STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aitkin Health Services	301 Minnesota Avenue South Aitkin, MN 56431

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on interviews and document review, the facility failed to notify the resident's physician timely with a change in condition for 1 of 3 residents (R1) when staff inserted an indwelling catheter three times, resulted in bleeding, blood clots, pain, discomfort, low urine output, and low blood pressure, sent to emergency room via ambulance, and developed sepsis, and admitted to intensive care unit. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified severely impaired cognition and no behaviors noted. MDS indicated R1 had an indwelling catheter, always incontinent of bowel, and neurogenic bladder (interference of the relationship between the nervous system and bladder function and affects the way bladder functions due to injury or disease). MDS also indicated R1 had impairment on one side of his upper and lower body and was dependent upon staff for all cares, transfers, and repositioning. R1's health conditions form dated 6/2/24, to 7/2/24, were identified as anemia, benign prostatic hyperplasia (enlargement of the prostate) (BPH) with lower urinary tract symptoms, hemiplegia and hemiparesis (weakness and/or paralysis on one side of the body) following cerebral infarction (stroke) affected left non-dominant side, neuromuscular dysfunction of bladder (the nerves and muscles don't work together very well. As a result, the bladder may not fill or empty correctly), and dementia. R1's care plan (CP) dated 7/10/24, identified risk for bleeding due to anticoagulant (blood thinner) use, directed staff to monitor vitals and for bleeding, and contact provider with changes and update as needed. CP identified R1 was at risk for urinary tract infection (UTI) due to indwelling catheter and directed staff to observe and monitor for signs of infection and urine quality changes (change in urine color/sediment). R1 had an indwelling Foley catheter 14 F (French) 10 cc (cubic centimeters), and to document urine output at the end of every shift. R1's physician order dated 6/21/24, identified change 14 F catheter with 10 cc every 28 days at evening 2 p. m. to 10:30 p.m. once a month and change the bag at the same time. R1's physician order dated 6/21/24, identified empty catheter bag and document output three times day (morning 6:00 a.m. to 2:30 p.m., evening 2:00 p.m. to 10:30 p.m., night 10:00 p.m. to 6:30 a.m.). (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's House Standing Orders signed and dated 2/29/24, identified may irrigate catheter with 30 to 60 ml (milliliters) of sterile normal saline with signs of blockage (clots, no urine flow or bypassing around catheter). Change indwelling catheter PRN (as needed) if becomes obstructed or comes out of bladder. R1's progress notes from 6/28/24, through 7/5/24, identified: -6/28/24, at 12:07 a.m. to 7/2/24, at 12:15 a.m. no documentation noted in R1's medical record (over four days). -7/2/24, at 12:15 a.m. 14 F was inserted at 9:20 p.m. and tolerated well. Later at 11:15 p.m. resident woke up screaming ouch and in pain. Irrigation, repositioning, and massage of bladder done but no urine output and still in a lot of pain. Small amount of thick blood and clots in bag and bloody urine bypassing. On call notified and she said to call on call provider if pain increased. -7/2/24, at 12:15 p.m. from report the evening nurse changed resident catheter with a 14 F (per interview with LPN-A this was a 16 F, see below) and then a 16 F with blood output. At 8:30 p.m. writer was called to R1's room, screaming in pain, and guarded his groin area whenever staff tried to reach for that area. R1 refused to have brief closed due to increased pain, bladder scanned for 216 cc. On call nurse was notified and suggested flush/irrigate catheter, push fluids and change catheter to 14 F. When catheter was gushed there was increased pain and no output. Removed 16 F and noted continuous gross hematuria (bleeding) with some blood clots from penis. On call was notified and she said to let him drain for 15 minutes then insert a 14 F. After 15 minutes the gross hematuria was minimum and R1 felt better with less pain. -7/2/24, at 5:09 a.m. R1 was screaming, reported a lot of pain (10 out of 10) when his brief was changed around 3:30 a.m. R1's vitals blood pressure (BP) 90/53, respirations 18, and oxygen saturation 92%. Bladder scan completed and resulted in 249 cc with no urine in output in bag. On call provider notified and gave order to send to emergency room (ER) at 4:30 a.m. -7/2/24, at 10:01 a.m. received call from local hospital, R1 had been admitted with diagnosis of sepsis. R1's family updated and placed on LOA (leave of absence). -7/4/24, at 5:53 p.m. called hospital for update. R1 was moved out of ICU (intensive care unit) and downgraded to medical unit, off drip and BP was ok, and placed on two antibiotics. Possibly be there for two more days. -7/5/24, at 2:13 p.m. was readmitted back to facility from hospital at 1:30 p.m. R1 had indwelling catheter in place that was free flowing, patent, urine was light yellow in color, without sediment, no blood no unusual odor. R1's catheter was to be changed every 28 days, if anticipated difficulty with catheter contact urology. Continued to be treated with antibiotics for UTI every 12 hours for 11 more days. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's hospital admission notes dated 7/2/24, indicated indwelling catheter change completed at nursing home facility last evening resulted in significant bleeding and no urine output. An attempted catheter placement in ER resulted in ongoing bleeding and no urine output. CT (computerized tomography) scan was completed and showed catheter balloon inflated in the urethra. Urology was contacted and replaced the catheter over a guidewire with cystoscopy (a hollow tube equipped with a lens inserted into urethra and slowly advanced into the bladder). Principle problems identified: urinary tract infection associated to indwelling catheter, sepsis (life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), with acute renal failure and septic shock, and anemia with acute blood loss from urethra resulting from Foley catheter placement. During an interview on 7/8/24, at 4:00 p.m. licensed practical nurse (LPN)-A stated R1 was due for a catheter change on July 1, 2024. LPN-A stated she had gathered supplies: catheter size 16 F, catheter bag, catheter change kit, and an extra syringe. LPN-A indicated pulled out R1's catheter 14 F after deflating balloon and noted urine was dark amber, cloudy, and sediment in the tubing without odor. LPN-A stated emptied 450 cc of urine from collection bag. LPN-A stated when she inserted the 16 F catheter bright red blood was seen, panicked, and pulled out the catheter. LPN-A stated talked with floor manager LPN-B and informed was normal for R1 to bleed a bit and instructed to insert another catheter. LPN-A stated went back and inserted 16 F catheter and bloody return was noted with a small amount of urine. LPN-A stated she had went to the EMAR and noted the order indicated 14 F, it was then she realized she had inserted the wrong size catheter twice. LPN-A stated she reported to LPN-B and DON and was told it was fine and instructed to let things settle down/stop bleeding before the catheter was changed again. LPN-A stated checked on R1 prior to end of shift and no pain, no urine was flowing out of the tube and offered to flush but RN-A said no it was ok and left for the day. LPN-A stated a provider should have been notified about the wrong size catheter (2 times) and blood returned with little to no urine but did not due to LPN-B and DON indicated it was normal for R1 to bleed some. LPN-A stated they did not document this and should have. