Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL348124663M
Compliance #: HL348127937C

Date Concluded: March 21, 2023

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 Dementia Care (ALFDC)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility neglected 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34812	A. BUILDING: _____ B. WING _____	C 02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC HOMES ENHANCED ASSISTED LIVING	1500 SOUTHWOOD DRIVE DILWORTH, MN 56529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL348124663M/ #HL348127937C On February 17, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 33 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL348124663M/ #HL348127937C, tag identification 0620, 1390, 2320, 2360, and 3000.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with	0 620		

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0 620	Continued From page 1 the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to timely submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R1) after the licensee failed to ensure a resident was provided appropriate treatment following a diagnosis of a urinary tract infection (UTI). The resident continued to show symptoms of a UTI over a period of several days and later died from septic shock (a widespread infection causing organ failure and dangerously low blood pressure.) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's 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 heart beat). R1's service plan, dated October 27, 2022, indicated the resident received assistance with	0 620		

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0 620	Continued From page 2 dressing, grooming, bathing, behavior management, catheter care three times per day, and medication administration. R1's most recent assessment dated November 9, 2022, indicated the resident had a Foley catheter (a tube in the urethra that carries urine out of the body) in place and had a history of UTI's. The resident was not able to complete effective peri cares and staff were to help daily and as needed. Staff were to check the catheter bag at night and empty as needed. The assessment noted an outside home health agency managed the monthly catheter change. Facility progress notes indicated R1 had an unwitnessed fall on December 21, 2022. A note was left for nurse practitioner (NP)-E to review the next time she was in the facility. Later that afternoon, staff notified registered nurse (RN)-B that there was blood present in the resident's urine. NP-E was updated via phone about the urine, the fall, and increased behaviors/confusion as charted by the caregivers. Verbal orders for a urine culture were received by RN-B . The lab requisition for the urinalysis indicated hematuria (blood in the urine) was the reason why the lab was being ordered. On December 22, 2022, licensed practical nurse (LPN)-C documented "a fax had been received from [unaffiliated healthcare facility] lab on 12/22/2022. UA (urinalysis) results received....Results to be faxed to NP-E." The results indicated a UTI was present. No additional responses or follow up from NP-E were noted. On December 22, 2022, a ULP documented in	0 620		

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0 620	Continued From page 3 the resident's Treatment Recap Summary there was blood mixed with urine in the resident's bag. On Sunday, December 25, 2022, licensed practical nurse (LPN)-D documented "nurse received a call that [R1] had blood in his urine this morning. It is stated that he plays with his catheter at times. When trying to redirect him, he becomes upset. No pain noted. Nurse placed another call to follow up on him, he continues to play with it from time to time. He still is not showing and (sic) sign of pain. Caregivers asked to update nurse if he pulls out the catheter, is showing pain, or blood increases. He is still having adequate output. Will follow up with provider during business hours if not needed sooner." On December 25, 2022, during the overnight shift, ULP-J documented in the resident's Treatment Recap Summary, "the resident's catheter is clot with blood, it needs Nurse's attention." On December 27, 2022, at 7:11 p.m., ULP-G documented a late entry from Monday, December 26, 2022, "yesterday I went to get [R1] for breakfast he was sitting with no pants on, when I asked if I could help him I noticed his bag was full of blood, the tubing was full of blood, brief was full of blood and you could tell he was in pain. We called on call nurse and she took it from there." On December 26, 2022, LPN-D documented "[R1] continues to have blood in his urine. Caregivers stated that he pulls at his catheter often. Message left for home health with no return call. Still awaiting UC (urine culture) results. Primary provider to be updated next business day."	0 620		

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0 620	Continued From page 4 On December 27, 2022, RN-B documented "awaiting urine culture, called lab who stated they have attempted to fax it 4 times. Received call from home health nurse...she relayed to me that culture grew Citrobacter koseri and pseudomonas aeruginosa. Home health nurse inquiring about catheter change, as [R1] will be due soon. Message left with [NP-E] nurse regarding this and requesting a call back ASAP and clarification on when to change catheter. RN-B entered two additional progress notes on December 27, 2022. One note entered at 10:56 a.m. indicated, "[R1] had a fall with staff present where he was unsteady and fell to the left while ambulating in his room. [R1] currently has a UTI that was awaiting treatment from provider. [R1] 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.) [R1] 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 [R1] if he wants to go to the hospital, he states "yes" Son updated on the phone...spoke with NP-E's nurse who will send a message to provider." Hospital records indicated the resident arrived at the emergency room (ER) on December 27, 2022, at 11:38 a.m. The ER physician's admission note contained the following; "Patient	0 620		

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0 620	Continued From page 5 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 came to see the patient in the ER, the patient became apenic (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 was stopped and the resident "went in to a cardiac arrest/asystole (a state of cardiac standstill, no cardiac output)" and was pronounced dead at 3:45 p.m., approximately four hours after his arrival in the ER. The ICU Admission History and Physical note from December 27, 2022, 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 indicates 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	0 620		

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0 620	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 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 no 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 approval, "I have to go with what the nurse says to not be in trouble."	0 620		

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0 620	Continued From page 7 On February 17, 2023, at 1:30 p.m., licensed assisted living director (LALD)-A stated staff had contacted NP-E after R1's fall on December 21st and they obtained orders to check his urine. LALD-A stated she was not aware of the issues with obtaining treatment orders for R1 until he after he had died. LALD-A stated to her knowledge, R1 was not symptomatic until December 27, 2022 and they had attributed the blood in his urine bag to be related to the resident pulling or tugging at the catheter. LALD-A stated she did not speak with RN-B about this incident since she had already put in her notice and had resigned her position. LALD-A stated the facility had not considered filing a MAARC report as she didn't believe neglect occurred but she had spoken with the nurses involved in the incident and felt they should have called to let family know about the blood in his urine bag and given them the choice to take him in over the weekend of December 24, 2022. LALD-A stated "it's just hard when we made all these phone calls and no one got back to us." On February 21, 2023, at 9:10 a.m., registered nurse (RN)-B stated she had asked NP-E for an order for a urinalysis after R1 had a fall and blood in his urine on December 21, 2022. RN-B stated the resident was not a huge fall risk so the fall was out of the norm for him and the symptoms observed seemed to indicate a UTI. RN-B stated she called NP-E's nurse, who then transferred her to NP-E and she spoke directly with her to report her concerns on a potential UTI. RN-B stated NP-E placed an order for a urinalysis but did not give any direction at that time on treatment or antibiotics if it was verified he had a UTI. RN-B stated she had made a few attempts to contact NP-E after the culture came back positive but was never able to get ahold of her.	0 620		

