

Protecting, Maintaining and Improving the Health of All Minnesotans

# State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL348124663M Date Concluded: March 21, 2023

**Compliance #:** HL348127937C

Name, Address, and County of Licensee Investigated:

Lilac Homes Enhanced Assisted Living Memory
Care
1500 Southwood Drive
Dilworth, MN 56529
Clay County

Facility Type: Assisted Living Facility with Evaluator's Name: Barbara Axness, RN

Dementia Care (ALFDC)
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 the resident when they failed to ensure a resident was provided appropriate treatment following a diagnoses of a urinary tract infection. The resident later died from septic shock.

# **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. A urinalysis indicated the resident had a urinary tract infection (UTI). The resident's provider did not respond to the culture results or order any treatment. However, the resident continued to have symptoms of a UTI, including ongoing blood in his urine, over several days. Facility nurses failed to assess the resident's condition despite staff's continued reports of blood in the resident's urine. Six days after the urinalysis culture was collected, the resident experienced a significant change in condition and level of

consciousness and the facility nurse called 911. The resident was taken to the emergency room where he died four hours later of septic shock attributed to the untreated UTI.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement. The investigation included review of facility records including progress notes, assessments, policies, and employee records, along with a review of hospital/emergency room records, home health records, and lab records. In addition, the investigator observed cares and medication administration at the time of the onsite visit to the facility.

The resident resided in an assisted living with dementia care facility. The resident's diagnoses included urinary retention, benign prostatic hyperplasia (a condition where the flow of urine is blocked due to an enlarged prostate gland), and atrial fibrillation (irregular or fast heartbeat). The resident's service plan included assistance with catheter cares and medication administration. The resident's assessment indicated the resident had a foley catheter (a tube in the urethra that carries urine out of the body) that was managed by an outside home health agency and the resident had a history of UTIs. The resident was not able to complete effective peri-care independently and staff were to assist with cares daily and as needed.

Facility progress notes indicated the resident sustained an unwitnessed fall on a Tuesday and staff reported the resident had blood in his urine, along with increased confusion and behaviors. The resident's primary care provider, a nurse practitioner (NP), was contacted, and a urinalysis was ordered due to hematuria (blood in the urine). The culture was collected that day and initial results came back a few hours later, indicating the resident had a UTI. A culture sensitivity resulted three days later. The lab requisition indicated the ordering NP received results of both cultures on the days they resulted. Facility progress notes indicated several attempts were made to contact the NP about the abnormal results, but no response or new orders were received.

Over the weekend, the resident continued to show symptoms of a UTI and refused cares. Unlicensed personnel (ULP) notified the on-call licensed practical nurse (LPN) about ongoing concerns with blood in the resident's urine and that the resident appeared to be in pain. The on-call LPN failed to send the resident in for further evaluation and failed to contact the facility registered nurse (RN) with the ongoing concerns of blood in the urine after several days of unsuccessful attempts to contact the NP to obtain orders for treatment. No attempts to reach another provider were made and the resident's family was not contacted about the ongoing concerns.

The next Tuesday, the resident fell while walking with staff. The facility RN wrote in a progress note, "[the resident] currently has a UTI that was awaiting treatment from provider. [the resident] did not hit his head but has an overall change in LOC (level of consciousness) due to suspected urosepsis (a condition when an untreated UTI spreads through your urinary tract to your kidney and causes sepsis, an infection of the blood stream.) [the resident] appears pale,

clammy, shaking, and is mumbling his words. No fever present. Blood draining into leg bag. 2+ pitting edema present...this is not baseline for resident. Blood pressure taken at 106/52 (normal range is 120/80), respirations at labored at 28 (normal ranges are 12-20 breaths per minute), oxygen saturation at 86% (normal is above 95%), temperature at 98.2, pulse 90. When asking [the resident] if he wants to go to the hospital, he states "yes" Son updated on the phone...spoke with [nurse practitioner's] nurse who will send a message to provider."

Hospital records included the emergency room (ER) physician's admission note, which contained the following: "Patient examined at bedside, currently is ill, distressed and I suspect sepsis from possible UTI/potential pneumonia...the plan was to admit the patient to the intensive care unit. However, shortly after the intensivist (an intensive care physician) came to see the patient in the ER, the patient became apneic (temporary cessation of breathing) and bradycardic (slow heart rate)." The resident was reported to have a "very thready pulse and very low blood pressure" and after discussions with the family on whether or not to intubate the resident, it was decided to provide only comfort cares. Medications and supplemental oxygen were stopped and the resident "went into a cardiac arrest/asystole (a state of cardiac standstill, no cardiac output)" and was pronounced dead approximately four hours after his arrival in the ER.

The ICU Admission History and Physical note indicated the intensive care physician was "called emergently to bedside due to rapid decompensation (a significant decline in health). I arrived immediately and found ED attending about to intubate due to respiratory arrest (when breathing stops). Patient was also much more hypotensive (abnormally low blood pressure) than an hour ago, which reportedly happened suddenly." The note indicated the ICU admission was canceled after it was decided to proceed with comfort measures only. The ICU physician's note indicated septic shock due to UTI was the primary diagnosis, in addition to acute hypoxic respiratory failure, likely in the setting of septic shock. The history of present illness indicated the resident "apparently had a positive urine culture from six days ago...but was not treated. For the next few days, he gradually became less responsive up to today where he was sent to the ED where he was noted to by hypoxic (low oxygen), hypotensive (low blood pressure), and tachycardic (elevated heart rate)."

During an interview, the facility RN stated she requested for the NP to order a urinalysis after the resident fell and blood was observed in his urine. The RN said the NP placed the order but did not provide further direction on treatment or antibiotics to be initiated if it was confirmed that the resident did have a UTI. The RN indicated she made a few attempts to contact the NP after the culture results came back positive but was never able to get ahold of her. The RN confirmed the resident's family was not updated of any issues of not being able to get ahold of the NP or that the resident had ongoing blood in his urine as "the resident was his own decision maker." The RN said she was not on call over the holiday weekend and when she came back to work on Tuesday, the resident wasn't looking good, appeared very weak, sweaty, clammy, and fell when he was walking with staff. The RN called 911 and had him sent to the emergency room for further evaluation.

During an interview, the facility LPN stated she was notified two days before the resident's death that the resident was having blood in his urine. The LPN said she was on call and staff reported the resident was playing with his catheter and had blood in his urine collection bag. Staff told the LPN that the resident had not reported pain at that time, so she [LPN] advised staff to monitor and call back if he had any pain or blood was increasing and stated she did not get a call back that day. The LPN indicated staff called back the following day as the resident still had blood in his urine collection bag. The LPN was not aware at that time that the resident had been diagnosed with a UTI and no treatment had been initiated. The LPN confirmed the resident's family was not updated of the ongoing reports of blood in his urine collection bag and confirmed the RN was also not notified of the reports of blood or that the facility was having difficulty getting ahold of the NP to obtain orders or further guidance for treatment of the resident's UTI.

During interviews with multiple ULP, it was reported the resident continued to have blood in his urine over the course of several days after the urinalysis was collected. One ULP stated that over the weekend, she was asked to help get the resident get up for breakfast as he was refusing care from another ULP. The ULP remembered walking into his room, and he was sitting in his recliner with no pants on, "just sitting in his brief with his catheter bag, having a lot of bloody urine in it". The ULP asked him what was going on. The resident told her "I don't know, it hurts." The ULP said she was "taken aback" by what she saw in his urine collection bag and didn't think it was normal. The ULP indicated that the resident was normally independent, so it was not normal for him to not want to go to breakfast. The ULP stated she called the on-call nurse twice that day to report her concerns and was directed to continue monitoring. Another ULP remembered the resident had bleeding from his penis over one weekend and that she had called the nurse with her concerns. The ULP was told that someone would come take a look at it, but she didn't see anyone come in before her shift ended and was not sure what happened after she left.

During an interview, the licensed assisted living director (LALD) stated staff contacted the NP after the resident fell and they obtained orders to check his urine. The LALD stated she was not aware of the issues with obtaining treatment orders for the resident until after he had died. The LALD stated to her knowledge, the resident was not symptomatic until the morning he died, and they had attributed the blood in his urine bag to be related to the resident pulling or tugging at the catheter. The LALD did not speak with the facility RN about the incident as she had already put in her notice and had resigned her position. The LALD felt the family should have been called about blood in the urine bag and offered the choice to take the resident in over the weekend before he died. The LALD stated, "it's just hard when we made all these phone calls, and no one got back to us."

During an interview with the resident's family member, they stated they were not aware the resident was not being treated for his UTI or that the facility was having issues getting ahold of his provider. The family member stated they were made aware of the resident's UTI when they

saw a notification pop up from the app for his healthcare system medical record that indicated his urine culture came back positive. The family member stated they did not receive any communication from the facility on results or what was going to be done to treat it. The family member stated they were not made aware of ongoing concerns with blood in the resident's urine collection bag. The family member said, "it seemed like they just let him sit there, he was just lying there sick, no one called for an ambulance until he was severely sick...They could have called the ambulance before that, he had pretty significant symptoms, blood in the urine and pain."