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 7/9/24, at 2:00 a.m. registered nurse (RN)-A stated she started her night shift at 6:00 p.m. RN-A indicted she had received report from the LPN-A regarding R1's Foley catheter change. RN-A stated LPN-A indicated she she inserted a 14 F and got blood so removed it, placed another catheter this time a 16 F and was still bleeding when she realized she had used the wrong size catheter. RN-A indicted LPN-A reported to DON and floor manager LPN-B and they both came to conclusion the urethra was already irritated, so it was ok to leave it in until morning, monitor for bleeding, and replace it the next day with a 14 F catheter. RN-A stated she had never seen blood in R1's catheter prior to this day. RN-A stated she peaked in on R1 at 6:30 p.m. prior to a medication pass that evening and there was approximately 100 cc of bloody drainage in the collection bag and in the catheter tubing and R1 reported no pain at that time. RN-A stated she had been told in the past when the catheter was not placed properly due to the BPH and neurogenic bladder a small amount of blood was normal for R1. RN-A stated when she had placed R1's catheter in the past, she had never seen any bleeding. RN-A stated later, a staff nursing assistant came and got her and indicated R1 was in pain. RN-A went to R1's room and he complained of pain and said, ouch ouch. RN-A stated she tried to close his brief, but he would not allow and yelled out. RN-A checked urinary output which had remained the same as earlier (6:30 p.m.) then called the on-call nurse (DON) and was directed to massage the bladder area, push fluids, and then flush the catheter tubing. RN-A stated a provider should have been notified when R1 started to have no urine output with bleeding but she relied on DON for direction instead. RN-A stated DON instructed her the provider did not have to be called because there was nothing he could do and would round the next day. RN-A indicated she was unable to flush the catheter tubing, R1 complained of more pain, then she contacted DON again. RN-A stated DON indicated R1's 16 F catheter should be removed and replaced with a 14 F. RN-A stated she removed the 16 F catheter and R1 had gross hematuria from the penis and replaced it with a 14 F with approximately 80 cc of bloody drainage in bag and allowed more time to see when urine would drain and what color. RN-A stated she had bladder scanned R1 prior to the insertion of the catheter and noted 216 cc. RN-A verified at 11:00 p. m. R1 complained of pain again, but was unable to give more Tylenol. RN-A texted DON and instructed to reposition R1, massage the bladder area and if in one hour still in pain call the on call provider and ask for order to use emergency kit to give a different analgesic. RN-A stated R1 indicated he was ok and then checked on him again at 3:00 a.m. bloody output had remained the same in bag at 50 ml and no urine noted and R1 had started to complain about pain again. RN-A called on call provider and informed them R1 had no urinary output and bladder pain then received order, and sent R1 into the hospital. During an interview on 7/9/24, at 11:00 a.m. hospital physician assistant (PA)-A (provided urological care to patients) verified she was notified about R1's admission to ER and asked to provide assistance with insertion of a catheter. PA-A stated R1 had a large prostate and obstructive urinary symptoms and required the use of a guide wire and cystoscopy (a hollow tube equipped with a lens to view the urethra and bladder) as she inserted the indwelling catheter. PA-A indicated was unable to see if there was a false tract (a false passage in the urethra is formation of an epithelialized tract created when the catheter was inserted aggressively against the urethral wall and/or a weak part of the urethra rather than guided through the urethra lumen, into the bladder, and may occur more often in men due to an enlarge prostate) due to excessive bleeding in the urethra. PA-A stated reinsertion of a catheter had the potential to cause more damage and/or bleeding. PA verified when staff nurse inserted the catheter, got blood return a provider should have been notified right away and not waited. PA-A stated additionally, no urine output for up to 12 hours can cause increased risk for infection due to stagnate urine and possibly go into the kidneys which can be serious. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/9/24, at 11:37 a.m. primary provider/physician assistant (PA)-B stated R1 had no urine output from 9 p.m. until sent to ER (7 hours). PA-B verified it would have been a good idea to have updated provider after the second time the wrong size catheter was inserted and bleeding continued. PA-B also stated when nurse had contacted the DON 4 to 6 times in a matter of 6 hours she was in over her head, clearly struggled, and required direction from the provider especially when R1 yelled out in pain, increased bleeding, and low urine output. PA-B stated she would have not recommended to change 16 F catheter a 14 F catheter, provider should have been contacted much sooner and R1 most likely sent into hospital earlier. During an interview on 7/9/24, at 2:05 p.m. floor manager registered nurse (RN)-C stated repeated insertion of a catheter risked irritation to the lining of the urethra, increased an entry of bacteria which increased risk for infection. RN-C stated it was basic nursing education/practice to not inflate balloon until you get urine back. R1's change in condition occurred when he had less than 50 cc of urine out for more than two to three hours and a provider should have been contacted especially when the bleeding should have subsided much sooner. During a telephone interview on 7/10/24, at 8:45 a.m. medical director (MD) stated staff nurses attempted to insert three catheters and the trauma to the urethra most likely was started with the first insertion, when the wrong sized catheter 16 F was used. MD stated a catheter balloon should never be inflated until you get a flow of urine. MD stated would have been important with blood return and no urine a provider should have been notified right away, sent to ER so an evaluation could have been completed at another facility. MD verified when a resident had ongoing bleeding, on an anticoagulant, and bled for more than two hours, would be alarming and something else was going on. MD stated he would have expected more documentation from the nursing especially with low urine output and bleeding, in the medical record, to establish a time-line, and what interventions were tried. During a telephone interview on 7/10/24, at 12:48 p.m. ER supervisor RN-D verified R1 arrived in ER with a 16 F catheter with no urine output and blood in bag. During an interview on 7/10/24, at 1:10 p.m. DON stated she had many conversations with both staff nurses starting from 7/1/24, at approximately 4:00 p.m. through 7/5/24, at 11:32 p.m. regarding R1. DON stated last time she had heard from RN-A was at 11:32 p.m. DON stated she arrived at the facility early the next morning on 7/2/24, asked RN-A how R1 was doing and was informed she had sent him to emergency room via ambulance. DON stated she would have expected to be notified R1 was sent to hospital but was not. DON stated repeated catheter insertion could have raised the risk of complications such as infection and urethral damage/bleeding. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 7/11/24, at 12:00 p.m. emergency care provider, osteopathic doctor (DO) (look at patients as a whole person consisting of a mind, body, and spirit, and tend to focus on preventative medicine) stated the facility inserted a Foley catheter more than once, no urine output and bleeding occurred, clearly it was placed in the wrong spot and not in the bladder. DO stated at that time most likely that was when they started the false tract. DO indicated no urine output was not due to a blood clot because they tried to flush the catheter at the facility, no urine output and only blood. DO stated we removed the Foley catheter once he arrived at ED and inserted a 3 -way catheter without resistance and only a small return of urine. DO stated this indicted there was a false tract prior to his arrival at ED. DO verified the CT scan confirmed the Foley balloon was in the penile urethra therefore suspected R1 had a false tract. DO indicted numerous insertions of a Foley catheter within 10 hours would have caused damage and a false tract when not inserted properly. DO stated the facility continued to re-insert catheters, with no urine out put and bleeding, caused urethra trauma, provider was not contacted right away and should have been, which delayed care and R1 became septic with bacteria in catheter. DO indicated she believed this cause R1 harm. Facility policy titled Notification of Significant Changes dated 5/2/22, identified policy provided guidance to staff when and who to notify of a significant change in a resident's status. Definition of a significant change meant a change in resident's status, a need to alter treatment, and accident results in injury, or a decision to transfer or discharge the individual receiving services from care center. The charge nurse will immediately (as indicated by the change of condition) informed the resident, consult with the physician, and notify the resident representative for the following significant change: an accident that involved the resident which results in injury and has the potential for required physician intervention, a deterioration in health, in either lift-threatening conditions or clinical complications, and decision to transfer to another provider from the care center without primary physician involvement. Review of facility policy titled Foley Catheter Insertion, Male Resident dated 2001 identified the purpose of the Foley catheter was to provide for and maintain constant urinary drainage. Verification that there was a physician order was required to identify what size Foley catheter was specified. After preparation insert the catheter gently into the meatus (end of penis) approximately five to seven inches until urine began to flow from the bladder then advance the catheter another two inches and inflate balloon with 5 cc (cubic centimeters) and removed syringe. If resistance met do not force the entry, stop the procedure, and notify supervisor. The physician would be expected to be notified of any abnormalities (i.e. bleeding, obstruction).

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on interview and document review, the facility failed to report to the State Agency (SA) for 1 of 1 resident (R1) whose indwelling catheter was incorrectly placed three times resulting in bleeding, blood clots, pain, discomfort, low urine output, prolonged provider notification, sepsis, sent to emergency room via ambulance, and admitted to intensive care unit (ICU). Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified severely impaired cognition and no behaviors noted. R1 had an indwelling catheter and always incontinent of bowel. R1 had a neurogenic bladder (interference of the relationship between the nervous system and bladder function and affects the way bladder functions due to injury or disease). R 1 had impairment on one side of his upper and lower body and was dependent upon staff for all cares, transfers, and repositioning. R1's hospital admission notes dated 7/2/24, indicated indwelling catheter change completed at nursing home facility last evening resulted in significant bleeding and no urine output. An attempted catheter placement in ER resulted in ongoing bleeding and no urine output. CT scan was completed and showed catheter balloon inflated in the urethra. Urology was contacted and replaced the catheter over a guidewire with cystoscopy (a hollow tube equipped with a lens inserted into urethra and slowly advanced into the bladder). Principle problems identified: urinary tract infection associated to indwelling catheter, sepsis with acute renal failure and septic shock, and anemia with acute blood loss from urethra (a muscular tube that conveys urine from the urinary bladder to the exterior at the end of the penis). resulting from Foley catheter placement. During an interview on 7/9/24, at 12:44 p.m. floor manager licensed practical nurse (LPN)-B stated R1 has had a history of difficult indwelling catheter attempts with scant amount of blood but would have expected the bleeding to stop within an hour. LPN-B stated on 7/1/24, LPN-A attempted to insert the wrong size catheter 16 French (F) (order was for a 14 F), larger than it should have been, and blood came through the tubing. LPN-B stated the bleeding was caused by insertion of a catheter too large and scraped his urethra. LPN-B stated along with the director of nursing (DON) we had chosen to wait to re-insert another catheter due to urethra being raw, could have caused more damage and discomfort, and allowed that area to recover. LPN-B stated there had been some harm done here, there had been damage to the urethra and he bled, required medical intervention, sent to hospital and admitted . LPN-B confirmed a vulnerable report (VA) probably should have been filed along with a facility incident report to review the entire situation and avoid it from happening again. During an interview on 7/9/24, at 2:05 p.m. floor manager registered nurse (RN)-C stated bleeding was not typical for any insertion of an indwelling catheter no matter what size it was. RN-C stated a change in condition would have been identified as less than 50 cubic centimeters (cc) of urine output an hour for more than two to three hours, blood in the urine should have subsided a lot sooner than it did, and a provider should have been contacted from the get-go. RN-C verified no facility incident report or VA report were filed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 7/10/24, at 12:48 p.m. ER supervisor RN-D verified R1 arrived in ER with a 16 F catheter with no urine output and blood in bag. During an interview with on 7/10/24, at 1:10 p.m. director of nursing (DON) stated A vulnerable adult (VA) report was not filed with the state, the nurses followed the facility policy, processes, and procedures, except for the wrong catheter size. DON stated an incident report should have been filed under medication error. DON stated she was not aware until Monday morning (7/6/24), R1 came back from hospital and CT (computerized tomography) scan showed R1 had a catheter balloon inflated in the urethra rather than the bladder. Review of facility policy titled Maltreatment Reporting Guidelines reviewed last on 10/18/21, identified any alleged maltreatment involving neglect must be reported by the supervising employee of the building to the administrator of the care center immediately and to the Minnesota Department of Health (MDH) and other officials according to the following timelines based on severity of alleged maltreatment. Review of facility policy titled SNF (Skilled Nursing Facility) Maltreatment Investigation and Reporting dated 10/18/21, identified an initial investigation must be conducted immediately to determine what happened and whether the incident requires reporting to the Office of Health Facility Complaints (OHFC) or the Minnesota Adult Abuse Reporting Center (MAARC). A report to OHFC must be initiated as soon as the incident is determined to be reportable.