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0 620	Continued From page 8 RN-B confirmed R1's family was not updated of any issues with not being able to get ahold of NP-E or that the resident had ongoing blood in his urine as "the resident was his own decision maker." RN-B stated she was not on call over the holiday weekend and when she came back to work on Tuesday, December 27, 2022, the resident wasn't looking good and appeared very weak, sweaty, clammy, and had a fall when he was walking with staff. RN-B stated she called 911 and had him sent to the emergency room for further evaluation. RN-B stated she wasn't sure what follow up action was done or if the facility had investigated the incident as her last day of employment there was December 31, 2022. On February 21, 2023, at 9:25 a.m., LPN-D stated she was notified on December 25, 2022, that R1 was having blood in his urine that morning. LPN-D stated she was not in the facility but staff reported he was seen playing with his catheter and had blood in his urine collection bag. LPN-D stated staff reported the resident was not reporting pain at that time so she advised staff to monitor and call back if he had any pain or blood was increasing and she did not get a call back that day. LPN-D stated staff called back the next day, December 26, 2022, as the resident still had blood in his urine collection bag. LPN-D stated she was not aware at that time the resident had been diagnosed with a UTI and had not started any treatment for it. LPN-D stated R1's family had not been updated of the ongoing reports of blood in his urine collection bag and the clinical nurse supervisor (LALD-A) had not been notified of the reports of blood or that the facility was having difficulty getting ahold of NP-E to obtain orders or further guidance for the resident's UTI. On February 21, 2023, at 9:55 a.m., ULP-G	0 620		

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0 620	Continued From page 9 stated she was asked by another ULP to help get R1 up the morning of December 26, 2022, because they were having trouble getting him up. ULP-G stated the other ULP told her R1 had been like this yesterday (December 25, 2022) and wasn't letting her get anywhere near him. ULP-G stated she remembered walking in 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. ULP-G stated the drainage tube had the same discolored urine in it and she had asked him what was going on. R1 told her "I don't know, it hurts." ULP-G stated she knew there were previous times he played with his catheter and thought maybe he was doing that as the resident "wouldn't even let me near his private area because he said it hurt so bad." ULP-G stated she was taken aback by what she saw in his urine collection bag and didn't think it was normal. ULP-G stated R1 was normally pretty independent so it was not normal for him to not want to go out for breakfast. ULP-G stated she had called the on call nurse twice that day to report her concerns. ULP-G stated she could not recall if she knew at that time the resident had a UTI. As of February 23, 2023, the licensee had not submitted a MAARC report for suspected neglect of R1. The licensee's undated vulnerable adult reporting and investigation policy indicated employees would report any suspected maltreatment (abuse, neglect or financial exploitation as defined in MN Statutes 626.5572) of our home care clients [assisted living residents]. Suspected abuse, neglect, or financial exploitation would be investigated by the RN in coordination with the home care director.	0 620		

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0 620	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
01390 SS=I	144G.62 Subdivision 1 Availability of contact person to staff (a) Assisted living facilities must have a registered nurse available for consultation by staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure a registered nurse (RN) was available for consultation to staff performing delegated nursing tasks for one of one resident (R1) with records reviewed. In addition, the licensee failed to ensure a RN was available for consultation to staff performing delegated nursing tasks when it designated a licensed practical nurse (LPN) as the nurse on call and failed to designate the RN on call for consultation. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01390		

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01390	Continued From page 11 Findings Include: The LPN on call failed to contact the RN when concerns regarding the provider's response to R1's urine culture result were not immediately addressed. The LPN on call failed to contact the RN when symptoms consistent with a urinary tract infection persisted over a holiday weekend. The resident was sent to the emergency room (ER) six days after a urinalysis was collected and symptoms of a UTI were first observed, including several days of reports of blood in the resident's urine collection bag. The resident died of septic shock (a widespread infection causing organ failure and dangerously low blood pressure) shortly after arriving to the ER. Review of medical record indicated R1'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 heart beat). R1's service plan, dated October 27, 2022, indicated R1 received staff assistance with dressing, grooming, bathing, behavior management, catheter care three times per day, and medication administration. R1's most recent assessment dated November 9, 2022, indicated R1 had a Foley catheter in place with a history of UTI's. R1 required staff assistance daily and as needed to complete effective peri-cares. The assessment directed staff to check R1's catheter bag at night and empty as needed. The assessment indicated an outside home health agency managed R1's monthly catheter change.	01390		

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01390	Continued From page 12 R1's medical record identified that on Wednesday, December 21, 2022, a urinalysis (UA) and urine culture was ordered for R1 due to the presence of blood in the urine and a change in R1's behaviors, including a fall. R1's medical record included documentation by Unlicensed personnel (ULP) on Thursday, December 22, 2022, that R1 continued to have blood mixed with urine in the resident's urine collection bag. A progress note dated December 22, 2022, indicated staff faxed the UA results to the nurse practitioner (NP)-E (R1's provider). The progress note did not address a response from NP-E regarding the results or treatment recommendations. On Sunday, December 25, 2022, LPN-D documented in R1's medical record "nurse on-call received a call that [R1] had blood in his urine this morning. It is stated that he plays with his catheter at times. When trying to redirect him he becomes upset. No pain noted. Nurse placed another call to follow up on him, he continues to play with it from time to time. He still is not showing and (sic) sign of pain. Caregivers asked to update nurse if he pulls out the catheter, is showing pain, or blood increases. He is still having adequate output. Will follow up with provider during business hours if not needed sooner." R1's Treatment Recap Summary included documentation entered on Sunday, December 25, 2022, during the overnight shift, ULP-J documented , "the resident's catheter is clot with blood, it needs Nurse's attention."	01390		

