Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL30696001M
Compliance #: HL30696002C

Date Concluded: March 22, 2022

Name, Address, and County of Licensee Investigated:
Inver Grove Heights White Pine
9056 Buchanan Trail
Inver grove Heights, MN 55077
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Jennifer Segal BSN RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Allegation(s):
It is alleged: The facility neglected the resident when the facility failed to ensure proper catheter care. In addition, the resident did not receive timely or reliable care and waited hours for help.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to ensure an adequate number of staff were available and competent to provide necessary care to prevent complications and infection. The resident required hospitalization twice for sepsis (body's extreme response to infection) and urinary tract infection (UTI).

The investigation included interviews with current and former facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator spoke with other health professionals involved in the resident's care. The investigation included an onsite visit with a tour, observations, review of the resident's medical record, review of facility records

including incident reports, employee training records and related policies and procedures. The investigator also reviewed external medical records including hospital, clinic, and home care agency documents.

The Centers for Disease Control and Prevention (CDC), Healthcare-Associated Infections last reviewed November 13, 2019, indicated Pseudomonas aeruginosa and Enterococcus faecalis germs can cause infections in the blood. In healthy people or when bacteria are present in standard amounts, they do not usually cause problems. People with a higher risk of infection include those who live in healthcare settings, have catheters and impaired immunity and mobility. Transmission occurs with insufficient cleaning of hands, objects and insufficiently cleaned tools such as catheters.

The CDC, Catheter-Associated Urinary Tract Infections (CAUTI) guideline dated February 2017., Section titled, “Proper Techniques for Urinary Catheter Maintenance,” indicated standard care of a catheter included: maintain a closed drainage system, empty the collection bag regularly and prevent contact of the drainage spigot with the nonsterile collecting container. Changing catheter drainage bags at routine, fixed intervals is not recommended. It is suggested catheters and drainage bags changed as based on clinical indications such as infection, obstruction or when the closed system is compromised. Routine hygiene during daily bathing or showering is appropriate. Ensure staff use proper hand hygiene.

The resident’s diagnoses included multiple sclerosis with severe debility and spastic paraparesis (lower limb muscle weakness stiffness and involuntary spasms) and neurogenic bladder. The resident was wheelchair bound and required assistance with all personal cares including mobility with use of a standing mechanical lift, catheter care, toileting, repositioning and feeding.

The facility service plan and nursing assessments were not provided to the investigator. During interviews with multiple facility registered nurses (RN)s, confirmed the resident received care for all mobility, included a mechanical lift, bathing, dressing, catheter care, feeding, toileting and repositioning.

One evening, a month after the resident moved into the facility the resident requested unlicensed personnel (ULP) call 911 for concern of worsening weakness, spasticity, and suspicion of UTI.

Hospital records indicated the resident arrived with a fever and acute onset weakness. The resident was hospitalized for four days to treat sepsis and UTI. A urine culture identified bacteria in the urine was Pseudomonas aeruginosa (spread through improper hygiene, such as from the unclean hands of healthcare workers, or via contaminated medical equipment) and Enterococcus faecalis (bacteria found in fecal matter most commonly transmitted due to poor hygiene, poor hand hygiene and transmitted through medical devices).

Two RNs from an outside agency, RN#1 and RN#2, visited the resident upon discharge from the hospital to reassess the resident. RN#1 was familiar with the resident and provided catheter management for over one year prior to resident moving to the facility and continued to see the resident while he lived in the facility. During reassessment, agency RNs #1 and #2, through discussion and assessment, discovered the facility staff were not following the standards of practice for catheter care. Every morning facility ULP would disconnect the drainage bag, drain the urine from the bag, clean the bag and hang to dry. The bag that was cleaned twelve hours earlier was reconnected to the resident's catheter. In the evening, staff would repeat the same process. The facility rotated disconnecting and reconnecting two drainage bags of the same size.

During an interview with agency RN #2, she stated she tried to coordinate with the facility RN to bring concerns of catheter care forward, but the facility RN did not engage in conversation, agency RN #2 was unsure if the facility RN knew who the resident was. Agency RN #2 faxed a follow up summary of the conversation outlining the recommendations to the facility RN for follow up and reference for appropriate catheter care, which included the ULP should stop changing and cleaning bags.

The facility lacked reassessment documentation following a change in condition and upon discharge from the hospital. The facility did not implement interventions for UTI prevention or monitoring for signs/symptoms of UTI. The facility lacked documentation of coordination and training of the ULP for resident specific catheter care.

