R1) who was recovering from neoplasm (growth of abnormal cells) bladder surgery, had pulled out their indwelling catheter and had specific orders to contact physician with change of condition. Findings include: R1's diagnoses list dated 9/5/24, identified: neoplasm of bladder, aftercare following surgery for neoplasm, acute post hemorrhagic anemia (excess bleeding), abnormal uterine and vaginal bleeding, heart failure, presence of coronary angioplasty implant and graft, diabetes mellitus (type II), history of venous thrombosis and embolism (blood clot), and gross hematuria (visible blood in urine). R1's orders from 8/27/24, through 8/29/24 included: -Code Status - Full Resuscitation order date 8/27/24. -Patient Instruction for urinary retention: If you are unable to urinate 6 to 8 hours after discharge,	2 265	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27996	A. BUILDING: _____ B. WING _____	C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 4 return to emergency room with your discharge instructions order date 8/27/24 -Discharge potential: length of stay less than 30 days order date 8/27/24. -Urology: call for any questions if your catheter is not draining well. If you begin to notice more blood or large clots. Order date 8/27/24. -Skilled Medicare charting. Document findings in progress not: Vital signs (VS), ADL (activities of daily living) functioning, pain status, neuro status, skin issues, respiratory status (especially SOB [shortness of breath] and any oxygen/CPAP used), any special care items for patient (e.g. IV, drains, etc.), and any changes in condition including hospitalizations and returns, MD (medical doctor) appointments and return. Use your nursing judgement to add pertinent additional information. Order date 8/28/24. -8/27/24, Patient instruction for Urinary Retention: If you are unable to urinate in 6-8 hours after discharge, return to Emergency Room with your discharge instructions. -8/27/24, Minnesota Urology: Call for any questions if your catheter is not draining well or if you begin to notice more blood or large clots. -8/29/24 at 11:59 p.m. replace and re-insert pulled out Foley catheter. Send patient to emergency if resistance is met. (order received after delay in contacting physician on 8/29/24, catheter never replaced, and resident never sent to emergency) R1's care plan dated 8/28/24, identified resident had Foley catheter due to bladder tumor diagnosis. Interventions directed staff to monitor/record/report to MD (medical doctor) for s/sx (signs and symptoms) of UTI (urinary tract infection): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pule, temperature, and urinary	2 265		

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	27996	A. BUILDING: _____ B. WING _____	C 09/12/2024

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2 265	Continued From page 5 frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns. R1's progress notes (PN) dated 8/27/24, through 8/29/24, identified: -on 8/27/24 at 5:23 p.m., R1 arrived at facility via EMT (emergency medical technicians) transport on w/c (wheelchair) accompanied by son. R1 was A & O x4 (alert and oriented times four), forgetfulness noted. -on 8/28/24 at 10:30 p.m., administered Acetaminophen oral tablet 500 mg (milligrams) two for sign of mild pain. -on 8/28/24 at 11:30 p.m., PRN (as needed) administration of Acetaminophen was effective, follow up pain scale was 0 out of 10. -on 8/29/24 at 1:17 a.m. replace and re-insert pulled out Foley catheter. Send patient to emergency if resistance is met. -on 8/29/24 at 6:22 a.m. R1pulled out indwelling catheter together with the water balloon that anchored it in place. Some bleeding noted, R1 was washed up and a brief was offered to patient pending an order from provider for further action. Writer put a call into provider and waited to be called back. (PN lacked detail on when R1 pulled out catheter and when call was made to provider). Later, nurse practitioner (NP)-A called back and after a thorough explanation of the situation, an order was given to re-insert catheter. R1 was approached for re-insertion but refused. Writer suspected pain and administered Tylenol then let R1 be for a while, leaving her door open for easy monitoring. At 12:30 a.m. patient was okay talking and breathing "without any sign of	2 265		

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2 265	Continued From page 6 impending doom. By around 1:00 a.m. writer saw patient lying across bed and was not responding to any stimulus and looked lifeless lying her head in vomited food and fluid with some in her mouth. Writer quickly called the other nurse who also noted that patient was lifeless and then left the room immediately. Writer then turned patient to her right side while the water was still oozing out. CNA [certified nursing assistant] then noted that patient had passage of bowel movement and quickly cleaned it. As more fluid was oozing out after the second nurse left. CNA left to go answer call light while writer let out the water in patient's mouth and raised head of bed [HOB] and went to the nursing station to check patient's code status. Have noted code status RESUSCITATION, writer dashed back and asked the other CNA for help with putting patient down and CPR initiated immediately. No time was wasted. Patient was on the floor with fluid oozing from the mouth and POLST status had to be ascertained. All these were satisfied in a short time, couple of minutes then CPR was started: 911 was called. Patient was not able to be resuscitated. Family was informed and family came and arranged funeral home. Patient has long been deposited in funeral home." During a telephone interview on 9/4/24 at 4:00 p.m., family member (FM) stated R1 had a bladder tumor and only half could be removed during the surgery because the bladder walls were very thin. FM stated the urologist wanted the urinary catheter left in place because if the bladder got too full and was not constantly draining, the bladder could rupture. FM stated R1 was to be discharged from hospital on 8/25/24 initially but had started to bleed again. FM stated once discharged from hospital they had planned on going back in a couple of weeks for the	2 265		

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2 265	Continued From page 7 remainder of the bladder tumor to be removed. FM stated he was visiting on 8/28/24 and R1 was a little sluggish, tired, refused to eat lunch and supper, which was rather odd for her. FM indicated around 6:00 p.m. R1 requested the bathroom, and he stepped out of room while staff assisted her. FM stated a few minutes later RN-A came out of the room looking flustered and informed him R1 had pulled out her urinary catheter, if they could get the bleeding under control, they would reinsert catheter and if not, she would be transferred back to the hospital. FM stated he did not get a sense that this was an everyday event, but none of the staff seemed concerned. FM indicated he had requested to be called with an update that evening, and left facility to go back home. FM stated when he had not received a call from the RN-A, at 9:15 p.m. FM he called and talked to her and was informed R1 was doing fine, but they had not gotten "a chance" to re-insert the urinary catheter. Adding, then at 1:15 a.m. he received a call from RN-A and was informed R1 was unresponsive and medical emergency had done CPR on her. FM stated RN-A had informed him they had packed a pullup with a hand towel used to prevent her from bleeding. FM express, R1 had not moved to the TCU to die, but to recover and go on to finish the rest of her surgery. During an interview on 9/4/24 at 4:40 p.m., NA-C stated between 5:30 p.m. to 6:00 p.m. she went to take R1 to the bathroom but R1 had already gotten herself up and was almost to the bathroom. NA-C stated R1 informed her she had to go bad and then noticed blood on the floor where her feet had walked through it. NA-C indicated she looked around room and noticed the urinary catheter bag hung on the side of R1's bed with tubing attached to it that was no longer	2 265		

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2 265	Continued From page 8 attached to R1. NA-C indicated she asked RN-A to assess R1 and see where the blood was coming from. NA-C stated RN-A entered R1's room as she cleaned up the drops of blood off the floor and suggested a brief be placed on R1. NA-C stated she noticed a dime sized blood clot stuck to the side of the toilet bowl when she flushed the toilet. NA-C also stated RN-A had picked up the catheter bag, held it up and looked at it. NA-C verified she was unsure as to where the blood came from, however there was approximately 300 cc of pink tinged urine in the collection bag. NA-C stated R1 appeared more confused. During a telephone interview on 9/5/24 at 11:07 a.m., RN-A stated on 8/28/24 between 6:30 p.m. and 7:00 p.m. a licensed practical nurse (LPN) informed her R1 was bleeding and she asked if it was R1 and she indicated yes. RN-A stated she immediately went to R1's room and observed her on toilet in bathroom. RN-A stated nursing assistant (NA)-A informed her R1 started to take herself to the bathroom when she entered the room, saw the catheter was pulled out with balloon still inflated and intact, and bleeding. RN-A stated she checked catheter tubing, bag, no blood identified, and approximately 250 milliliters (ml) of tea colored urine noted in collection bag. RN-A indicated this must have caused R1 some trauma, but she denied pain. RN-A confirmed there was a small amount of blood in the toilet. RN-A verified at 7:00 p.m. she instructed the NA to place a brief on R1 and indicated she would contact the provider for instruction possibly re-insert the catheter or send R1 to the ER. RN-A stated she decided to wait to call provider because she had to check another resident's orders, complete a wound dressing changed, and finish up with her medication pass, so it was later	2 265		

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2 265	Continued From page 9 in the evening when she placed a call to the on-call provider. RN-A indicated she had to leave a message and when the NP-A called her back she informed her that R1 pulled out her catheter, no additional bleeding noted, and was resting in bed. RN-A indicated she asked NP-A what she should do and received an order to re-insert catheter now as she must have one in. RN-A stated she informed NP-A there was trauma and suggested R1 be sent to the ER, as she was concerned if she reinserted the catheter, it could possibly push a blood clot back into R1's bladder. RN-A indicted NP-A provided an order: re-insert and if resistance was met, send to ER. RN-A stated she entered the order into the electronic health record (order shows it was entered at 1:17 a.m. 8/29/24 after R1's passing in record) and finished a few other things, then went to R1's room. RN-A stated R1 refused to have catheter re-inserted and denied pain. RN-A stated she returned to R1's room at 12:30 a.m. and again she refused re-insertion of the catheter, so she finished up a few things and was then was going to call 911 and send her to the ER. RN-A stated at 1:00 a.m. she noticed R1 was laying across her bed with her feet on the floor, so she quickly went to room 301 and got NA-B (without assessing R1). RN-A stated both staff entered R1's room and she was lifeless, quiet, and body was still warm. RN-A verified with RN-B, no heartbeat, no respirations, and unresponsive. During a follow up interview via telephone on 9/6/24 at 12:11 p.m., RN-A stated called the on-call provider around 9:00 p.m., passed medications around that time also, time was not checked when she called back or documented in progress notes. RN-A stated was extremely busy that evening, resident with wound dressing change, new admission, and administered	2 265		

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2 265	Continued From page 10 medications. RN-A stated DON was there, indicated those tasks needed to be completed first, wound cares around 8:30 p.m. and informed DON there was the whole night to get that catheter placed back in and DON indicated that was ok. RN-A stated she wanted R1 to have time to calm down, when catheter was pulled out sometimes it was hard on the resident especially when the balloon was still intact, and again stated she was in no hurry to contact provider. RN-A verified she did not document assessments completed as she was too busy, and no noted changes. RN-A indicated she was unsure what she told the triage and on-call provider but told them only what they asked for and they should have asked for more information. RN-A did confirm she should have told provide the catheter had been out for hours prior to the call, past medical history of bleeding and recent bladder surgery. RN-A stated the order that was given indicated to contact provider back if resistance was met and that did not happen because R1 refused. RN-A indicated she planned on sending R1 into ER but had medications to administer to other residents first. During a telephone interview on 9/6/24 at 9:24 a.m., on call NP-A stated RN-A first contacted triage on 8/28/24 at 10:02 p.m. (approximately 4 hours after R1 pulled out her catheter) NP-A indicated she had returned the call to RN-A on 8/28/24 at 10:16 p.m. NP-A verified RN-A had informed the triage nurse R1 had a recent bladder resection, pulled out indwelling catheter, bleeding had stopped, blood only noted when the peri area was wiped, and wore incontinent product. NP-A stated RN-A asked if R1's catheter could be replaced. NP-A stated the conversation was very short with triage nurse and was surprised she had not provided more information.	2 265		

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2 265	Continued From page 11 NP-A stated she was the overnight on call provider and relied on what the nurse told the triage nurse. NP-A also stated the responsibility/burden lied with RN-A to have explained the situation to the triage nurse such as her history of bleeding issues. NP-A indicated she was not made aware R1 had gross hematuria (visible blood in the urine), anemia with Hgb of 5.9 g/dL, and a bladder tumor. NP-A stated she had given RN-A orders to replace, and re-insert pulled out Foley catheter and send to emergency if resistance was met. NP-A verified R1 had been seen earlier in the day by her primary provider NP-B. NP-A stated after R1 refused to have the catheter reinserted that would have fallen under an identified problem and would have expected RN-A to have called back right away with an update, re-assessed, and would have sent to emergency room to be assessed. NP-A verified she was not aware R1 had been without the catheter for over 4 hours, and was not contacted by RN-A after their initial conversation at 10:16 p.m. During an interview on 9/6/24 at 10:49 a.m., primary provider NP-B stated she would have expected RN-A to have sent R1 into the emergency room (ER) or call triage back when unable to reinsert the urinary catheter. NP-B indicated R1 just had a huge surgery and we wanted to avoid urinary retention. NP-B stated had seen R1 the morning of 8/28/24 around 9:00 a.m. to 10:00 a.m. while she made rounds at the facility. NP-B stated she was informed by physical therapy R1 was fatigued and confused. NP-B indicated she was surprised R1 had died. During an interview on 9/6/24 at 2:20 p.m., director of nursing (DON) indicated she was at the facility later that evening but was unable to	2 265		

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2 265	Continued From page 12 provide an approximate time she was onsite. DON stated prior to leaving the facility later during the p.m. shift on 8/28/24, she was made aware by RN-A and R1's son of R1's indwelling catheter being pulled out. DON stated she informed R1's son the provider would be contacted to get direction on what to do, and he requested a follow up call once that was completed. DON informed RN-A R1's son requested an update once provider was contacted. DON verified during the facility's investigation following R1's death, RN-A verified she contacted the provider, but no time was provided, and the facility did not ask for a specific time. DON indicated she would have expected RN-A to contact the provider immediately and follow the orders due to history of bladder cancer, recent bladder surgery. DON stated it was unknown if R1's bladder was empty or full due to a lack of assessment by RN-A, and she would have expected RN-A to have completed and documented abdominal assessments, bladder scans, output, and ongoing monitoring to demonstrate R1's nursing care needs were being met and she was not having a change in condition. DON stated she would have expected RN-A to have followed up with the provider as soon as possible to update the provider on R1's refusal for re-insertion along with her assessment information and to received further direction and orders. DON indicated it may had been concerning to have R1's catheter out over six hours with her history of current bladder surgery but was unable to determine without the assessments having been completed. DON stated she did not delegate as to what steps RN-A should have taken or prioritized during her shift. DON indicated RN-A was expected to ask for help if needed and communicate that to her. During an interview on 9/9/24 at 4:30 p.m.,	2 265		

