Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL373156324M
Compliance #: HL373159434C

Date Concluded: February 18, 2025

Name, Address, and County of Licensee Investigated:
NorBella Senior Living
4285 Fountain Hills Drive
Prior Lake, MN 55435
Scott County

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

Evaluator's Name: Michele Larson, RN
Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility neglected a resident when they failed to appropriately respond and provide necessary medical care when the resident was found unresponsive and in medical distress. The resident experienced a medical emergency, but the facility waited an hour before calling 911 which delayed the resident receiving necessary emergency medical care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Although facility staff were educated to contact the emergency number 911 if they found a resident unconscious, instead staff contacted leadership and an on-call nurse, and attempted to contact the resident's family prior to contacting 911. That resulted in a delay of treatment for the resident of over one hour from the time when staff found the resident unresponsive until 911 was contacted. The resident was transported to the hospital where he later died from septic shock (life threatening condition) and aspiration pneumonia (accidentally inhaling food, liquid, or vomit into the lungs).

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family members, law enforcement, and the resident's primary care provider. The investigation included review of the resident's facility record, in-house provider's record, police body cam footage and transcription, the resident's death record, hospital record, facility internal investigation, personnel files, staff schedules, law enforcement report, ambulance run report, and related facility policy and procedures. Also, the investigator observed direct cares during the onsite investigation.

The resident resided in an assisted living memory care unit. The resident's diagnoses included emphysema (chronic lung disease), dementia, lymphoblastic lymphoma (aggressive cancer that affects the bone marrow), and diabetes with diabetic neuropathy (numbness and pain from nerve damage.) The resident's service plan included assistance with personal cares, orientation for confusion, toileting, medication management, transfers, walking, insulin administration, and blood sugar checks four times per day. The resident was oriented to person and time and was unable to use a call pendant due to lacking the physical or cognitive capability. The resident had difficulty with communication but was able to make his needs known.

The resident's Physician Orders for Life Sustaining Treatment (POLST) indicated the resident wanted full resuscitation, and other treatments in the event of a medical emergency.

A progress note indicated one early evening at 4:58 p.m., the facility nurse (who was the on-call nurse) received a call from unlicensed staff indicating the resident appeared lethargic (weak.) Vital signs indicated the resident's heart rate was fast (tachycardic) at 124 beats per minute (normal 60-100) with a low blood sugar of 84 mg/dL (considered a low blood sugar reading for the resident). The on-call nurse advised staff to monitor the resident and update her of any changes in the resident's status. Approximately 20 minutes later, staff contacted the on-call nurse to report the resident vomited and appeared to be feeling better. The on-call nurse directed staff to continue to monitor the resident.

About 10 hours later, unlicensed staff contacted the on-call nurse to report the resident was cold, clammy, had vomited, with a change noticed in his breathing. The resident's pulse was elevated at 102 and his blood sugar was 452 mg/dL (elevated.) The nurse advised staff to contact the resident's family to confirm their preference of keeping the resident at the facility or being evaluated at a hospital. The nurse documented, "Unable to get ahold of family." After staff's few attempts to reach the family member, unlicensed staff called the on-call nurse again who directed staff to call 911. The documentation failed to indicate whether unlicensed staff reported to the on-call nurse they found the resident unresponsive.

Review of the resident's ambulance run report indicated early morning about one hour and 15 minutes after finding the resident unresponsive, emergency medical services were dispatched to the facility after receiving a call from unlicensed staff regarding the resident's breathing

problem. The report indicated unlicensed staff reported the resident was unresponsive, with cyanosis (bluish/purple skin due to low oxygen levels) and agonal breathing (gasping breathing signaling near death) for approximately one hour before 911 was called. Vital signs obtained from the emergency medical personnel indicated the resident's oxygen saturation (level of oxygen in the blood) was at 54% on room air (normal readings 94%-100%). During the transfer to a hospital, the resident required supplemental oxygen and breathing treatments.

Review of the police body cam footage and transcription indicated three facility staff stated two hours before finding the resident unresponsive, they opened the resident's door to look at the resident but did not enter his room because he was "sleeping." Staff stated two hours later when checking the resident, the resident had vomited and was gasping in distress. On the police body cam, the three unlicensed staff stated it was a facility policy to contact the on-call nurse first before contacting 911.