One evening, six weeks after the previous hospitalization the resident requested ULP call 911 for increased weakness and concern of UTI.

Hospital records indicated the resident arrived with a fever and weakness. The resident diagnosed with sepsis and UTI and required hospitalization for four days. The urine culture identified bacteria was Pseudomonas aeruginosa and Enterococcus faecalis as previous.

Clinic and hospital records indicated the resident stated the facility was not providing adequate catheter care when facility staff were careless with the tip of catheter, changed catheter bags twice daily when not indicated, did not use alcohol swabs when connecting and disconnecting bag and left the resident sitting in feces for over one hour increasing risk of UTI. The resident suggested he would move to a new facility because untrained ULPs provided improper catheter care and left the resident waiting for hours without care.

Upon resident return from the hospital, a facility RN noted the resident did not want staff changing his catheter bag or rinsing it out every day. The facility RN did not elaborate on resident request, there was no documentation of assessment or change in plan to identify or implement the request. There was no record of coordination with facility ULP regarding catheter care.

During an interview with the resident, he stated that he reminded the facility RN after the second hospitalization he did not want the ULP removing the catheter bag. He wanted the ULP to drain the urine from the bag and leave the bag connected as directed by the agency RN because each time the bag was disconnected it increased risk for infection. The resident stated the practice of changing bags every morning and every evening was not a normal practice for him, and he did not do that when he lived in his own home. The resident was unsure why staff insisted on the practice and requested they stop. The resident provided examples of improper catheter care:

Alcohol swabs were not used to wipe the tip of the drainage tubing when accessing to drain the bag or change the bag.
The catheter bag (large/night bag) was changed every morning and every night. The resident did not use a small/day leg bag. ULPs changed from night bag to night bag.
After cleaning the bag and left to hang dry the tip of drainage tube would touch the bathroom floor.
ULPs emptied the resident's urinal (a collection device to drain urine from the bag) into his bathroom sink. The resident used the sink to brush his teeth and wash his hands. Urine would splash on the bathroom counter.
When the resident disposed of the urinal to avoid ULPs draining urine in bathroom sink ULPs drained the bag into the toilet, and were careless with the tip of tube, allowing contact with the inside of the toilet.

The resident explained one occasion when he needed to have a bowel movement and pulled his call light, no staff responded. He used voice activated phone to dial the front desk several times to call for help when the call light went unanswered. After two hours of waiting for the ULP, he was unable to hold the bowel movement (BM). The resident was incontinent of BM and then sat in the BM for over 60 minutes until someone came to help him. The resident said the agency RN taught him it was imperative to keep the catheter clean especially from BM to decrease the risk of contamination and infection. The resident said he hired his past private caregiver to help him while living in the facility because he was not receiving the necessary care. In addition, the outside agency provided a bath aide twice weekly to assist the resident with bathing because facility staff were not available.

During interviews with agency RNs #1 and #2, they explained disconnecting and reconnecting a catheter bag is done when a someone uses a leg bag during the daytime for discreetness and changes to the large night bag at bedtime. However, the resident never used a leg bag therefore no reason to open a closed system. The agency RNs also stated standard practice for catheter care was the facility ULPs should report changes noted in urine, color, odor, amount and document the findings daily. The agency RNs stated the resident's immune system was compromised and infection control with good handwashing, gloves, alcohol wipes to clean the tip of drainage tube was imperative. The agency RNs explained their role was to change the entire catheter system monthly and the facility role was the daily management emptying/draining the collection bag.

During interviews with multiple facility RNs, they confirmed the resident had no memory impairment and had proper understanding of his needs. The RN's stated RN turnover was high, and the facility had a staffing shortage of ULPs and frequently relied on a staffing agency. The RNs stated training agency ULPs was a challenge in addition, agency ULPs did not have computer access for training, therefore they were unable to review care notes or document care provided. Five of the facility RNs reported they were aware of the resident's complaints of call lights not answered they stated it was a common complaint from several residents. The RNs stated the lack of trained and consistent staff negatively affected the resident.

During an interview with former administrative staff, she stated staff were found sleeping during the night shift and there were ongoing concerns of call lights not answered.

During an interview with agency RN #1, she stated the resident had no memory impairment, had excellent insight to his disease process and appropriately directed and followed up on his health. She worked with the resident in his home prior to admit to the facility and stated the problems the resident was having with UTIs were new. She was concerned about the facility management of daily catheter care. Agency RN #1 followed the resident to his new facility. She stated the problems have resolved.