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2 265	Continued From page 13 administrator stated he would have expected RN-A to follow up with the provider to get the order timely. Administrator also stated if R1 had any resistance and/or refused re-insertion, R1 should have been sent to the hospital and was not sure why Tylenol and monitoring was the plan of care when that was not what the physician's order stated. During a telephone interview on 9/6/24 at 5:00 p.m., medical director (MD) stated would not be concerned with R1's history when catheter was out over six hours and there was no doubt the staff nurse should have contacted the provider timely and updated her when R1 refused to have catheter re-inserted and along with following providers orders. Facility policy Change in Resident Condition dated 8/18/21, identified physicians will be notified of acute changes in a resident's condition in health include but not limited to: bowel and bladder continence and refusal of treatment as soon as possible. Notifications to physicians/NP (nurse practitioners) and condition changes would be documented in progress notes in medical record. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures to assure the resident's physician is notified of significant change in a resident's condition and/or the need to alter treatment and educate staff on these requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One	2 265		

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2 265	Continued From page 14 (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 provide the necessary care and services for 1 of 3 residents who was recovering from bladder surgery, had pulled out their indwelling catheter and the provider was not contacted timely, provider orders to replace catheter or send to Emergency Department were not followed and ongoing assessment and monitoring for bladder retention, bleeding, or change of condition were not completed. Findings include: R1's diagnoses list dated 9/5/24, identified: neoplasm (growth of abnormal cells) of bladder, aftercare following surgery for neoplasm, acute post hemorrhagic anemia (excess bleeding),	2 830	Corrected	10/22/24

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2 830	Continued From page 15 abnormal uterine and vaginal bleeding, heart failure, presence of coronary angioplasty implant and graft, diabetes mellitus (type II), history of venous thrombosis and embolism (blood clot), and gross hematuria (visible blood in urine). R1's orders from 8/27/24, through 8/29/24 included: -Code Status - Full Resuscitation order date 8/27/24. -Patient Instruction for urinary retention: If you are unable to urinate 6 to 8 hours after discharge, return to emergency room with your discharge instructions order date 8/27/24 -Discharge potential: length of stay less than 30 days order date 8/27/24. -Urology: call for any questions if your catheter is not draining well. If you begin to notice more blood or large clots. Order date 8/27/24. -Skilled Medicare charting. Document findings in progress not: Vital signs (VS), ADL (activities of daily living) functioning, pain status, neuro status, skin issues, respiratory status (especially SOB [shortness of breath] and any oxygen/CPAP used), any special care items for patient (e.g. IV, drains, etc.), and any changes in condition including hospitalizations and returns, MD (medical doctor) appointments and return. Use your nursing judgement to add pertinent additional information. Order date 8/28/24. -8/27/24, Patient instruction for Urinary Retention: If you are unable to urinate in 6-8 hours after discharge, return to Emergency Room with your discharge instructions.	2 830		

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2 830	Continued From page 16 -8/27/24, Minnesota Urology: Call for any questions if your catheter is not draining well or if you begin to notice more blood or large clots. -8/29/24 at 11:59 p.m. replace and re-insert pulled out Foley catheter. Send patient to emergency if resistance is met. (order received after delay in contacting physician on 8/29/24, catheter never replaced, and resident never sent to emergency) R1's care plan dated 8/28/24, identified resident had Foley catheter due to bladder tumor diagnosis. Interventions directed staff to monitor/record/report to MD (medical doctor) for s/sx (signs and symptoms) UTI (urinary tract infection): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pule, temperature, and urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns. R1's progress notes (PN) dated 8/27/24, through 8/29/24, identified: -on 8/27/24 at 5:23 p.m., R1 arrived at facility via EMT (emergency medical technicians) transport on w/c (wheelchair) accompanied by son. R1 was A & O x4 (alert and oriented times four), forgetfulness noted. -on 8/28/24 at 10:30 p.m., administered Acetaminophen oral tablet 500 mg (milligrams) two for sign of mild pain. -on 8/28/24 at 11:30 p.m., PRN (as needed) administration of Acetaminophen was effective, follow up pain scale was 0 out of 10.	2 830		

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2 830	Continued From page 17 -on 8/29/24 at 1:17 a.m. replace and re-insert pulled out Foley catheter. Send patient to emergency if resistance is met. -on 8/29/24 at 6:22 a.m. R1 pulled out indwelling catheter together with the water balloon that anchored it in place. Some bleeding noted, R1 was washed up and a brief was offered to patient pending an order from provider for further action. Writer put a call into provider and waited to be called back. (PN lacked detail on when R1 pulled out catheter and when call was made to provider). Later, nurse practitioner (NP)-A called back and after a thorough explanation of the situation, an order was given to re-insert catheter. R1 was approached for re-insertion but refused. Writer suspected pain and administered Tylenol then let R1 be for a while, leaving her door open for easy monitoring. At 12:30 a.m. patient was okay talking and breathing "without any sign of impending doom. By around 1:00 a.m. writer saw patient lying across bed and was not responding to any stimulus and looked lifeless lying her head in vomited food and fluid with some in her mouth. Writer quickly called the other nurse who also noted that patient was lifeless and then left the room immediately. Writer then turned patient to her right side while the water was still oozing out. CNA [certified nursing assistant] then noted that patient had passage of bowel movement and quickly cleaned it. As more fluid was oozing out after the second nurse left. CNA left to go answer call light while writer let out the water in patient's mouth and raised head of bed [HOB] and went to the nursing station to check patient's code status. Have noted code status RESUSCITATION, writer dashed back and asked the other CNA for help with putting patient down and CPR initiated immediately. No time was wasted. Patient was on	2 830		

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2 830	Continued From page 18 the floor with fluid oozing from the mouth and POLST status had to be ascertained. All these were satisfied in a short time, couple of minutes then CPR was started: 911 was called. Patient was not able to be resuscitated. Family was informed and family came and arranged funeral home. Patient has long been deposited in funeral home." R1's medication administration record for month of November 2024 identified acetaminophen oral tablet 500 mg two tablets by mouth every 6 hours as needed for mild pain was administered to R1 on 9/28/24 at 10:30 p.m. and pain level determined was 4 out of 10 (a numerical scale ranging from zero to 10: zero indicates no pain and 10 represents pain so severe that an individual loses consciousness). R1's treatment administration record (TAR) documentation of urinary output entered per shift (a.m. 0700-1500, p.m. 1500-2300, night shift 2300-0700). -8/27/24 evening output 350 cubic centimeters (cc) and night output 700 cc. -8/28/24 evening output 500 cc and night output 300 cc. R1's electronic medical record did not identify R1's urinary output on 8/28/24 day shift. NP-B visit note dated 8/28/24, identified R1's advanced directives: Full Code. R1 had been hospitalized from 8/18/24, through 8/27/24, due to vaginal bleeding and concern for urinary source bleeding which resulted in increasing lightheadedness, dyspnea (shortness of breath), and a low hemoglobin 5.9 hemoglobin (Hgb)	2 830		

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2 830	Continued From page 19 grams per deciliter (g/dL) (normal range 11.5 to 15). R1 received two units of red packed blood cells (RBC) upon admission and Hgb improved to 7.9, 8.4, and 8.3. On 8/21/24, R1 underwent D & C (dilation and curettage) (removed tissue from uterus), cystoscopy with fulguration of vessels (heat derived from an electrical current to destroy atypical /cancer tissue), and 50% removal of the bladder tumor. Additionally, on 8/22/24, R1 had an inferior vena cava filter placed due to unable to restart anticoagulant. R1 had an indwelling foley catheter placed to have remained in while at TCU. R1 was seen today 8/29/24, for an admission visit in the TCU. R1 had just finished up therapy and reported she was worn out. Appetite fair and no further bleeding. R1's vital signs 107/67, 97.3 Fahrenheit (F), pulse 86 per minute, 16 breathes per minute, and oxygen saturation level (Sa02) 98% (normal range 90 to 100%). R1's last Hgb on 8/27/24, was 8.9 g/dL. During a telephone interview on 9/4/24 at 4:00 p.m., family member (FM) stated R1 had a bladder tumor and only half could be removed during the surgery because the bladder walls were very thin. FM stated the urologist wanted the urinary catheter left in place because if the bladder got too full and was not constantly draining, the bladder could rupture. FM stated R1 was to be discharged from hospital on 8/25/24 initially but had started to bleed again. FM stated once discharged from hospital they had planned on going back in a couple of weeks for the remainder of the bladder tumor to be removed. FM stated he was visiting on 8/28/24 and R1 was a little sluggish, tired, refused to eat lunch and supper, which was rather odd for her. FM indicated around 6:00 p.m. R1 requested the bathroom, and he stepped out of room while staff assisted her. FM stated a few minutes later RN-A	2 830		

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2 830	Continued From page 20 came out of the room looking flustered and informed him R1 had pulled out her urinary catheter, if they could get the bleeding under control, they would reinsert catheter and if not, she would be transferred back to the hospital. FM stated he did not get a sense that this was an everyday event, but none of the staff seemed concerned. FM indicated he had requested to be called with an update that evening, and left facility to go back home. FM stated when he had not received a call from the RN-A, at 9:15 p.m. FM he called and talked to her and was informed R1 was doing fine, but they had not gotten "a chance" to re-insert the urinary catheter. Adding, then at 1:15 a.m. he received a call from RN-A and was informed R1 was unresponsive and medical emergency had done CPR on her. FM stated RN-A had informed him they had packed a pullup with a hand towel used to prevent her from bleeding. FM express, R1 had not moved to the TCU to die, but to recover and go on to finish the rest of her surgery. During an interview on 9/4/24 at 4:40 p.m., NA-C stated between 5:30 p.m. to 6:00 p.m. she went to take R1 to the bathroom but R1 had already gotten herself up and was almost to the bathroom. NA-C stated R1 informed her she had to go bad and then noticed blood on the floor where her feet had walked through it. NA-C indicated she looked around room and noticed the urinary catheter bag hung on the side of R1's bed with tubing attached to it that was no longer attached to R1. NA-C indicated she asked RN-A to assess R1 and see where the blood was coming from. NA-C stated RN-A entered R1's room as she cleaned up the drops of blood off the floor and suggested a brief be placed on R1. NA-C stated she noticed a dime sized blood clot stuck to the side of the toilet bowl when she	2 830		

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2 830	Continued From page 21 flushed the toilet. NA-C also stated RN-A had picked up the catheter bag, held it up and looked at it. NA-C verified she was unsure as to where the blood came from, however there was approximately 300 cc of pink tinged urine in the collection bag. NA-C stated R1 appeared more confused. During a telephone interview on 9/5/24 at 11:07 a.m., RN-A stated on 8/28/24 between 6:30 p.m. and 7:00 p.m. a licensed practical nurse (LPN) informed her R1 was bleeding and she asked if it was R1 and she indicated yes. RN-A stated she immediately went to R1's room and observed her on toilet in bathroom. RN-A stated nursing assistant (NA)-A informed her R1 started to take herself to the bathroom when she entered the room, saw the catheter was pulled out with balloon still inflated and intact, and bleeding. RN-A stated she checked catheter tubing, bag, no blood identified, and approximately 250 milliliters (ml) of tea colored urine noted in collection bag. RN-A indicated this must have caused R1 some trauma, but she denied pain. RN-A confirmed there was a small amount of blood in the toilet. RN-A verified at 7:00 p.m. she instructed the NA to place a brief on R1 and indicated she would contact the provider for instruction possibly re-insert the catheter or send R1 to the ER. RN-A stated she decided to wait to call provider because she had to check another resident's orders, complete a wound dressing changed, and finish up with her medication pass, so it was later in the evening when she placed a call to the on-call provider. RN-A indicated she had to leave a message and when the NP-A called her back she informed her that R1 pulled out her catheter, no additional bleeding noted, and was resting in bed. RN-A indicated she asked NP-A what she should do and received an order to re-insert	2 830		

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2 830	Continued From page 22 catheter now as she must have one in. RN-A stated she informed NP-A there was trauma and suggested R1 be sent to the ER, as she was concerned if she reinserted the catheter, it could possibly push a blood clot back into R1's bladder. RN-A indicted NP-A provided an order: re-insert and if resistance was met, send to ER. RN-A stated she entered the order into the electronic health record (order shows it was entered at 1:17 a.m. 8/29/24 after R1's passing in record) and finished a few other things, then went to R1's room. RN-A stated R1 refused to have catheter re-inserted and denied pain. RN-A stated she returned to R1's room at 12:30 a.m. and again she refused re-insertion of the catheter, so she finished up a few things and was then was going to call 911 and send her to the ER. RN-A stated at 1:00 a.m. she noticed R1 was laying across her bed with her feet on the floor, so she quickly went to room 301 and got NA-B (without assessing R1). RN-A stated both staff entered R1's room and she was lifeless, quiet, and body was still warm. RN-A verified with RN-B, no heartbeat, no respirations, and unresponsive. During a follow up interview via telephone on 9/6/24 at 12:11 p.m., RN-A stated called the on-call provider around 9:00 p.m., passed medications around that time also, time was not checked when she called back or documented in progress notes. RN-A stated was extremely busy that evening, resident with wound dressing change, new admission, and administered medications. RN-A stated DON was there, indicated those tasks needed to be completed first, wound cares around 8:30 p.m. and informed DON there was the whole night to get that catheter placed back in and DON indicated that was ok. RN-A stated she wanted R1 to have time to calm down, when catheter was pulled out	2 830		