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on interview and document review, the facility failed to thoroughly investigate and take steps to correct neglect of care for 1 of 1 resident (R1) who did not receive the necessary care and monitoring when facility staff inserted an indwelling catheter incorrectly three times, resulted in bleeding, blood clots, pain, discomfort, low urine output, prolonged provider notification, and low blood pressure, sent to emergency room via ambulance, and developed sepsis, and admitted to intensive care unit (ICU). Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified severely impaired cognition and no behaviors noted. R1 had an indwelling catheter and always incontinent of bowel. R1 had a neurogenic bladder (interference of the relationship between the nervous system and bladder function and affects the way bladder functions due to injury or disease). R 1 had impairment on one side of his upper and lower body and was dependent upon staff for all cares, transfers, and repositioning. R1's hospital admission notes dated 7/2/24, indicated indwelling catheter change completed at nursing home facility last evening resulted in significant bleeding and no urine output. An attempted catheter placement in ER resulted in ongoing bleeding and no urine output. CT scan was completed and showed catheter balloon inflated in the urethra. Urology was contacted and replaced the catheter over a guidewire with cystoscopy (a hollow tube equipped with a lens inserted into urethra and slowly advanced into the bladder). Principle problems identified: urinary tract infection associated to indwelling catheter, sepsis with acute renal failure and septic shock, and anemia with acute blood loss from urethra (a muscular tube that conveys urine from the urinary bladder to the exterior at the end of the penis). resulting from Foley catheter placement. During a telephone interview on 7/10/24, at 12:48 p.m. ER supervisor RN-D verified R1 arrived in ER with a 16 F catheter with no urine output and blood in bag. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/8/24, at 4:00 p.m. licensed practical nurse (LPN)-A stated R1 was due for a catheter change on July 1, 2024. LPN-A stated she had gathered supplies: catheter size 16 F, catheter bag, catheter change kit, and an extra syringe. LPN-A indicated pulled out R1's catheter 14 F after deflating balloon and noted urine was dark amber, cloudy, and sediment in the tubing without odor. LPN-A stated emptied 450 cc of urine from collection bag. LPN-A stated when she inserted the 16 F catheter bright red blood was seen, panicked, and pulled out the catheter. LPN-A stated talked with floor manager LPN-B and informed was normal for R1 to bleed a bit and instructed to insert another catheter. LPN-A stated went back and inserted 16 F catheter and bloody return was noted with a small amount of urine. LPN-A stated she had went to the EMAR and noted the order indicated 14 F, it was then she realized she had inserted the wrong size catheter twice. LPN-A stated she reported to LPN-B and DON and was told it was fine and instructed to let things settle down/stop bleeding before the catheter was changed again. LPN-A stated checked on R1 prior to end of shift and no pain, no urine was flowing out of the tube and offered to flush but RN-A said no it was ok and left for the day. LPN-A stated a provider should have been notified about the wrong size catheter (2 times) and blood returned with little to no urine but LPN-B and DON indicated it was normal for R1 to bleed some. LPN-A stated no one talked to me about this again after I left for the day nor was there education provided to me. LPN-A stated did not document this and should have. During an interview on 7/9/24, at 11:00 a.m. physician assistant (PA)-A (provided urological care to patients) verified she was notified about R1's admission to ER and asked to provide assistance with insertion of a catheter. PA stated R1 had a large prostate and obstructive urinary symptoms and required the use of a guide wire and cystoscopy (a hollow tube equipped with a lens to view the urethra and bladder) as she inserted the indwelling catheter. PA-A indicated was unable to see if there was a false tract (a false passage in the urethra is formation of an epithelialized tract created when the catheter was inserted aggressively against the urethral wall and/or a weak part of the urethra rather than guided through the urethra lumen, into the bladder, and may occur more often in men due to an enlarge prostate) due to excessive bleeding in the urethra. PA-A stated reinsertion of a catheter had the potential to cause more damage and/or bleeding. PA-A verified when staff nurse inserted the catheter, got blood return a provider should have been notified right away and not waited. PA-A stated additionally, no urine output for up to 12 hours can cause increased risk for infection due to stagnate urine and possibly go into the kidneys which can be serious. During an interview on 7/9/24, at 11:37 a.m. primary provider physician assistant (PA)-B stated R1 had no urine output from 9 p.m. until sent to ER (7 hours). PA-B indicated when a nurse lacked skill for catheter insertion they may butt up to the inside of the urethra and felt like it was in the bladder, but no urine appeared. PA-B stated lack of urine would be the most thing to worry about but when catheter was placed incorrectly and in the wrong spot and/or a clot blocked off urine flow that would have been concerning. PA-B stated when R1 was catheterized improperly more than once that increased his risk for urethral damage and increased bleeding. PA-B stated R1's gross hematuria was caused by trauma from catheterization that was for sure and the only thing that made sense. (continued on next page)

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	245119	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aitkin Health Services	301 Minnesota Avenue South Aitkin, MN 56431