The resident's hospital record indicated the resident presented to the emergency department unresponsive, in respiratory distress, and high fever (102.2 Fahrenheit (F)). The resident was diagnosed with aspiration pneumonia and sepsis (rapid breathing, fast heart rate, fever, low blood pressure, and chills). Despite hospital staff's attempts at treatment the resident was placed on comfort care and died hours later.

The resident's death certificate listed septic shock as the resident's immediate cause of death.

Review of employee files for facility staff indicated all staff were trained on when to call 911 and facility policies related to resident medical emergencies.

A facility document titled Medical Emergencies, indicated if a resident was found unconscious, facility staff were to call 911 right away before calling the on-call nurse.

The facility internal investigation indicated during the evening meal, resident appeared lethargic, so unlicensed staff called and updated the facility nurse on the resident's condition. When interviewed, unlicensed staff stated the nurse thought the resident's vitals seemed "okay" but said the nurse told them to keep an "eye" on the resident. The unlicensed staff member stated around 3:00 a.m., there were three unlicensed staff in the resident's room trying to clean the resident after the resident vomited. The unlicensed staff member stated the resident had vomit coming from his mouth, down his chest, body, and "all over" his bed sheets. The unlicensed staff member observed the resident's breathing was shallow and his hands were blue. After finding the resident in distress, staff immediately called facility leadership because they did not know who the on-call nurse was that night. Facility leadership instructed staff to obtain the resident's vitals then call the on-call nurse. The on-call nurse documented the resident's vitals were "stable, other than the resident's pulse of 102 and blood sugar reading of 452 mg/dL." The on-call nurse instructed staff to call the resident's family member first, "to be sure they wanted to send the resident out." After three unsuccessful attempts to contact the

resident's family member, unlicensed staff called the on-call nurse back who directed staff to call 911.

During an interview, an unlicensed staff member stated at 3:00 a.m. they observed the resident was unresponsive with mottling (blotching skin) and his feet were cold. The unlicensed staff member contacted the on-call nurse who told her to call the resident's family member. After not being able to contact the resident's family, the unlicensed staff stated they called the on-call nurse back telling the on-call nurse "we need to call 911." The unlicensed staff stated they called the on-call nurse back who agreed the resident should be evaluated at a hospital.

During an interview, leadership stated they received a call from unlicensed staff between 3:00 a.m. and 3:15 a.m. reporting the resident vomited and appeared to not be well. Leadership stated unlicensed staff did not know who the on-call nurse was, so leadership advised staff to call the facility nurse who was the on-call nurse to update the nurse on the resident's condition.

When interviewed, the nurse stated she thought the resident had an upset stomach based on the information provided to her from unlicensed staff. The nurse stated she did tell staff to monitor the resident and update her regarding any change in his status. The nurse received no further updates until 3:50 a.m. when the unlicensed staff contacted her about the resident's cold, clammy appearance, and abnormal vital signs. The nurse stated she instructed the unlicensed staff to contact the resident's family member to confirm whether they wanted the resident evaluated at the hospital. When unlicensed staff were not able to reach the resident's family, the nurse instructed the unlicensed staff to contact 911.

In conclusion, the Minnesota Department of Health determined 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 neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes No. The resident is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Scott County Attorney
Prior Lake City Attorney
Prior Lake Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37315	A. BUILDING: _____ B. WING _____	C 11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORBELLA SENIOR LIVING PRIOR LAKE	4285 FOUNTAIN HILL DRIVE NE PRIOR LAKE, MN 55372

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER 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. INITIAL COMMENTS: #HL373159434C/#HL373156324M On November 25, 2024, 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 38 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL373159434C/#HL373156324M, tag identification 2310 and 2360.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 evaluators' 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 SUBDIVISION 1-3.	