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01390	Continued From page 13 On December 26, 2022, LPN-D documented in R1's medical record "[R1] continues to have blood in his urine. Caregivers stated that he pulls at his catheter often. Message left for [healthcare system] home health with no return call. Still awaiting UC (urine culture) results. Primary provider to be updated next business day." R1's progress notes dated December 27, 2022, at 7:11 p.m., identified ULP-G documented a late entry from Monday, December 26, 2022, "yesterday I went to get [R1] for breakfast he was sitting with no pants on, when I asked if I could help him I noticed his bag was full of blood, the tubing was full of blood, brief was full of blood and you could tell he was in pain. We called on call nurse and she took it from there." The nurse on call at that time was a LPN. During this time, neither RN-B or the licensed assisted living director (LALD)-A/RN, were contacted by LPN-D regarding the ULPs ongoing concerns of blood in R1's urine, reports of pain, and that NP-E made no response regarding treatment for R1's UTI. A progress note dated December 27, 2022, indicated R1 had a fall that morning and that "[R1] currently has a UTI that was awaiting treatment from provider. [R1] did not hit his head but has an overall change in LOC (level of consciousness) due to suspected urosepsis (infection in the blood). [R1] 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%),	01390		

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01390	Continued From page 14 temperature at 98.2, pulse 90. When asking [R1] if he wants to go to the hospital, he states "yes" Son updated on the phone...spoke 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 ago...but 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 sick...They could have called the ambulance before that, he had pretty significant symptoms, blood in the urine and pain."	01390		

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01390	Continued From page 15 During an interview on February 17, 2023, at 11:15 a.m., ULP-I stated R1 was bled from his penis the weekend of December 23, 2022. ULP-I reported the concerns to the on-call nurse. The on-call nurse stated someone would visit R1 for an assessment. ULP-I stated R1 refused help with cares one morning and that was not normal for him. ULP-I stated she was not aware a nurse visited R1 that day. ULP-I stated staff contacted the on-call nurse with questions about the residents, report concerns, and to provide direction to staff. ULP-I stated the licensee only allowed the licensed nurse to contact 911 for emergency transport of a resident. During an interview on February 21, 2023, at 9:10 a.m., registered nurse (RN)-B stated she contacted R1's provider NP-E requesting an urinalysis after R1 fell, and had blood in his urine, with symptoms of a UTI on December 21, 2022. RN-B stated when the urine culture was positive she was unsuccessful contacting NP-E with R1's positive culture. RN-B confirmed R1's family was not updated of any issues with not being able to get ahold of NP-E or that the resident had ongoing blood in his urine as "the resident was his own decision maker." RN-B stated she was not on call from the evening of December 23, 2022, through the morning of December 27, 2022. On Tuesday, December 27, 2022, R1 was, sweaty, clammy, weaker, and fell when walking with staff. RN-B stated she arranged for R1's evaluation at a local hospital. RN-B stated she wasn't sure what follow up action was done or if the facility had investigated the incident as her last day of employment there was December 31, 2022. RN-B stated she was not involved in how the on call schedule was determined as that was done by the clinical nurse supervisor (LALD-A).	01390		

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01390	Continued From page 16 During an interview on February 21, 2023, at 9:25 a.m., LPN-D stated she was the nurse on-call nurse on December 25, 2022, when a ULP reported R1 played with his catheter and had blood in his urine that morning. LPN-D stated R1 had no pain therefore, she directed the ULPS to monitor R1 and call back with any signs of pain or increased bleeding. LPN-D stated the ULPs did not call back with concerns. LPN-D stated the next day, December 26, 2022, a ULP contacted LPN-D due to R1's continued having blood in his urine collection bag. LPN-D stated she was not aware at that time that R1 had been diagnosed with a UTI or started on treatment for the UTI. LPN-D stated R1's family had not been updated of the ongoing reports of blood in his urine collection bag and LPN-D stated she did not notify the clinical nurse supervisor (LALD-A)/RN of the continued reports of blood in R1's urine or the facility continued difficulty contacting NP-E to obtain orders or further guidance for R1's UTI. During an interview on February 21, 2023, at 9:55 a.m., ULP-G stated assisted another ULP with cares the morning of December 26, 2022, because they were having trouble getting him up. ULP-G stated the other ULP told her R1 had been like this yesterday (December 25, 2022) and wasn't letting her get anywhere near him. ULP-G stated R1 sat in his recliner in a brief and blood in his catheter bag. ULP stated R1 previously played with his catheter and thought maybe he was doing that as R1 "wouldn't even let me near his private area because he said it hurt so bad." ULP-G stated she was taken aback by what she saw in his urine collection bag and didn't think it was normal. ULP-G stated R1 was normally pretty independent so it was not normal for him to not want to go out for breakfast. ULP-G stated she contact the nurse on-call (LPN-D)	01390		