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2 830	Continued From page 23 sometimes it was hard on the resident especially when the balloon was still intact, and again stated she was in no hurry to contact provider. RN-A verified she did not document assessments completed as she was too busy, and no noted changes. RN-A indicated she was unsure what she told the triage and on-call provider but told them only what they asked for and they should have asked for more information. RN-A did confirm she should have told provide the catheter had been out for hours prior to the call, past medical history of bleeding and recent bladder surgery. RN-A stated the order that was given indicated to contact provider back if resistance was met and that did not happen because R1 refused. RN-A indicated she planned on sending R1 into ER but had medications to administer to other residents first. During a telephone interview on 9/6/24 at 9:24 a.m., on call NP-A stated RN-A first contacted triage on 8/28/24 at 10:02 p.m. (approximately 4 hours after R1 pulled out her catheter) NP-A indicated she had returned the call to RN-A on 8/28/24 at 10:16 p.m. NP-A verified RN-A had informed the triage nurse R1 had a recent bladder resection, pulled out indwelling catheter, bleeding had stopped, blood only noted when the peri area was wiped, and wore incontinent product. NP-A stated RN-A asked if R1's catheter could be replaced. NP-A stated the conversation was very short with triage nurse and was surprised she had not provided more information. NP-A stated she was the overnight on call provider and relied on what the nurse told the triage nurse. NP-A also stated the responsibility/burden lied with RN-A to have explained the situation to the triage nurse such as her history of bleeding issues. NP-A indicated she was not made aware R1 had gross hematuria	2 830		

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2 830	Continued From page 24 (visible blood in the urine), anemia with Hgb of 5.9 g/dL, and a bladder tumor. NP-A stated she had given RN-A orders to replace, and re-insert pulled out Foley catheter and send to emergency if resistance was met. NP-A verified R1 had been seen earlier in the day by her primary provider NP-B. NP-A stated after R1 refused to have the catheter reinserted that would have fallen under an identified problem and would have expected RN-A to have called back right away with an update, re-assessed, and would have sent to emergency room to be assessed. NP-A verified she was not aware R1 had been without the catheter for over 4 hours, and was not contacted by RN-A after their initial conversation at 10:16 p.m. During an interview on 9/6/24 at 10:49 a.m., primary provider NP-B stated she would have expected RN-A to have sent R1 into the emergency room (ER) or call triage back when unable to reinsert the urinary catheter. NP-B indicated R1 just had a huge surgery and we wanted to avoid urinary retention. NP-B stated had seen R1 the morning of 8/28/24 around 9:00 a.m. to 10:00 a.m. while she made rounds at the facility. During an interview on 9/6/24 at 2:20 p.m., director of nursing (DON) indicated she was at the facility later that evening but was unable to provide an approximate time she was onsite. DON stated prior to leaving the facility later during the p.m. shift on 8/28/24, she was made aware by RN-A and R1's son of R1's indwelling catheter being pulled out. DON stated she informed R1's son the provider would be contacted to get direction on what to do, and he requested a follow up call once that was completed. DON informed RN-A R1's son requested an update once	2 830		

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2 830	Continued From page 25 provider was contacted. DON verified during the facility's investigation following R1's death, RN-A verified she contacted the provider, but no time was provided, and the facility did not ask for a specific time. DON indicated she would have expected RN-A to contact the provider immediately and follow the orders due to history of bladder cancer, recent bladder surgery. DON stated it was unknown if R1's bladder was empty or full due to a lack of assessment by RN-A, and she would have expected RN-A to have completed and documented abdominal assessments, bladder scans, output, and ongoing monitoring to demonstrate R1's nursing care needs were being met and she was not having a change in condition. DON stated she would have expected RN-A to have followed up with the provider as soon as possible to update the provider on R1's refusal for re-insertion along with her assessment information and to received further direction and orders. DON indicated it may had been concerning to have R1's catheter out over six hours with her history of current bladder surgery but was unable to determine without the assessments having been completed. DON stated she did not delegate as to what steps RN-A should have taken or prioritized during her shift. DON indicated RN-A was expected to ask for help if needed and communicate that to her. During an interview on 9/9/24 at 4:30 p.m., administrator stated he would have expected RN-A to follow up with the provider to get the order timely. Administrator also stated if R1 had any resistance and/or refused re-insertion, R1 should have been sent to the hospital and was not sure why Tylenol and monitoring was the plan of care when that was not what the physician's order stated. Administrator added, she was unable to speak to RN-A's judgment, but if RN-A	2 830		

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2 830	Continued From page 26 indicated she monitored R1 then she would have expected documentation of that monitoring to be completed. Administrator stated monitoring this resident would have been important due to their acuteness when admitted to the facility. Administrator also stated RN-A did not demonstrate critical thinking regarding necessary care and treatment R1 was ordered and required and it was unfortunate but was unsure if that would have changed the outcome. During a telephone interview on 9/6/24 at 5:00 p.m. medical director (MD) stated the nurse should have completed assessments and bladder scans to helped determined if R1's bladder was full. MD stated no doubt the staff nurse should have contacted the provider and updated her when R1 refused to have catheter re-inserted and providers orders were not followed. MD stated there were some bad nursing decisions made regarding R1's care here. During a telephone interview on 9/10/24 at 3:20 p.m. medical doctor/urologist (MDU) stated R1 was diagnosed with bladder cancer with a very large tumor that occupied half of her bladder. MDU also stated R1 had bled for one month prior to her diagnosis and became very anemic. MDU verified on 8/20/24, he removed half of the R1's tumor, hospitalized for seven days, and was stable enough when discharged to TCU with an indwelling urinary catheter. MDU stated R1's son had informed him she had pulled out her catheter at the TCU prior to her death. It would have been important to have kept the urinary catheter in place due to the large resection of the bladder tumor, a very thin bladder, and history of bleeding that resulted in a Hgb of 5.9. MDU added, it would have also been important for nursing to monitor, assess, and document R1's urinary output	2 830		

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2 830	Continued From page 27 amount and color of urine. MDU stated R1's bladder cancer extended into the neck of the bladder, when the catheter was pulled out, and the balloon remained intact, that could have caused bleeding, which in turn, could have caused R1's bladder to ruptured if she had urinary retention. MDU stated R1 most likely had something going on earlier in the day and could have been a DVT/PE (blood clots) or cardiac issues, ultimately, we do not know, but her death was unexpected. Facility policy Nursing Assessments dated 11/28/16, identified licensed nurses would conduct initial and periodic comprehensive, standardized, and accurate reproducible assessments for each resident's functional status and should contain sufficient information related to the resident's condition. In addition to direct observation and communication with the resident licensed nurses will use a variety of other sources and may include discussions with physicians and review of the clinical record. Facility policy Change in Resident Condition dated 8/18/21, identified physicians will be notified of acute changes in a resident's condition in health include but not limited to: bowel and bladder continence and refusal of treatment as soon as possible. Notifications to physicians/NP (nurse practitioners) and condition changes would be documented in progress notes in medical record. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could assure that policies are reviewd, revised as necessary, staff are trained and monitored to assure all residens with an indwelling urinary catheter receive nursing care and treatment,	2 830		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 28 personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a	21980		10/22/24

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	27996	A. BUILDING: _____ B. WING _____	C 09/12/2024

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21980	Continued From page 29 reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to immediately report to the state agency (SA) when a provider orders for life sustaining treatment (POLST) and cardiopulmonary resuscitation was not initiated timely, as per the resident wishes for 1 of 1 resident (R1) reviewed for neglect. Findings include: R1's diagnoses' list dated 9/5/24, identified: neoplasm (growth of abnormal cells) of bladder, aftercare following surgery for neoplasm, acute post hemorrhagic anemia (excess bleeding), abnormal uterine and vaginal bleeding, heart failure, presence of coronary angioplasty implant and graft, diabetes mellitus (type II), history of	21980	Corrected	

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21980	Continued From page 30 venous thrombosis and embolism (blood clot), and gross hematuria (visible blood in urine). R1's Provider Orders for Life-Sustaining Treatment (POLST) prepared and signed by healthcare agent/son on 8/27/24 (box checked: patient has capacity), and signed by provider on 8/28/24, identified: Attempt resuscitation/CPR (cardiac pulmonary resuscitation) (NOTE: selecting this requires selecting "Full Treatment" in section B). Section B Full Treatment. Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments. R1's orders from 8/27/24, through 8/29/24 included: -Code Status - Full Resuscitation order date 8/27/24. The facility's Incident Report submitted to the State Agency (SA) on 8/29/24 at 9:44 p.m., identified incident occurred on 8/29/24 at 1:00 a.m., administrator was notified of incident on 8/29/24 at 2:36 a.m. Nursing staff noted R1 had cessation of pulse and respirations on the morning of 8/29/24 at 1:00 a.m. The timeline of events from nurse progress notes were not conclusive as to when CPR (Cardiac pulmonary resuscitation) was initiated. Registered Nurse (RN)-A was suspended pending further investigation. Investigation was started. The SA was notified of the facility's failure to provide CPR timely 20 hours and 44 minutes after the facility (RN-A) suspected R1 was neglected. The facility's investigation submitted to the MDH	21980		

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21980	Continued From page 31 on 9/6/24 at 9:17 a.m., identified this was an isolated incident, resident expired. The facility findings were inconclusive due to inconsistencies with staff statements and inability to establish and verify timeline of events. The resident's primary nurse resigned from her position effective immediately 8/30/24. Review of West St. Paul Police Incident Report with a creation date and time of 8/29/24 at 5:43 a.m. revealed the following: "[RN-B] was agitated and noted that [R1] had been unconscious for an extended period and that [RN-A] had failed to provide or render proper aid for an extended period. [RN-B] alleged that [R1] had been unconscious since midnight, approximately one hour before the call for service. [RN-B] was upset and contacted the state because of the neglect. I spoke with Mhealth's supervisor, who noted he asked [RN-B] if she had contacted first responders to assist with the medical, and she said she had not because it was not her patient. I spoke with [RN-A], who noted she was in [R1]'s room around 00:40. Around 01:00, she walked past the room and saw [R1] lying across the bed, so she entered the room to assist her. [RN-A] found another employee to help with moving [R1] when she realized she had been vomiting. [RN-A] ran and found [RN-B] and advised her of the situation. [RN-B] followed her to the room and eventually left. [RN-A] saw food in [R1]'s mouth, so she moved her to the floor to begin to render aid. While speaking with [RN-A], [RN-B] approached and began to allege she was lying about what had occurred. I separated the two and asked [RN-B] to provide us with some privacy. After speaking with [RN-A], I found [RN-B] and learned the following: anytime the facility has a death, nurses will request a second nurse to verify the information. This includes checking the	21980		

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21980	Continued From page 32 heart, checking the pupils, and confirming the individual is deceased. [RN-A] called [RN-B] to the room at 00:30 hours, where she checked the pulse and pupils. [R1] showed no pupillary response and had no heartbeat; however, she was still warm. [RN-B] asked if this was an expected death, which is frequent due to the facility's nature, and [RN-A] advised it was. [RN-A] and the nursing assistant began straining the body and cleaning the bed. Around 01:00, [RN-A] asked for the nursing assistants help, entered [R1]'s room, and began to perform CPR. According to [RN-B], before requesting the nursing assistant to perform aid, there were no resuscitation attempts, and aid took 35 minutes before [RN-A] began to render assistance. But there should have been. [RN-B] stated she tried to contact management, but they had not contacted her, and she needed to contact the state within two hours since Jean was a vulnerable adult. Medics continued to render assistance, but [R1] was eventually declared deceased at 01:47 hours ...Due to the neglect and serious allegations, I contacted on-duty investigators and informed them of the situation. I also called the Hennepin County Coroner's Office and explained the situation. They said they would not respond to the location based on what they had learned. During interview on 9/10/24 at 11:52 a.m. DON stated she received noticed of the incident on 8/29/24 around 1:00 a.m. DON indicated per our facility policy all alleged violations are immediately reported to the community's administrator. DON stated at the time of the incident the RN that worked that night reported there were no concerns regarding delayed CPR. DON indicated it was not until after all of the statements were received that there were concerns related to	21980		

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21980	Continued From page 33 timeliness and initiation of CPR and then it was reported to the MDH at that time. During an interview on 9/9/24 at 4:30 p.m., administrator stated he was notified on 8/29/24 at 1:36 a.m., about the incident with R1. Administrator indicated the report was filed with the SA with a time stamp of 8/29/24 at 9:44 p.m. Administrator indicated after the incident happened R1's progress noted were reviewed and there were no concerns of timelessness and once the night shift staff statements were gathered and completed, we felt it was reportable. Administrator stated there was no delay as far as he could see. Review of facility policy Vulnerable Adult Abuse Prevention Plan and Suspicion of a Crime Reporting dated 3/15/23, identified definition of neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident(s) that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility was aware of or should have been aware of good or services that a resident(s) required but facility failed to provide them to the resident, that have resulted in or may result in physical harm, pain, mental anguish, or emotional stress. Employees must report a reasonable suspicion of a crime by email, fax, or telephone, committed against any resident to the MDH (Minnesota Department of Health) OHFC and to local law enforcement immediately but not later than two hours after forming suspicion if the events resulted in serious bodily injury which means injury involving extreme physical pain; substantial risk of death; protracted loss or impairment of the function of a bodily member, organ, or mental faculty; required medical intervention such as	21980		

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21980	Continued From page 34 surgery, hospitalization, or physical rehabilitation; or an injury that resulted from criminal sexual abuse. SUGGESTED METHOD OF CORRECTION: The administrator and/or designee could review the facility polices in regards to reporting of allegations of abuse to the State Agency. The administrator and/or designee could educate staff on ensuring reports are submitted in a timely manner. The administrator or designee could routinely monitor to ensure reports are submitted in a timely manner. Suggested Date of Correction: Twenty One (21) days	21980		

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F 000	INITIAL COMMENTS On 9/4/24, to 9/6/24, and 9/9/24, to 9/12/24, 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. H56187782C (MN00106264) with deficiencies cited at F678. As a result of the investigation, additional deficiencies were cited at F580, F609, F684. The survey resulted in an Immediate Jeopardy (IJ) at F678 when the facility failed to follow resident wishes for cardiac pulmonary resuscitation (CPR), failed to follow Orders for Life Sustaining Treatment (POLST) and did not initiate CPR timely, as per the resident's wishes. On 9/6/24, at 5:15 p.m. the administrator and director of nursing (DON) were notified of the IJ situation. The facility implemented corrective action during the onsite investigation, therefore the IJ was removed on 9/7/24, when the majority of the staff had been re-educated and plans had been implemented for education for the remaining staff and the CPR policy had been revised. The noncompliance remained at the lower pattern scope and severity level of E, and no actual harm with potential for more than minimal harm that is not immediate jeopardy. The above findings constituted substandard quality of care, and an extended survey was conducted on 9/9/24, through 9/12/24.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/17/2024

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.