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:

- (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: No, deceased Family/Responsible Party interviewed: Yes Alleged Perpetrator interviewed: Not Applicable

## Action taken by facility:

No action taken.

### **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 651-201-4890 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
Clay County Attorney
Dilworth City Attorney
Dilworth Police Department
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing
Medical Examiner

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		(X3) DATE SURVEY COMPLETED	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Minnesota Department of Health

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	COMPLETED		
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ginosa. Home health nurse				
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	normal is above 95%), 2, pulse 90. When asking [R1]				
	the hospital, he states "yes"				
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Hospital records inc	dicated the resident arrived at				
the emergency rooi	m (ER) on December 27,				
	The ER physician's tained the following: "Patient				

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0 620	and I suspect sepsi pneumoniathe plate the intensive care unintensivist came to patient became apport breathing) and brack resident was report pulse and very low discussions with the intubate the resider only comfort cares. supplemental oxygoresident "went in to state of cardiac state was pronounced deapproximately four ER.  The ICU Admission from December 27, care physician was due to rapid decomple in health). I ED attending about arrest (when breath much more hypoter pressure) than an intensive care in health and in the pressure) than an intensive care in the pressure in the pr	le, currently is ill, distressed, is from possible UTI/potential an was to admit the patient to unit. However, shortly after the see the patient in the ER, the enic (temporary cessation of dycardic (slow heart rate)." The ed to have a "very thready blood pressure" and after e family on whether or not to nt, it was decided to provide Medications and en was stopped and the a cardiac arrest/asystole (a ndstill, no cardiac output)" and ead at 3:45 p.m., hours after his arrival in the "History and Physical note 2022, indicated the intensive "called emergently to bedside pensation (a significant arrived immediately and found to intubate due to respiratory sing stops). Patient was also nsive (abnormally low blood four ago, which reportedly				
	admission was can proceed with comfort physician's note independent	v." The note indicates the ICU celed after it was decided to ort measures only. The ICU licated septic shock due to y diagnosis in addition to				
	acute hypoxic respinsetting of septic should illness indicated the positive urine culturnot treated. For the became less response	ratory failure, likely in the ock. The history of present resident "apparently had a re from six days agobut was next few days, he gradually nsive up to today where he where he was noted to by				

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  LILAC HOMES ENHANCED ASSISTED LIVING  SUMMARY STATEMENT OF DEFICIENCIES DIWORTH, MN 58529  CX4) ID PRECEDUATOR OR LISE DIECTIONS IN THE PRECEDED BY FULL PRECEDED B	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER  LILAC HOMES ENHANCED ASSISTED LIVING  SUMMARY STATEMENT OF DEFICIENCIES (LEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG)  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG)  TAG  O 620  Continued From page 6 hypoxic (low oxygen), hypotensive (low blood pressure), and tachycardic (elevated heart rate).  On February 9, 2023, at 1.35 p.m., family member (FM)-H stated they were not aware R1 was not being treated for his UT1 or that the facility was having issues getting shold of his provider. FM-H stated they were made aware of the resident's UT1 when they saw a MyChart notification (electronic medical record used by the clinic) pop up that indicated his urine culture came back positive. FM-H stated they did not get any communication from the facility on results or what was going to be done to treat it. FM-H stated they were not made aware of ongoing concerns with blood in the resident's urine collection bag leading up to the holiday weekend or over the weekend.  On February 17, 2023, at 11:15 a.m., ULP-I stated she had worked with R1 since he admitted to the facility. ULP-I stated she remembered the resident was bleeding from his penis and it happened on a weekend. ULP-I did not recall any other instances where the resident had blood in his unine collection bag. ULP-I stated she came would come in to look at it. ULP-I stated the resident refused help with cares one morning and that was not normal for him. ULP-I stated she had not seen a nurse or anyone come in to look at R1 by the end of her shift so she had no idea what happened next. ULP-I stated the no call nurse will answer questions and tell them what to do next and they follow whatever the nurse directs them to do, ULP-I stated she cant call 911 without		24040	B WING		
SUMMARY STATEMENT OF DEFICIENCIES   DEPRETAL   SUMMARY STATEMENT OF DEFICIENCIES   DEPRETAL   CACHO DEFICIENCY MUST BE PRECEDED BY FULL   DEPRETAL   TAG   DEPRETAL   CACHO DEFICIENCY MUST BE PRECEDED BY FULL   DEPRETAL   TAG   DEPRETAL   CACHO DEFICIENCY MUST BE PRECEDED BY FULL   DEPRETAL   TAG   DEPRETAL   CACHO DEFICIENCY   DATE		34812	D. WING		02/17/2023
PREFIX TAG  REGULATORY OR ISC IDENTIFYING INFORMATION)  O 620  Continued From page 6 hypoxic (low oxygen), hypotensive (low blood pressure), and tachycardic (elevated heart rate).  On February 9, 2023, at 1:35 p.m., family member (FM)-H stated they were not aware R1 was not being treated for his UTI or that the facility was having issues getting ahold of his provider. FM-H stated they were made aware of the resident's UTI when they saw a MyChart notification (electronic medical record used by the clinic) pop up that indicated his urine culture came back positive. FM-H stated they did not get any communication from the facility on results or what was going to be done to treat it. FM-H stated they were not made aware of ongoing concerns with blood in the resident's urine collection bag leading up to the holiday weekend or over the weekend.  On February 17, 2023, at 11:15 a.m., ULP-I stated she had worked with R1 since he admitted to the facility. ULP-I stated she remembered the resident was bleeding from his penis and it happened on a weekend. ULP-I stated she called the on call nurse said someone would come in to look at it. ULP-I stated she removing and that was not normal for him. ULP-I stated he resident refused help with cares one morning and that was not normal for him. ULP-I stated the no call nurse will answer questions and tell them what to do next and they follow whatever the rurse directs them to do. ULP-I stated she called the on call nurse will answer questions and tell them what to do next and they follow whatever the rurse directs them to do. ULP-I stated she called the on call nurse will answer questions and tell them what to do next and they follow whatever the rurse directs them to do. ULP-I stated she called the on call nurse will answer questions and tell them what to do next and they follow whatever the rurse directs them		SSISTED LIVING 1500 SOU	THWOOD D	RIVE	
hypoxic (low oxygen), hypotensive (low blood pressure), and tachycardic (elevated heart rate).  On February 9, 2023, at 1:35 p.m., family member (FM)-H stated they were not aware R1 was not being treated for his UTI or that the facility was having issues getting ahold of his provider. FM-H stated they were made aware of the resident's UTI when they saw a MyChart notification (electronic medical record used by the clinic) pop up that indicated his urine culture came back positive. FM-H stated they did not get any communication from the facility on results or what was going to be done to treat it. FM-H stated they were not made aware of ongoing concerns with blood in the resident's urine collection bag leading up to the holiday weekend or over the weekend.  On February 17, 2023, at 11:15 a.m., ULP-I stated she had worked with R1 since he admitted to the facility. ULP-I stated she remembered the resident was bleeding from his penis and it happened on a weekend. ULP-I did not recall any other instances where the resident had blood in his urine collection bag. ULP-I stated she called the on call nurse and told her what was happening and the nurse said someone would come in to look at it. ULP-I stated the resident refused help with cares one morning and that was not normal for him. ULP-I stated she had not seen a nurse or anyone come in to look at R1 by the end of her shift so she had not idea what happened next. ULP-I stated the on call nurse will answer questions and tell them what to do next and they follow whatever the nurse directs them to do. ULP-I stated she can't call 911 without	PREFIX (EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE COMPLETE
appioval, i have to go with what the huise says	hypoxic (low oxyge pressure), and tach On February 9, 202 member (FM)-H state was not being treat facility was having in provider. FM-H state the resident's UTI would not ification (electroclinic) pop up that it came back positive any communication what was going to be they were not made with blood in the releading up to the howekend.  On February 17, 20 stated she had wor to the facility. ULP-resident was bleed happened on a week other instances whis urine collection the on call nurse and happening and the come in to look at it refused help with continuous and they follow what to do. ULP-I stated	n), hypotensive (low blood ycardic (elevated heart rate).  3, at 1:35 p.m., family ated they were not aware R1 ed for his UTI or that the ssues getting ahold of his ed they were made aware of when they saw a MyChart nic medical record used by the adicated his urine culture. FM-H stated they did not get from the facility on results or be done to treat it. FM-H stated aware of ongoing concerns sident's urine collection bag oliday weekend or over the stated she remembered the ng from his penis and it exend. ULP-I did not recall any ere the resident had blood in bag. ULP-I stated she called and told her what was nurse said someone would at ULP-I stated the resident ares one morning and that was ULP-I stated she had not yone come in to look at R1 by so she had no idea what P-I stated the on call nurse will not tell them what to do next atever the nurse directs them			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	` '	E SURVEY PLETED	
		34812	B. WING			C <b>17/2023</b>
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOU	DRESS, CITY, ST JTHWOOD DF TH, MN 56529	RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
0 620	assisted living direct contacted NP-E after and they obtained of LALD-A stated she with obtaining treater after he had died. Liknowledge, R1 was December 27, 2022 blood in his urine be pulling or tugging as she did not speak was since she had alread resigned her position had not considered didn't believe negles spoken with the number and felt they should about the blood in his the choice to take his December 24, 2022 when we made all the got back to us."	ge 7 23, at 1:30 p.m., licensed ctor (LALD)-A stated staff had er R1's fall on December 21st orders to check his urine.  was not aware of the issues ment orders for R1 until he ALD-A stated to her is not symptomatic until 2 and they had attributed the ag to be related to the resident at the catheter. LALD-A stated with RN-B about this incident ady put in her notice and had on. LALD-A stated the facility filing a MAARC report as she ct occurred but she had reses involved in the incident of the layer called to let family known is urine bag and given them aim in over the weekend of 2. LALD-A stated "it's just hard these phone calls and no one				
	nurse (RN)-B stated order for a urinalysis in his urine on Decetor the resident was now was out of the normal state.	d she had asked NP-E for an safter R1 had a fall and blood ember 21, 2022. RN-B stated a huge fall risk so the fall for him and the symptoms o indicate a UTI. RN-B stated				
	her to NP-E and she report her concerns stated NP-E placed did not give any direct treatment or antibio UTI. RN-B stated sto contact NP-E after the contact NP-E	e spoke directly with her to on a potential UTI. RN-B an order for a urinalysis but ection at that time on tics if it was verified he had a he had made a few attempts er the culture came back ver able to get ahold of her.				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE	
	34812	B. WING		02/1	; 7/2023
LILAC HOMES ENHANCED ASSISTED LIVING		DRESS, CITY, S THWOOD D H, MN 5652		•	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
any issues with not NP-E or that the resurine as "the reside maker." RN-B state holiday weekend ar work on Tuesday, E resident wasn't look weak, sweaty, clam was walking with st 911 and had him se further evaluation. If what follow up actions had investigated the employment there were catheter and had blue the temployment that R1 was having morning. LPN-D stated staff reporting pain at the monitor and call ba was increasing and that day. LPN-D stated day, December 26, blood in his urine conshe was not aware been diagnosed with any treatment for it, not been updated on in his urine collections upervisor (LALD-A reports of blood or the difficulty getting and further guidance for the state of the stat	's family was not updated of being able to get ahold of sident had ongoing blood in his nt was his own decision d she was not on call over the nd when she came back to becember 27, 2022, the sing good and appeared very my, and had a fall when he aff. RN-B stated she called ent to the emergency room for RN-B stated she wasn't sure on was done or if the facility endent as her last day of was December 31, 2022.  23, at 9:25 a.m., LPN-D fied on December 25, 2022, blood in his urine that atted she was not in the facility endent was seen playing with his good in his urine collection bag. The reported the resident was not at time so she advised staff to call the had any pain or blood she did not get a call back atted staff called back the next 2022, as the resident still had believed that time the resident had her a UTI and had not started LPN-D stated R1's family had for the ongoing reports of blood on bag and the clinical nurse of had not been notified of the chat the facility was having old of NP-E to obtain orders or				