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01390	Continued From page 17 twice that day to report her concerns. On February 17, 2023, at 1:30 p.m., LALD-A stated their process was to have the nurse make the decision on calling 911 versus allowing the ULPs to call 911, as they have a lot of residents on hospice so they have them go through nursing. LALD-A added a number of families choose not to treat so they would not be happy if staff called 911. RN ON CALL SCHEDULE: The licensee failed to ensure the designated nurse on call was a registered nurse (RN). The facility utilized a call triage service and scheduled licensed practical nurses (LPN)s on-call and the first contact for ULPs to report resident concerns. The licensee identified the LPNs as the on-call nurse on the RN call schedule and did not specify on the schedule whether a RN was available or provide further contact information for staff to contact the RN. Review of the licensee's nurse on-call schedule dated October 2022, November 2022, December 2022, January 2023, and February 2023, all had a mix of LPNs and RNs designated as the RN on-call. The schedules failed to identify the RN on-call to back-up the LPN when the LPN required consultation of a residents condition and contact information for the RN when the ULPs needed to contact the RN. -Out of 31 days in October 2022, a RN was on the on call schedule for 8 days. The October 2022, RN on-call schedule indicated LALD-A/RN was on vacation October 14 through October 21, 2022. A LPN was listed as the RN on call from October 17 through October 30, 2022. RN-B was not on call and would not have been available for	01390		

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01390	Continued From page 18 consultation by the ULP's during the time LALD-A was out of the office. -Out of 30 days in November, 2022, a RN was on the on call schedule for 13 days. -Out of 31 days in December, 2022, a RN was on the on call schedule for 13 days. -Out of 31 days in January, 2023, a RN was on the on call schedule for 9 days. -Out of 28 days in February, 2023, a RN was on the on call schedule for 7 days. During a tour of nurse station on February 17, 2023, at 10:00 a.m., ULP-L showed the investigator the contact telephone numbers for the nurses. ULP-L stated when needed, staff contact the nurse on-call through a virtual receptionist called "Ruby." ULP-L stated the service verified staff identity and transferred their call to the nurse on-call. ULP-L stated they do not have personal numbers for the nurses and have to go through Ruby. The telephone numbers on the list for the staff nurses were to their portable phones used only when at the facility. ULP-L stated when a LPN was on call, the LPN handled the issue themselves and it does not get referred to a RN. ULP-L stated they would not be able to contact 911 unless it had been okayed by a nurse and a resident could not be sent in without a nurse approval. ULP-L stated, "I guess you could contact the DON [director of nursing] if you don't feel like you're being heard by the on call nurse, but we can't override the nurse." During an interview on February 17, 2023, at 11:30 a.m., was asked to show the investigator where contact information for the RN on call was located. ULP-I showed the investigator a phone at the nurses station where the number for the virtual receptionist "Ruby" was programmed in to the phone. ULP-I stated staff use "Ruby" to	01390		

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01390	Continued From page 19 contact the nurse on call. ULP-I stated when the LPN was scheduled on call, they would answer any nursing related questions. and the RN would not be contacted. ULP-I stated they would have to contact who is on call and couldn't call the RN if she wasn't on call. ULP-I showed the investigator a binder with contact numbers for nurses located at the nurses station and stated the numbers listed were for the nurse's portable work phones they used while at the facility. During an interview on February 17, 2023, at 12:30 p.m., RN-N confirmed ULPs did not have access to the nurse's numbers and the numbers listed for nurses were for the work phone numbers only answered during business hours. If a ULP needed to contact a nurse on-call the were required to call "Ruby", the virtual receptionist service, and connected with the scheduled nurse on-call. RN-N confirmed if a LPN was on call, they would triage and handle the nursing concerns and did not contact the RN unless the LPN had a question on something. During an interview on February 17, 2023, at 1:30 p.m., LALD-A confirmed she is also a RN. The LALD-A stated when a LPN was scheduled on call, the LPN managed the call and would only contact her if there was a problem. The LALD-A/RN stated she was the back up for the LPNs. LALD-A confirmed she was the Director of Record for two locations operated by the licensee and was considered the Clinical Nurse Supervisor and divided her time between the two locations. LALD-A stated she was always available to staff. The licensee's on call policy, dated December 23, 2019, indicated a registered nurse would be available for consultation at all times when staff was providing services to clients [residents] and	01390		

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01390	Continued From page 20 to respond to concerns from clients [residents] and clients' [residents'] representatives. The licensee would make adequate provisions to ensure RN coverage was available at all times whenever staff was providing services, including when regular nursing staff was off duty, on vacation or on sick leave. The policy directed staff to call "Ruby" (the virtual receptionist) after hours from 5 p.m. to 8 a.m. Monday through Friday and on weekends Friday 5 p.m. to Monday 9 a.m. with any medical concerns. The policy indicated when a LPN was scheduled to take initial calls from non-licensed personnel providing services, a RN must be accessible to respond to the LPN with question or any issues that exceed the LPN's scope of practice. The policy lacked guidance on how unlicensed personnel could access the RN. No further information provided. TIME PERIOD TO CORRECT: Seven (7) days.	01390		
02320 SS=J	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure reporting of a resident's change in condition to the appropriate supervisor or health care professional for one of one	02320		

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02320	Continued From page 21 residents (R1) reviewed following a diagnoses of a urinary tract infection (UTI). Facility nurses failed to assess the resident's condition after staff continued to report blood in the resident's urine. The resident experienced a significant change in condition and change in level of consciousness and later died from septic shock (a widespread infection causing organ failure and dangerously low blood pressure) related to the UTI. In addition, the licensee failed to have a system in place for nurse to nurse communication to ensure follow-up on R1's condition, pending lab results, attempts to contact the physician, or pending medication and/or treatment orders. The facility's on-call service utilized licensed practical nurses (LPN)s as first contact for staff without a requirement to inform or contact a registered nurse (RN). This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: Review of R1's medical record indicated R1'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 heart beat). R1's service plan, dated October 27, 2022, indicated R1 received assistance with dressing, grooming, bathing, behavior management, catheter care three times per day, and medication	02320		