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F 000	Continued From page 1 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; (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)	F 580		10/22/24

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F 580	Continued From page 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 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to notify the physician timely for 1 of 1 resident (R1) who was recovering from neoplasm (growth of abnormal cells) bladder surgery, had pulled out their indwelling catheter and had specific orders to contact physician with change of condition. Findings include: R1's diagnoses list dated 9/5/24, identified: neoplasm of bladder, aftercare following surgery for neoplasm, acute post hemorrhagic anemia	F 580	The resident affected by the deficient practice is deceased. For other residents, the facility staff will notify the resident's PCP and designated representative with any noted change of condition. This includes licensed staff updating the physician/nurse practitioner when a change of condition is identified. Licensed staff will also contact the designated representative with any significant change in condition. 911 will be activated, if given the order to by a physician or if the	

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F 580	Continued From page 3 (excess bleeding), abnormal uterine and vaginal bleeding, heart failure, presence of coronary angioplasty implant and graft, diabetes mellitus (type II), history of venous thrombosis and embolism (blood clot), and gross hematuria (visible blood in urine). R1's orders from 8/27/24, through 8/29/24 included: -Code Status - Full Resuscitation order date 8/27/24. -Patient Instruction for urinary retention: If you are unable to urinate 6 to 8 hours after discharge, return to emergency room with your discharge instructions order date 8/27/24 -Discharge potential: length of stay less than 30 days order date 8/27/24. -Urology: call for any questions if your catheter is not draining well. If you begin to notice more blood or large clots. Order date 8/27/24. -Skilled Medicare charting. Document findings in progress not: Vital signs (VS), ADL (activities of daily living) functioning, pain status, neuro status, skin issues, respiratory status (especially SOB [shortness of breath] and any oxygen/CPAP used), any special care items for patient (e.g. IV, drains, etc.), and any changes in condition including hospitalizations and returns, MD (medical doctor) appointments and return. Use your nursing judgement to add pertinent additional information. Order date 8/28/24. -8/27/24, Patient instruction for Urinary Retention: If you are unable to urinate in 6-8 hours after discharge, return to Emergency Room with your discharge instructions. -8/27/24, Minnesota Urology: Call for any questions if your catheter is not draining well or if you begin to notice more blood or large clots. -8/29/24 at 11:59 p.m. replace and re-insert	F 580	situation warrants immediate action. All residents who have a change in their condition will be audited to ensure appropriate action was taken. Appropriate action includes notification to the medical provider, resident representative, and that the provider orders were followed. Facility nursing staff will be educated on the policy "Change in Resident Condition." This includes notifying the resident's physician or nurse practitioner immediately when a change in the resident's condition is noted. This includes but is not limited to resident signs, symptoms, and laboratory values suggestive of acute illness needing immediate assessment when identified. Staff will also be educated that 911 may be activated before physician/nurse practitioner notification if there is a delay in response and/or the situation warrants immediate action. Education for this policy be completed by 10/22/2024 for all nursing staff. Facility audits will be conducted on five random residents weekly. Audits will review if a resident has had a change in condition and if the "Change in Resident Condition" policy was followed. Audits will be brought to the QAPI committee for further review and recommendations. The Director of Nursing and/or designee	

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F 580	Continued From page 4 pulled out Foley catheter. Send patient to emergency if resistance is met. (order received after delay in contacting physician on 8/29/24, catheter never replaced, and resident never sent to emergency) R1's care plan dated 8/28/24, identified resident had Foley catheter due to bladder tumor diagnosis. Interventions directed staff to monitor/record/report to MD (medical doctor) for s/sx (signs and symptoms) of UTI (urinary tract infection): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pule, temperature, and urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns. R1's progress notes (PN) dated 8/27/24, through 8/29/24, identified: -on 8/27/24 at 5:23 p.m., R1 arrived at facility via EMT (emergency medical technicians) transport on w/c (wheelchair) accompanied by son. R1 was A & O x4 (alert and oriented times four), forgetfulness noted. -on 8/28/24 at 10:30 p.m., administered Acetaminophen oral tablet 500 mg (milligrams) two for sign of mild pain. -on 8/28/24 at 11:30 p.m., PRN (as needed) administration of Acetaminophen was effective, follow up pain scale was 0 out of 10. -on 8/29/24 at 1:17 a.m. replace and re-insert pulled out Foley catheter. Send patient to emergency if resistance is met. -on 8/29/24 at 6:22 a.m. R1pulled out indwelling	F 580	will be in charge of the audit.	

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F 580	Continued From page 5 catheter together with the water balloon that anchored it in place. Some bleeding noted, R1 was washed up and a brief was offered to patient pending an order from provider for further action. Writer put a call into provider and waited to be called back. (PN lacked detail on when R1 pulled out catheter and when call was made to provider). Later, nurse practitioner (NP)-A called back and after a thorough explanation of the situation, an order was given to re-insert catheter. R1 was approached for re-insertion but refused. Writer suspected pain and administered Tylenol then let R1 be for a while, leaving her door open for easy monitoring. At 12:30 a.m. patient was okay talking and breathing "without any sign of impending doom. By around 1:00 a.m. writer saw patient lying across bed and was not responding to any stimulus and looked lifeless lying her head in vomited food and fluid with some in her mouth. Writer quickly called the other nurse who also noted that patient was lifeless and then left the room immediately. Writer then turned patient to her right side while the water was still oozing out. CNA [certified nursing assistant] then noted that patient had passage of bowel movement and quickly cleaned it. As more fluid was oozing out after the second nurse left. CNA left to go answer call light while writer let out the water in patient's mouth and raised head of bed [HOB] and went to the nursing station to check patient's code status. Have noted code status RESUSCITATION, writer dashed back and asked the other CNA for help with putting patient down and CPR initiated immediately. No time was wasted. Patient was on the floor with fluid oozing from the mouth and POLST status had to be ascertained. All these were satisfied in a short time, couple of minutes then CPR was started: 911 was called. Patient was not able to be resuscitated. Family was	F 580		

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	245618	A. BUILDING _____ B. WING _____	C 09/12/2024

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F 580	Continued From page 6 informed and family came and arranged funeral home. Patient has long been deposited in funeral home." During a telephone interview on 9/4/24 at 4:00 p.m., family member (FM) stated R1 had a bladder tumor and only half could be removed during the surgery because the bladder walls were very thin. FM stated the urologist wanted the urinary catheter left in place because if the bladder got too full and was not constantly draining, the bladder could rupture. FM stated R1 was to be discharged from hospital on 8/25/24 initially but had started to bleed again. FM stated once discharged from hospital they had planned on going back in a couple of weeks for the remainder of the bladder tumor to be removed. FM stated he was visiting on 8/28/24 and R1 was a little sluggish, tired, refused to eat lunch and supper, which was rather odd for her. FM indicated around 6:00 p.m. R1 requested the bathroom, and he stepped out of room while staff assisted her. FM stated a few minutes later RN-A came out of the room looking flustered and informed him R1 had pulled out her urinary catheter, if they could get the bleeding under control, they would reinsert catheter and if not, she would be transferred back to the hospital. FM stated he did not get a sense that this was an everyday event, but none of the staff seemed concerned. FM indicated he had requested to be called with an update that evening, and left facility to go back home. FM stated when he had not received a call from the RN-A, at 9:15 p.m. FM he called and talked to her and was informed R1 was doing fine, but they had not gotten "a chance" to re-insert the urinary catheter. Adding, then at 1:15 a.m. he received a call from RN-A and was informed R1 was unresponsive and	F 580		

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F 580	Continued From page 7	F 580		

medical emergency had done CPR on her. FM stated RN-A had informed him they had packed a pullup with a hand towel used to prevent her from bleeding. FM express, R1 had not moved to the TCU to die, but to recover and go on to finish the rest of her surgery.

During an interview on 9/4/24 at 4:40 p.m., NA-C stated between 5:30 p.m. to 6:00 p.m. she went to take R1 to the bathroom but R1 had already gotten herself up and was almost to the bathroom. NA-C stated R1 informed her she had to go bad and then noticed blood on the floor where her feet had walked through it. NA-C indicated she looked around room and noticed the urinary catheter bag hung on the side of R1's bed with tubing attached to it that was no longer attached to R1. NA-C indicated she asked RN-A to assess R1 and see where the blood was coming from. NA-C stated RN-A entered R1's room as she cleaned up the drops of blood off the floor and suggested a brief be placed on R1. NA-C stated she noticed a dime sized blood clot stuck to the side of the toilet bowl when she flushed the toilet. NA-C also stated RN-A had picked up the catheter bag, held it up and looked at it. NA-C verified she was unsure as to where the blood came from, however there was approximately 300 cc of pink tinged urine in the collection bag. NA-C stated R1 appeared more confused.

During a telephone interview on 9/5/24 at 11:07 a.m., RN-A stated on 8/28/24 between 6:30 p.m. and 7:00 p.m. a licensed practical nurse (LPN) informed her R1 was bleeding and she asked if it was R1 and she indicated yes. RN-A stated she immediately went to R1's room and observed her on toilet in bathroom. RN-A stated nursing

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F 580	Continued From page 8 assistant (NA)-A informed her R1 started to take herself to the bathroom when she entered the room, saw the catheter was pulled out with balloon still inflated and intact, and bleeding. RN-A stated she checked catheter tubing, bag, no blood identified, and approximately 250 milliliters (ml) of tea colored urine noted in collection bag. RN-A indicated this must have caused R1 some trauma, but she denied pain. RN-A confirmed there was a small amount of blood in the toilet. RN-A verified at 7:00 p.m. she instructed the NA to place a brief on R1 and indicated she would contact the provider for instruction possibly re-insert the catheter or send R1 to the ER. RN-A stated she decided to wait to call provider because she had to check another resident's orders, complete a wound dressing changed, and finish up with her medication pass, so it was later in the evening when she placed a call to the on-call provider. RN-A indicated she had to leave a message and when the NP-A called her back she informed her that R1 pulled out her catheter, no additional bleeding noted, and was resting in bed. RN-A indicated she asked NP-A what she should do and received an order to re-insert catheter now as she must have one in. RN-A stated she informed NP-A there was trauma and suggested R1 be sent to the ER, as she was concerned if she reinserted the catheter, it could possibly push a blood clot back into R1's bladder. RN-A indicted NP-A provided an order: re-insert and if resistance was met, send to ER. RN-A stated she entered the order into the electronic health record (order shows it was entered at 1:17 a.m. 8/29/24 after R1's passing in record) and finished a few other things, then went to R1's room. RN-A stated R1 refused to have catheter re-inserted and denied pain. RN-A stated she returned to R1's room at 12:30 a.m. and again	F 580		

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F 580	Continued From page 9 she refused re-insertion of the catheter, so she finished up a few things and was then was going to call 911 and send her to the ER. RN-A stated at 1:00 a.m. she noticed R1 was laying across her bed with her feet on the floor, so she quickly went to room 301 and got NA-B (without assessing R1). RN-A stated both staff entered R1's room and she was lifeless, quiet, and body was still warm. RN-A verified with RN-B, no heartbeat, no respirations, and unresponsive. During a follow up interview via telephone on 9/6/24 at 12:11 p.m., RN-A stated called the on-call provider around 9:00 p.m., passed medications around that time also, time was not checked when she called back or documented in progress notes. RN-A stated was extremely busy that evening, resident with wound dressing change, new admission, and administered medications. RN-A stated DON was there, indicated those tasks needed to be completed first, wound cares around 8:30 p.m. and informed DON there was the whole night to get that catheter placed back in and DON indicated that was ok. RN-A stated she wanted R1 to have time to calm down, when catheter was pulled out sometimes it was hard on the resident especially when the balloon was still intact, and again stated she was in no hurry to contact provider. RN-A verified she did not document assessments completed as she was too busy, and no noted changes. RN-A indicated she was unsure what she told the triage and on-call provider but told them only what they asked for and they should have asked for more information. RN-A did confirm she should have told provide the catheter had been out for hours prior to the call, past medical history of bleeding and recent bladder surgery. RN-A stated the order that was given	F 580		

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F 580	Continued From page 10	F 580		

indicated to contact provider back if resistance was met and that did not happen because R1 refused. RN-A indicated she planned on sending R1 into ER but had medications to administer to other residents first.