During an interview with an RN, from the facility the resident transferred to after discharge, she reported the resident shared concern about the lack of care and improper catheter care from the discharging facility. The resident requested the RN not coordinate with the discharging facility because the resident was concerned inaccurate information would be provided. The RN reported the staff of the new facility empty the resident's bag, they do not change or clean the bag. The RN stated best practice is keep the catheter a closed system and there was no clinical reason to clean or change the bag twice daily with the type of bag that the resident used. If any change in the resident's condition including urine or mobility the staff would notify the RN. The RN would contact the agency RN for follow up. In addition, the RN stated the agency RN provided an update after each visit with the resident to ensure collaborative care.

In conclusion, neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Not applicable.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility called 911 when the resident requested for signs/symptoms of UTI.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Dakota County Attorney
Inver Grove Heights City Attorney
Inver Grove Heights Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30696	A. BUILDING: _____ B. WING _____	C 11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVER GROVE HEIGHTS WHITE PINE	**9056 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077**

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance *******REVISED******* Results issued on December 16, 2021 were before the investigation was complete. INITIAL COMMENTS: #HL30696001M/#HL30696002C On Novemeber 19, 2021 the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 51 clients receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL30696001M/#HL30696002C, tag identification 2320, 2360	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is 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. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
02320 SS=H	144G.91 Subd. 4 Appropriate care and services	02320		

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02320	Continued From page 1 (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to provide standard urinary catheter care maintenance per the Center for Disease Control (CDC) for two of two resident's (R1,R2) reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive) The findings include: The Centers for Disease Control and Prevention (CDC), Catheter Associated Urinary Tract Infections guideline dated February 2017 found on CDC website indicated proper techniques for urinary catheter maintenance included: -Maintain a closed drainage system -Empty the collection bag regularly -Prevent contact of the drainage spigot with non-sterile collection container -Changing catheter drainage bags at routine, fixed intervals not recommended.	02320		

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02320	Continued From page 2 -Routine hygiene during daily bathing is appropriate. -Ensure staff use proper hand hygiene CDC Healthcare-Associated Infections dated November 2019, on CDC's website, indicated Pseudomonas aeruginosa and Enterococcus faecalis germs can cause infections in the blood. Transmission occurs with insufficient cleaning of hands, and insufficiently cleaned tools such as catheters. Resident 1 R1's diagnoses included multiple sclerosis, with severe debility, spastic paraparesis and neurogenic bladder. R1 required indwelling urinary catheter R1's licensee record did not include a service plan from admission June 2, 2021, to discharge September 28, 2021 R1's licensee record did not include an initial nursing assessment. During an interview on December 13, 2021, at 3:54 p.m., licensee registered nurse (RN)-E stated he admitted R1 to the facility and confirmed R1 services included mechanical lift for all transfers, feeding, bathing and catheter care. RN-E stated an outside agency changed the catheter, but the facility managed the daily maintenance of the catheter. RN-E stated unlicensed personnel (ULP) were trained to perform the required care for R1. R1's home care agency note dated June 17, 2021, at 3:27 p.m.; signed by RN-G recertification visit with assessment and plan of care, indicated R1's multiple sclerosis progressed and R1 moved	02320		

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02320	Continued From page 3 to facility for more help. R1 required assistance with all personal cares and feeding assistance. R1 used a power wheelchair, able to stand briefly for transfer and no recent falls. R1 had no cognitive deficits, weak, non-ambulatory, and total assistance with all cares. R1 denied any recent signs and symptoms of UTI. R1 educated on urinary tract infections (UTI) prevention and verbalized understanding. R1's home care agency note dated June 21, 2021, at 6:23 p.m.; signed by a triage RN indicated R1 called to repor his catheter was plugged. RN returned call to R1, but R1 did not answer. R1's home care agency note dated June 21, 2021, at 7:55 p.m.; indicated the triage RN visited R1 to assess his catheter, replaced the catheter and noted large amounts of sediment, pain and pressure. R1's home care agency note dated July 1, 2021, at 1:31 p.m. signed by RN-G indicated R1 was scheduled to see a urologist July 2, 2021, to assess an increase in urinary sediments. R1's licensee record did not include documentation of monitoring his urine status. R1's facility On-Call Nurse Report dated July 8, 2021, at 1:52 a.m., indicated R1 requested ULP contact 911 for transport to the hospital due to weakness and symptoms of a UTI. R1's hospital record dated July 10, 2021, indicated R1 arrived at the hospital with a fever of 101.3 degrees Fahrenheit and acute onset weakness. Diagnosed with sepsis secondary to acute UTI. Urine culture indicated Pseudomonas	02320		