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02320	Continued From page 22 administration. R1's most recent assessment dated November 9, 2022, indicated R1 had a Foley catheter (a tube in the urethra that carries urine out of the body) and had a history of UTI's. R1 required staff assistance for daily and as needed for peri cares. The assessment directed staff to check R1's catheter bag at night and empty as needed. The assessment indicated an outside home health agency managed R1's monthly catheter change. R1's Treatment Recap Summary dated December 2, 2022, indicated unlicensed personnel (ULP)-J documented catheter care "didn't happen this morning because staff doesn't know how to use the new catheter." R1's behavior note dated December 18, 2022, indicated staff told registered nurse (RN)-B R1 disconnected his catheter tubing and tied it to his walker, causing urine to leak all over his bed and carpets. The note indicated the housekeeper reported she had cleaned the resident's carpets two times that week for similar incidents. A progress note dated December 21, 2022 indicated R1 had an unwitnessed fall. A note was left for nurse practitioner (NP)-E to review the next time she was in the facility. Later that afternoon, staff notified RN-B R1 had blood present in the resident's urine. RN-B updated NP-E about R1's urine, fall, and increased behaviors/confusion as charted by the caregivers. NP-E gave verbal orders to RN-B to obtain a urine culture for R1. The lab requisition for the urinalysis slip dated December 21, 2022 indicated hematuria (blood in the urine) was the reason for R1's lab.	02320		

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02320	Continued From page 23 On December 22, 2022, licensed practical nurse (LPN)-C documented "a fax had been received from [unaffiliated healthcare facility] lab on 12/22/2022. UA (urinalysis) results received....Results to be faxed to NP-E." The results indicated a UTI was present. Lab records indicated the urine was collected on Wednesday, December 21, 2022, with the results released to the ordering provider, NP-E. The culture required re-testing due to insufficient baterial growth. On December 24, 2022, at 12:50 p.m., the urine culture sensitivity results were communicated to NP-E. R1's Treatment Recap Summary dated December 22, 2022, indicated R1 had blood mixed with urine in the catheter bag. On December 28, 2022, RN-B documented in R1's medical record a late entry from Thursday, December 22, 2022 indicating the lab results were forwarded to R1's provider. On December 28, 2022, RN-B documented in R1's medical record a late entry from Friday, December 23, 2022, indicating the lab results were forwarded to R1's provider again. There was no documentation of RN-B contacting LALD-A/RN or making further attempts before the holiday weekend to reach anyone, including the on-call provider, from NP-E's office. RN-B left work and was off through the holiday weekend. The facility utilized LPNs within their RN on-call schedule, leaving a LPN as the designated nurse on call over the holiday weekend. On Sunday, December 25, 2022, LPN-D	02320		

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02320	Continued From page 24 documented in R1's medical record "nurse received a call that [R1] had blood in his urine this morning. It is stated that he plays with his catheter at times. When trying to redirect him he becomes upset. No pain noted. Nurse placed another call to follow up on him, he continues to play with it from time to time. He still is not showing and (sic) sign of pain. Caregivers asked to update nurse if he pulls out the catheter, is showing pain, or blood increases. He is still having adequate output. Will follow up with provider during business hours if not needed sooner." There was no documentation provided to indicate LPN-D assessed R1 after staff notified LPN-D of blood in R1's urine, failed to notify the licensee's RN of R1's ongoing UTI symptoms, and concerns regarding the provider's lack of response to R1's urine culture results. In addition, LPN-D failed to notify R1's family of R1's change of condition. R1's Treatment Recap Summary dated December 25, 2022, indicated "the resident's catheter is clotted with blood, it needs nurse's attention." On December 26, 2022, LPN-D documented in R1's medical record "[R1] continues to have blood in his urine. Caregivers stated that he pulls at his catheter often. Message left for [healthcare system] home health with no return call. Still awaiting UC (urine culture) results. Primary provider to be updated next business day." On December 27, 2022, at 7:11 p.m., ULP-G documented in R1's medical record a late entry from Monday, December 26, 2022, "yesterday I went to get [R1] for breakfast he was sitting with no pants on, when I asked if I could help him I	02320		

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02320	Continued From page 25 noticed his bag was full of blood, the tubing was full of blood, brief was full of blood and you could tell he was in pain. We called on call nurse and she took it from there." The nurse on call at that time was a LPN. LPN-D again failed to appropriately assess the ongoing reports of blood in the resident's urine and take immediate action to seek further care for the resident. LPN-D was aware urine culture results had not been addressed and failed to immediately notify the resident's provider and the on-call RN of this and that the resident was still showing symptoms of a UTI. LPN-D failed to notify R1's family of what was going on. On December 27, 2022, when she returned to work after the holiday weekend, RN-B documented in R1's medical record "awaiting urine culture, called lab who stated they have attempted to fax it 4 times. Received call from home health nurse...she relayed to me that culture grew Citrobacter koseri and pseudomonas aeruginosa. Home health nurse inquiring about catheter change, as [R1] will be due soon. Message left with [NP-E] nurse regarding this and requesting a call back ASAP and clarification on when to change catheter. RN-B entered two additional progress notes on December 27, 2022. One note entered at 10:56 a.m. indicated, "[R1] had a fall with staff present where he was unsteady and fell to the left while ambulating in his room. [R1] currently has a UTI that was awaiting treatment from provider. [R1] 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	02320		

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02320	Continued From page 26 stream.) [R1] 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 [R1] if he wants to go to the hospital, he states "yes" Son updated on the phone...spoke with NP-E's nurse who will send a message to provider." A records request was sent to the health care system NP-E worked for on February 1, 2023, and again on February 16, 2023, requesting all records related to R1 for December 1 through December 27, 2022, including communication from the licensee and notes related to the resident's urine culture ordered by NP-E. Both requests were unable to be fulfilled with the reason listed as, "We show no treatment at this facility for the dates of service you requested." Hospital records indicated the resident arrived at the emergency room (ER) on December 27, 2022, at 11:38 a.m. The ER physician's admission note 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 came to see the patient in the ER, the patient became apenic (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	02320		

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02320	Continued From page 27 supplemental oxygen was stopped and the resident "went in to a cardiac arrest/asystole (a state of cardiac standstill, no cardiac output)" and was pronounced dead at 3:45 p.m., approximately four hours after his arrival in the ER. The ICU Admission History and Physical note from December 27, 2022, 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 indicates 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). 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	02320		