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02310	Continued From page 1	02310		
02310 SS=J	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure facility staff responded appropriately to one of one resident (R1) with records reviewed. R1 experienced a medical emergency and was in medical distress when unlicensed personnel found R1 unconscious and gasping for air. Instead of calling 911 first, they called licensed assisted living director (LALD)-I then registered nurse (RN)-H first, which delayed R1's emergency medical care by over an hour, even though their employee files indicated they were trained on resident medical emergencies on when to call 911 as well training on the licensee's policies on medical emergencies. R1 died. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's medical record indicated R1 was admitted to the licensee's facility on February 15, 2024, and resided in the licensee's memory care unit. R1's diagnoses included panlobular emphysema	02310		

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02310	Continued From page 2 (chronic lung disease), dementia, lymphoblastic lymphoma (aggressive cancer that affects the bone marrow), bone marrow transplant, and Type 2 diabetes mellitus with diabetic neuropathy. R1's service plan dated February 16, 2024, indicated R1 received daily assistance with personal cares, orientation for confusion, toileting, transfers, ambulation, medication management, insulin administration and blood sugar checks four times per day. Overnight services included assistance with toileting at 12:00 a.m. and 4:00 a.m., and as needed assistance with transfers, orientation/confusion, and ambulation. R1's assessment dated September 13, 2024, indicated R1 was oriented to person and time. R1 was unable to use a call pendant due to the lack of physical and cognitive capability to recognize danger, signals, or alarm requiring emergency action. R1 had difficulty with communication but was able to make his needs known. R1 used a manual wheelchair for mobility. R1's Physician Orders for Life Sustaining Treatment (POLST) indicated R1 wanted full resuscitation, and other treatments in the event of a medical emergency. R1's vulnerability assessment dated September 13, 2024, indicated R1 was unable to report neglect, abuse, or financial exploitation. Staff were trained to notify the nurse of any real or potential concerns. R1 was at risk for self- abuse due to his lack of self-preservation skills and ignoring his own safety. R1's progress note (documented late entry on October 3, 2024, at 11:20 a.m.), indicated on October 2, 2024, at 4:58 p.m., the on-call RN (RN-H), indicated she received a call from unlicensed staff indicating R1 appeared lethargic.	02310		

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02310	Continued From page 3 RN-H documented, "Vital signs stable other that pulse of 124 (normal 60-100) and blood sugar of 84 mg/dL." RN-H advised staff to monitor and update her on any changes in R1's health status. R1's progress note (documented late entry on October 3, 2024, at 11:21 a.m.) indicated on October 2, 2024, at 5:15 p.m., facility staff called RN-H stating R1 vomited a large amount but appeared to feel better after he vomited. RN-H advised staff to update for any further changes. R1's progress note (documented late entry on October 3, 2024, at 11:21 a.m.), indicated on October 3, 2024, at 3:50 a.m., staff called RN-H to report R1 vomited, appeared cold, clammy, with a change observed in his breathing. Documentation indicated RN-H did not ask staff to clarify what a "change in breathing" meant and staff did not provide additional information about the resident's breathing. R1's pulse was 102 and R1's blood sugars were 452 mg/dL. RN-H advised staff to contact family member (FM)-D to "confirm their preference." RN-H documented, "unable to get a hold of family." After a few attempts to reach a family member, staff called RN-H again who directed them to call 911. Review of FM-D's audio voice message translated to text dated October 3, 2024, at 3:56 a.m., indicated unlicensed personnel (ULP)-A left a voice message for FM-D indicating the following, "Calling about R1. R1 has not been doing well. R1 has threw up all over the bed. R1 started throwing up in the evening and he is not doing well. He's having problem with breathing, and I don't know we're just calling to find to see if you guys can let us send him to the hospital, OK, call us back." Two minutes later, at 3:58 a.m., the facility called FM-D again but did not leave a	02310		

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02310	Continued From page 4 voice message. Review of R1's police report, dated October 3, 2024, at 4:07 a.m., indicated R1 was lying supine (lying flat on back) and gasping for air when the police officer (PO)-C arrived at the facility. PO-C observed R1 was unconscious and appeared to be in respiratory failure. PO-C talked to unlicensed personnel (ULP)-A, ULP-B, and ULP-E who told PO-C on October 2, 2024, R1 had been throwing up at dinner time due to suspected flu. Staff indicated R1's vitals were checked at 3:00 a.m., an hour earlier before PO-C arrived. Staff indicated R1's blood pressure was 101/67, pulse 101, but they were unable to obtain R1's oxygen reading due to R1's fingers were too cold. PO-C asked ULP-A if R1 had been gasping for air when his vitals were checked at 3:00 a.m., and ULP-A responded, "yes that he was gasping." PO-C indicated R1 experienced a medical emergency for approximately one hour before first responders were contacted. ULP-A, ULP-B, and ULP-E stated they reported R1's condition to the on-call nurse RN-H, stating all resident medical issues were always presented to the on-call nurse before calling 911, even if it appeared to be a medical emergency. Review of R1's ambulance run report, dated October 3, 2024, at 4:09 a.m., indicated emergency medical services (EMS) was dispatched to the facility after receiving a call from staff about R1's breathing problem. EMS documented they were initially locked out of the facility and were unable to locate R1's room as staff were "either unaware of us being called or had neglected the fact that we were on our way." The report indicated R1 was unresponsive, with cyanosis (bluish/purple skin due to low oxygen levels) and agonal (labored) breathing for one	02310		