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/9/24, at 12:44 p.m. floor manager licensed practical nurse (LPN)-B stated R1 has had a history of difficult indwelling catheter attempts with scant amount of blood but would have expected that to stop within an hour. LPN-B stated on 7/1/24, LPN-A informed him she attempted to insert the wrong size catheter 16 F(should have been a 14 F), larger than it should have been, and blood came through the tubing. LPN-B stated the bleeding was caused by insertion of a catheter too large and scraped his urethra (a muscular tube that conveys urine from the urinary bladder to the exterior at the end of the penis). LPN-B stated along with the director of nursing (DON) we had chosen to wait to re-insert another catheter due to urethra being raw, could have caused more damage and discomfort, and allowed that area to recover. LPN-B stated there had been some harm done here, there had been damage to the urethra, R1 bled, required medical intervention, sent to hospital and admitted . During an interview on 7/10/24, at 1:10 p.m. DON stated no incident report was filed. DON also verified no investigation was started prior to 7/8/24, when surveyor arrived at their facility and at that time she started reviewing the documents such as medical record and hospital visit notes. DON indicated she had talked to LPN-A on 7/8/24, in the morning after surveyor had already interviewed her and education was completed briefly about lack of documentation, checking doctor's orders more thoroughly prior to changing out of the catheter to ensure the correct size was used. DON stated she had not visited and /or provided RN-A with education since incident. DON also verified there was no internal investigation or root/cause analysis completed within the facility. Review of facility policy titled SNF (Skilled Nursing Facility) Maltreatment Investigation and Reporting dated 10/18/21, identified Our care center will investigate all incidents and allegations of maltreatment to determine the cause (if able), and to determine if the incident needs to be reported to the appropriate authorities. An initial investigation must be conducted immediately to determine what happened and whether the incident requires reporting to the Office of Health Facility Complaints (OHFC) or the Minnesota Adult Abuse Reporting Center (MAARC). Once the incident is initially assessed by the person in charge and immediate interventions are initiated to prevent any further occurrences, the incident report will be further assessed by the Interdisciplinary Team (IDT) or responsible person(s) to evaluate the effectiveness of the current interventions and/or implementation of any further interventions.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on interview and document review, the facility failed to ensure the resident or resident's representative was informed of the bed hold policy at the time of hospitalization for 1 of 3 residents (R1) reviewed for hospitalization . Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified severely impaired cognition and no behaviors noted. R1 had an indwelling catheter and always incontinent of bowel. R1 had a neurogenic bladder (interference of the relationship between the nervous system and bladder function and affects the way your bladder function due to injury or disease). R1 had impairment on one side of his upper and lower body and was dependent upon staff for all cares, transfers, and repositioning. Review of R1's progress notes from 7/2/24, through 7/5/24, identified: - On 7/2/24, at 5:09 a.m. R1 screaming, reported a lot of pain rated 10 out of 10, blood pressure 90/53, bladder scanned 249 milliliters (ml), no urine in bag. On call provider notified and gave order to send to emergency room for evaluation due to low urine output for more than six hours. EMT (emergency medical technicians) were called, and R1 left for ER (emergency room) at 4:30 a.m. -On 7/2/24, at 10:01 a.m. received call from local hospital, R1 was admitted with diagnosis of sepsis. Resident's family updated and resident placed on LOA (leave of absence). -On 7/4/24, at 5:53 p.m. writer called local hospital for an update on R1. Out of ICU (intensive care unit) and downgrade to medical unit, might be there for another two days. -On 7/5/24, at 2:13 p.m. R1 readmitted to facility at 1:30 p.m. Further review of R28's medical record lacked documentation that R1 or family/legal representative had been provided information on the facility's bed hold policy at the time of the hospital transfer. During an interview on 7/9/24, at 4:37 p.m. floor manager registered nurse (RN)-C stated reviewed R1's chart and confirmed on 7/2/24, R1's LOA started and ended on 7/5/24. RN-C confirmed R1/family/legal representative were not provided a bed hold policy/information prior to his discharge to the hospital. During an interview on 7/9/24, at 4:29 p.m. social service designee (SSD) stated reviewed R1's chart and a bed hold was not provided to R1/family/legal representative or documented a bed hold was issued. SSD verified she had never done a bed hold before should have been done prior to R1's discharge to hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Bed Hold Election and Hospital Transfer dated 11/16/23, identified the care center will assure each resident, responsible person or legal representative is provided the option to hold their bed during a hospitalization or a therapeutic leave.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on interview and document review, the facility failed to ensure treatment and care in accordance with professional standards of practice for 1 of 3 residents (R1) reviewed who did not receive the necessary care and monitoring related to multiple incorrect insertion attempts of an indwelling catheter which resulted in bleeding, blood clots, pain, discomfort, low urine output, and low blood pressure, leading to a diagnosis of sepsis and admission to the Intensive Care Unit (ICU) via ambulance. This resulted in actual harm for R1. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified severely impaired cognition and no behaviors noted. MDS indicated R1 had an indwelling catheter, always incontinent of bowel, and neurogenic bladder (interference of the relationship between the nervous system and bladder function and affects the way bladder functions due to injury or disease). MDS also indicated R1 had impairment on one side of his upper and lower body and was dependent upon staff for all cares, transfers, and repositioning. R1's health conditions form dated 6/2/24, to 7/2/24, were identified as anemia, benign prostatic hyperplasia (enlargement of the prostate) (BPH) with lower urinary tract symptoms, hemiplegia and hemiparesis (weakness and/or paralysis on one side of the body) following cerebral infarction (stroke) affected left non-dominant side, neuromuscular dysfunction of bladder (the nerves and muscles don't work together very well. As a result, the bladder may not fill or empty correctly), and dementia. R1's care plan (CP) dated 7/10/24, identified risk for bleeding due to anticoagulant (blood thinner) use, directed staff to monitor vitals and for bleeding, and contact provider with changes and update as needed. CP identified R1 was at risk for urinary tract infection (UTI) due to indwelling catheter and directed staff to observe and monitor for signs of infection and urine quality changes (change in urine color/sediment). R1 had an indwelling Foley catheter 14 F (French) 10 cc (cubic centimeters), and directed staff to document urine output at the end of every shift. R1's physician order dated 6/21/24, identified change 14 F catheter with 10 cc every 28 days at evening 2 p. m. to 10:30 p.m. once a month and change the bag at the same time. R1's physician order dated 6/21/24, identified empty catheter bag and document output three times day (morning 6:00 a.m. to 2:30 p.m., evening 2:00 p.m. to 10:30 p.m., night 10:00 p.m. to 6:30 a.m.). R1's House Standing Orders signed and dated 2/29/24, identified may irrigate catheter with 30 to 60 ml (milliliters) of sterile normal saline with signs of blockage (clots, no urine flow or bypassing around