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02320	Continued From page 28 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. 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 sick...They could have called the ambulance before that, he had pretty significant symptoms, blood in the urine and pain." On February 14, 2023, at 9:35 a.m., home care registered nurse (RN)-F stated they had been changing R1's catheter for several months prior to his death and that was the only service they were providing. Home care staff changed his catheter on December 2, 2022 with no concerns noted. A reassessment visit was completed on December 13, 2022 and no concerns were noted at that time. RN-F stated they were not updated by the assisted living facility of any concerns with a UTI or that a urine culture had been ordered and collected. Since the urine culture was ordered by a provider from a different health system, RN-F stated the home care agency would not have been made aware of any results. RN-F stated their documentation shows the provider who ordered the culture, NP-E, was updated on December 21, 2022 at 3:31 p.m., the day the results came back, and she should have been aware of the abnormal result. On February 16, 2023, at 11:15 a.m., the elder care program manager (PM)-K with the health system NP-E worked for, confirmed there were no records involving R1 for the month of December, including no laboratory results, no notifications from the facility, and no visits with NP-E and the resident. PM-K stated she was	02320		

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02320	Continued From page 29 aware of the situation regarding the resident's UTI but declined to provide any further comment. PM-K stated "I'm not involved as the department manager, I'm aware of the concerns with the family because the facility themselves reached out to me, but I have a license to protect." PM-K declined to provide the investigator with contact information for NP-E, stating the nurse practitioner was on leave. PM-K later followed up with an email indicating patient relations and risk management would follow up with the investigator to provide additional information. 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 no 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 approval, "I have to go with what the nurse says to not be in trouble." On February 17, 2023, at 1:30 p.m., licensed assisted living director (LALD)-A stated staff had contacted NP-E after R1's fall on December 21st and they obtained orders to check his urine. LALD-A stated the resident's lab was run through a different health care facility than what NP-E	02320		

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02320	Continued From page 30 worked at since the other facility was able to pick up samples but as far as she knew, NP-E would be able to see the results in Epic (clinical documentation software) and she would be able to monitor the results. LALD-A stated she was not aware of the issues with obtaining treatment orders for R1 until he had died. After his death, LALD-A reached out to the healthcare system NP-E worked at to get some more information on what happened. LALD-A stated she did not speak directly to NP-E as she didn't want to upset her so she spoke with PM-K after the incident occurred. LALD-A stated she was told that NP-E knew about the faxes with 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 culture results to come back before any antibiotics or other treatment was prescribed. LALD-A stated the facility called NP-E's office on Tuesday, December 27, 2022 asking for a call back ASAP but did not get a response. LALD-A stated to her knowledge, R1 was not symptomatic until December 27, 2022 and they had attributed the blood in his urine bag to be related to the resident pulling or tugging at the catheter. LALD-A stated she did not speak with RN-B about this incident since she had already put in her notice and had resigned her position. LALD-A stated the facility had not considered filing a MAARC report as she didn't believe neglect occurred but she had spoken with the nurses involved in the incident and felt they should have called to let family know about the blood in his urine bag and given them the choice to take him in over the weekend of December 24, 2022. LALD-A stated "it's just hard when we made all these phone calls and no one got back to us." LALD-A stated their process is to have the nurse make the decision on calling 911 versus allowing the staff to call 911 as they have a lot of	02320		

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02320	Continued From page 31 residents on hospice so they have them go through nursing. LALD-A added a number of families choose not to treat so they would not be happy if staff called 911. On February 21, 2023, at 9:10 a.m., registered nurse (RN)-B stated she had asked NP-E for an order for a urinalysis after R1 had a fall and blood in his urine on December 21, 2022. RN-B stated the resident was not a huge fall risk so the fall was out of the norm for him and the symptoms observed seemed to indicate a UTI. RN-B stated she called NP-E's nurse, who then transferred her to NP-E and she spoke directly with her to report her concerns on a potential UTI. RN-B stated NP-E placed an order for a urinalysis but did not give any direction at that time on treatment or antibiotics if it was verified he had a UTI. RN-B stated she had made a few attempts to contact NP-E after the culture came back positive but was never able to get ahold of her and didn't know what else to do. RN-B confirmed LPNs were used in the RN on-call rotation and they didn't have a formal system to hand off information like pending lab results or other care related issues to the on-call nurse. RN-B did not think she had updated LPN-D of the issues she was having obtaining orders for treatment from NP-E. RN-B confirmed R1's family was not updated of any issues with not being able to get ahold of NP-E or that the resident had ongoing blood in his urine as "the resident was his own decision maker." RN-B stated she was not on call over the holiday weekend and when she came back to work on Tuesday, December 27, 2022, the resident wasn't looking good and appeared very weak, sweaty, clammy, and had a fall when he was walking with staff. RN-B stated she called 911 and had him sent to the emergency room for further evaluation. RN-B stated she wasn't sure	02320		

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02320	Continued From page 32 what follow up action was done or if the facility had investigated the incident as her last day of employment there was December 31, 2022. On February 21, 2023, at 9:25 a.m., LPN-D stated she was notified on December 25, 2022, that R1 was having blood in his urine that morning. LPN-D stated she was not in the facility since she was working as the on-call nurse and she did not primarily work at this location so did not know R1 as well as his primary nurse did. LPN-D stated staff reported he was seen playing with his catheter and had blood in his urine collection bag. LPN-D stated staff reported the resident was not reporting pain at that time so she advised staff to monitor and call back if he had any pain or blood was increasing and she did not get a call back that day. LPN-D stated staff called back the next day, December 26, 2022, as the resident still had blood in his urine collection bag. LPN-D stated she was not aware at that time the resident had been diagnosed with a UTI and had not started any treatment for it. LPN-D stated R1's family had not been updated of the ongoing reports of blood in his urine collection bag and the clinical nurse supervisor (LALD-A) had not been notified of the reports of blood or that the facility was having difficulty getting ahold of NP-E to obtain orders or further guidance for the resident's UTI. LPN-D stated she would triage and handle all incoming nursing related calls and would rarely have to contact a RN. On February 21, 2023, at 9:45 a.m., LPN-C stated that while she works primarily at this location, she did not work much with R1 since she was not his primary nurse. LPN-C stated she saw a fax come through on December 22, 2022, with his UA results and she faxed the results to NP-E. LPN-C stated she recalls getting a	02320		

