STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245618	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walker Methodist Westwood Ridge II	61 Thompson Avenue West West Saint Paul, MN 55118

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 interview, and document review the facility failed to notify the physician timely for 1 of 1 resident (R1) who was recovering from neoplasm (growth of abnormal cells) bladder surgery, had pulled out their indwelling catheter and had specific orders to contact physician with change of condition. Findings include: R1's diagnoses list dated [DATE], identified: neoplasm of bladder, aftercare following surgery for neoplasm, acute post hemorrhagic anemia (excess bleeding), abnormal uterine and vaginal bleeding, heart failure, presence of coronary angioplasty implant and graft, diabetes mellitus (type II), history of venous thrombosis and embolism (blood clot), and gross hematuria (visible blood in urine). R1's orders from [DATE], through [DATE] included: -Code Status - Full Resuscitation order date [DATE]. -Patient Instruction for urinary retention: If you are unable to urinate 6 to 8 hours after discharge, return to emergency room with your discharge instructions order date [DATE] -Discharge potential: length of stay less than 30 days order date [DATE]. -Urology: call for any questions if your catheter is not draining well. If you begin to notice more blood or large clots. Order date [DATE]. -Skilled Medicare charting. Document findings in progress not: Vital signs (VS), ADL (activities of daily living) functioning, pain status, neuro status, skin issues, respiratory status (especially SOB [shortness of breath] and any oxygen/CPAP used), any special care items for patient (e.g. IV, drains, etc.), and any changes in condition including hospitalization s and returns, MD (medical doctor) appointments and return. Use your nursing judgement to add pertinent additional information. Order date [DATE]. -[DATE], Patient instruction for Urinary Retention: If you are unable to urinate in ,d+[DATE] hours after discharge, return to emergency room with your discharge instructions. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-[DATE], Minnesota Urology: Call for any questions if your catheter is not draining well or if you begin to notice more blood or large clots. -[DATE] at 11:59 p.m. replace and re-insert pulled out Foley catheter. Send patient to emergency if resistance is met. (order received after delay in contacting physician on [DATE], catheter never replaced, and resident never sent to emergency) R1's care plan dated [DATE], identified resident had Foley catheter due to bladder tumor diagnosis. Interventions directed staff to monitor/record/report to MD (medical doctor) for s/sx (signs and symptoms) of UTI (urinary tract infection): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased [NAME], temperature, and urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns. R1's progress notes (PN) dated [DATE], through [DATE], identified: -on [DATE] at 5:23 p.m., R1 arrived at facility via EMT (emergency medical technicians) transport on w/c (wheelchair) accompanied by son. R1 was A & O x4 (alert and oriented times four), forgetfulness noted. -on [DATE] at 10:30 p.m., administered Acetaminophen oral tablet 500 mg (milligrams) two for sign of mild pain. -on [DATE] at 11:30 p.m., PRN (as needed) administration of Acetaminophen was effective, follow up pain scale was 0 out of 10. -on [DATE] at 1:17 a.m. replace and re-insert pulled out Foley catheter. Send patient to emergency if resistance is met. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-on [DATE] at 6:22 a.m. R1pulled out indwelling catheter together with the water balloon that anchored it in place. Some bleeding noted, R1 was washed up and a brief was offered to patient pending an order from provider for further action. Writer put a call into provider and waited to be called back. (PN lacked detail on when R1 pulled out catheter and when call was made to provider). Later, nurse practitioner (NP)-A called back and after a thorough explanation of the situation, an order was given to re-insert catheter. R1 was approached for re-insertion but refused. Writer suspected pain and administered Tylenol then let R1 be for a while, leaving her door open for easy monitoring. At 12:30 a.m. patient was okay talking and breathing without any sign of impending doom. By around 1:00 a.m. writer saw patient lying across bed and was not responding to