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>`</b>	E CONSTRUCTION	COMP	SURVEY
		34812	B. WING		02/1	7/2023
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOU	DRESS, CITY, S THWOOD D H, MN 5652			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)	D BE	(X5) COMPLETE DATE
0 620	R1 up the morning because they were ULP-G stated the obeen like this yeste and wasn't letting hulp-G stated she room and he was sipants on, just sitting bag having a lot of stated the drainage urine in it and she hon. R1 told her "I do stated she knew the played with his cath was doing that as the mear his private so bad." ULP-G stawhat she saw in his didn't think it was no normally pretty indefor him to not want stated she had called day to report her co-could not recall if shresident had a UTI.  As of February 23, submitted a MAARG of R1.  The licensee's undand investigation power would report any suneglect or financial Statutes 626.5572) [assisted living residence] [assisted living residenc	ed by another ULP to help get of December 26, 2022, having trouble getting him up. ther ULP told her R1 had rday (December 25, 2022) er get anywhere near him. emembered walking in his atting in his recliner with no g in his brief with his catheter bloody urine in it. ULP-G tube had the same discolored ad asked him what was going on't know, it hurts." ULP-G ere were previous times he eter and thought maybe he he resident "wouldn't even let area because he said it hurt ted she was taken aback by urine collection bag and ormal. ULP-G stated R1 was pendent so it was not normal to go out for breakfast. ULP-G ed the on call nurse twice that nocerns. ULP-G stated she he knew at that time the	0 620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE S	
		34812	B. WING		0 <b>2/1</b>	; 7/2023
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOU	DRESS, CITY, S THWOOD D H, MN 5652			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
0 620	Continued From pa	ge 10	0 620			
	No further informati	on was provided.				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
01390 SS=I		n 1 Availability of contact	01390			
	registered nurse av performing delegate have an appropriate	acilities must have a ailable for consultation by staff ed nursing tasks and must e licensed health professionaling other delegated services				
	by: Based on interview licensee failed to en was available for condelegated nursing to the licensee failed to en consultation to staff tasks when it designance (LPN) as the	and document review, the sure a registered nurse (RN) onsultation to staff performing asks for one of one resident eviewed. In addition, the sure a RN was available for performing delegated nursing nated a licensed practical nurse on call and failed to n call for consultation.				
	violation that harmed not including serious or a violation that has serious injury, impa- issued at a widesprare pervasive or rep	ed in a level three violation (a ed a resident's health or safety, s injury, impairment, or death, as the potential to lead to irment, or death) and was ead scope (when problems present a systemic failure that potential to affect a large residents).				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		34812	B. WING		02/1	7/2023
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOU	DRESS, CITY, S  JTHWOOD D  TH, MN 5652	<del></del>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
01390	concerns regarding R1's urine culture readdressed. The LPRN when symptoms tract infection persist The resident was set (ER) six days after symptoms of a UTI several days of repurine collection bag shock (a widespread failure and dangerous shortly after arriving Review of medical indicated R1 received dressing, grooming management, cather and medication admitted R1's most recent as 2022, indicated R1 with a history of UT assistance daily and effective peri-cares staff to check R1's empty as needed. The standard received resident and medication admitted R1 with a history of UT assistance daily and effective peri-cares staff to check R1's empty as needed. The standard received resident received resident received resident received resident received received resident received rece	led to contact the RN when the provider's response to esult were not immediately N on call failed to contact the sconsistent with a urinary sted over a holiday weekend. ent to the emergency room a urinalysis was collected and were first observed, including orts of blood in the resident's. The resident died of septic diffection causing organ usly low blood pressure) to the ER.  record indicated R1's urinary retention, benign a (a condition where the flow due to an enlarged prostate orillation (irregular or fast heart lated October 27, 2022, ed staff assistance with, bathing, behavior eter care three times per day, ministration.  seessment dated November 9, had a Foley catheter in place I's. R1 required staff das needed to complete. The assessment directed catheter bag at night and The assessment indicated an hagency managed R1's				

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DATE S  COMPL		
		34812	B. WING		02/1	7/ <b>2023</b>
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOU	DRESS, CITY, S THWOOD D H, MN 5652			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
01390	(UA) and urine culture the presence of blooming R1's behaviors, in R1's medical record Unlicensed personned December 22, 2022 blood mixed with ur collection bag.  A progress note data indicated staff faxed practitioner (NP)-E	d identified that on other 21, 2022, a urinalysis are was ordered for R1 due to od in the urine and a change ocluding a fall.  I included documentation by nel (ULP) on Thursday, 2, that R1 continued to have ine in the resident's urine  ed December 22, 2022, at the UA results to the nurse (R1's provider). The progress is a response from NP-E	01390			
	documented in R1's received a call that morning. It is stated catheter at times. Very becomes upset. No another call to follow play with it from times showing and (sic) seto update nurse if he showing pain, or blow having adequate out provider during bus sooner."  R1's Treatment Received documentation enterests, 2022, during the	ber 25, 2022, LPN-D a medical record "nurse on-call [R1] had blood in his urine this I that he plays with his When trying to redirect him he pain noted. Nurse placed w up on him, he continues to e to time. He still is not ign of pain. Caregivers asked e pulls out the catheter, is not increases. He is still atput. Will follow up with iness hours if not needed ered on Sunday, December e overnight shift, ULP-J resident's catheter is clot with se's attention."				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		34812	B. WING			C <b>17/2023</b>
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOL	DRESS, CITY, ST JTHWOOD DF TH, MN 56529	RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
01390	R1's medical record blood in his urine. Out at his catheter ofter system] home head awaiting UC (urine provider to be updated R1's progress notes at 7:11 p.m., identificantly from Monday, "yesterday I went to sitting with no pants help him I noticed he tubing was full of blyou could tell he wanurse and she took call at that time was During this time, ne assisted living direct concerns of blood in and that NP-E maded treatment for R1's UNA progress note data indicated R1 had a currently has a UTI from provider. [R1] overall change in Ledue to suspected uplood). [R1] appear is mumbling his wood raining into leg bas presentthis is not pressure taken at 1 120/80), respiration ranges are 12-20 by	2022, LPN-D documented in d "[R1] continues to have Caregivers stated that he pulls in Message left for [healthcare th with no return call. Still culture) results. Primary ited next business day."  Is dated December 27, 2022, ited ULP-G documented a late in December 26, 2022, ited ULP-G documented a late in December 26, 2022, ited get [R1] for breakfast he was it is bag was full of blood, the lood, brief was full of blood, the lood, brief was full of blood and it is pain. We called on call it from there." The nurse on it is a LPN.  Setther RN-B or the licensed corn (LALD)-A/RN, were D regarding the ULPs ongoing in R1's urine, reports of pain, it is unine, re				