During a telephone interview on 9/6/24 at 9:24 a.m., on call NP-A stated RN-A first contacted triage on 8/28/24 at 10:02 p.m. (approximately 4 hours after R1 pulled out her catheter) NP-A indicated she had returned the call to RN-A on 8/28/24 at 10:16 p.m. NP-A verified RN-A had informed the triage nurse R1 had a recent bladder resection, pulled out indwelling catheter, bleeding had stopped, blood only noted when the peri area was wiped, and wore incontinent product. NP-A stated RN-A asked if R1's catheter could be replaced. NP-A stated the conversation was very short with triage nurse and was surprised she had not provided more information. NP-A stated she was the overnight on call provider and relied on what the nurse told the triage nurse. NP-A also stated the responsibility/burden lied with RN-A to have explained the situation to the triage nurse such as her history of bleeding issues. NP-A indicated she was not made aware R1 had gross hematuria (visible blood in the urine), anemia with Hgb of 5.9 g/dL, and a bladder tumor. NP-A stated she had given RN-A orders to replace, and re-insert pulled out Foley catheter and send to emergency if resistance was met. NP-A verified R1 had been seen earlier in the day by her primary provider NP-B. NP-A stated after R1 refused to have the catheter reinserted that would have fallen under an identified problem and would have expected RN-A to have called back right away with an update, re-assessed, and would have sent to emergency room to be assessed. NP-A verified

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F 580	Continued From page 11	F 580		

she was not aware R1 had been without the catheter for over 4 hours, and was not contacted by RN-A after their initial conversation at 10:16 p.m.

During an interview on 9/6/24 at 10:49 a.m., primary provider NP-B stated she would have expected RN-A to have sent R1 into the emergency room (ER) or call triage back when unable to reinsert the urinary catheter. NP-B indicated R1 just had a huge surgery and we wanted to avoid urinary retention. NP-B stated had seen R1 the morning of 8/28/24 around 9:00 a.m. to 10:00 a.m. while she made rounds at the facility. NP-B stated she was informed by physical therapy R1 was fatigued and confused. NP-B indicated she was surprised R1 had died.

During an interview on 9/6/24 at 2:20 p.m., director of nursing (DON) indicated she was at the facility later that evening but was unable to provide an approximate time she was onsite. DON stated prior to leaving the facility later during the p.m. shift on 8/28/24, she was made aware by RN-A and R1's son of R1's indwelling catheter being pulled out. DON stated she informed R1's son the provider would be contacted to get direction on what to do, and he requested a follow up call once that was completed. DON informed RN-A R1's son requested an update once provider was contacted. DON verified during the facility's investigation following R1's death, RN-A verified she contacted the provider, but no time was provided, and the facility did not ask for a specific time. DON indicated she would have expected RN-A to contact the provider immediately and follow the orders due to history of bladder cancer, recent bladder surgery. DON stated it was unknown if R1's bladder was empty

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F 580	Continued From page 12 or full due to a lack of assessment by RN-A, and she would have expected RN-A to have completed and documented abdominal assessments, bladder scans, output, and ongoing monitoring to demonstrate R1's nursing care needs were being met and she was not having a change in condition. DON stated she would have expected RN-A to have followed up with the provider as soon as possible to update the provider on R1's refusal for re-insertion along with her assessment information and to received further direction and orders. DON indicated it may had been concerning to have R1's catheter out over six hours with her history of current bladder surgery but was unable to determine without the assessments having been completed. DON stated she did not delegate as to what steps RN-A should have taken or prioritized during her shift. DON indicated RN-A was expected to ask for help if needed and communicate that to her. During an interview on 9/9/24 at 4:30 p.m., administrator stated he would have expected RN-A to follow up with the provider to get the order timely. Administrator also stated if R1 had any resistance and/or refused re-insertion, R1 should have been sent to the hospital and was not sure why Tylenol and monitoring was the plan of care when that was not what the physician's order stated. During a telephone interview on 9/6/24 at 5:00 p.m., medical director (MD) stated would not be concerned with R1's history when catheter was out over six hours and there was no doubt the staff nurse should have contacted the provider timely and updated her when R1 refused to have catheter re-inserted and along with following providers orders.	F 580		

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F 580	Continued From page 13 Facility policy Change in Resident Condition dated 8/18/21, identified physicians will be notified of acute changes in a resident's condition in health include but not limited to: bowel and bladder continence and refusal of treatment as soon as possible. Notifications to physicians/NP (nurse practitioners) and condition changes would be documented in progress notes in medical record.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §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	F 609		10/22/24

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F 609	Continued From page 14 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 record review, the facility failed to immediately report to the state agency (SA) when a provider orders for life sustaining treatment (POLST) and cardiopulmonary resuscitation was not initiated timely, as per the resident wishes for 1 of 1 resident (R1) reviewed for neglect. Findings include: R1's diagnoses' list dated 9/5/24, identified: neoplasm (growth of abnormal cells) of bladder, aftercare following surgery for neoplasm, acute post hemorrhagic anemia (excess bleeding), abnormal uterine and vaginal bleeding, heart failure, presence of coronary angioplasty implant and graft, diabetes mellitus (type II), history of venous thrombosis and embolism (blood clot), and gross hematuria (visible blood in urine). R1's Provider Orders for Life-Sustaining Treatment (POLST) prepared and signed by healthcare agent/son on 8/27/24 (box checked: patient has capacity), and signed by provider on 8/28/24, identified: Attempt resuscitation/CPR (cardiac pulmonary resuscitation) (NOTE: selecting this requires selecting "Full Treatment" in section B). Section B Full Treatment. Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments.	F 609	The resident affected by the deficient practice is deceased. All facility nursing staff will be educated on the policy "Vulnerable Adult Abuse Prevention Plan and Suspicion of a Crime Reporting" during new hire orientation, annually, and by 10/22/2024. This includes "Employee Reporting Requirements" that states, "Employees must report a reasonable suspicion of a crime by email, fax, or telephone, committed against any resident to the MDH OHFC and to local law enforcement immediately, but no later than 2 hours after forming the suspicion if: the events result in serious bodily injury to a resident. Serious bodily injury means an injury involving extreme physical pain; substantial risk of death; protracted loss or impairment of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization, or physical rehabilitation; or an injury resulting from criminal sexual abuse." Facility will randomly audits 5 residents weekly to ensure that any potential allegation or concern of abuse, neglect, and maltreatment is reported timely to the appropriate state agency.	

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F 609	Continued From page 15 R1's orders from 8/27/24, through 8/29/24 included: -Code Status - Full Resuscitation order date 8/27/24. The facility's Incident Report submitted to the State Agency (SA) on 8/29/24 at 9:44 p.m., identified incident occurred on 8/29/24 at 1:00 a.m., administrator was notified of incident on 8/29/24 at 2:36 a.m. Nursing staff noted R1 had cessation of pulse and respirations on the morning of 8/29/24 at 1:00 a.m. The timeline of events from nurse progress notes were not conclusive as to when CPR (Cardiac pulmonary resuscitation) was initiated. Registered Nurse (RN)-A was suspended pending further investigation. Investigation was started. The SA was notified of the facility's failure to provide CPR timely 20 hours and 44 minutes after the facility (RN-A) suspected R1 was neglected. The facility's investigation submitted to the MDH on 9/6/24 at 9:17 a.m., identified this was an isolated incident, resident expired. The facility findings were inconclusive due to inconsistencies with staff statements and inability to establish and verify timeline of events. The resident's primary nurse resigned from her position effective immediately 8/30/24. Review of West St. Paul Police Incident Report with a creation date and time of 8/29/24 at 5:43 a.m. revealed the following: "[RN-B] was agitated and noted that [R1] had been unconscious for an extended period and that [RN-A] had failed to provide or render proper aid for an extended period. [RN-B] alleged that [R1] had been	F 609	Facility audit results will be brought to QAPI (Quality Assurance and Performance Improvement) for review and any further recomendations. The Director of Nursing and/or designee will be in charge of the audit.	

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F 609	Continued From page 16 unconscious since midnight, approximately one hour before the call for service. [RN-B] was upset and contacted the state because of the neglect. I spoke with Mhealth's supervisor, who noted he asked [RN-B] if she had contacted first responders to assist with the medical, and she said she had not because it was not her patient. I spoke with [RN-A], who noted she was in [R1]'s room around 00:40. Around 01:00, she walked past the room and saw [R1] lying across the bed, so she entered the room to assist her. [RN-A] found another employee to help with moving [R1] when she realized she had been vomiting. [RN-A] ran and found [RN-B] and advised her of the situation. [RN-B] followed her to the room and eventually left. [RN-A] saw food in [R1]'s mouth, so she moved her to the floor to begin to render aid. While speaking with [RN-A], [RN-B] approached and began to allege she was lying about what had occurred. I separated the two and asked [RN-B] to provide us with some privacy. After speaking with [RN-A], I found [RN-B] and learned the following: anytime the facility has a death, nurses will request a second nurse to verify the information. This includes checking the heart, checking the pupils, and confirming the individual is deceased. [RN-A] called [RN-B] to the room at 00:30 hours, where she checked the pulse and pupils. [R1] showed no pupillary response and had no heartbeat; however, she was still warm. [RN-B] asked if this was an expected death, which is frequent due to the facility's nature, and [RN-A] advised it was. [RN-A] and the nursing assistant began straining the body and cleaning the bed. Around 01:00, [RN-A] asked for the nursing assistants help, entered [R1]'s room, and began to perform CPR. According to [RN-B], before requesting the nursing assistant to perform aid,	F 609		

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WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

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F 609	Continued From page 17	F 609		

there were no resuscitation attempts, and aid took 35 minutes before [RN-A] began to render assistance. But there should have been. [RN-B] stated she tried to contact management, but they had not contacted her, and she needed to contact the state within two hours since Jean was a vulnerable adult. Medics continued to render assistance, but [R1] was eventually declared deceased at 01:47 hours ...Due to the neglect and serious allegations, I contacted on-duty investigators and informed them of the situation. I also called the Hennepin County Coroner's Office and explained the situation. They said they would not respond to the location based on what they had learned.

During interview on 9/10/24 at 11:52 a.m. DON stated she received noticed of the incident on 8/29/24 around 1:00 a.m. DON indicated per our facility policy all alleged violations are immediately reported to the community's administrator. DON stated at the time of the incident the RN that worked that night reported there were no concerns regarding delayed CPR. DON indicated it was not until after all of the statements were received that there were concerns related to timeliness and initiation of CPR and then it was reported to the MDH at that time.

During an interview on 9/9/24 at 4:30 p.m., administrator stated he was notified on 8/29/24 at 1:36 a.m., about the incident with R1. Administrator indicated the report was filed with the SA with a time stamp of 8/29/24 at 9:44 p.m. Administrator indicated after the incident happened R1's progress noted were reviewed and there were no concerns of timelessness and once the night shift staff statements were gathered and completed, we felt it was

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F 609	Continued From page 18 reportable. Administrator stated there was no delay as far as he could see. Review of facility policy Vulnerable Adult Abuse Prevention Plan and Suspicion of a Crime Reporting dated 3/15/23, identified definition of neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident(s) that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility was aware of or should have been aware of good or services that a resident(s) required but facility failed to provide them to the resident, that have resulted in or may result in physical harm, pain, mental anguish, or emotional stress. Employees must report a reasonable suspicion of a crime by email, fax, or telephone, committed against any resident to the MDH (Minnesota Department of Health) OHFC and to local law enforcement immediately but not later than two hours after forming suspicion if the events resulted in serious bodily injury which means injury involving extreme physical pain; substantial risk of death; protracted loss or impairment of the function of a bodily member, organ, or mental faculty; required medical intervention such as surgery, hospitalization, or physical rehabilitation; or an injury that resulted from criminal sexual abuse.	F 609		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's	F 678		10/22/24

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F 678	Continued From page 19 advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide basic life support, including cardiopulmonary resuscitation (CPR) in accordance with resident wishes and physician orders for full code status of CPR to 1 of 3 residents (R1) reviewed. This deficient practice resulted in an immediate jeopardy (IJ) situation when R1 was found not breathing, had no pulse, CPR was not initiated timely, and R1 passed away at the facility. The IJ began on 8/29/24, at 12:30 a.m. when R1 was noted to have no respirations or pulse, and no immediate action was taken by Registered Nurse (RN)-A, including CPR, which resulted in a missed opportunity to resuscitate R1, resulting in certain death. On 9/6/24, at 5:15 p.m. the administrator and director of nursing (DON) were notified of the IJ. The IJ was removed on 9/7/24, following verification of an acceptable removal plan however, noncompliance remained at the lower scope and severity level D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's diagnoses list dated 9/5/24, identified: neoplasm (growth of abnormal cells) of bladder, aftercare following surgery for neoplasm, acute post hemorrhagic anemia (excess bleeding), abnormal uterine and vaginal bleeding, heart failure, presence of coronary angioplasty implant and graft, diabetes mellitus (type II), history of venous thrombosis and embolism (blood clot), and gross hematuria (visible blood in urine).	F 678	The resident affected by the deficient practice is deceased. As part of the immediate jeopardy abatement, all facility staff were educated on the revised policy "Cardiopulmonary Resuscitation (CPR)", starting September 6 and completed on September 11, 2024. This policy identifies staff that are responsible for providing CPR (only licensed nurses), and the necessity for immediate response when a resident is found to be with no pulse and/or no active breaths, following the resident wishes with their POLST. This policy also includes how those not participating in performing CPR should assist in other duties to expedite emergency procedures. Duties such as, calling 911, obtaining the medical record to verify code status, assisting with timely repositioning for CPR preparation, and obtaining copies of the residents advance directives, POLST, transfer forms and provide to ambulance team. All residents that wish to be a full code have the potential for serious harm, injury or death due to this deficient practice. Three at-random code drills were run by the Director of Nursing, in accordance with the immediate jeopardy abatement plan. These drills were conducted on	

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F 678	Continued From page 20 R1's Provider Orders for Life-Sustaining Treatment (POLST) prepared and signed by healthcare agent family member (FM)-A on 8/27/24 (box checked: patient has capacity), and signed by provider on 8/28/24, identified: Attempt resuscitation /CPR (cardiac pulmonary resuscitation) (NOTE: selecting this requires selecting "Full Treatment" in section B). Section B Full Treatment. Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments. R1's orders from 8/27/24, through 8/29/24 included: Code Status - Full Resuscitation order date 8/27/24. R1's care plan dated 8/28/24, identified resident had Foley catheter due to bladder tumor diagnosis. Interventions directed staff to monitor/record/report to MD (medical doctor) for s/sx (signs and symptoms) of UTI (urinary tract infection): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pule, temperature, and urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns. R1's progress notes (PN) dated 8/27/24, through 8/29/24, identified: -on 8/27/24 at 5:23 p.m., R1 arrived at facility via EMT (emergency medical technicians) transport on w/c (wheelchair) accompanied by son. R1 was A & O x4 (alert and oriented times four),	F 678	September 18 at 1400, September 19 at 0530, and September 19 at 1551. All on duty nursing staff were required to respond to an emergency code and participate in the drill. Facility audits will be conducted on all nursing staff to ensure they will have received education on the facility CPR policy, and the necessity for immediate response when a resident is found to be with no pulse and/or no active breaths, following the resident wishes with their POLST by 10-22-24. Facility audits will be conducted on all nursing staff to ensure they will have received education on where the resident code status is kept for each resident, the location of the crash cart, who can perform CPR, and staff knowledge to immediately start CPR after verifying the resident's code status by 10-22-24. Facility audit results will be brought to QAPI (Quality Assurance and Performance Improvement) for review and any further recommendations. The Director of Nursing and/or designee will be in charge of the audit.	