any stimulus and looked lifeless lying her head in vomited food and fluid with some in her mouth. Writer quickly called the other nurse who also noted that patient was lifeless and then left the room immediately. Writer then turned patient to her right side while the water was still oozing out. CNA [certified nursing assistant] then noted that patient had passage of bowel movement and quickly cleaned it. As more fluid was oozing out after the second nurse left. CNA left to go answer call light while writer let out the water in patient's mouth and raised head of bed [HOB] and went to the nursing station to check patient's code status. Have noted code status RESUSCITATION, writer dashed back and asked the other CNA for help with putting patient down and CPR initiated immediately. No time was wasted. Patient was on the floor with fluid oozing from the mouth and POLST status had to be ascertained. All these were satisfied in a short time, couple of minutes then CPR was started: 911 was called. Patient was not able to be resuscitated. Family was informed and family came and arranged funeral home. Patient has long been deposited in funeral home. During a telephone interview on [DATE] at 4:00 p.m., family member (FM) stated R1 had a bladder tumor and only half could be removed during the surgery because the bladder walls were very thin. FM stated the urologist wanted the urinary catheter left in place because if the bladder got too full and was not constantly draining, the bladder could rupture. FM stated R1 was to be discharged from hospital on [DATE] initially but had started to bleed again. FM stated once discharged from hospital they had planned on going back in a couple of weeks for the remainder of the bladder tumor to be removed. FM stated he was visiting on [DATE] and R1 was a little sluggish, tired, refused to eat lunch and supper, which was rather odd for her. FM indicated around 6:00 p.m. R1 requested the bathroom, and he stepped out of room while staff assisted her. FM stated a few minutes later RN-A came out of the room looking flustered and informed him R1 had pulled out her urinary catheter, if they could get the bleeding under control, they would reinsert catheter and if not, she would be transferred back to the hospital. FM stated he did not get a sense that this was an everyday event, but none of the staff seemed concerned. FM indicated he had requested to be called with an update that evening, and left facility to go back home. FM stated when he had not received a call from the RN-A, at 9:15 p.m. FM he called and talked to her and was informed R1 was doing fine, but they had not gotten a chance to re-insert the urinary catheter. Adding, then at 1:15 a.m. he received a call from RN-A and was informed R1 was unresponsive and medical emergency had done CPR on her. FM stated RN-A had informed him they had packed a pullup with a hand towel used to prevent her from bleeding. FM express, R1 had not moved to the TCU to die, but to recover and go on to finish the rest of her surgery. (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 [DATE] at 4:40 p.m., NA-C stated between 5:30 p.m. to 6:00 p.m. she went to take R1 to the bathroom but R1 had already gotten herself up and was almost to the bathroom. NA-C stated R1 informed her she had to go bad and then noticed blood on the floor where her feet had walked through it. NA-C indicated she looked around room and noticed the urinary catheter bag hung on the side of R1's bed with tubing attached to it that was no longer attached to R1. NA-C indicated she asked RN-A to assess R1 and see where the blood was coming from. NA-C stated RN-A entered R1's room as she cleaned up the drops of blood off the floor and suggested a brief be placed on R1. NA-C stated she noticed a dime sized blood clot stuck to the side of the toilet bowl when she flushed the toilet. NA-C also stated RN-A had picked up the catheter bag, held it up and looked at it. NA-C verified she was unsure as to where the blood came from, however there was approximately 300 cc of pink tinged urine in the collection bag. NA-C stated R1 appeared more confused. During a telephone interview on [DATE] at 11:07 a.m., RN-A stated on [DATE] between 6:30 p.m. and 7:00 p. m. a licensed practical nurse (LPN) informed her R1 was bleeding and she asked if it was R1 and she indicated yes. RN-A stated she immediately went to R1's room and observed her on toilet in bathroom. RN-A stated nursing assistant (NA)-A informed her R1 started to take herself