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02310	Continued From page 5 hour. Unlicensed staff indicated they obtained R1's blood sugar reading but were unable to state when they obtained the reading. R1's code status was determined to be full resuscitation (full code). EMS indicated R1's oxygen status was at 54% on room air (normal readings 94%-100%). Facility staff informed EMS R1 had been unresponsive for about one hour. EMS observed R1 was in "eminent danger of cardiac arrest." EMS administered supplemental oxygen and breathing treatments during R1's transfer to the hospital. R1 arrived at the hospital at 4:52 a.m. Review of police body cam footage and transcription dated October 3, 2024, indicated at 4:19 a.m., EMS and police entered the facility. R1 was unconscious, lying face up and flat on his back, wearing a brief. R1's breathing was short and gasping so EMS administered supplemental oxygen. When interviewed by police, ULP-A. ULP-B, and ULP-E stated RN-H told them R1 had the "flu" because he vomited at 5:30 p.m. while eating supper. ULP-E stated at 1:00 a.m., she opened R1's door and looked at him but did not enter his room because R1 was "sleeping." ULP-E stated at 3:00 a.m. they took R1's vitals while RN-H was on the phone with them but were unable to obtain R1's oxygen level because his "hands were too cold." When asked by police, ULP-A, ULP-B, and ULP-E all agreed R1 was in distress and gasping for air when they checked on him at 3:00 a.m. ULP-E stated, "I said from the get-go we should call 911, but we still have to confirm with RN-H." R1's hospital record dated October 3, 2024, indicated R1 presented to the emergency department unresponsive, in respiratory distress, and high fever (102.2 Fahrenheit [F]). R1 was diagnosed with aspiration pneumonia and sepsis	02310		

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02310	Continued From page 6 (rapid breathing, fast heart rate, fever, low blood pressure, and chills. Despite hospital staff's attempts at all life saving measures, R1 died on October 3, 2024, at 7:01 p.m. R1's death certificate dated October 3, 2024, at 7:01 p.m., listed septic shock as R1's immediate cause of death. Review of the facility's internal investigation report dated October 7, 2024, indicated during interviews with staff, ULP-F stated on October 2, 2024, at 4:58 p.m., R1 was "very lethargic" and "out of it" at dinnertime. R1 threw up orange juice and was brought back to his apartment to get cleaned up. At 5:15 p.m., ULP-F called RN-H to report R1 vomited again after eating bites of food. RN-H stated she thought R1 "could have just had the flu," ULP-F stated RN-H thought R1's vitals seemed "okay," and to keep an "eye" on R1. On October 2, 2024, at 10:25 p.m., and on October 3, 2024, at 1:10 a.m., ULP-E stated she opened R1's door and "checked" on R1 stating R1 appeared to be sleeping soundly but did not take R1's vitals or update RN-H. On October 3, 2024, around 3:15 p.m., ULP-E stated she checked on R1 and observed vomit all over his clothing. ULP-E indicated R1's hands were very cold, and his breathing was labored, stating he did "not look well." When interviewed, ULP-A stated ULP-E asked her to come to R1's room to help her and ULP-B. ULP-A stated R1 had vomit coming out of his mouth, chest, and body, and on his bed sheets. ULP-A observed R1's breathing was shallow and his hands were blue. ULP-A stated she called LALD-I first since she did not know who the on-call nurse was that night. LALD-I instructed her to call RN-H. At 3:50 a.m., RN-H received a call that R1 vomited and appeared cold and clammy with a change in his breathing.	02310		