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F 678	Continued From page 21 forgetfulness noted. -on 8/28/24 at 10:30 p.m., administered Acetaminophen oral tablet 500 mg (milligrams) two for sign of mild pain. -on 8/28/24 at 11:30 p.m., PRN (as needed) administration of Acetaminophen was effective, follow up pain scale was 0 out of 10. -on 8/29/24 at 1:17 a.m. replace and re-insert pulled out Foley catheter. Send patient to emergency if resistance is met. -on 8/29/24 at 6:22 a.m. R1 pulled out indwelling catheter together with the water balloon that anchored it in place. Some bleeding noted, R1 was washed up and a brief was offered to patient pending an order from provider for further action. Writer put a call into provider and waited to be called back. (PN lacked detail on when R1 pulled out catheter and when call was made to provider). Later, nurse practitioner (NP)-A called back and after a thorough explanation of the situation, an order was given to re-insert catheter. R1 was approached for re-insertion but refused. Writer suspected pain and administered Tylenol then let R1 be for a while, leaving her door open for easy monitoring. At 12:30 a.m. patient was okay talking and breathing "without any sign of impending doom. By around 1:00 a.m. writer saw patient lying across bed and was not responding to any stimulus and looked lifeless lying her head in vomited food and fluid with some in her mouth. Writer quickly called the other nurse who also noted that patient was lifeless and then left the room immediately. Writer then turned patient to her right side while the water was still oozing out. CNA [certified nursing assistant] then noted that	F 678		

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F 678	Continued From page 22 patient had passage of bowel movement and quickly cleaned it. As more fluid was oozing out after the second nurse left. CNA left to go answer call light while writer let out the water in patient's mouth and raised head of bed [HOB] and went to the nursing station to check patient's code status. Have noted code status RESUSCITATION, writer dashed back and asked the other CNA for help with putting patient down and CPR initiated immediately. No time was wasted. Patient was on the floor with fluid oozing from the mouth and POLST status had to be ascertained. All these were satisfied in a short time, couple of minutes then CPR was started: 911 was called. Patient was not able to be resuscitated. Family was informed and family came and arranged funeral home. Patient has long been deposited in funeral home." R1's treatment administration record (TAR) documentation of urinary output entered per shift (a.m. 0700-1500, p.m. 1500-2300, night shift 2300-0700. 8/27/24 evening output 350 cubic centimeters (cc) and night output 700 cc. 8/28/24 Evening output 500 cc and night output 300 cc. R1's electronic medical record did not identify R1's urinary output on 8/28/24 day shift. Review of NP-B visit dated 8/28/24, identified R1's advanced directives: Full Code. R1 had been hospitalized from 8/18/24, through 8/27/24, due to vaginal bleeding and concern for urinary source bleeding which resulted in increasing lightheadedness, dyspnea (shortness of breath),	F 678		

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F 678	Continued From page 23	F 678		

and a low hemoglobin 5.9 hemoglobin (Hgb) grams per deciliter (g/dL) (normal range 11.5 to 15). R1 received two units of red packed blood cells (RBC) upon admission and Hgb improved to 7.9, 8.4, and 8.3. On 8/21/24, R1 underwent D & C (dilation and curettage) (removed tissue from uterus), cystoscopy with fulguration of vessels (heat derived from an electrical current to destroy atypical /cancer tissue), and 50% removal of the bladder tumor. Additionally, on 8/22/24, R1 had an inferior vena cava filter placed due to unable to restart anticoagulant. R1 had an indwelling foley catheter placed to have remained in while at TCU. R1 was seen today 8/29/24, for an admission visit in the TCU. R1 had just finished up therapy and reported she was worn out from therapy. Appetite fair and no further bleeding. R1's vital signs 107/67, 97.3 Fahrenheit (F), pulse 86 per minute, 16 breathes per minute, and oxygen saturation level (Sa02) 98% (normal range 90 to 100%). R1's last Hgb on 8/27/24, was 8.9 g/dL.

The facility's Incident Report submitted to the State Agency (SA) on 8/29/24 at 9:44 p.m., identified incident occurred on 8/29/24 at 1:00 a.m., administrator was notified of incident on 8/29/24 at 2:36 a.m. Nursing staff noted R1 had cessation of pulse and respirations on the morning of 8/29/24 at 1:00 a.m. The timeline of events from nurse progress notes were not conclusive as to when CPR (Cardiac pulmonary resuscitation) was initiated. Registered Nurse (RN)-A was suspended pending further investigation. Investigation was started.

The facility's investigation submitted to the MDH on 9/6/24 at 9:17 a.m., identified this was an isolated incident, resident expired. The facility

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F 678	Continued From page 24	F 678		

findings were inconclusive due to inconsistencies with staff statements and inability to establish and verify timeline of events. The resident's primary nurse resigned from her position effective immediately 8/30/24.

Review of West St. Paul Police Incident Report with a creation date and time of 8/29/24 at 5:43 a.m. revealed the following: "[RN-B] was agitated and noted that [R1] had been unconscious for an extended period and that [RN-A] had failed to provide or render proper aid for an extended period. [RN-B] alleged that [R1] had been unconscious since midnight, approximately one hour before the call for service. [RN-B] was upset and contacted the state because of the neglect. I spoke with Mhealth's supervisor, who noted he asked [RN-B] if she had contacted first responders to assist with the medical, and she said she had not because it was not her patient. I spoke with [RN-A], who noted she was in [R1]'s room around 00:40. Around 01:00, she walked past the room and saw [R1] lying across the bed, so she entered the room to assist her. [RN-A] found another employee to help with moving [R1] when she realized she had been vomiting. [RN-A] ran and found [RN-B] and advised her of the situation. [RN-B] followed her to the room and eventually left. [RN-A] saw food in [R1]'s mouth, so she moved her to the floor to begin to render aid. While speaking with [RN-A], [RN-B] approached and began to allege she was lying about what had occurred. I separated the two and asked [RN-B] to provide us with some privacy. After speaking with [RN-A], I found [RN-B] and learned the following: anytime the facility has a death, nurses will request a second nurse to verify the information. This includes checking the heart, checking the pupils, and confirming the

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F 678	Continued From page 25 individual is deceased. [RN-A] called [RN-B] to the room at 00:30 hours, where she checked the pulse and pupils. [R1] showed no pupillary response and had no heartbeat; however, she was still warm. [RN-B] asked if this was an expected death, which is frequent due to the facility's nature, and [RN-A] advised it was. [RN-A] and the nursing assistant began straightening the body and cleaning the bed. Around 01:00, [RN-A] asked for the nursing assistants help, entered [R1]'s room, and began to perform CPR. According to [RN-B], before requesting the nursing assistant to perform aid, there were no resuscitation attempts, and aid took 35 minutes before [RN-A] began to render assistance. But there should have been. [RN-B] stated she tried to contact management, but they had not contacted her, and she needed to contact the state within two hours since R1 was a vulnerable adult. Medics continued to render assistance, but [R1] was eventually declared deceased at 01:47 hours ...Due to the neglect and serious allegations, I contacted on-duty investigators and informed them of the situation. I also called the Hennepin County Coroner's Office and explained the situation. They said they would not respond to the location based on what they had learned. During a telephone interview on 9/4/24 at 10:30 a.m., RN-B indicated at 12:30 a.m. on 8/29/24, RN-A walked over to the 400 Wing of the nursing home; did not appear frantic or hurried and stated to her, "300 just died, come over to verify the death." RN-B stated she grabbed her stethoscope and one minute later entered R1's room. RN-B stated nursing assistant (NA)-A and RN-A were in R1's room, stood together one side of R1's bed, had repositioned R1's bed sheets,	F 678		

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F 678	Continued From page 26 there was no sign of emesis on or around R1, and no CPR was being done. RN-B indicated she checked R1's apical pulse, with no pulse response, then both pupils (nonresponsive), skin was pale but remained warm, no breathing noted, and unresponsive. RN-B stated she asked RN-A if R1's death was expected, and she replied yes. RN-B stated an expected death only meant one thing which was a hospice death, so no code status was checked, and RN-A never requested and further help so she exited R1's room. RN-B stated she informed NA-B there had been a death because now many resident call lights had gone off. RN-B stated then at 12:55 a.m. she observed RN-A walking down the 400 hallway again and asked where NA-B was, so she informed her NA-B was at the end of the 400 hallway. RN-A indicated RN-A walked down to end of 400 hallway yelling out NA-B's name loudly three times. RN-A stated NA-B and RN-A walked together into R1's room and closed the door. RN-A stated right before 1:08 a.m. RN-A exited R1's room and right after that she received a text message from NA-B that said, "not sure what was going on but RN-A had us place [R1] on the floor and we are doing CPR ..... she was already dead ..." adding, then she looked up from her computer and NA-B was frantically waved at her and she looked scared, so RN-B indicated she got up and went over to NA-B immediately and into R1's room. RN-B stated NA-B informed her RN-A completed some compressions, then left the room, to call EMS, adding NA-B stated she was not comfortable doing CPR by herself, then turned around, and RN-A had returned to R1's room with no exchange of conversation and just started chest compressions on R1 again. RN-B stated when EMS arrived shortly after and entered R1's room, RN-A mislead the entire R1	F 678		

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F 678	Continued From page 27 situation. RN-B stated when EMS had taken her statement, she informed them at 12:30 a.m. she confirmed with RN-A that R1 had died, body was warm, and RN-A informed her it was an expected death. RN-B stated there was no crash cart or ambu bag in R1's room. RN-B stated at 2:23 a.m. she called DON, but got no response, then called floor manager licensed practical nurse (LPN)-D and reviewed the events with her, which most likely met state notification, and unexpected death of a vulnerable adult (VA). RN-B received a call back at 2:47 a.m. from LPN-D who had informed the administrator. During a telephone interview on 9/4/24 at 3:40 p.m., NA-A stated RN-A stood in front of R1's door and asked for help, R1 needed to be repositioned. NA-A verified both of us entered R1's room as she laid on her back across the bed with her feet on the floor and head towards the window. NA-A stated as they walked closer to R1 they realized she was dead, color was baize/yellow and unresponsive. RN-A indicated as they repositioned and boosted R1 up into the bed throw up came out of her mouth. NA-A also stated RN-A checked R1's hear rate and said out loud "no heart rate". RN-B also entered R1's room, assessed R1's pupils and confirmed she was not breathing, and left R1's room. NA-A stated no CPR was started and she changed R1's sheets twice with RN-A's assistance due to the throw up and bowel. NA-A confirmed R1's body was still warm and stated she said out loud to RN-A that this "must have just happened". NA-A stated RN-A told her she had to call 911, her son, and the DON and left the room. NA-A stated she left her room after 10 or more minutes and answered other call lights.	F 678		

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	245618	A. BUILDING _____ B. WING _____	C 09/12/2024

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F 678	Continued From page 28 During an interview on 9/5/24 at 10:36 a.m., NA-B stated at about 12:30 a.m. RN-B informed her R1 had passed away. NA-B stated she walked down to R1's room, peaked into the room and R1 looked white, was not moving, and appeared deceased. NA-B stated there was no one in the room with R1. NA-B stated at about 12:45 a.m. she heard hollering in the hallway, and it was RN-A yelling for her to come help her. NA-B stated she followed RN-A to R1's room and was told to hurry, "R1 needed to be placed on the ground." NA-B stated she was confused as to what was going on as she was previously told R1 was deceased. NA-B verified she assisted RN-A and lifted R1 from the bed with a lift sheet located underneath her and placed her onto the floor, her body was still warm and R1 was unresponsive the entire time. NA-B stated she felt very uneasy with the situation, but RN-A was very confrontational and not easy to work with, so she did what she asked. NA-B indicated RN-A and RN-B do not get along and she felt that was why she walked past RN-B and had chosen her go to R1's room. NA-B verified RN-A started chest compressions on R1 and stopped after one minute at around 1:05 a.m. NA-B stated RN-A instructed her to keep doing the compressions, and she had her CPR certification so she started compressions when RN-A left the room stating she was going to call 911. NA-B stated nothing had been put in place for CPR, no crash cart, no oxygen, no ambu bag and RN-A had not completed an assessment on R1's heartbeat/pulse while she was in the room. NA-B stated she was left in the room alone with R1 and completed chest compressions until she got tired, then stopped, opened R1's door, waved down RN-B and informed what they were doing (CPR/chest compressions only). NA-B stated RN-A had not returned to R1's room to help with	F 678		