to the bathroom when she entered the room, saw the catheter was pulled out with balloon still inflated and intact, and bleeding. RN-A stated she checked catheter tubing, bag, no blood identified, and approximately 250 milliliters (ml) of tea colored urine noted in collection bag. RN-A indicated this must have caused R1 some trauma, but she denied pain. RN-A confirmed there was a small amount of blood in the toilet. RN-A verified at 7:00 p.m. she instructed the NA to place a brief on R1 and indicated she would contact the provider for instruction possibly re-insert the catheter or send R1 to the ER. RN-A stated she decided to wait to call provider because she had to check another resident's orders, complete a wound dressing changed, and finish up with her medication pass, so it was later in the evening when she placed a call to the on-call provider. RN-A indicated she had to leave a message and when the NP-A called her back she informed her that R1 pulled out her catheter, no additional bleeding noted, and was resting in bed. RN-A indicated she asked NP-A what she should do and received an order to re-insert catheter now as she must have one in. RN-A stated she informed NP-A there was trauma and suggested R1 be sent to the ER, as she was concerned if she reinserted the catheter, it could possibly push a blood clot back into R1's bladder. RN-A indicted NP-A provided an order: re-insert and if resistance was met, send to ER. RN-A stated she entered the order into the electronic health record (order shows it was entered at 1:17 a.m. [DATE] after R1's passing in record) and finished a few other things, then went to R1's room. RN-A stated R1 refused to have catheter re-inserted and denied pain. RN-A stated she returned to R1's room at 12:30 a.m. and again she refused re-insertion of the catheter, so she finished up a few things and was then was going to call 911 and send her to the ER. RN-A stated at 1:00 a.m. she noticed R1 was laying across her bed with her feet on the floor, so she quickly went to room [ROOM NUMBER] and got NA-B (without assessing R1). RN-A stated both staff entered R1's room and she was lifeless, quiet, and body was still warm. RN-A verified with RN-B, no heartbeat, no respirations, and unresponsive. (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 follow up interview via telephone on [DATE] at 12:11 p.m., RN-A stated called the on-call provider around 9:00 p.m., passed medications around that time also, time was not checked when she called back or documented in progress notes. RN-A stated was extremely busy that evening, resident with wound dressing change, new admission, and administered medications. RN-A stated DON was there, indicated those tasks needed to be completed first, wound cares around 8:30 p.m. and informed DON there was the whole night to get that catheter placed back in and DON indicated that was ok. RN-A stated she wanted R1 to have time to calm down, when catheter was pulled out sometimes it was hard on the resident especially when the balloon was still intact, and again stated she was in no hurry to contact provider. RN-A verified she did not document assessments completed as she was too busy, and no noted changes. RN-A indicated she was unsure what she told the triage and on-call provider but told them only what they asked for and they should have asked for more information. RN-A did confirm she should have told provide the catheter had been out for hours prior to the call, past medical history of bleeding and recent bladder surgery. RN-A stated the order that was given indicated to contact provider back if resistance was met and that did not happen because R1 refused. RN-A indicated she planned on sending R1 into ER but had medications to administer to other residents first. During a telephone interview on [DATE] at 9:24 a.m., on call NP-A stated RN-A first contacted triage on [DATE] at 10:02 p.m. (approximately 4 hours after R1 pulled out her catheter) NP-A indicated she had returned the call to RN-A on [DATE] at 10:16 p.m. NP-A verified RN-A had informed the triage nurse R1 had a recent bladder resection, pulled out indwelling catheter, bleeding had stopped, blood only noted when the peri area was wiped, and wore incontinent product. NP-A stated RN-A asked if R1's catheter could be replaced. NP-A stated the conversation was very short with triage nurse and was surprised she had not provided more information. NP-A stated she was the overnight on call provider and relied on what the nurse told