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/\! Boilebii\o		COMPLETED
		С
<b>34812</b> B. WING		02/17/2023
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST	TATE, ZIP CODE	
LILAC HOMES ENHANCED ASSISTED LIVING DILWORTH, MN 56529		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
temperature at 98.2, pulse 90. When asking [R1] if he wants to go to the hospital, he states "yes" Son updated on the phonespoke with NP-E's nurse who will send a message to provider."  Review of R1's hospital records indicated R1 arrived at the emergency room (ER) on December 27, 2022, at 11:38 a.m. The ER physician's admission note indicated R1 appeared distressed from sepsis from possible UTI. The plan was to admit R1 to the intensive care unit (ICU), however R1 declined quickly and died in the ER at 3:45 p.m., before they were able to transfer him to the ICU. The ICU physician documented R1's admitting diagnosis was septic shock due to a UTI and R1 "apparently had a positive urine culture from six days agobut was not treated. For the next few days, he gradually became less responsive up to today"  During an interview on February 9, 2023, at 1:35 p.m., family member (FM)-H stated they were not aware R1 was not being treated for his UTI or that the facility was having issues contacting R1's provider. FM-H stated they were made aware of the resident's UTI when they saw a "My Chart" (electronic medical record) notification that indicated R1's urine culture came back was positive. FM-H stated they did not get any communication from the facility or the on call nurse on results or what was going to be done to treat it. FM-H stated they were not made aware of ongoing concerns with blood in the resident's urine collection bag. FM-H stated "it seemed like they just let him sit there, he was just laying there sick, no one called for an ambulance until he was severely sickThey could have called the ambulance before that, he had pretty significant symptoms, blood in the urine and pain."		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		34812	B. WING		<b>02/1</b>	) 7/2023
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOU	DRESS, CITY, S THWOOD D TH, MN 5652			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01390	11:15 a.m., ULP-I signeris the weekend reported the concernon-call nurse stated an assessment. UL with cares one more for him. ULP-I state visited R1 that day. The on-call nurse wiresidents, report condirection to staff. Uthallowed the licensed emergency transpoond uring an interview a.m., registered nurcontacted R1's provurinalysis after R1 find with symptoms of a RN-B stated when the she was unsuccess positive culture. RN not updated of any get ahold of NP-E congoing blood in his his own decision manot on call from the 2022, through the necession of the staff. RN-B stated evaluation at a local wasn't sure what for the facility had investigated and scheduled the on call scheduled the on call scheduled.	on February 17, 2023, at tated R1 was bled from his of December 23, 2022. ULP-I rns to the on-call nurse. The someone would visit R1 for P-I stated R1 refused help ning and that was not normal d she was not aware a nurse ULP-I stated staff contacted th questions about the ncerns, and to provide P-I stated the licensee only d nurse to contact 911 for	01390			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMP	SURVEY
		34812	B. WING		02/1	7/ <b>2023</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
LILAC H	OMES ENHANCED AS	SSISTED LIVING	THWOOD D H, MN 5652			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
	a.m., LPN-D stated nurse on December reported R1 played blood in his urine the had no pain thereformonitor R1 and call increased bleeding not call back with conext day, December LPN-D due to R1's urine collection bag aware at that time the with a UTI or started LPN-D stated R1's of the ongoing reported.	on February 21, 2023, at 9:25 she was the nurse on-call 25, 2022, when a ULP with his catheter and had at morning. LPN-D stated R1 re, she directed the ULPS to back with any signs of pain or LPN-D stated the ULPs did oncerns. LPN-D stated the r 26, 2022, a ULP contacted continued having blood in his . LPN-D stated she was not hat R1 had been diagnosed d on treatment for the UTI. family had not been updated rts of blood in his urine LPN-D stated she did not				
	notify the clinical number of the continued repartite facility continued obtain orders or further a.m., ULP-G stated cares the morning of because they were ULP-G stated the obeen like this yester and wasn't letting hulled the cathete previously played was maybe he was doin me near his private	rse supervisor (LALD-A)/RN ports of blood in R1's urine or difficulty contacting NP-E to ther guidance for R1's UTI.  on February 21, 2023, at 9:55 assisted another ULP with of December 26, 2022, having trouble getting him up. ther ULP told her R1 had rday (December 25, 2022) er get anywhere near him. At in his recliner in a brief and r bag. ULP stated R1 ith his catheter and thought g that as R1 "wouldn't even let area because he said it hurt				
	what she saw in his didn't think it was no normally pretty indefor him to not want	ted she was taken aback by urine collection bag and ormal. ULP-G stated R1 was pendent so it was not normal to go out for breakfast. ULP-G the nurse on-call (LPN-D)				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		34812	B. WING		02/	C <b>17/2023</b>
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOL	DRESS, CITY, STATEMENT OF THE STATEMENT	RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
01390	stated their process the decision on call ULPs to call 911, as on hospice so they nursing. LALD-A ac choose not to treat staff called 911.  RN ON CALL SCHI The licensee failed nurse on call was a facility utilized a cal licensed practical n first contact for ULF The licensee identif nurse on the RN ca on the schedule wh provide further cont contact the RN.  Review of the licens dated October 2022 2022, January 2023 a mix of LPNs and on-call. The schedu on-call to back-up t required consultation contact information needed to contact to -Out of 31 days in of the on call schedule 2022, RN on-call so was on vacation Oc 2022. A LPN was lice October 17 through	port her concerns.  23, at 1:30 p.m., LALD-A was to have the nurse make ing 911 versus allowing the sthey have a lot of residents have them go through lded a number of families so they would not be happy if  EDULE:  to ensure the designated registered nurse (RN). The I triage service and scheduled urses (LPN)s on-call and the Ps to report resident concerns. fied the LPNs as the on-call all schedule and did not specify the ther a RN was available or tact information for staff to  see's nurse on-call schedule process on the left of the RN was available or tact information for staff to the left of the RN when the LPN on of a residents condition and for the RN when the ULPs	01390			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE S COMPL	
	24040	B. WING		C 00/4	
	34812	D. WING		02/1	7/2023
NAME OF PROVIDER OR SUPPLIER  LILAC HOMES ENHANCED AS	SSISTED LIVING 1500 SOU	THWOOD D			
	DILWORT	H, MN 5652	9		
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01390 Continued From pa	ge 18	01390			
consultation by the was out of the office. Out of 30 days in the on call schedule. Out of 31 days in the on call schedule. Out of 31 days in the on call schedule. Out of 28 days in the on call schedule. Out of 28 days in the on call schedule. Out of 28 days in the on call schedule. Out of 28 days in the on call schedule. Out of 28 days in the on call schedule. Out of 28 days in the on call schedule. Out of 28 days in the on call schedule. Out of 28 days in the on call schedule. Out of 28 days in the on call schedule. Out of 28 days in the on call schedule. Outpelled investigator the contact the nurse of receptionist called 'service verified staticall to the nurse on have personal num to go through Ruby the list for the staff phones used only we stated when a LPN the issue themselve to a RN. ULP-L staticontact 911 unless and a resident coul nurse approval. UL contact the DON [difeel like you're bein but we can't overrid. Ouring an interview 1:30 a.m., was as where contact infor located. ULP-I show	ULP's during the time LALD-A e. November, 2022, a RN was on e for 13 days. December, 2022, a RN was on e for 13 days. Ianuary, 2023, a RN was on e for 9 days. February, 2023, a RN was on e for 7 days.  The stated of the stated the stated when needed, staff on-call through a virtual stated when needed, staff on-call through a virtual stated when transferred their call. ULP-L stated the stated they do not bers for the nurses and have on the telephone numbers on nurses were to their portable when at the facility. ULP-L was on call, the LPN handled are and it does not get referred the they would not be able to it had been okayed by a nurse of not be sent in without a P-L stated, "I guess you could irector of nursing] if you don't g heard by the on call nurse,				
<u>-</u>	'Ruby" was programmed in to ated staff use "Ruby" to				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		34812	B. WING			C 1 <b>7/2023</b>
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOU	DRESS, CITY, ST THWOOD DF H, MN 56529			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
01390	LPN was scheduled any nursing related not be contacted. Use contact who is on call. It is a binder with contact at the nurses stational listed were for the return they used while at the service of the nurses listed for nurses we numbers only answer a ULP needed to concern they would triage and concerns and did nurse would triage and contact her if there LALD-A stated whe call, the LPN manaccontact her if there LALD-A/RN stated LPNs. LALD-A confine contact for two local and was considered and divided her time LALD-A stated she	n call. ULP-I stated when the d on call, they would answer questions. and the RN would ILP-I stated they would have to all and couldn't call the RN if ULP-I showed the investigator of numbers for nurses located in and stated the numbers hurse's portable work phones he facility.  on February 17, 2023, at confirmed ULPs did not have es numbers and the numbers are for the work phone for the scheduled nurse for the work phone for the formation and the nursing for the scheduled on something.  on February 17, 2023, at 1:30 med she is also a RN. The non something.  on February 17, 2023, at 1:30 med she is also a RN. The non something.  on February 17, 2023, at 1:30 med she is also a RN. The non something.  The she was the back up for the firmed she was the back up for the firmed she was the Director of the total Nurse Supervisor to be tween the two locations, was always available to staff.				
	2019, indicated a reavailable for consul	all policy, dated December 23, egistered nurse would be tation at all times when staff ces to clients [residents] and				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPI	LETED
		34812	B. WING		02/1	7/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LILAC H	OMES ENHANCED AS	SSISTED LIVING	THWOOD D H, MN 5652			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
01390	Continued From pa	ge 20	01390			
	to respond to conce and clients' [resider licensee would makensure RN coverage whenever staff was when regular nursing vacation or on sick to call "Ruby" (the vacatio	erns from clients [residents] hts'] representatives. The ke adequate provisions to le was available at all times providing services, including http://www.mas.org/liented/lien				
	by: Based on interview licensee failed to en change in condition	and record review, the sure reporting of a resident's to the appropriate supervisor essional for one of one				