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F 678	Continued From page 29 CPR until she saw RN-B in R1's doorway. NA-B indicated at that time she heard the EMS sirens and went to front door and let them in. EMS went directly into R1's room and stated CPR. NA-B indicated unsure if or when RN-A checked R1's code status but felt like she panicked when she realized she was a full code. During a telephone interview on 9/5/24 at 11:07 a.m., RN-A stated on 8/28/24 between 6:30 p.m. and 7:00 p.m. she was notified R1 had pulled out her indwelling catheter. RN-A she stated she decided to wait to call provider, checked another resident's orders, completed a wound dressing changed, and finished up with her medication pass. RN-A stated it was later in the evening NP-A provided an order: re-insert and if resistance was met send to ER. RN-A stated she entered the order into the electronic health record and finished a few other things, then went to R1's room. RN-A stated R1 refused to have catheter re-inserted, denied pain but could see "her face frown" so she administered Tylenol between 10:00 p.m. and 11:00 p.m. RN-A stated she returned back to R1's room at 12:30 a.m. and again she refused re-insertion of the catheter. After finishing up a few things, RN-A stated she was then going to call 911 and send her to the ER but at 1:00 a.m. she noticed R1 laid across her bed with her feet on the floor, quickly went to room 301 and got a NA-A. RN-A stated both staff entered R1's room and she was lifeless and "so quiet". RN-A stated she removed fluid from R1's mouth three times, turned her onto her side, and within a few seconds called RN-B and she rushed into R1's room. RN-A stated RN-B placed a stethoscope on her chest over her heart and stated she's dead. RN-A stated she shouted out, "I had just talked to her". RN-A verified she	F 678		

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F 678	Continued From page 30	F 678		

checked as soon as she could R1's carotid and apical pulses and no heartbeat, skin color had not changed, and R1's body was still warm. RN-A stated RN-B rushed out of room, adding voluntarily, "we are enemies, she had been fighting with all of us, accused me of things, and liked to control people." RN-A indicated R1's mouth continued to drain a cloudy fluid that smelled like undigested food with particles in it. RN-A stated she assisted NA-A to clean R1 up (brief change) and change her sheets twice. RN-A stated she had left R1's room and checked her POLST for code status and confirmed she was a full code. RN-A stated NA-A had left R1's room. RN-A indicated RN-B sat at the 300 nurse's station, she saw NA-B down the hallway and said "come, come, come" and together they entered R1's room. RN-A stated she chose NA-B because she was stronger and RN-A would not have helped immediately, said R1 was already dead, and asked a lot of questions. RN-A stated together with NA-B they lifted R1 off the bed with a lift sheet located underneath her and placed her onto the floor. RN-A stated no urine output was noted and unsure of what time this had been done. RN-A stated she started CPR without assistance, two minutes after she found her, "I did not keep track of time", completed 30 chest compressions, stopped, checked neck pulse and no pulse then asked NA-B to complete chest compressions. RN-A stated she left the room called 911 and planned on grabbing ambu bag. RN-A stated she called DON first, didn't answer, left message, adding R1 was confirmed not breathing and "like she was dead". RN-A verified she then called 911 but knew she should have called 911 prior to starting CPR and this was all completed in "two seconds". RN-A indicated she returned back to R1's room and RN-B stood

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F 678	Continued From page 31	F 678		

outside her bedroom door and said "you are doing CPR on someone that has died," while NA-B continued chest compressions alone. RN-A stated EMS arrived, entered R1's room and took over. RN-A verified she should have asked RN-B to check R1's code status, would have saved time then CPR could have been started sooner. RN-A stated if this situation happened again, would do it differently and after no pulse, started CPR even if code status was not verified, to avoid something like this happening again. RN-A stated, "it would have been a good idea to start CPR right away". RN-A also indicated she would have checked the code status for each resident at the beginning of the shift so that there would be no wasted time to go look.

During a telephone interview on 9/4/24 at 4:00 p.m., family member FM-A stated on 8/28/24, R1 was a little sluggish, tired, refused to eat lunch and supper which was rather odd for her. FM indicated around 6:00 p.m. requested bathroom and he stepped out of room while staff assisted her. FM stated a few minutes later RN-A came out of the room looking flustered and informed him R1 had pulled out her urinary catheter, if they could get the bleeding under control, they would reinsert catheter and if not, she would be transferred back to the hospital. FM stated did not get a sense that this was an everyday event but none of the staff seemed concerned, requested to be called with an update that evening, and left facility to go back home. FM stated had not heard received a call from the RN-A, called and talked to her and was informed my mother was doing fine, had not gotten a chance to re-insert the urinary catheter. FM stated then at 1:15 a.m. on 8/29/24, received a call from RN-A and was informed R1 was unresponsive and medical

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F 678	Continued From page 32 emergency had done CPR on her. FM stated RN-A had informed him they had packed a pullup with a hand towel used to prevent her from bleeding. FM stated R1 had not moved to TCU to die and was expected to have returned to the hospital in two weeks for the remainder of the tumor to be removed. During an interview on 9/6/24 at 2:20 p.m., director of nursing (DON) verified interviews were completed with all staff working the night shift the evening of R1's passing. DON indicated timelines varied, staff were unable to identify times things occurred, events were not consistent with RN-A's interview, and verification of consistencies was challenging. DON stated certain aspects aligned with RN-A's interview but what stood out was when the staff NA completed chest compressions, she indicated the body was warm. DON stated RN-A informed her she removed fluid from her mouth, cleaned her up and applied a new brief. DON stated a code status should have been checked, CPR started immediately instead, and another staff should have brought the crash cart into the room with suction machine on it, which would have helped remove R1's secretions out of her mouth. DON verified CPR should only be completed by certified licensed staff to assure the resident was getting high quality CPR, timing, and document the incident. DON also verified the staff NA should not be asked to complete chest compressions, especially after RN-A left the room. DON indicted R1's cause of death was not identified, and her death was unexpected. During a telephone interview on 9/6/24 at 5:00 p.m. medical director (MD) stated there were poor nursing decisions made throughout the night	F 678		

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F 678	Continued From page 33 regarding R1. MD stated after review of the incident, it was identified CPR should have been initiated sooner and was not completed in a timely manner. MD stated R1's death appeared to be unexpected, could have been a cardiac arrest or maybe threw a big blood clot and had a PE (pulmonary embolism), this is unknown, but chance of survival would be about 80% and with her type of diagnoses could still have lived for another 6 months. Facility policy Emergency Response Cardiopulmonary Resuscitation (CPR) dated 7/26/24, basic life support including initiation of CPR to a resident who experiences cardiac arrest (cessation of respirations and/or pulse) in accordance with the resident's advance directives or in the absence of advance directives or a Do Not Resuscitate (DNR) order. The facility will ensure that properly trained personnel and certified in CPR for Healthcare Providers are available immediately 24 hours a day to provide basic life support, including CPR to residents requiring emergency care prior to the arrival of emergency medical personnel, and subject to accepted professional guidelines, the advance directives and physician orders. All licensed nurses are required to maintain current CPR BLS certification through certification through training that includes hands-on practice and in person skills assessment. Per American Heart Association (AHA) recommendations, all potential rescuers initiate CPR unless: 1. A valid DNR is in place. 2. Obvious signs of clinical death (e.g. rigor mortis, dependent lividity, decapitation, transection, or decomposition) are present. Continue CPR until emergency personnel arrive and take over. The licensed nurse will run the code, instruct staff to obtain the medical record to	F 678		

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F 678	Continued From page 34 verify the code status prior to initiating CPR. Once the code status is verified, the licensed nurse will give further directions to staff. The IJ which began on 8/29/24, was removed on 9/7/24, when the facility successfully implemented a removal plan which included: -All nursing staff will be retrained on CPR policy, responding to unresponsive residents, code status and any revisions made to the policy. -All facility staff will be trained on who in the facility should and should not perform CPR -Include the necessity for an immediate response -Outline how those who may not participate in performing CPR should assist to expedite emergency procedures (such as call 911, assist with timely repositioning for CPR preparation ...etc.).	F 678		
F 684 SS=D	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 provide the necessary care and services for 1 of 3 residents who was recovering from bladder surgery, had pulled out their indwelling catheter and the provider was not contacted timely, provider orders to replace	F 684	The resident found to have been affected is deceased. For other facility residents, all licensed nursing staff will be educated on the policies "Nursing Assessments" and	10/22/24

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F 684	Continued From page 35 catheter or send to Emergency Department were not followed and ongoing assessment and monitoring for bladder retention, bleeding, or change of condition were not completed. Findings include: R1's diagnoses list dated 9/5/24, identified: neoplasm (growth of abnormal cells) of bladder, aftercare following surgery for neoplasm, acute post hemorrhagic anemia (excess bleeding), abnormal uterine and vaginal bleeding, heart failure, presence of coronary angioplasty implant and graft, diabetes mellitus (type II), history of venous thrombosis and embolism (blood clot), and gross hematuria (visible blood in urine). R1's orders from 8/27/24, through 8/29/24 included: -Code Status - Full Resuscitation order date 8/27/24. -Patient Instruction for urinary retention: If you are unable to urinate 6 to 8 hours after discharge, return to emergency room with your discharge instructions order date 8/27/24 -Discharge potential: length of stay less than 30 days order date 8/27/24. -Urology: call for any questions if your catheter is not draining well. If you begin to notice more blood or large clots. Order date 8/27/24. -Skilled Medicare charting. Document findings in progress not: Vital signs (VS), ADL (activities of daily living) functioning, pain status, neuro status, skin issues, respiratory status (especially SOB [shortness of breath] and any oxygen/CPAP	F 684	"Change in Resident Condition." This policy education outlines the need for ongoing resident assessment and monitoring and also includes notifying the provider timely of any resident change in condition, following medical providers orders as prescribed. In addition, completing ongoing assessments and monitoring for a resident's change of condition.This education will be completed by 10/22/2024. The facility will conduct audits ensuring that any resident with a change of condition has been monitored and assessed properly with timely notification to the provider. This includes licensed staff following provider orders timely and completing ongoing assessments and monitoring. Facility audits will be conducted on five random residents weekly to ensure that if a resident has had a change in condition, the "Nursing Assessments" and "Change in Resident Condition" policy was followed. Facility audit results will be brought to QAPI (Quality Assurance and Performance Improvement) for review and any further recommendations. The Director of Nursing and/or designee will be in charge of the audit.	

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F 684	Continued From page 36 used), any special care items for patient (e.g. IV, drains, etc.), and any changes in condition including hospitalizations and returns, MD (medical doctor) appointments and return. Use your nursing judgement to add pertinent additional information. Order date 8/28/24. -8/27/24, Patient instruction for Urinary Retention: If you are unable to urinate in 6-8 hours after discharge, return to Emergency Room with your discharge instructions. -8/27/24, Minnesota Urology: Call for any questions if your catheter is not draining well or if you begin to notice more blood or large clots. -8/29/24 at 11:59 p.m. replace and re-insert pulled out Foley catheter. Send patient to emergency if resistance is met. (order received after delay in contacting physician on 8/29/24, catheter never replaced, and resident never sent to emergency) R1's care plan dated 8/28/24, identified resident had Foley catheter due to bladder tumor diagnosis. Interventions directed staff to monitor/record/report to MD (medical doctor) for s/sx (signs and symptoms) UTI (urinary tract infection): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pule, temperature, and urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns. R1's progress notes (PN) dated 8/27/24, through 8/29/24, identified:	F 684		

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F 684	Continued From page 37 -on 8/27/24 at 5:23 p.m., R1 arrived at facility via EMT (emergency medical technicians) transport on w/c (wheelchair) accompanied by son. R1 was A & O x4 (alert and oriented times four), forgetfulness noted. -on 8/28/24 at 10:30 p.m., administered Acetaminophen oral tablet 500 mg (milligrams) two for sign of mild pain. -on 8/28/24 at 11:30 p.m., PRN (as needed) administration of Acetaminophen was effective, follow up pain scale was 0 out of 10. -on 8/29/24 at 1:17 a.m. replace and re-insert pulled out Foley catheter. Send patient to emergency if resistance is met. -on 8/29/24 at 6:22 a.m. R1 pulled out indwelling catheter together with the water balloon that anchored it in place. Some bleeding noted, R1 was washed up and a brief was offered to patient pending an order from provider for further action. Writer put a call into provider and waited to be called back. (PN lacked detail on when R1 pulled out catheter and when call was made to provider). Later, nurse practitioner (NP)-A called back and after a thorough explanation of the situation, an order was given to re-insert catheter. R1 was approached for re-insertion but refused. Writer suspected pain and administered Tylenol then let R1 be for a while, leaving her door open for easy monitoring. At 12:30 a.m. patient was okay talking and breathing "without any sign of impending doom. By around 1:00 a.m. writer saw patient lying across bed and was not responding to any stimulus and looked lifeless lying her head in vomited food and fluid with some in her mouth. Writer quickly called the other nurse who also	F 684		

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F 684	Continued From page 38 noted that patient was lifeless and then left the room immediately. Writer then turned patient to her right side while the water was still oozing out. CNA [certified nursing assistant] then noted that patient had passage of bowel movement and quickly cleaned it. As more fluid was oozing out after the second nurse left. CNA left to go answer call light while writer let out the water in patient's mouth and raised head of bed [HOB] and went to the nursing station to check patient's code status. Have noted code status RESUSCITATION, writer dashed back and asked the other CNA for help with putting patient down and CPR initiated immediately. No time was wasted. Patient was on the floor with fluid oozing from the mouth and POLST status had to be ascertained. All these were satisfied in a short time, couple of minutes then CPR was started: 911 was called. Patient was not able to be resuscitated. Family was informed and family came and arranged funeral home. Patient has long been deposited in funeral home." R1's medication administration record for month of November 2024 identified acetaminophen oral tablet 500 mg two tablets by mouth every 6 hours as needed for mild pain was administered to R1 on 9/28/24 at 10:30 p.m. and pain level determined was 4 out of 10 (a numerical scale ranging from zero to 10: zero indicates no pain and 10 represents pain so severe that an individual loses consciousness). R1's treatment administration record (TAR) documentation of urinary output entered per shift (a.m. 0700-1500, p.m. 1500-2300, night shift 2300-0700). -8/27/24 evening output 350 cubic centimeters	F 684		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