the triage nurse. NP-A also stated the responsibility/burden lied with RN-A to have explained the situation to the triage nurse such as her history of bleeding issues. NP-A indicated she was not made aware R1 had gross hematuria (visible blood in the urine), anemia with Hgb of 5.9 g/dL, and a bladder tumor. NP-A stated she had given RN-A orders to replace, and re-insert pulled out Foley catheter and send to emergency if resistance was met. NP-A verified R1 had been seen earlier in the day by her primary provider NP-B. NP-A stated after R1 refused to have the catheter reinserted that would have fallen under an identified problem and would have expected RN-A to have called back right away with an update, re-assessed, and would have sent to emergency room to be assessed. NP-A verified she was not aware R1 had been without the catheter for over 4 hours, and was not contacted by RN-A after their initial conversation at 10:16 p.m. During an interview on [DATE] at 10:49 a.m., primary provider NP-B stated she would have expected RN-A to have sent R1 into the emergency room (ER) or call triage back when unable to reinsert the urinary catheter. NP-B indicated R1 just had a huge surgery and we wanted to avoid urinary retention. NP-B stated had seen R1 the morning of [DATE] around 9:00 a.m. to 10:00 a.m. while she made rounds at the facility. NP-B stated she was informed by physical therapy R1 was fatigued and confused. NP-B indicated she was surprised R1 had died . (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 [DATE] at 2:20 p.m., director of nursing (DON) indicated she was at the facility later that evening but was unable to provide an approximate time she was onsite. DON stated prior to leaving the facility later during the p.m. shift on [DATE], she was made aware by RN-A and R1's son of R1's indwelling catheter being pulled out. DON stated she informed R1's son the provider would be contacted to get direction on what to do, and he requested a follow up call once that was completed. DON informed RN-A R1's son requested an update once provider was contacted. DON verified during the facility's investigation following R1's death, RN-A verified she contacted the provider, but no time was provided, and the facility did not ask for a specific time. DON indicated she would have expected RN-A to contact the provider immediately and follow the orders due to history of bladder cancer, recent bladder surgery. DON stated it was unknown if R1's bladder was empty or full due to a lack of assessment by RN-A, and she would have expected RN-A to have completed and documented abdominal assessments, bladder scans, output, and ongoing monitoring to demonstrate R1's nursing care needs were being met and she was not having a change in condition. DON stated she would have expected RN-A to have followed up with the provider as soon as possible to update the provider on R1's refusal for re-insertion along with her assessment information and to received further direction and orders. DON indicated it may had been concerning to have R1's catheter out over six hours with her history of current bladder surgery but was unable to determine without the assessments having been completed. DON stated she did not delegate as to what steps RN-A should have taken or prioritized during her shift. DON indicated RN-A was expected to ask for help if needed and communicate that to her. During an interview on [DATE] at 4:30 p.m., administrator stated he would have expected RN-A to follow up with the provider to get the order timely. Administrator also stated if R1 had any resistance and/or refused re-insertion, R1 should have been sent to the hospital and was not sure why Tylenol and monitoring was the plan of care when that was not what the physician's order stated. During a telephone interview on [DATE] at 5:00 p.m., medical director (MD) stated would not be concerned with R1's history when catheter was out over six hours and there was no doubt the staff nurse should have contacted the provider timely and updated her when R1 refused to have catheter re-inserted and along with following providers orders. Facility policy Change in Resident Condition dated [DATE], identified physicians will be notified of acute changes in a resident's condition in health include but not limited to: bowel and bladder continence and refusal of treatment as soon as possible. Notifications to physicians/NP (nurse practitioners) and condition changes would be documented in progress notes in medical record.