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02320	Continued From page 4 aeruginosa and Enterococcus faecalis. R1's facility progress note dated July 12, 2021, at 2:55 p.m. signed by facility RN-E indicated R1 returned from the hospital with a new diagnosis of sepsis and UTI. R1's licensee record did not include a nursing reassessment following hospitalization, physician orders, service plan changes, interventions for management/prevention of UTI. During an interview on January 26, 2022, at 11:13 a.m., RN-H, from the outside home care agency, stated she assessed R1 upon return from first hospitalization for UTI and sepsis. During assessment RN-H identified concerns with catheter care and discussed with the facility RN. R1's home care agency note dated July 13, 2021, at 12:33 p.m. signed by RN-H indicated a resumption of care assessment following hospitalization for sepsis/UTI. On the day of hospitalization R1 was weak all day and progressed to point that he couldn't pull is his call cord. R1 used voice command on his phone to dial facility staff. R1 was catheter dependent for several years with last UTI in February 2020. During assessment, RN-H discovered facility staff provided unusual catheter care included removing the night bag multiple times in the day for draining and replacing with another washed and rinsed bag for R1. RN-H sought out the facility RN to discuss findings and recommendations for catheter care. RN-H informed the facility RN frequent changing of the bags without proper infection control introduces bacteria into the catheter and can cause infection. RN-H requested staff stop changing, cleaning and disconnecting the bag, rather bring R1 to the	02320		

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02320	Continued From page 5 bathroom to drain urine. RN-H educated if bag must be changed then staff must use alcohol swab on both bag end and the catheter tubing for infection prevention. RN-H informed the facility RN home care agency RNs would change the bag every two weeks and as needed and replace the catheter monthly and as needed. RN-H reviewed assessment findings and plan with R1's medical provider. The provider agreed and authorized the plan of care. RN-H notified facility RN of provider order. R1's home care agency Coordination of Care note dated July 13, 2021, at 4:57 p.m. signed by RN-H and faxed to the facility RN, a summary of the findings and providers order for R1's catheter care. A home care visit note dated July 26, 2021, 3:24 p.m.; signed by the outside home care agency bath aide indicated R1 had trouble with urination and concerned about blockage. R1's licensee record did not have documentation of monitoring of R1's urine status. R1's licensee On-Call Nurse Report dated August 27, 2021, at approximately 9:00 p.m., indicated a change in R1 status included symptoms of UTI. R1 requested ULP call 911. R1 transported to the hospital. R1's hospital record dated August 27, 2021, indicated R1 arrived at the emergency department with a fever of 102.5 degrees Fahrenheit. R1 reported to hospital staff he did not receive adequate care including catheter care from the facility and planned to move. Urine culture identified Pseudomonas and Enterococcus. R1 was hospitalized for four days	02320		

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02320	Continued From page 6 with sepsis and UTI. R1's licensee progress note dated September 1, 2021, at 4:05 p.m. signed by RN-F indicated R1 returned from the hospital with a UTI. RN-F noted R1 "stated that he did not want staff changing his bag and rinsing it out every day". R1 reminded RN-F, the home care agency RN would change the bag and/or catheter when she visited. R1's record lacked a licensee RN assessment following second hospitalization. R1's record did not include a service record that identified how staff were to perform catheter cares or document cares were completed. R1's licensee progress note dated September 29, 2021, at 11:27 a.m. signed by RN-F indicated R1 discharged to a new facility. During an interview on December 8, 2021, at 3:14 p.m., R1 explained he had a urinary catheter long term and managed it with the help of RN-G from an outside agency. RN-G assisted R1 when he lived in a private home and continued when he moved to the facility. RN-G replaced the catheter on average every month and changed the catheter bag approximately every two weeks. R1 did not disconnect the bag to empty, change or clean the bag. R1 only drained urine from the bag. R1 stated when he moved to the facility, the facility staff began a new process for catheter care. In the morning, ULP would disconnect the bag, drain the urine out, clean the bag, hang to dry, and replace with another bag the same size as the bag removed. At bedtime, the ULP would disconnect the bag and replace with the bag from the morning and repeat the process of cleaning, hang dry and exchange the same size bag	02320		