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F 684	Continued From page 39 (cc) and night output 700 cc. -8/28/24 evening output 500 cc and night output 300 cc. R1's electronic medical record did not identify R1's urinary output on 8/28/24 day shift. NP-B visit note dated 8/28/24, identified R1's advanced directives: Full Code. R1 had been hospitalized from 8/18/24, through 8/27/24, due to vaginal bleeding and concern for urinary source bleeding which resulted in increasing lightheadedness, dyspnea (shortness of breath), and a low hemoglobin 5.9 hemoglobin (Hgb) grams per deciliter (g/dL) (normal range 11.5 to 15). R1 received two units of red packed blood cells (RBC) upon admission and Hgb improved to 7.9, 8.4, and 8.3. On 8/21/24, R1 underwent D & C (dilation and curettage) (removed tissue from uterus), cystoscopy with fulguration of vessels (heat derived from an electrical current to destroy atypical /cancer tissue), and 50% removal of the bladder tumor. Additionally, on 8/22/24, R1 had an inferior vena cava filter placed due to unable to restart anticoagulant. R1 had an indwelling foley catheter placed to have remained in while at TCU. R1 was seen today 8/29/24, for an admission visit in the TCU. R1 had just finished up therapy and reported she was worn out. Appetite fair and no further bleeding. R1's vital signs 107/67, 97.3 Fahrenheit (F), pulse 86 per minute, 16 breathes per minute, and oxygen saturation level (Sa02) 98% (normal range 90 to 100%). R1's last Hgb on 8/27/24, was 8.9 g/dL. During a telephone interview on 9/4/24 at 4:00 p.m., family member (FM) stated R1 had a bladder tumor and only half could be removed	F 684		

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F 684	Continued From page 40 during the surgery because the bladder walls were very thin. FM stated the urologist wanted the urinary catheter left in place because if the bladder got too full and was not constantly draining, the bladder could rupture. FM stated R1 was to be discharged from hospital on 8/25/24 initially but had started to bleed again. FM stated once discharged from hospital they had planned on going back in a couple of weeks for the remainder of the bladder tumor to be removed. FM stated he was visiting on 8/28/24 and R1 was a little sluggish, tired, refused to eat lunch and supper, which was rather odd for her. FM indicated around 6:00 p.m. R1 requested the bathroom, and he stepped out of room while staff assisted her. FM stated a few minutes later RN-A came out of the room looking flustered and informed him R1 had pulled out her urinary catheter, if they could get the bleeding under control, they would reinsert catheter and if not, she would be transferred back to the hospital. FM stated he did not get a sense that this was an everyday event, but none of the staff seemed concerned. FM indicated he had requested to be called with an update that evening, and left facility to go back home. FM stated when he had not received a call from the RN-A, at 9:15 p.m. FM he called and talked to her and was informed R1 was doing fine, but they had not gotten "a chance" to re-insert the urinary catheter. Adding, then at 1:15 a.m. he received a call from RN-A and was informed R1 was unresponsive and medical emergency had done CPR on her. FM stated RN-A had informed him they had packed a pullup with a hand towel used to prevent her from bleeding. FM express, R1 had not moved to the TCU to die, but to recover and go on to finish the rest of her surgery.	F 684		

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F 684	Continued From page 41 During an interview on 9/4/24 at 4:40 p.m., NA-C stated between 5:30 p.m. to 6:00 p.m. she went to take R1 to the bathroom but R1 had already gotten herself up and was almost to the bathroom. NA-C stated R1 informed her she had to go bad and then noticed blood on the floor where her feet had walked through it. NA-C indicated she looked around room and noticed the urinary catheter bag hung on the side of R1's bed with tubing attached to it that was no longer attached to R1. NA-C indicated she asked RN-A to assess R1 and see where the blood was coming from. NA-C stated RN-A entered R1's room as she cleaned up the drops of blood off the floor and suggested a brief be placed on R1. NA-C stated she noticed a dime sized blood clot stuck to the side of the toilet bowl when she flushed the toilet. NA-C also stated RN-A had picked up the catheter bag, held it up and looked at it. NA-C verified she was unsure as to where the blood came from, however there was approximately 300 cc of pink tinged urine in the collection bag. NA-C stated R1 appeared more confused. During a telephone interview on 9/5/24 at 11:07 a.m., RN-A stated on 8/28/24 between 6:30 p.m. and 7:00 p.m. a licensed practical nurse (LPN) informed her R1 was bleeding and she asked if it was R1 and she indicated yes. RN-A stated she immediately went to R1's room and observed her on toilet in bathroom. RN-A stated nursing assistant (NA)-A informed her R1 started to take herself to the bathroom when she entered the room, saw the catheter was pulled out with balloon still inflated and intact, and bleeding. RN-A stated she checked catheter tubing, bag, no blood identified, and approximately 250 milliliters (ml) of tea colored urine noted in collection bag.	F 684		

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F 684	Continued From page 42 RN-A indicated this must have caused R1 some trauma, but she denied pain. RN-A confirmed there was a small amount of blood in the toilet. RN-A verified at 7:00 p.m. she instructed the NA to place a brief on R1 and indicated she would contact the provider for instruction possibly re-insert the catheter or send R1 to the ER. RN-A stated she decided to wait to call provider because she had to check another resident's orders, complete a wound dressing changed, and finish up with her medication pass, so it was later in the evening when she placed a call to the on-call provider. RN-A indicated she had to leave a message and when the NP-A called her back she informed her that R1 pulled out her catheter, no additional bleeding noted, and was resting in bed. RN-A indicated she asked NP-A what she should do and received an order to re-insert catheter now as she must have one in. RN-A stated she informed NP-A there was trauma and suggested R1 be sent to the ER, as she was concerned if she reinserted the catheter, it could possibly push a blood clot back into R1's bladder. RN-A indicted NP-A provided an order: re-insert and if resistance was met, send to ER. RN-A stated she entered the order into the electronic health record (order shows it was entered at 1:17 a.m. 8/29/24 after R1's passing in record) and finished a few other things, then went to R1's room. RN-A stated R1 refused to have catheter re-inserted and denied pain. RN-A stated she returned to R1's room at 12:30 a.m. and again she refused re-insertion of the catheter, so she finished up a few things and was then was going to call 911 and send her to the ER. RN-A stated at 1:00 a.m. she noticed R1 was laying across her bed with her feet on the floor, so she quickly went to room 301 and got NA-B (without assessing R1). RN-A stated both staff entered R1's room	F 684		

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F 684	Continued From page 43 and she was lifeless, quiet, and body was still warm. RN-A verified with RN-B, no heartbeat, no respirations, and unresponsive. During a follow up interview via telephone on 9/6/24 at 12:11 p.m., RN-A stated called the on-call provider around 9:00 p.m., passed medications around that time also, time was not checked when she called back or documented in progress notes. RN-A stated was extremely busy that evening, resident with wound dressing change, new admission, and administered medications. RN-A stated DON was there, indicated those tasks needed to be completed first, wound cares around 8:30 p.m. and informed DON there was the whole night to get that catheter placed back in and DON indicated that was ok. RN-A stated she wanted R1 to have time to calm down, when catheter was pulled out sometimes it was hard on the resident especially when the balloon was still intact, and again stated she was in no hurry to contact provider. RN-A verified she did not document assessments completed as she was too busy, and no noted changes. RN-A indicated she was unsure what she told the triage and on-call provider but told them only what they asked for and they should have asked for more information. RN-A did confirm she should have told provide the catheter had been out for hours prior to the call, past medical history of bleeding and recent bladder surgery. RN-A stated the order that was given indicated to contact provider back if resistance was met and that did not happen because R1 refused. RN-A indicated she planned on sending R1 into ER but had medications to administer to other residents first. During a telephone interview on 9/6/24 at 9:24	F 684		

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F 684	Continued From page 44 a.m., on call NP-A stated RN-A first contacted triage on 8/28/24 at 10:02 p.m. (approximately 4 hours after R1 pulled out her catheter) NP-A indicated she had returned the call to RN-A on 8/28/24 at 10:16 p.m. NP-A verified RN-A had informed the triage nurse R1 had a recent bladder resection, pulled out indwelling catheter, bleeding had stopped, blood only noted when the peri area was wiped, and wore incontinent product. NP-A stated RN-A asked if R1's catheter could be replaced. NP-A stated the conversation was very short with triage nurse and was surprised she had not provided more information. NP-A stated she was the overnight on call provider and relied on what the nurse told the triage nurse. NP-A also stated the responsibility/burden lied with RN-A to have explained the situation to the triage nurse such as her history of bleeding issues. NP-A indicated she was not made aware R1 had gross hematuria (visible blood in the urine), anemia with Hgb of 5.9 g/dL, and a bladder tumor. NP-A stated she had given RN-A orders to replace, and re-insert pulled out Foley catheter and send to emergency if resistance was met. NP-A verified R1 had been seen earlier in the day by her primary provider NP-B. NP-A stated after R1 refused to have the catheter reinserted that would have fallen under an identified problem and would have expected RN-A to have called back right away with an update, re-assessed, and would have sent to emergency room to be assessed. NP-A verified she was not aware R1 had been without the catheter for over 4 hours, and was not contacted by RN-A after their initial conversation at 10:16 p.m. During an interview on 9/6/24 at 10:49 a.m., primary provider NP-B stated she would have	F 684		

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F 684	Continued From page 45 expected RN-A to have sent R1 into the emergency room (ER) or call triage back when unable to reinsert the urinary catheter. NP-B indicated R1 just had a huge surgery and we wanted to avoid urinary retention. NP-B stated had seen R1 the morning of 8/28/24 around 9:00 a.m. to 10:00 a.m. while she made rounds at the facility. During an interview on 9/6/24 at 2:20 p.m., director of nursing (DON) indicated she was at the facility later that evening but was unable to provide an approximate time she was onsite. DON stated prior to leaving the facility later during the p.m. shift on 8/28/24, she was made aware by RN-A and R1's son of R1's indwelling catheter being pulled out. DON stated she informed R1's son the provider would be contacted to get direction on what to do, and he requested a follow up call once that was completed. DON informed RN-A R1's son requested an update once provider was contacted. DON verified during the facility's investigation following R1's death, RN-A verified she contacted the provider, but no time was provided, and the facility did not ask for a specific time. DON indicated she would have expected RN-A to contact the provider immediately and follow the orders due to history of bladder cancer, recent bladder surgery. DON stated it was unknown if R1's bladder was empty or full due to a lack of assessment by RN-A, and she would have expected RN-A to have completed and documented abdominal assessments, bladder scans, output, and ongoing monitoring to demonstrate R1's nursing care needs were being met and she was not having a change in condition. DON stated she would have expected RN-A to have followed up with the provider as soon as possible to update the	F 684		

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F 684	Continued From page 46 provider on R1's refusal for re-insertion along with her assessment information and to received further direction and orders. DON indicated it may had been concerning to have R1's catheter out over six hours with her history of current bladder surgery but was unable to determine without the assessments having been completed. DON stated she did not delegate as to what steps RN-A should have taken or prioritized during her shift. DON indicated RN-A was expected to ask for help if needed and communicate that to her. During an interview on 9/9/24 at 4:30 p.m., administrator stated he would have expected RN-A to follow up with the provider to get the order timely. Administrator also stated if R1 had any resistance and/or refused re-insertion, R1 should have been sent to the hospital and was not sure why Tylenol and monitoring was the plan of care when that was not what the physician's order stated. Administrator added, she was unable to speak to RN-A's judgment, but if RN-A indicated she monitored R1 then she would have expected documentation of that monitoring to be completed. Administrator stated monitoring this resident would have been important due to their acuteness when admitted to the facility. Administrator also stated RN-A did not demonstrate critical thinking regarding necessary care and treatment R1 was ordered and required and it was unfortunate but was unsure if that would have changed the outcome. During a telephone interview on 9/6/24 at 5:00 p.m. medical director (MD) stated the nurse should have completed assessments and bladder scans to helped determined if R1's bladder was full. MD stated no doubt the staff nurse should have contacted the provider and updated her	F 684		

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F 684	Continued From page 47 when R1 refused to have catheter re-inserted and providers orders were not followed. MD stated there were some bad nursing decisions made regarding R1's care here. During a telephone interview on 9/10/24 at 3:20 p.m. medical doctor/urologist (MDU) stated R1 was diagnosed with bladder cancer with a very large tumor that occupied half of her bladder. MDU also stated R1 had bled for one month prior to her diagnosis and became very anemic. MDU verified on 8/20/24, he removed half of the R1's tumor, hospitalized for seven days, and was stable enough when discharged to TCU with an indwelling urinary catheter. MDU stated R1's son had informed him she had pulled out her catheter at the TCU prior to her death. It would have been important to have kept the urinary catheter in place due to the large resection of the bladder tumor, a very thin bladder, and history of bleeding that resulted in a Hgb of 5.9. MDU added, it would have also been important for nursing to monitor, assess, and document R1's urinary output amount and color of urine. MDU stated R1's bladder cancer extended into the neck of the bladder, when the catheter was pulled out, and the balloon remained intact, that could have caused bleeding, which in turn, could have caused R1's bladder to ruptured if she had urinary retention. MDU stated R1 most likely had something going on earlier in the day and could have been a DVT/PE (blood clots) or cardiac issues, ultimately, we do not know, but her death was unexpected. Facility policy Nursing Assessments dated 11/28/16, identified licensed nurses would conduct initial and periodic comprehensive, standardized, and accurate reproducible	F 684		

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F 684	Continued From page 48 assessments for each resident's functional status and should contain sufficient information related to the resident's condition. In addition to direct observation and communication with the resident licensed nurses will use a variety of other sources and may include discussions with physicians and review of the clinical record. Facility policy Change in Resident Condition dated 8/18/21, identified physicians will be notified of acute changes in a resident's condition in health include but not limited to: bowel and bladder continence and refusal of treatment as soon as possible. Notifications to physicians/NP (nurse practitioners) and condition changes would be documented in progress notes in medical record.	F 684		