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	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMP	PLETED
		34812	B. WING			7/ <b>2023</b>
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOU	DRESS, CITY, S THWOOD D TH, MN 5652			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
02320	a urinary tract infect failed to assess the continued to report. The resident experi condition and chang and later died from infection causing or low blood pressure; addition, the license place for nurse to n follow-up on R1's coattempts to contact medication and/or ton-call service utiliz (LPN)s as first contrequirement to informurse (RN).  This practice results or death), and was (when one or a limit affected or one or a involved, or the situ occasionally).  The findings included Prostatic hyperplasi of urine is blocked of gland), and atrial fit beat).	ewed following a diagnoses of tion (UTI). Facility nurses resident's condition after staff blood in the resident's urine. enced a significant change in ge in level of consciousness septic shock (a widespread gan failure and dangerously) related to the UTI. In the failed to have a system in the urse communication to ensure condition, pending lab results, the physician, or pending reatment orders. The facility's the ed licensed practical nurses act for staff without a sin serious injury, impairment, issued at an isolated scope and the facility of the ed number of residents are a limited number of staff are ation has occurred only  etc.  dical record indicated R1's urinary retention, benign a (a condition where the flow due to an enlarged prostate orillation (irregular or fast heart				
	indicated R1 receive grooming, bathing,	lated October 27, 2022, ed assistance with dressing, behavior management, times per day, and medication				

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AND PLAN OF CO	PRECTION	IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPLE	
		34812	B. WING		C <b>02/17</b> /	2023
	DER OR SUPPLIER	SSISTED LIVING 1500 SOL	DRESS, CITY, S  JTHWOOD D  H, MN 5652		-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
R1's 2022 in the assistance of the cather age.  R1's 2022 in the assistance of the cather age.  R1's 1's 1's 1's 1's 1's 1's 1's 1's 1's	e urethra that of had a history of stance for daily assessment directly assessment indicated and an analysis of the factor of th	ssessment dated November 9, had a Foley catheter (a tube carries urine out of the body) f UTI's. R1 required staff and as needed for peri cares. rected staff to check R1's at and empty as needed. The ed an outside home health at smonthly catheter change.  Cap Summary dated indicated unlicensed documented catheter care morning because staff doesn't e new catheter."  dated December 18, 2022, registered nurse (RN)-B R1 atheter tubing and tied it to his ne to leak all over his bed and adicated the housekeeper leaned the resident's carpets of for similar incidents.  ted December 21, 2022 in unwitnessed fall. A note was sioner (NP)-E to review the nother facility. Later that fied RN-B R1 had blood ent's urine. RN-B updated in as charted by the caregivers. orders to RN-B to obtain a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
	34812	B. WING		02/1	7/2023
NAME OF PROVIDER OR SUPPLIE	ASSISTED LIVING 1500 SOL	DDRESS, CITY, S  JTHWOOD D  TH, MN 5652			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
02320 Continued From	page 23	02320			
(LPN)-C document from [unaffiliated 12/22/2022. UA (unaffiliated 12/222. Ua (unaffiliated 12/2	s to be faxed to NP-E." The UTI was present.  ated the urine was collected on ember 21, 2022, with the results dering provider, NP-E. The e-testing due to insufficient on December 24, 2022, at 12:50 Iture sensitivity results were				
R1's medical reco	, 2022, RN-B documented in ord a late entry from Thursday, 22 indicating the lab results R1's provider.				
R1's medical reco December 23, 20	, 2022, RN-B documented in ord a late entry from Friday, 22, indicating the lab results or R1's provider again.				
LALD-A/RN or mand holiday weekend on-call provider, for work and was off. The facility utilized schedule, leaving on call over the holiday weekend on call over the holiday weekend on call over the holiday weekend on call provider, for work and was off.					
On Sunday, Dece	mber 25, 2022, LPN-D				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		34812	B. WING		02/1	) 7/2023
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOU	DRESS, CITY, S THWOOD D H, MN 5652			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPORTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
02320	received a call that morning. It is stated catheter at times. We becomes upset. No another call to follow play with it from times showing and (sic) is to update nurse if he showing pain, or blow having adequate our provider during bus sooner."  There was no docut LPN-D assessed Resolved in R1's urine, RN of R1's ongoing regarding the provider durine culture results notify R1's family of R1's Treatment Recomber 25, 2022 catheter is clotted we attention."  On December 26, 28 R1's medical record blood in his urine. On this catheter ofter system home health awaiting UC (urine provider to be updated). On December 27, 28 documented in R1's from Monday, December 18, 29 from Monday, December 27, 20 from Monday, December 28, 20 from Monday,	ge 24  If medical record "nurse [R1] had blood in his urine this I that he plays with his When trying to redirect him he pain noted. Nurse placed w up on him, he continues to e to time. He still is not ign of pain. Caregivers asked e pulls out the catheter, is odd increases. He is still itput. Will follow up with iness hours if not needed  mentation provided to indicate 1 after staff notified LPN-D of failed to notify the licensee's UTI symptoms, and concerns der's lack of response to R1's in addition, LPN-D failed to R1's change of condition.  Cap Summary dated 2, indicated "the resident's with blood, it needs nurse's caregivers stated that he pulls in Message left for [healthcare in with no return call. Still culture) results. Primary ted next business day."  2022, at 7:11 p.m., ULP-G is medical record a late entry imber 26, 2022, "yesterday I breakfast he was sitting with asked if I could help him I	02320			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		` '	(X3) DATE SURVEY COMPLETED	
		34812	B. WING			C <b>17/2023</b>
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOL	DRESS, CITY, ST JTHWOOD DF H, MN 56529	RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
02320	full of blood, brief we tell he was in pain. She took it from the time was a LPN.  LPN-D again failed ongoing reports of and take immediate for the resident. LP results had not bee immediately notify ton-call RN of this a showing symptoms notify R1's family of On December 27, 2 work after the holid documented in R1's urine culture, called attempted to fax it home health nurse culture grew Citrob pseudomonas aeru inquiring about cath due soon. Message regarding this and and clarification on RN-B entered two a December 27, 2022 a.m. indicated, "[R1 where he was unstand and clarification on that was awaiting the did not hit his head LOC (level of conscurosepsis (a condit spreads through your specific property to the condition of t	s full of blood, the tubing was as full of blood and you could We called on call nurse and tre." The nurse on call at that to appropriately assess the blood in the resident's urine action to seek further care N-D was aware urine culture in addressed and failed to the resident's provider and the ind that the resident was still of a UTI. LPN-D failed to f what was going on.  2022, when she returned to ay weekend, RN-B is medical record "awaiting I lab who stated they have the times. Received call from the income that the relayed to me that	02320			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		` '	(X3) DATE SURVEY COMPLETED	
		34812	B. WING			C <b>17/2023</b>
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOU	DRESS, CITY, S ITHWOOD DE TH, MN 56529			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPROPRIES (EACH COSS-REFERENCE)	ULD BE	(X5) COMPLETE DATE
02320	and is mumbling his Blood draining into presentthis is not present taken at 1 120/80), respiration ranges are 12-20 b saturation at 86% (temperature at 98.2 if he wants to go to Son updated on the nurse who will send A records request v system NP-E worke and again on Februare and again on Februare are sident's urine cult requests were unable reason listed as, "V facility for the dates." Hospital records incompatible and I suspect sepsion pneumoniathe plants and I suspect sepsion pneumoniathe plants in the intensive care unitensivist came to patient became appropriate and very low discussions with the	ars pale, clammy, shaking, s words. No fever present. leg bag. 2+ pitting edema baseline for resident. Blood 06/52 (normal range is s at labored at 28 (normal reaths per minute), oxygen normal is above 95%), 2, pulse 90. When asking [R1] the hospital, he states "yes" phonespoke with NP-E's a message to provider."  Was sent to the health care and for on February 1, 2023, lary 16, 2023, requesting all left for December 1 through 2, including communication and notes related to the sure ordered by NP-E. Both ole to be fulfilled with the left to be fulfilled with the left of service you requested."  dicated the resident arrived at an (ER) on December 27, The ER physician's stained the following; "Patient left, currently is ill, distressed is from possible UTI/potential an was to admit the patient to unit. However, shortly after the see the patient in the ER, the enic (temporary cessation of lycardic (slow heart rate)." The ed to have a "very thready blood pressure" and after a family on whether or not to out, it was decided to provide	02320			