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02320	Continued From page 7 approximately twelve hours later. R1 stated there was no need to disconnect the bag for cleaning or emptying and said he did not approve of the process and requested the facility stop disconnecting the bag. In addition, R1 provided examples of improper catheter care by facility ULP included: -Alcohol swabs were not used to wipe the tip of the drainage tubing when accessing to drain the bag or change bag. -After cleaning the bag and left to hang dry the tip of drainage tube would touch the bathroom floor. -ULPs emptied the resident's urinal (a collection device to drain urine from the bag) into his bathroom sink. The resident used the sink to brush his teeth and wash his hands. Urine would splash on the bathroom counter. -When R1 disposed of the urinal to avoid ULP draining urine in bathroom sink, ULP drained the bag into the toilet, and careless with the tip of tube, allowing contact with the inside of the toilet. -R1 recalled one evening he called multiple times for ULP to assist to the toilet for a bowel movement (BM) and staff did not arrive for hours. R1 stated he was unable to hold the BM in any longer and sat in the BM for over one hour until ULP were available to help. During an interview on December 13, 2021, at 3:54 p.m., RN-E stated he worked through a nursing agency at the facility from March 2021 to July 2021 said he "jumped right in because the facility was so understaffed, we played catch up". RN-E said he remembered R1 and did his admission assessment, which included R1 had a catheter, ULP emptied the catheter bag and "left the tubing intact". RN-E said an outside agency managed the catheter; he did not recall speaking with R1 outside agency nurse. RN-E stated the facility was responsible for the daily management	02320		

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02320	Continued From page 8 of the catheter, but the home care agency changed the catheter. During an interview on January 9, 2022, at 8:35 a.m., RN-F said when she began filling in at the facility, she discovered R1's record lacked assessments and reported findings to management. RN-F stated the facility was short staffed and residents complained of call lights not being answered. RN-F stated the facility had to use agency ULP and that was difficult because agency ULP were not familiar with the residents. RN-E was unsure who would orient the agency ULP if after hours, evenings or weekends when a nurse was not in the facility. During an interview on January 9, 2022, at 1:49 p.m., former housing manager (HM)-B stated the facility had high nurse and ULP turnover. She remembered R1 and other residents reported a problem with call lights going unanswered. HM-B confirmed one-night R1 did not receive care because ULP was found sleeping on night shift During an interview on January 10, 2022, at 1:49 p.m., with former director of nursing (DON)-C she stated she knew R1 during her brief employment. DON-C stated it was required all ULP that worked with R1 were oriented by a RN to provide delegated services for R1. DON-C stated it was "a major challenge" to confirm orientation completed or ULP service provided because agency ULP did not have computer log in access. When DON-C identified concern, she instituted paper charting immediately for all ULPs. DON-C stated awareness of missed nursing assessments, outdated or no service plans for some residents including R1. DON-C stated she notified management and they were working on improvements, but frequent turnover of staff	02320		

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02320	Continued From page 9 made it difficult in addition the facility changed resident record management system and there were ongoing challenges integrating programs and transferring documentation. DON-C discovered other concerns from R1 and other residents regarding turnover of ULP and nurses and unanswered call lights. During an interview on January 24, 2022, at 2:34 p.m., RN-G, from the home care agency, said she began seeing R1 February 2020 in his private home for catheter management to include changing the catheter monthly and additional visits if needed for changes or concerns with the catheter. RN-G stated that R1 did not have history of UTIs and sepsis until he lived in the facility. RN-G stated the expectation/customary process of the facility was to provide R1 with routine catheter care by draining the urine bag at minimum every shift. RN-G stated the facility staff were expected to contact the outside agency with any concerns or changes with R1's urine or catheter. The facility staff and R1 had the outside agency twenty-four-hour contact information and were encouraged to call with changes. RN-G stated she was "puzzled" when R1 explained to her that the facility ULPs changed R1's catheter bag multiple times per day rather than emptying the bag. RN-G explained the process was not standard and not part of R1's plan. RN-G explained that R1 did not use a leg bag therefore no clinical reason for ULPs to change from night bag to night bag. RN-G said when R1 lived in his home he used a night bag all the time and it was changed only when needed approximately every two weeks. During an interview on February 2, 2022, at 9:13 a.m., RN-I said when she assessed R1 for admission to the new facility in September 2021	02320		