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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 record review, the facility failed to immediately report to the state agency (SA) when a provider orders for life sustaining treatment (POLST) and cardiopulmonary resuscitation was not initiated timely, as per the resident wishes for 1 of 1 resident (R1) reviewed for neglect. Findings include: R1's diagnoses' list dated [DATE], identified: neoplasm (growth of abnormal cells) of bladder, aftercare following surgery for neoplasm, acute post hemorrhagic anemia (excess bleeding), abnormal uterine and vaginal bleeding, heart failure, presence of coronary angioplasty implant and graft, diabetes mellitus (type II), history of venous thrombosis and embolism (blood clot), and gross hematuria (visible blood in urine). R1's Provider Orders for Life-Sustaining Treatment (POLST) prepared and signed by healthcare agent/son on [DATE] (box checked: patient has capacity), and signed by provider on [DATE], identified: Attempt resuscitation/CPR (cardiac pulmonary resuscitation) (NOTE: selecting this requires selecting Full Treatment in section B). Section B Full Treatment. Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments. R1's orders from [DATE], through [DATE] included: -Code Status - Full Resuscitation order date [DATE]. The facility's Incident Report submitted to the State Agency (SA) on [DATE] at 9:44 p.m., identified incident occurred on [DATE] at 1:00 a.m., administrator was notified of incident on [DATE] at 2:36 a.m. Nursing staff noted R1 had cessation of pulse and respirations on the morning of [DATE] at 1:00 a.m. The timeline of events from nurse progress notes were not conclusive as to when CPR (Cardiac pulmonary resuscitation) was initiated. Registered Nurse (RN)-A was suspended pending further investigation. Investigation was started. The SA was notified of the facility's failure to provide CPR timely 20 hours and 44 minutes after the facility (RN-A) suspected R1 was neglected. The facility's investigation submitted to the MDH on [DATE] at 9:17 a.m., identified this was an isolated incident, resident expired. The facility findings were inconclusive due to inconsistencies with staff statements and inability to establish and verify timeline of events. The resident's primary nurse resigned from her position effective immediately [DATE]. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of [NAME] St. [NAME] Police Incident Report with a creation date and time of [DATE] at 5:43 a.m. revealed the following: [RN-B] was agitated and noted that [R1] had been unconscious for an extended period and that [RN-A] had failed to provide or render proper aid for an extended period. [RN-B] alleged that [R1] had been unconscious since midnight, approximately one hour before the call for service. [RN-B] was upset and contacted the state because of the neglect. I spoke with Mhealth's supervisor, who noted he asked [RN-B] if she had contacted first responders to assist with the medical, and she said she had not because it was not her patient. I spoke with [RN-A], who noted she was in [R1]'s room around 00:40. Around 01:00, she walked past the room and saw [R1] lying across the bed, so she entered the room to assist her. [RN-A] found another employee to help with moving [R1] when she realized she had been vomiting. [RN-A] ran and found [RN-B] and advised her of the situation. [RN-B] followed her to the room and eventually left. [RN-A] saw food in [R1]'s mouth, so she moved her to the floor to begin to render aid. While speaking with [RN-A], [RN-B] approached and began to allege she was lying about what had occurred. I separated the two and asked [RN-B] to provide us with some privacy. After speaking with [RN-A], I found [RN-B] and learned the following: anytime the facility has a death, nurses will request a second nurse to verify the information. This includes checking the heart, checking the pupils, and confirming the individual is deceased . [RN-A] called [RN-B] to the room at 00:30 hours, where she checked the pulse and pupils. [R1] showed no pupillary response and had no heartbeat; however, she was still warm. [RN-B] asked if this was an expected death, which is frequent due to the facility's nature, and [RN-A] advised it was. [RN-A] and the nursing assistant began straining the body and cleaning the bed. Around 01:00, [RN-A] asked for the nursing assistants help, entered [R1]'s room, and began to perform CPR. According to [RN-B], before requesting the nursing assistant to perform aid, there were no resuscitation attempts, and aid took 35 minutes before [RN-A] began to render assistance. But there should have been. [RN-B] stated she tried to contact management, but they had not contacted her, and she needed to contact the state within two hours since [NAME] was a vulnerable adult. Medics continued to render assistance, but [R1] was eventually declared deceased at 01:47 hours .Due to