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		34812	B. WING			C <b>17/2023</b>
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOU	DRESS, CITY, S ITHWOOD DI TH, MN 56529			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
02320	resident "went in to state of cardiac sta was pronounced de approximately four ER.  The ICU Admission from December 27 care physician was due to rapid decom decline in health). I ED attending about arrest (when breath much more hypoter pressure) than an happened suddenly admission was can proceed with comform physician's note incut UTI was the primar acute hypoxic respisetting of septic she illness indicated the positive urine cultur not treated. For the became less respo was sent to the ED hypoxic (low oxygen pressure), and tach On February 9, 202 member (FM)-H state was not being treat facility was having it provider. FM-H state the resident's UTI was notification (electron to state of the care in the c	en was stopped and the a cardiac arrest/asystole (a ndstill, no cardiac output)" and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		` '	(X3) DATE SURVEY COMPLETED	
		34812	B. WING			C <b>17/2023</b>
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOU	DRESS, CITY, ST THWOOD DF H, MN 56529			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)	ULD BE	(X5) COMPLETE DATE
02320	what was going to be they were not made with blood in the resileading up to the howeekend. FM-H state let him sit there, he one called for an arsick They could have before that, he had blood in the urine a changing R1's cath to his death and that were providing. Howere providing. Howere providing. Howere have a catheter on Decemnoted. A reassess December 13, 2022 at that time. RN-F stopy the assisted living a UTI or that a urine and collected. Since ordered by a providing system, RN-F state would not have been aware of the accordance of the ac	a from the facility on results or be done to treat it. FM-H stated aware of ongoing concerns sident's urine collection bag oliday weekend or over the ated "it seemed like they just was just laying there sick, no inbulance until he was severely ave called the ambulance pretty significant symptoms, and pain."  123, at 9:35 a.m., home care N)-F stated they had been eter for several months prior at was the only service they me care staff changed his ber 2, 2022 with no concerns nent visit was completed on 2 and no concerns were noted stated they were not updated ag facility of any concerns with the culture had been ordered at the urine culture was the from a different health of the home care agency on made aware of any results. In occumentation shows the ed the culture, NP-E, was ber 21, 2022 at 3:31 p.m., the ne back, and she should have				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		` '	X3) DATE SURVEY COMPLETED	
		34812	B. WING			C <b>17/2023</b>
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOL	DRESS, CITY, STATE OF THE STATE	RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
02320	UTI but declined to PM-K stated "I'm not manager, I'm award family because the out to me, but I have declined to provide information for NP-practitioner was on with an email indicated management would to provide additional on February 17, 20 stated she had wor to the facility. ULP-I resident was bleeding happened on a week other instances who his urine collection the on call nurse are happening and the come in to look at it refused help with canot normal for him, seen a nurse or any the end of her shift happened next. UL answer questions a and they follow what to do. ULP-I stated	on regarding the resident's provide any further comment of involved as the department of the concerns with the facility themselves reached re a license to protect." PM-K the investigator with contact E, stating the nurse leave. PM-K later followed up atting patient relations and risk of follow up with the investigator all information.  123, at 11:15 a.m., ULP-I ked with R1 since he admitted is stated she remembered the ng from his penis and it exend. ULP-I did not recall any ere the resident had blood in bag. ULP-I stated she called and told her what was nurse said someone would at ULP-I stated the resident eres one morning and that was ULP-I stated she had not yone come in to look at R1 by so she had no idea what P-I stated the on call nurse will and tell them what to do next at ever the nurse directs them she can't call 911 without go with what the nurse says				
	assisted living direct contacted NP-E after and they obtained the LALD-A stated the	23, at 1:30 p.m., licensed tor (LALD)-A stated staff had er R1's fall on December 21st orders to check his urine. resident's lab was run through are facility than what NP-E				

Minneso	Minnesota Department of Health					
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	I OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		34812	B. WING		1	7/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1500 SOL	JTHWOOD D	RIVE		
LILAC H 	OMES ENHANCED AS	DILWOR	ΓH, MN 5652	9		
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TAG	INCOULATION ON L	OO IDENTII TIINO IINI ORNII/ATION)	TAG	DEFICIENCY)		
00000	O a satisace at Essays as a	00	00000			
02320	Continued From pa	ge 30	02320			
	worked at since the	other facility was able to pick				
		far as she knew, NP-E would				
		esults in Epic (clinical				
		ware) and she would be able				
		lts. LALD-A stated she was not				
		with obtaining treatment				
		ne had died. After his death,				
		It to the healthcare system get some more information on				
		LD-A stated she did not speak				
	· •	she didn't want to upset her so				
		-K after the incident occurred.				
	•	was told that NP-E knew				
		h the lab results that were sent				
	but wasn't sure why	she didn't reach back out to				
	us. LALD-A stated	she was told by PM-K that they	,			
	had wanted the cult	ture results to come back				
	before any antibioti	cs or other treatment was				
	, •	stated the facility called				
		esday, December 27, 2022				
		ck ASAP but did not get a				
	-	stated to her knowledge, R1				
		tic until December 27, 2022				
	_	Ited the blood in his urine bag				
		resident pulling or tugging at -A stated she did not speak				
		is incident since she had				
		otice and had resigned her				
	<b>,</b> ,	ated the facility had not				
	•	MAARC report as she didn't				
		urred but she had spoken with				