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02320	Continued From page 33 confirmation that the fax went through but they didn't get an acknowledgement of it from NP-E or her staff as they generally only get acknowledgements of things if there's new orders being written. On February 21, 2023, at 9:55 a.m., ULP-G stated she was asked by another ULP to help get R1 up the morning of December 26, 2022, because they were having trouble getting him up. ULP-G stated the other ULP told her R1 had been like this yesterday (December 25, 2022) and wasn't letting her get anywhere near him. ULP-G stated she remembered walking in 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. ULP-G stated the drainage tube had the same discolored urine in it and she had asked him what was going on. R1 told her "I don't know, it hurts." ULP-G stated she knew there were previous times he played with his catheter and thought maybe he was doing that as the resident "wouldn't even let me near his private area because he said it hurt so bad." ULP-G stated she was taken aback by what she saw in his urine collection bag and didn't think it was normal. ULP-G stated R1 was normally pretty independent so it was not normal for him to not want to go out for breakfast. ULP-G stated she had called the on call nurse twice that day to report her concerns. ULP-G stated she could not recall if she knew at that time the resident had a UTI. On February 22, 2023, at 9:30 a.m., a patient relations representative from the healthcare system NP-E worked for contacted the investigator after the investigator sent a follow up email on February 22, 2023. Patient relations representative (PR)-M was not able to answer	02320		

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02320	Continued From page 34 questions regarding the process for contacting the Elder Care provider team, how lab results are processed, or if NP-E had reviewed the resident's urine culture results. PR-M confirmed if a facility were to call and speak to a nurse in the Elder Care team, a phone encounter note would be entered in Epic so if the facility had called to update NP-E on December 21, 2022, and on December 27, 2022, there would be a phone encounter documented. PR-M stated if anything was faxed to the Elder Care provider team, the fax would be scanned in to the patient's medical record. PR-M confirmed no documentation related to R1 had been entered in Epic from the date range of December 1, 2022, through December 27, 2022. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure 1 of 1 residents reviewed (R1) was free from maltreatment. The resident was neglected. Findings include: The Minnesota Department of Health (MDH)	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

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02360	Continued From page 35 issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has	03000		

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03000	Continued From page 36 reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to timely submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R1) after the licensee failed to ensure a resident was provided appropriate treatment following a diagnosis of a urinary tract infection (UTI). The resident continued to show symptoms of a UTI over a period of several days and later died from septic shock (a widespread infection causing organ failure and dangerously low blood pressure). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	03000		

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03000	Continued From page 37 situation has occurred only occasionally). The findings include: R1'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 heart beat). R1's service plan, dated October 27, 2022, indicated the resident received assistance with dressing, grooming, bathing, behavior management, catheter care three times per day, and medication administration. R1's most recent assessment dated November 9, 2022, indicated the resident had a Foley catheter (a tube in the urethra that carries urine out of the body) in place and had a history of UTI's. The resident was not able to do effective peri cares and staff were to help daily and as needed. Staff were to check the catheter bag at night and empty as needed. The assessment noted an outside home health agency managed the monthly catheter change. Facility progress notes indicated R1 had an unwitnessed fall on December 21, 2022. A note was left for nurse practitioner (NP)-E to review the next time she was in the facility. Later that afternoon, staff notified registered nurse (RN)-B that there was blood present in the resident's urine. NP-E was updated via phone about the urine, the fall, and increased behaviors/confusion as charted by the caregivers. Verbal orders for a urine culture were received by RN-B . The lab requisition for the urinalysis indicated hematuria (blood in the urine) was the reason	03000		

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03000	Continued From page 38 why the lab was being ordered. On December 22, 2022, licensed practical nurse (LPN)-C documented "a fax had been received from [unaffiliated healthcare facility] lab on 12/22/2022. UA (urinalysis) results received....Results to be faxed to NP-E." The results indicated a UTI was present. No additional responses or follow up from NP-E was noted. On December 22, 2022, a ULP documented in the residents Treatment Recap Summary there was blood mixed with urine in the resident's bag. On Sunday, December 25, 2022, licensed practical nurse (LPN)-D documented "nurse received a call that [R1] had blood in his urine this morning. It is stated that he plays with his catheter at times. When trying to redirect him he becomes upset. No pain noted. Nurse placed another call to follow up on him, he continues to play with it from time to time. He still is not showing and (sic) sign of pain. Caregivers asked to updated nurse if he pulls out the catheter, is showing pain, or blood increases. He is still having adequate output. Will follow up with provider during business hours if not needed sooner." On December 25, 2022, during the overnight shift, ULP-J documented in the resident's Treatment Recap Summary, "the resident's catheter is clot with blood, it needs Nurse's attention." On December 27, 2022, at 7:11 p.m., ULP-G documented a late entry from Monday, December 26, 2022, "yesterday I went to get [R1] for breakfast he was sitting with no pants on, when I asked if I could help him I noticed his bag was full	03000		

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03000	Continued From page 39 of blood, the tubing was full of blood, brief was full of blood and you could tell he was in pain. We called on call nurse and she took it from there." On December 26, 2022, LPN-D documented "[R1] continues to have blood in his urine. Caregivers stated that he pulls at his catheter often. Message left for home health with no return call. Still awaiting UC (urine culture) results. Primary provider to be updated next business day." On December 27, 2022, RN-B documented "awaiting urine culture, called lab who stated they have attempted to fax it 4 times. Received call from home health nurse...she relayed to me that culture grew Citrobacter koseri and pseudomonas aeruginosa. Home health nurse inquiring about catheter change, as [R1] will be due soon. Message left with [NP-E] nurse regarding this and requesting a call back ASAP and clarification on when to change catheter. RN-B entered two additional progress notes on December 27, 2022. One note entered at 10:56 a.m. indicated, "[R1] had a fall with staff present where he was unsteady and fell to the left while ambulating in his room. [R1] currently has a UTI that was awaiting treatment from provider. [R1] 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.) [R1] 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	03000		