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02310	Continued From page 7 RN-H noted R1's vital signs were "stable other than R1's pulse of 102 and blood sugar of 452 mg/dL." RN-H advised ULP-A to contact R1's family member (FM)-D to "be sure they wanted to send R1 out." ULP-A called RN-H back after three unsuccessful attempts to reach FM-D. RN-H then told ULP-A to call 911. ULP-A stated after calling 911 she left R1's room to continue working on the other side of the facility. The internal investigation report concluded R1 was "okay" until staff checked on him at 3:15 a.m. The report indicated R1's care plan (service plan) and licensee's policy and procedures were followed and "RN-H responded appropriately." During an interview on November 25, 2024, at 2:00 p.m., ULP-A stated ULP-B and ULP-E were trying to clean up R1 when she entered his room. ULP-A stated she saw R1's veins were "black" on his legs stating, "like mottling and his feet were cold." ULP-A stated, "I said shoot, I think he's dying," stating she then called RN-H who advised ULP-A to call FM-D. ULP-A called RN-H back after she was unable to reach FM-D, and stated RN-H agreed ULP-A should call 911 since ULP-A laid eyes on R1 and she had not. ULP-A stated police asked her why they delayed calling 911. ULP-A stated she told police they were supposed to call the on-call nurse first. During an interview on December 5, 2024, at 12:30 p.m., ULP-E stated on October 2, 2024, at 11:00 p.m., she opened R1's door and "peeked" on him, stating R1 was lying flat on his back at that time. ULP-E stated on October 3, 2024, around 3:00 a.m., ULP-B asked her to come to R1's room after he checked on R1. ULP-E stated R1 had "puked" and was gasping for air. ULP-E stated RN-H was called at 3:00 a.m. while they cleaned R1. ULP-E stated staff were trained on	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37315	A. BUILDING: _____ B. WING _____	C 11/25/2024

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02310	Continued From page 8 resident emergencies. During an interview on December 6, 2024, at 8:30 a.m., ULP-F stated on October 2, 2024, at 4:15 p.m. R1 appeared lethargic when another ULP wheeled him up to her medication cart. ULP-F stated, "I thought oh boy, he must not be feeling well." ULP-F stated R1 threw up the orange juice she gave him so she cleaned R1 and brought him back to his room. ULP-F stated at 5:15 p.m., she gave R1 food, but he immediately vomited up his meal in his garbage can. During an interview on December 6, 2024, at 10:12 a.m., primary care provider (PCP)-G of R1 stated although R1 was frail she was surprised he passed so quickly. During an interview on December 6, 2024, at 12:30 p.m., RN-H stated she advised staff to monitor R1. RN-H stated she thought R1 had an "upset stomach" based upon the information she received from staff. RN-H stated she was never updated again until 3:50 a.m. when ULP-E called telling her R1 appeared cold and clammy with an elevated pulse of 102. RN-H stated ULP-E reported R1's breathing was "different" from what it normally was, but she instructed ULP-E to call R1's family to "confirm what their preference" would be." Although RN-H agreed R1's record indicated he was a full code, RN-H refused to answer why she did not advise staff to call 911 first instead of delaying R1's medical treatment by having staff call R1's family first. RN-H stated, "Every family's preference is different. In my experience I've had families choose not to transport someone to the hospital because they don't feel it's in align with the resident's quality of life."	02310		

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02310	Continued From page 9 During follow-up interviews on December 11, 2024, at 2:50 p.m. and 2:55 p.m., ULP-E and ULP-B both confirmed R1 was unresponsive on October 3, 2024, around 3:00 a.m. when they checked on him. In addition, both ULP-A and ULP-E confirmed they told RN-H that R1 was unresponsive when they checked on him. During an interview on December 20, 2024, at 11:30 a.m., LALD-I stated on October 3, 2024, around 3:00 a.m., she received a phone call from ULP-A and ULP-E stating R1 vomited on himself and appeared to not be well. LALD-I stated ULP-A told her she thought R1 needed to "go out," stating ULP-A stated R1 was cold and clammy, stating the phone call lasted 2-3 minutes. LALD-I stated RN-H acted appropriately and staff were following the resident's care plan along with the licensee's policies and procedures through providing R1 with his services and medications. The licensee procedure titled, What Do You Prepare When Calling Triage, undated, staff were to call 911 right away if a resident was found unconscious. TIME PERIOD TO CORRECT: Seven (7) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident	02360		

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02360	Continued From page 10 reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		