Minnesota Department of Health

the nurses involved in the incident and felt they

should have called to let family know about the

2022. LALD-A stated "it's just hard when we

blood in his urine bag and given them the choice

to take him in over the weekend of December 24,

made all these phone calls and no one got back

nurse make the decision on calling 911 versus

to us." LALD-A stated their process is to have the

allowing the staff to call 911 as they have a lot of

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED	
			D VA/INIO		С	
		34812	B. WING		02/1	7/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1500 SOU	THWOOD D	RIVE		
LILAC H	OMES ENHANCED AS	DILWORT	H, MN 5652	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
02320	Continued From pa	ae 31	02320			
02020	residents on hospic through nursing. LA	ce so they have them go ALD-A added a number of t to treat so they would not be	02020			
	nurse (RN)-B stated order for a urinalysic in his urine on December the resident was not was out of the norm observed seemed to she called NP-E's report her concerns stated NP-E and she report her concerns stated NP-E placed did not give any direct treatment or antibio UTI. RN-B stated sto contact NP-E after positive but was nearly didn't know whe LPNs were used in they didn't have a feature.	d she had asked NP-E for an is after R1 had a fall and blood ember 21, 2022. RN-B stated of a huge fall risk so the fall in for him and the symptoms to indicate a UTI. RN-B stated nurse, who then transferred e spoke directly with her to so on a potential UTI. RN-B I an order for a urinalysis but ection at that time on offics if it was verified he had a he had made a few attempts er the culture came back ver able to get ahold of her at else to do. RN-B confirmed the RN on-call rotation and ormal system to hand officialing lab results or other care				
	related issues to the think she had updated was having obtaining NP-E. RN-B confirmupdated of any issuahold of NP-E or the blood in his urine as decision maker." Rover the holiday we back to work on Tuthe resident wasn't very weak, sweaty, he was walking with 911 and had him see	e on-call nurse. RN-B did not ted LPN-D of the issues she ng orders for treatment from ned R1's family was not ses with not being able to get at the resident had ongoing s "the resident was his own N-B stated she was not on call ekend and when she came esday, December 27, 2022, looking good and appeared clammy, and had a fall when a staff. RN-B stated she called ent to the emergency room for RN-B stated she wasn't sure				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	CONSTRUCTION	` ′	(X3) DATE SURVEY COMPLETED	
		34812	B. WING			C <b>17/2023</b>
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOU	DRESS, CITY, ST ITHWOOD DF H, MN 56529	RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
02320	had investigated the employment there was not that R1 was having morning. LPN-D stated she was work she did not primaril not know R1 as we LPN-D stated staff with his catheter an collection bag. LPN resident was not re she advised staff to had any pain or blo not get a call back to called back the next the resident still had bag. LPN-D stated the resident had be had not started any R1's family had not reports of blood in It clinical nurse super notified of the report was having difficulty obtain orders or fur resident's UTI. LPN and handle all incomposed in the composed in the stated that while she was not his print saw a fax come throwith his UA results.	on was done or if the facility e incident as her last day of was December 31, 2022.  23, at 9:25 a.m., LPN-D fied on December 25, 2022, blood in his urine that ated she was not in the facility sing as the on-call nurse and y work at this location so did ll as his primary nurse did. The reported he was seen playing and had blood in his urine land blood in his urine land that day. LPN-D stated staff at day, December 26, 2022, as a blood in his urine collection she was not aware at that time are diagnosed with a UTI and a treatment for it. LPN-D stated been updated of the ongoing his urine collection bag and the revisor (LALD-A) had not been at sof blood or that the facility y getting ahold of NP-E to ther guidance for the land and a treatment she would triage ming nursing related calls and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			,
34812		34812	B. WING		02/17/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LILAC HC	MES ENHANCED AS	SSISTED LIVING	THWOOD D H, MN 5652			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	didn't get an acknowher staff as they ge acknowledgements being written.  On February 21, 20 stated she was ask R1 up the morning because they were ULP-G stated the obeen like this yeste and wasn't letting h ULP-G stated she room and he was spants on, just sitting bag having a lot of stated the drainage urine in it and she hon. R1 told her "I do stated she knew the played with his cath was doing that as the mear his private so bad." ULP-G stawhat she saw in his didn't think it was nonmally pretty indefor him to not want stated she had called day to report her co-could not recall if she resident had a UTI.  On February 22, 20 relations represents system NP-E worked investigator after the email on February 22.	e fax went through but they wledgement of it from NP-E or nerally only get of things if there's new orders of things if there's new orders of things if there's new orders of December 26, 2022, having trouble getting him up. ther ULP told her R1 had rday (December 25, 2022) er get anywhere near him. The emembered walking in his itting in his recliner with no go in his brief with his catheter bloody urine in it. ULP-G tube had the same discolored had asked him what was going on't know, it hurts." ULP-G ere were previous times he neter and thought maybe he ne resident "wouldn't even let area because he said it hurt ted she was taken aback by a urine collection bag and formal. ULP-G stated R1 was ependent so it was not normal to go out for breakfast. ULP-G ed the on call nurse twice that oncerns. ULP-G stated she he knew at that time the	02320			

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		` ′	.E CONSTRUCTION	COMPLETED		
		34812	B. WING		C <b>02/17/2023</b>	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LILAC H	OMES ENHANCED AS	SSISTED LIVING	THWOOD D H, MN 5652			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INCOMPAGE OF THE APPROPERT	D BE COMPLETE	
02320	Continued From pa	ge 34	02320			
	the Elder Care proving processed, or if NP urine culture results were to call and special care team, a phone entered in Epic so it update NP-E on De December 27, 2022 encounter documer was faxed to the Elefax would be scann record. PR-M confir related to R1 had be date range of December 27, 2022 No further informatic					
	days					
02360		reedom from maltreatment	02360			
	sexual, and emotion exploitation; and all	right to be free from physical, nal abuse; neglect; financial forms of maltreatment Vulnerable Adults Act.				
	by: Based on interviews facility failed to ensi	ent is not met as evidenced s and document review, the ure 1 of 1 residents reviewed maltreatment. The resident		No Plan of Correction (PoC) required Please refer to the public maltreat report (report sent separately) for of this tag.	ment	
	Findings include:			or this tag.		
		partment of Health (MDH)				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DATE S  COMPLI				
			7t. Boilebirto.		C	
		34812	B. WING			7/2023
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOL	DRESS, CITY, S  JTHWOOD D  H, MN 5652			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
02360	Continued From pa	ge 35	02360			
	and the facility was maltreatment, in co	nnection with incidents which lity. Please refer to the public				
03000 SS=D	0 626.557 Subd. 3 Timing of report		03000			
	believe that a vulne been maltreated, or vulnerable adult has which is not reason immediately report common entry poin vulnerable adult sol admitted to a facility required to report s individual that occu unless:  (1) the individual was another facility and believe the vulneral previous facility; or (2) the reporter knothat the individual is in section 626.5572 (a), clause (4).  (b) A person not record provisions of this section of the control of	orter who has reason to rable adult is being or has who has knowledge that a sustained a physical injury ably explained shall the information to the t. If an individual is a ely because the individual is y, a mandated reporter is not uspected maltreatment of the red prior to admission,  as admitted to the facility from the reporter has reason to be adult was maltreated in the ws or has reason to believe a vulnerable adult as defined the subdivision 21, paragraph quired to report under the ection may voluntarily report as ection requires a report of the maltreatment, if the reporter on to know that a report has ommon entry point, ection shall preclude a reporting to a law enforcement of the who knows or has				

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AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		,	E CONSTRUCTION	COMPLETED		
		34812	B. WING		C 02/17/2023	
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOU	DRESS, CITY, S THWOOD D H, MN 5652			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INC.)	D BE	(X5) COMPLETE DATE
03000	(5), occurred must a subdivision. If the rebelieves that an invinvestigative agency determine that the reaccording to the crissubdivision 17, parareporter or facility mentry point or direct agency information meets the criteria usubdivision 17, paralead investigative as information when meets the report under sufficense failed to time. This MN Requirements when meets the criteria usubdivision 17, paralead investigative as information when meets the criteria usubdivision 17, paralead investigative as information when meets the criteria usubdivision that did not license failed to enappropriate treatments urinary tract infection continued to show a period of several dashock (a widespread failure and dangerous this practice results violation that did not safety but had the president's health or cause serious injury was issued at an isolimited number of resident of the safety	nat an error under section on 17, paragraph (c), clause make a report under this eporter or a facility, at any time estigation by a lead y will determine or should reported error was not neglect teria under section 626.5572, agraph (c), clause (5), the nay provide to the common ly to the lead investigative explaining how the event nder section 626.5572, agraph (c), clause (5). The gency shall consider this naking an initial disposition of	03000			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	` '	(X3) DATE SURVEY COMPLETED		
		34812	B. WING			C <b>17/2023</b>
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOL	DRESS, CITY, ST JTHWOOD DF TH, MN 56529	RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
03000	R1's diagnoses incorprostatic hyperplast of urine is blocked or gland), and atrial fit beat).  R1's service plan, or indicated the resided dressing, grooming management, cather and medication administration and medication administration and resident was not at and staff were to he were to check the cempty as needed. To outside home healt monthly catheter check there was left for nurse put the next time she was left for nurse put that there was bloourine. NP-E was upurine, the fall, and it as charted by the curine culture were resident was resident was upurine culture were resident.	red only occasionally).  e:  luded urinary retention, benign ia (a condition where the flow due to an enlarged prostate orillation (irregular or fast heart lated October 27, 2022, ent received assistance with bathing, behavior eter care three times per day, ministration.  ssessment dated November 9, resident had a Foley catheter ra that carries urine out of the had a history of UTI's. The ole to do effective peri cares elp daily and as needed. Staff eatheter bag at night and The assessment noted an hagency managed the nange.  otes indicated R1 had an December 21, 2022. A note ractitioner (NP)-E to review ras in the facility. Later that ified registered nurse (RN)-B d present in the resident's odated via phone about the increased behaviors/confusion aregivers. Verbal orders for a received by RN-B.				
	•	for the urinalysis indicated the urine) was the reason				