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03000	Continued From page 40 ranges are 12-20 breaths per minute), oxygen saturation at 86% (normal is above 95%), temperature at 98.2, pulse 90. When asking [R1] if he wants to go to the hospital, he states "yes" Son updated on the phone...spoke with NP-E's nurse who will send a message to provider." Hospital records indicate the resident arrived at the emergency room (ER) on December 27, 2022, at 11:38 a.m. The ER physician's admission note 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 came to see the patient in the ER, the patient became apenic (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 was stopped and the resident "went in to a cardiac arrest/asystole (a state of cardiac standstill, no cardiac output)" and was pronounced dead at 3:45 p.m., approximately four hours after his arrival in the ER. The ICU Admission History and Physical note from December 27, 2022, 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 indicates the ICU	03000		

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03000	Continued From page 41 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). 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	03000		

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03000	Continued From page 42 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 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 approval, "I have to go with what the nurse says to not be in trouble." On February 17, 2023, at 1:30 p.m., licensed assisted living director (LALD)-A stated staff had contacted NP-E after R1's fall on December 21st and they obtained orders to check his urine. LALD-A stated she was not aware of the issues with obtaining treatment orders for R1 until he had died. LALD-A stated to her knowledge, R1 was not symptomatic until December 27, 2022 and they had attributed the blood in his urine bag to be related to the resident pulling or tugging at the catheter. LALD-A stated she did not speak with RN-B about this incident since she had already put in her notice and had resigned her position. LALD-A stated the facility had not considered filing a MAARC report as she didn't believe neglect occurred but she had spoken with the nurses involved in the incident and felt they should have called to let family know about the blood in his urine bag and given them the choice to take him in over the weekend of December 24, 2022. LALD-A stated "it's just hard when we made all these phone calls and no one got back to us." On February 21, 2023, at 9:10 a.m., registered nurse (RN)-B stated she had asked NP-E for an order for a urinalysis after R1 had a fall and blood in his urine on December 21, 2022. RN-B stated the resident was not a huge fall risk so the fall	03000		

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03000	Continued From page 43 was out of the norm for him and the symptoms observed seemed to indicate a UTI. RN-B stated she called NP-E's nurse, who then transferred her to NP-E and she spoke directly with her to report her concerns on a potential UTI. RN-B stated NP-E placed an order for a urinalysis but did not give any direction at that time on treatment or antibiotics if it was verified he had a UTI. RN-B stated she had made a few attempts to contact NP-E after the culture came back positive but was never able to get ahold of her. RN-B confirmed R1's family was not updated of any issues with not being able to get ahold of NP-E or that the resident had ongoing blood in his urine as "the resident was his own decision maker." RN-B stated she was not on call over the holiday weekend and when she came back to work on Tuesday, December 27, 2022, the resident wasn't looking good and appeared very weak, sweaty, clammy, and had a fall when he was walking with staff. RN-B stated she called 911 and had him sent to the emergency room for further evaluation. RN-B stated she wasn't sure what follow up action was done or if the facility had investigated the incident as her last day of employment there was December 31, 2022. On February 21, 2023, at 9:25 a.m., LPN-D stated she was notified on December 25, 2022, that R1 was having blood in his urine that morning. LPN-D stated she was not in the facility but staff reported he was seen playing with his catheter and had blood in his urine collection bag. LPN-D stated staff reported the resident was not reporting pain at that time so she advised staff to monitor and call back if he had any pain or blood was increasing and she did not get a call back that day. LPN-D stated staff called back the next day, December 26, 2022, as the resident still had blood in his urine collection bag. LPN-D stated	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34812	A. BUILDING: _____ B. WING _____	C 02/17/2023

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03000	Continued From page 44 she was not aware at that time the resident had been diagnosed with a UTI and had not started any treatment for it. LPN-D stated R1's family had not been updated of the ongoing reports of blood in his urine collection bag and the clinical nurse supervisor (LALD-A) had not been notified of the reports of blood or that the facility was having difficulty getting ahold of NP-E to obtain orders or further guidance for the resident's UTI. On February 21, 2023, at 9:55 a.m., ULP-G stated she was asked by another ULP to help get R1 up the morning of December 26, 2022, because they were having trouble getting him up. ULP-G stated the other ULP told her R1 had been like this yesterday (December 25, 2022) and wasn't letting her get anywhere near him. ULP-G stated she remembered walking in 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. ULP-G stated the drainage tube had the same discolored urine in it and she had asked him what was going on. R1 told her "I don't know, it hurts." ULP-G stated she knew there were previous times he played with his catheter and thought maybe he was doing that as the resident "wouldn't even let me near his private area because he said it hurt so bad." ULP-G stated she was taken aback by what she saw in his urine collection bag and didn't think it was normal. ULP-G stated R1 was normally pretty independent so it was not normal for him to not want to go out for breakfast. ULP-G stated she had called the on call nurse twice that day to report her concerns. ULP-G stated she could not recall if she knew at that time the resident had a UTI. As of February 23, 2023, the licensee had not submitted a MAARC report for suspected neglect	03000		

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03000	Continued From page 45 of R1. The licensee's undated vulnerable adult reporting and investigation policy indicated employees would report any suspected maltreatment (abuse, neglect or financial exploitation as defined in MN Statutes 626.5572) of our home care clients [assisted living residents]. Suspected abuse, neglect, or financial exploitation would be investigated by the RN in coordination with the home care director. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		