catheter). Change indwelling catheter PRN (as needed) if becomes obstructed or comes out of bladder. R1's electronic medication administration record (EMAR) from 6/29/24, through 7/2/24, identified: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-6/29/34, urine output evening shift 2:00 p.m. to 10:30 p.m. 150 ml; EMAR lacked documentation for morning or night shift output. -6/30/23, urine output evening shift 2:00 p.m. to 10:30 p.m. 600 ml; EMAR lacked documentation for morning or night shift output. -7/1/24, urine output 6:00 a.m. to 2:35 p.m. 450 ml, 2:00 p.m. to 10:30 p.m. 300 ml, and 10:00 p.m. to 6:30 am. 0 ml. -7/1/24, Acetaminophen oral tablet 500 mg (milligrams) 2 tablets by mouth as needed one time per day was documented as administered at 9:30 p.m., not effective. -7/1/24, 2:00 p.m. to 10:30 p.m. blood pressure (BP) 97/57 mmHg (millimeters of mercury) and the only blood pressure documented in R1's EMAR. -7/1/24, evening shift 2:00 p.m. to 10:30 p.m. change 14 F catheter with 10 cc balloon every 28 days (once a month). R1's progress notes from 6/28/24, through 7/5/24, identified: -6/28/24, at 12:07 a.m. to 7/2/24, at 12:15 a.m. no documentation noted in R1's medical record (four days). -7/2/24, at 12:15 a.m. 14 F was inserted at 9:20 p.m. and tolerated well. Later at 11:15 p.m. resident woke up screaming ouch and in pain. Irrigation, repositioning, and massage of bladder done but no urine output and still in a lot of pain. Small amount of thick blood and clots in bag and bloody urine bypassing. On call notified and she said to call on call provider if pain increased. -7/2/24, at 12:15 p.m. From report the evening nurse changed resident catheter with a 14 F (per interview with LPN-A this was a 16 F see below) and then a 16 F with blood output. At 8:30 p.m. writer was called to R1's room, screaming in pain, and guarded his groin area whenever staff tried to reach for that area. R1 refused to have brief closed due to increased pain, bladder scanned for 216 cc. On call nurse was notified and suggested flush/irrigate catheter, push fluids and change catheter to 14 F. When catheter was flushed there was increased pain and no output. Removed 16 F and noted continuous gross hematuria (bleeding) with some blood clots from penis. On call was notified and she said to let him drain for 15 minutes then insert a 14 F. After 15 minutes the gross hematuria was minimum and R1 felt better with less pain. -7/2/24, at 5:09 a.m. R1 was screaming, reported a lot of pain (10 out of 10) when his brief was changed around 3:30 a.m. R1's vitals blood pressure (BP) 90/53, respirations 18, and oxygen saturation 92%. Bladder scan completed and resulted in 249 cc with no urine in output in bag. On call provider notified and gave order to send to emergency room (ER) at 4:30 a.m. -7/2/24, at 10:01 a.m. received call from local hospital, R1 had been admitted with diagnosis of sepsis. R1's family updated and placed on LOA (leave of absence). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-7/4/24, at 5:53 p.m. called hospital for update. R1 was moved out of ICU (intensive care unit) and downgraded to medical unit, off drip and BP was ok, and placed on two antibiotics. Possibly be there for two more days. -7/5/24, at 2:13 p.m. was readmitted back to facility from hospital at 1:30 p.m. R1 had indwelling catheter in place that was free flowing, patent, urine was light yellow in color, without sediment, no blood no unusual odor. R1's catheter was to be changed every 28 days, if anticipated difficulty with catheter contact urology. Continued to be treated with antibiotics for UTI every 12 hours for 11 more days. R1's hospital admission notes dated 7/2/24, indicated indwelling catheter change completed at nursing home facility last evening resulted in significant bleeding and no urine output. An attempted catheter placement in ER resulted in ongoing bleeding and no urine output. CT (computerized tomography) scan was completed and showed catheter balloon inflated in the urethra. Urology was contacted and replaced the catheter over a guidewire with cystoscopy (a hollow tube equipped with a lens inserted into urethra and slowly advanced into the bladder). Principle problems identified: urinary tract infection associated to indwelling catheter, sepsis (life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), with acute renal failure and septic shock, and anemia with acute blood loss from urethra resulting from Foley catheter placement. R1's lab results dated 7/2/24, urine collected at 9:14 a.m. revealed: urine was amber colored, turbid (cloudy), trace of ketones, large amount of blood, severely increased protein levels (indicates problems with the kidneys), positive nitrate (most likely indicates a bacterial infection in the bladder), and a small number of leukocytes (white blood cells). R1's Complete Blood Count (CBC) dated 7/2/24, identified hemoglobin low 10.7 g/dl (grams/Deciliter) (normal range 13.5 to 17.5. g/dl). R1's CT scan of abdomen pelvis dated 7/2/24, at 6:32 a.m. identified indication: gross hematuria and decreased urine output, sepsis. Impression: malposition Foley catheter with balloon inflated with in the penile urethra. Only mild urinary bladder distension. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/8/24, at 4:00 p.m. licensed practical nurse (LPN)-A stated R1 was due for a catheter change on July 1, 2024. LPN-A stated she had gathered supplies: catheter size 16 F, catheter bag, catheter change kit, and an extra syringe. LPN-A indicated pulled out R1's catheter 14 F after deflating balloon and noted urine was dark amber, cloudy, and sediment in the tubing without odor. LPN-A stated emptied 450 cc of urine from collection bag. LPN-A stated when she inserted the 16 F catheter bright red blood was seen, panicked, and pulled out the catheter. LPN-A stated talked with floor manager LPN-B and informed was normal for R1 to bleed a bit and instructed to insert another catheter. LPN-A stated went back and inserted 16 F catheter and bloody return was noted with a small amount of urine. LPN-A stated she had went to the EMAR and noted the order indicated 14 F, it was then she realized she had inserted the wrong size catheter twice. LPN-A stated she reported to LPN-B and DON and was told it was fine and instructed to let things settle down/stop bleeding before the catheter was changed again. LPN-A stated checked on R1 prior to end of shift and no pain, no urine was flowing out of the tube and offered to flush but RN-A said no it was ok and left for the day. LPN-A stated a provider should have been notified about the wrong size catheter (2 times) and blood returned with little to no urine but did not due to LPN-B and DON indicated it was normal for R1 to bleed some. LPN-A stated they did not document this and should have. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 7/9/24, at 2:00 a.m. registered nurse (RN)-A stated she started her night shift at 6:00 p.m. RN-A indicted she had received report from the LPN-A regarding R1's Foley catheter change. RN-A stated LPN-A indicated she she inserted a 14 F and got blood so removed it, placed another catheter this time a 16 F and was still bleeding when she realized she had used the wrong size catheter. RN-A indicted LPN-A reported to DON and floor manager LPN-B and they both came to conclusion the urethra was already irritated, so it was ok to leave it in until morning, monitor for bleeding, and replace it the next day with a 14 F catheter. RN-A stated she had never seen blood in R1's catheter prior to this day. RN-A stated she peaked in on R1 at 6:30 p.m. prior to a medication pass that evening and there was approximately 100 cc of bloody drainage in the collection bag and in the catheter tubing and R1 reported no pain at that time. RN-A stated she had been told in the past when the catheter was not placed properly due to the BPH and neurogenic bladder a small amount of blood was normal for R1. RN-A stated when she had placed R1's catheter in the past, she had never seen any bleeding. RN-A stated later, a staff nursing assistant came and got her and indicated R1 was in pain. RN-A went to R1's room and he complained of pain and said, ouch ouch. RN-A stated she tried to close his brief, but he would not allow and yelled out. RN-A checked urinary output which had remained the same as earlier (6:30 p.m.) then called the on-call nurse (DON) and was directed to massage the bladder area, push fluids, and then flush the catheter tubing. RN-A stated a provider should have been notified when R1 started to have no urine output with bleeding but she relied on DON for direction instead. RN-A stated DON instructed her the provider did not have to be called because there was nothing he could do and would round the next day. RN-A indicated she was unable to flush the catheter tubing, R1 complained of more pain, then she contacted DON again. RN-A stated DON indicated R1's 16 F catheter should be removed and replaced with a 14 F. RN-A stated she removed the 16 F catheter and R1 had gross hematuria from the penis and replaced it with a 14 F with approximately 80 cc of bloody drainage in bag and allowed more time to see when urine would drain and what color. RN-A stated she had bladder scanned R1 prior to the insertion of the catheter and noted 216 cc. RN-A verified at 11:00 p. m. R1 complained of pain again, but was unable to give more Tylenol. RN-A texted DON and instructed to reposition R1, massage the bladder area and if in one hour still in pain call the on call provider and ask for order to use emergency kit to give a different analgesic. RN-A stated R1 indicated he was ok and then checked on him again at 3:00 a.m. bloody output had remained the same in bag at 50 ml and no urine noted and R1 had started to complain about pain again. RN-A called on call provider and informed them R1 had no urinary output and bladder pain then received order, and sent R1 into the hospital. During an interview on 7/9/24, at 11:00 a.m. hospital physician assistant (PA)-A (provided urological care to patients) verified she was notified about R1's admission to ER and asked to provide assistance with insertion of a catheter. PA-A stated R1 had a large prostate and obstructive urinary symptoms and required the use of a guide wire and cystoscopy (a hollow tube equipped with a lens to view the urethra and bladder) as she inserted the indwelling catheter. PA-A indicated was unable to see if there was a false tract (a false passage in the urethra is formation of an epithelialized tract created when the catheter was inserted aggressively against the urethral wall and/or a weak part of the urethra rather than guided through the urethra lumen, into the bladder, and may occur more often in men due to an enlarge prostate) due to excessive bleeding in the urethra. PA-A stated reinsertion of a catheter had the potential to cause more damage and/or bleeding. PA verified when staff nurse inserted the catheter, got blood return a provider should have been notified right away and not waited. PA-A stated additionally, no urine output for up to 12 hours can cause increased risk for infection due to stagnate urine and possibly go into the kidneys which can be serious. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/9/24, at 11:37 a.m. primary provider/physician assistant (PA)-B stated R1 had no urine output from 9 p.m. until sent to ER (7 hours). PA-B indicated when a nurse lacked skill for catheter insertion they may butt up to the inside of the urethra and felt like it was in the bladder, but no urine appeared. PA-B stated lack of urine would be the most thing to worry about but when catheter was placed incorrectly and in the wrong spot and/or a clot blocked off urine flow that would have been concerning. PA-B stated when R1 was catheterization improperly more than once that increased his risk for urethral damage and increased bleeding. PA-B stated R1's gross hematuria was caused by trauma from cauterization that was for sure and the only thing that made sense. PA-B verified it would have been a good idea to have updated provider after the second time the wrong size catheter was inserted and bleeding continued. PA-B also stated when nurse had contacted the DON 4 to 6 times in a matter of 6 hours she was in over her head, clearly struggled, and required direction from the provider especially when R1 yelled out in pain, increased bleeding, and low urine output. PA-B stated she would have not recommended to change 16 F catheter a 14 F catheter, provider should have been contacted much sooner and R1 most likely sent into hospital earlier. During an interview on 7/9/24, at 12:44 p.m. floor manager (LPN)-B stated R1 has had a history of difficult indwelling catheter attempts with scant amount of blood but would have expected that to stop within an hour. LPN-B stated on 7/1/24, LPN-A informed him she attempted to insert the wrong size catheter 16 French (F) (should have been a 14 F), larger than it should have been, and blood came through the tubing. LPN-B stated the bleeding was caused by insertion of a catheter too large and scraped his urethra (a muscular tube that conveys urine from the urinary bladder to the exterior at the end of the penis). LPN-B stated along with the director of nursing (DON) we had chosen to wait to re-insert another catheter due to urethra being raw, could have caused more damage and discomfort, and allowed that area to recover. LPN-B stated there had been some harm done here, there had been damage to the urethra and R1 bled, required medical intervention, sent to hospital, and admitted . During an interview on 7/9/24, at 2:05 p.m. floor manager registered nurse (RN)-C stated staff had difficulty with catheter placement with R1 in the past with flank blood upon insertion then subsided. RN-C indicated she would have been concerned from the word go when there was more blood than urine that would not be a typical finding after placement of a urinary catheter. RN-C also stated if there was flank blood after insertion of the catheter would have expected it to dissipate and see clean urine within in four hours with at least 50 cc an hour while fluids were pushed also. RN-C stated R1 had an extremely enlarge prostate and therefore made it a more difficult insertion and caused irritation of the urethra which caused bleeding. RN-C verified repeated insertion of a catheter risked irritation to the lining of the urethra, creased an entry of bacteria which increased risk for infection. RN-C stated it was basic nursing education/practice to not inflate balloon until you get urine back. R1's change in condition occurred when he had less than 50 cc of urine out for more than two to three hours and a provider should have been contacted especially when the bleeding should have subsided much sooner. RN-C stated LPN-A placed a larger sized catheter (16 F) rather than 14 F that was ordered and bleeding occurred. RN-C stated LPN-C would be expected to document in the progress notes what transpired from the insertion of the catheters and what was going on during shift change. RN-C stated no follow up had been completed since the incident, no root cause analysis, and had been done or education with the nurses involved. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aitkin Health Services	301 Minnesota Avenue South Aitkin, MN 56431