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AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	COMPLETED		
		34812	B. WING		02/1	7/ <b>2023</b>
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOU	DRESS, CITY, S THWOOD DI TH, MN 56529			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
03000	(LPN)-C documents from [unaffiliated he 12/22/2022. UA (uri receivedResults results indicated a laresponses or follow. On December 22, 2 the residents Treatment was blood mixed with the catheter at times. We becomes upset. No another call to follow play with it from times showing and (sic) seto updated nurse if showing adequate outprovider during bus sooner."  On December 25, 2 shift, ULP-J documented a late 26, 2022, "yesterday breakfast he was si	ng ordered. 2022, licensed practical nurse ed "a fax had been received ealthcare facility] lab on				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	` ′	(X3) DATE SURVEY COMPLETED		
		34812	B. WING			C 1 <b>7/2023</b>
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
LILAC H	OMES ENHANCED AS	SSISTED LIVING	THWOOD DE H, MN 56529			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
03000	of blood and you concalled on call nurse.  On December 26, 2 "[R1] continues to he Caregivers stated to often. Message left call. Still awaiting Uprimary provider to day."  On December 27, 2 "awaiting urine culture grew Citrobe pseudomonas aeru inquiring about cathe due soon. Message regarding this and regarding in his regarding in his regarding in his regarding this head LOC (level of consequences).	was full of blood, brief was full buld tell he was in pain. We and she took it from there."  2022, LPN-D documented have blood in his urine. Hat he pulls at his catheter for home health with no return C (urine culture) results. be updated next business  2022, RN-B documented have, called lab who stated they fax it 4 times. Received call hurseshe relayed to me that		BELIGITION		
	stream.) [R1] appearand is mumbling his Blood draining into presentthis is not pressure taken at 1	an infection of the blood ars pale, clammy, shaking, s words. No fever present. leg bag. 2+ pitting edema baseline for resident. Blood 06/52 (normal range is s at labored at 28 (normal				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		34812	B. WING			C <b>17/2023</b>
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOU	DRESS, CITY, STATEMENT OF THE STATEMENT			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES (ENCY)	ULD BE	(X5) COMPLETE DATE
03000	saturation at 86% (temperature at 98.2 if he wants to go to Son updated on the nurse who will send Hospital records into the emergency roof 2022, at 11:38 a.m. admission note con examined at bedsic and I suspect sepsion pneumoniathe plate intensivist came to patient became apport breathing) and brack resident was report pulse and very low discussions with the intubate the resider only comfort cares. supplemental oxygoresident "went in to state of cardiac state was pronounced deapproximately four ER.	reaths per minute), oxygen normal is above 95%), 2, pulse 90. When asking [R1] the hospital, he states "yes" phonespoke with NP-E's a message to provider."  dicate the resident arrived at m (ER) on December 27, The ER physician's stained the following; "Patient le, currently is ill, distressed is from possible UTI/potential an was to admit the patient to unit. However, shortly after the see the patient in the ER, the enic (temporary cessation of lycardic (slow heart rate)." The ed to have a "very thready blood pressure" and after e family on whether or not to int, it was decided to provide Medications and en was stopped and the a cardiac arrest/asystole (a indstill, no cardiac output)" and ead at 3:45 p.m., hours after his arrival in the	03000			
	from December 27, care physician was due to rapid decom decline in health). I ED attending about arrest (when breath much more hypoter pressure) than an h	History and Physical note 2022, indicated the intensive "called emergently to bedside pensation (a significant arrived immediately and found to intubate due to respiratory ing stops). Patient was also sive (abnormally low blood our ago, which reportedly "." The note indicates the ICU				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		,		COMPLETED		
		34812	B. WING		02/1	7/ <b>2023</b>
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOU	DRESS, CITY, S THWOOD D H, MN 5652			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
03000	proceed with comformation of the positive urine culturn not treated. For the became less responsas sent to the ED hypoxic (low oxygen pressure), and tach On February 9, 202 member (FM)-H state was not being treate facility was having in provider. FM-H state the resident's UTI was notification (electron clinic) pop up that in came back positive any communication what was going to be they were not made with blood in the residend up to the howeekend.	ge 41 celed after it was decided to out measures only. The ICU licated septic shock due to y diagnosis in addition to ratory failure, likely in the ock. The history of present e resident "apparently had a re from six days agobut was next few days, he gradually nsive up to today where he where he was noted to by n), hypotensive (low blood cycardic (elevated heart rate).  3, at 1:35 p.m., family ated they were not aware R1 ed for his UTI or that the ssues getting ahold of his ed they were made aware of when they saw a MyChart nic medical record used by the ndicated his urine culture. FM-H stated they did not get from the facility on results or be done to treat it. FM-H stated aware of ongoing concerns sident's urine collection bag oliday weekend or over the	03000			
	stated she had work to the facility. ULP-I resident was bleedi happened on a wee other instances who his urine collection the on call nurse an happening and the	ked with R1 since he admitted stated she remembered the ng from his penis and it kend. ULP-I did not recall any ere the resident had blood in bag. ULP-I stated she called nd told her what was nurse said someone would to ULP-I stated the resident				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		34812	B. WING			
	PROVIDER OR SUPPLIER	SSISTED LIVING 1500 SOU	DRESS, CITY, STATEMENT OF THE STATEMENT			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
03000	not normal for him. seen a nurse or any the end of her shift happened next. UL answer questions a and they follow what to do. ULP-I stated approval, "I have to to not be in trouble.  On February 17, 20 assisted living direct contacted NP-E after and they obtained of LALD-A stated she with obtaining treated had died. LALD-A swas not symptomate and they had attribut to be related to the the catheter. LALD-with RN-B about the already put in her no position. LALD-A stated should have called blood in his urine be to take him in over 2022. LALD-A stated made all these photo us."	ares one morning and that was ULP-I stated she had not yone come in to look at R1 by so she had no idea what P-I stated the on call nurse will and tell them what to do next atever the nurse directs them she can't call 911 without go with what the nurse says				
	nurse (RN)-B stated order for a urinalysi in his urine on Dece	d she had asked NP-E for an safter R1 had a fall and blood ember 21, 2022. RN-B stated a huge fall risk so the fall				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		34812	2 B. WING 02		C / <b>17/2023</b>	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S			
LILAC H	OMES ENHANCED AS	SSISTED LIVING	TH, MN 56529			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
03000	observed seemed to she called NP-E's report her concerns stated NP-E placed did not give any direct treatment or antibio UTI. RN-B stated sto contact NP-E after positive but was ne RN-B confirmed R1 any issues with not NP-E or that the resurine as "the reside maker." RN-B state holiday weekend are work on Tuesday, I resident wasn't look weak, sweaty, clamwas walking with stand had him sefurther evaluation. If what follow up actions had investigated the employment there were considered as the employment there were considered as the content of the content o	ge 43 In for him and the symptoms o indicate a UTI. RN-B stated durse, who then transferred e spoke directly with her to son a potential UTI. RN-B an order for a urinalysis but ection at that time on stics if it was verified he had a he had made a few attempts er the culture came back ever able to get ahold of being able to get ahold of being able to get ahold of being able to get ahold of sident had ongoing blood in his ent was his own decision and she was not on call over the end when she came back to becember 27, 2022, the king good and appeared very amy, and had a fall when he aff. RN-B stated she wasn't sure on was done or if the facility er incident as her last day of was December 31, 2022.  123, at 9:25 a.m., LPN-D fied on December 25, 2022, blood in his urine that ated she was not in the facility er was seen playing with his ood in his urine collection bag, reported the resident was not at time so she advised staff to ck if he had any pain or blood she did not get a call back at time so she advised staff to ck if he had any pain or blood she did not get a call back at time so she advised staff to ck if he had any pain or blood she did not get a call back at time so she advised staff to ck if he had any pain or blood she did not get a call back at time so she advised staff to ck if he had any pain or blood she did not get a call back at time so she resident still had bllection bag. LPN-D stated				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b> </b> ` ´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				C		
	34812	B. WING	_		7/2023	
NAME OF PROVIDER OR SUPPLIER  LILAC HOMES ENHANCED A	SSISTED LIVING 1500 SOU	DDRESS, CITY, STATE, ZIP CODE  JTHWOOD DRIVE  TH, MN 56529				
PREFIX (EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE	
been diagnosed with any treatment for ith not been updated on his urine collectic supervisor (LALD-Areports of blood or difficulty getting and further guidance for the collection of the collec	at that time the resident had th a UTI and had not started. LPN-D stated R1's family had of the ongoing reports of blood on bag and the clinical nurse A) had not been notified of the that the facility was having old of NP-E to obtain orders or the resident's UTI.  23, at 9:55 a.m., ULP-G and by another ULP to help get of December 26, 2022, having trouble getting him up. Other ULP told her R1 had arday (December 25, 2022) her get anywhere near him. The remembered walking in his aitting in his recliner with no g in his brief with his catheter bloody urine in it. ULP-G at tube had the same discolored had asked him what was going on't know, it hurts." ULP-G are were previous times he he resident "wouldn't even let area because he said it hurt ated she was taken aback by a urine collection bag and ormal. ULP-G stated R1 was appendent so it was not normal to go out for breakfast. ULP-G ed the on call nurse twice that oncerns. ULP-G stated she he knew at that time the					
	C report for suspected neglect					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				С	
	34812	B. WING		02/1	7/2023
NAME OF PROVIDER OR SUPPLIER  LILAC HOMES ENHANCED ASSISTED LIVING  STREET ADDRESS, CITY, STATE, ZIP CODE  1500 SOUTHWOOD DRIVE  DILWORTH, MN 56529					
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
03000 Continued From page	ge <b>45</b>	03000			
of R1.					
and investigation power would report any surplect or financial estatutes 626.5572) [assisted living residence, or financial investigated by the home care director.  No further information					