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02320	Continued From page 10 she did not coordinate with the facility for discharge planning at R1's request. R1 expressed to RN-I that he feared the facility would not provide accurate information to the new facility. RN-I stated under her direction the staff empty R1's catheter bag at minimum every shift. RN-I stated there is no indication to change R1's catheter bag and if a change was needed then she would contact RN-G. RN-I stated changing the bag daily placed R1 at increased risk of infection. RN-I explained the closed system catheter should be kept closed. R1 developed weakness and symptoms of UTI one month after moving into the facility. RN-I reported this immediately to RN-G. RN-G coordiated plan with RN-I and R1 received appropriate tests and treatment. RN-I stated R1 had no cognitive impairment and appropriately directed his own care. Resident 2 R2's medical record was reviewed. R2's diagnoses included spinal cord injury with quadriplegia and neurogenic bladder. R2 required a suprapubic catheter. R2's medical provider visit dated June 21, 2021, indicated reason for appointment R2 was moving to a new facility (the licensee) and needed facility paperwork completed. During the appointment R2 reported symptoms of UTI, cloudy urine, felt fatigued and not herself. R2 was prescribed antibiotics for UTI, provider noted potential change in plan based on culture results and follow up if no improvement. The clinic visit note was faxed to the facility for admission planning. The investigator was provided the pre-admission clinic visit note by the facility. R2 moved to the facility on June 30, 2021.	02320		

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02320	Continued From page 11 R2's record lacked initial/admission assessment and service plan. R2's record lacked information about recent UTI, signs/symptoms for ULPs to watch for or any interventions to decrease risk of infection or delegation to ULPs for suprapubic catheter care. R2's signed service plan dated July 29, 2021, (one month following admission) included assistance with catheter care, mobility with use of a total body lift and two people, feeding, repositioning, dressing, showers and medication administration. R2's nursing assessment dated July 29, 2021, (one month following admission) indicated R2 required staff assistance with medication administration, unspecified treatment twice daily and catheter care management. Interventions listed under catheter management included, "change per physician order" and "report leaking, pain or concerns to nurse." Under bladder/bowel section, R2 would receive full assistance from staff for catheter care, empty bag three times daily and assist with "urinal being emptied and cleaned". The assessment indicated R2 had ostomy for suprapubic catheter but lacked intervention for ostomy care. The assessment indicated R2 had no open areas on skin. R2's record lacked specific instruction or service delivery record for staff to perform R2's individualized catheter care. R2's Routine Standing Order dated August 8, 2021, signed by R2's medical provider indicated the facility could provide as needed skin care to include Bacitracin ointment for minor abrasions and a skin seal moisture barrier cream for	02320		

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02320	Continued From page 12 irritated skin caused by incontinence. R2's nursing assessment dated September 30, 2021, indicated suprapubic catheter care interventions included empty bag three times daily, "requires assistance with urinal being emptied and cleaned" and change catheter per physician order. Report leaking, pain and concerns to nurse. No significant changes to previous nursing assessment. R2's record lacked specific interventions for UTI prevention, lacked specific instructions for suprapubic catheter care including emptying, cleaning bag or skin care at the insertion site on abdomen. R2's record indicated an outside home care agency managed R2's catheter R2's progress note dated November 9, 2021, signed by on call facility RN indicated R2 complained of vaginal pain, urine draining from urethra, skin on left side sore from urine. On call RN directed bacitracin to skin to protect from urine and Tylenol for discomfort and outside agency nurse scheduled to visit the following day. R2's record lacked coordination or education with facility ULPs regarding new vaginal pain, skin irritation or report that urine was not draining from the bag. R2's progress note dated November 10, 2021, indicated facility RN assisted outside agency RN to change supra pubic catheter and observed swelling, discharge, and bleeding at the insertion site of catheter and mucous drainage in bag. R2's progress note dated November 11, 2021,	02320		

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02320	Continued From page 13 indicated R2 wondered why an antibiotic was not started for UTI. Facility RN contacted pharmacy, provider, and skilled nurse for follow up. R2's progress note dated November 12, 2021, indicated R2 had early change of supra pubic catheter for signs/symptoms of UTI. Catheter was not draining due to large amounts of sediment. R2 had a virtual visit with her provider and antibiotics were prescribed. R2's record lacked coordination, ULP education or implementation of UTI prevention or skin care to ostomy. R2's service delivery record for November 1 through November 30, 2021, indicated, catheter care every shift (three times per day or 90 times during the month of November). ULPs initialed completion of service 12 times of 90 times expected. The licensee's Catheter Care policy dated August 1, 2021, indicated residents would receive safe, hygienic, and thorough catheter care. A document titled Practical Skills test undated, located in catheter care section of document indicated staff would be taught about specific devices for each resident and the RN would complete a practical skills test on the equipment for the specific resident. Time Period for Correction: Seven (7) days	02320		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 14 exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On March 22, 2021 the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	