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 7/10/24, at 8:45 a.m. medical director (MD) stated staff nurses attempted to insert three catheters and the trauma to the urethra most likely was started with the first insertion, when the wrong sized catheter 16 F was used. MD stated a catheter balloon should never be inflated until you get a flow of urine. MD stated would have been important with blood return and no urine a provider should have been notified right away, sent to ER so an evaluation could have been completed at another facility. MD verified when a resident had ongoing bleeding, on an anticoagulant, and bled for more than two hours, would be alarming and something else was going on. MD stated he would have expected more documentation from the nursing especially with low urine output and bleeding, in the medical record, to establish a time-line, and what interventions were tried. During a telephone interview on 7/10/24, at 12:48 p.m. ER supervisor RN-D verified R1 arrived in ER with a 16 F catheter with no urine output and blood in bag. RN-D stated the 16 F was removed and a 5:45 a.m. another catheter was placed by the ER staff with no resistance and into a suspected false tract. RN-D stated if the false tract would have not been there previously before R1 came to ER would have most likely met up with resistance due to R1's BPH but would have then inserted directly into the bladder. RN-D stated urology PA-C was contacted and a catheter was placed with a scope and guide wire into the bladder. During an interview on 7/10/24, at 1:10 p.m. DON stated she had many conversations with both staff nurses starting from 7/1/24, at approximately 4:00 p.m. through 7/5/24, at 11:32 p.m. regarding R1. DON stated last time she had heard from RN-A was at 11:32 p.m. DON stated she arrived at the facility early the next morning on 7/2/24, asked RN-A how R1 was doing and was informed she had sent him to emergency room via ambulance. DON stated she would have expected to be notified R1 was sent to hospital but was not. A vulnerable adult (VA) report was not filed with the State Agency, because the nurses did follow the facility policy, processes, and procedures, except for inserting the wrong catheter size. DON stated because of the long holiday weekend she was not aware until Monday morning (7/6/24), when R1 came back from hospital, and the cat scan (CT) (computer tomography scan) showed R1 had a catheter balloon inflated in the urethra rather than the bladder. DON stated repeated catheter insertion could have raised the risk of complications such as infection and urethral damage/bleeding. DON stated an incident report should have been filed under medication error. DON verified no incident report was filed. DON also verified no investigation was started prior to 7/8/24, when surveyor arrived at their facility and at that time she started reviewing the documents such as medical record and hospital visit notes. DON indicated she had talked to LPN-A on 7/8/24, in the morning after surveyor had already interviewed her and education was completed briefly about lack of documentation, checking doctor's orders more thoroughly prior to changing out of the catheter to ensure the correct size was used. DON stated she had not visited and /or provided RN-A with education since incident. DON also verified there was no internal investigation or root/cause analysis completed within the facility. (continued on next page)

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	245119	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aitkin Health Services	301 Minnesota Avenue South Aitkin, MN 56431

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 7/11/24, at 12:00 p.m. emergency care provider, osteopathic doctor (DO) (look at patients as a whole person consisting of a mind, body, and spirit, and tend to focus on preventative medicine) stated the facility inserted a Foley catheter more than once, no urine output and bleeding occurred, clearly it was placed in the wrong spot and not in the bladder. DO stated at that time most likely that was when they started the false tract. DO indicated no urine output was not due to a blood clot because they tried to flush the catheter at the facility, no urine output and only blood. DO stated we removed the Foley catheter once he arrived at ED and inserted a 3 -way catheter without resistance and only a small return of urine. DO stated this indicted there was a false tract prior to his arrival at ED. DO verified the CT scan confirmed the Foley balloon was in the penile urethra therefore suspected R1 had a false tract. DO indicted numerous insertions of a Foley catheter within 10 hours would have caused damage and a false tract when not inserted properly. DO stated the facility continued to re-insert catheters, with no urine out put and bleeding, caused urethra trauma, provider was not contacted right away and should have been, which delayed care and R1 became septic with bacteria in catheter. DO indicated she believed this cause R1 harm. Review of facility policy titled Foley Catheter Insertion, Male Resident dated 2001 identified the purpose of the Foley catheter was to provide for and maintain constant urinary drainage. Verification that there was a physician order was required to identify what size Foley catheter was specified. After preparation insert the catheter gently into the meatus (end of penis) approximately five to seven inches until urine began to flow from the bladder then advance the catheter another two inches and inflate balloon with 5 cc (cubic centimeters) and removed syringe. If resistance met do not force the entry, stop the procedure, and notify supervisor. The physician would be expected to be notified of any abnormalities (i.e. bleeding, obstruction). The following information should be recorded in the resident's medical record: -date and time of procedure -name, title of individual who preformed procedure -all assessment data (e.g. character, color, clarity) obtained during the procedure -the size of the Foley catheter inserted and amount of fluid used to inflate the balloon -how resident tolerated procedure -signature and title of person recording data Facility policy titled Notification of Significant Changes dated 5/2/22, identified policy provided guidance to staff when and who to notify of a significant change in a resident's status. Definition of a significant change meant a change in resident's status, a need to alter treatment, and accident results in injury, or a decision to transfer or discharge the individual receiving services from care center. The charge nurse will immediately (as indicated by the change of condition) informed the resident, consult with the physician, and notify the resident representative for the following significant change: an accident that involved the resident which results in injury and has the potential for required physician intervention, a deterioration in health, in either lift-threatening conditions or clinical complications, and decision to transfer to another provider from the care center without primary physician involvement.