the neglect and serious allegations, I contacted on-duty investigators and informed them of the situation. I also called the Hennepin County Coroner's Office and explained the situation. They said they would not respond to the location based on what they had learned. During interview on [DATE] at 11:52 a.m. DON stated she received noticed of the incident on [DATE] around 1:00 a.m. DON indicated per our facility policy all alleged violations are immediately reported to the community's administrator. DON stated at the time of the incident the RN that worked that night reported there were no concerns regarding delayed CPR. DON indicated it was not until after all of the statements were received that there were concerns related to timeliness and initiation of CPR and then it was reported to the MDH at that time. During an interview on [DATE] at 4:30 p.m., administrator stated he was notified on [DATE] at 1:36 a.m., about the incident with R1. Administrator indicated the report was filed with the SA with a time stamp of [DATE] at 9:44 p.m. Administrator indicated after the incident happened R1's progress noted were reviewed and there were no concerns of timelessness and once the night shift staff statements were gathered and completed, we felt it was reportable. Administrator stated there was no delay as far as he could see. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy Vulnerable Adult Abuse Prevention Plan and Suspicion of a Crime Reporting dated [DATE], identified definition of neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident(s) that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility was aware of or should have been aware of good or services that a resident(s) required but facility failed to provide them to the resident, that have resulted in or may result in physical harm, pain, mental anguish, or emotional stress. Employees must report a reasonable suspicion of a crime by email, fax, or telephone, committed against any resident to the MDH (Minnesota Department of Health) OHFC and to local law enforcement immediately but not later than two hours after forming suspicion if the events resulted in serious bodily injury which means injury involving extreme physical pain; substantial risk of death; protracted loss or impairment of the function of a bodily member, organ, or mental faculty; required medical intervention such as surgery, hospitalization , or physical rehabilitation; or an injury that resulted from criminal sexual abuse.

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on interview and document review, the facility failed to provide basic life support, including cardiopulmonary resuscitation (CPR) in accordance with resident wishes and physician orders for full code status of CPR to 1 of 3 residents (R1) reviewed. This deficient practice resulted in an immediate jeopardy (IJ) situation when R1 was found not breathing, had no pulse, CPR was not initiated timely, and R1 passed away at the facility. The IJ began on [DATE], at 12:30 a.m. when R1 was noted to have no respirations or pulse, and no immediate action was taken by Registered Nurse (RN)-A, including CPR, which resulted in a missed opportunity to resuscitate R1, resulting in certain death. On [DATE], at 5:15 p.m. the administrator and director of nursing (DON) were notified of the IJ. The IJ was removed on [DATE], following verification of an acceptable removal plan however, noncompliance remained at the lower scope and severity level D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's diagnoses list dated [DATE], identified: neoplasm (growth of abnormal cells) of bladder, aftercare following surgery for neoplasm, acute post hemorrhagic anemia (excess bleeding), abnormal uterine and vaginal bleeding, heart failure, presence of coronary angioplasty implant and graft, diabetes mellitus (type II), history of venous thrombosis and embolism (blood clot), and gross hematuria (visible blood in urine). R1's Provider Orders for Life-Sustaining Treatment (POLST) prepared and signed by healthcare agent family member (FM)-A on [DATE] (box checked: patient has capacity), and signed by provider on [DATE], identified: Attempt resuscitation /CPR (cardiac pulmonary resuscitation) (NOTE: selecting this requires selecting Full Treatment in section B). Section B Full Treatment. Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments. R1's orders from [DATE], through [DATE] included: Code Status - Full Resuscitation order date [DATE]. R1's care plan dated [DATE], identified resident had Foley catheter due to bladder tumor diagnosis. Interventions directed staff to monitor/record/report to MD (medical doctor) for s/sx (signs and symptoms) of UTI (urinary tract infection): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased [NAME], temperature, and urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns. R1's progress notes (PN) dated [DATE], through [DATE], identified: -on [DATE] at 5:23 p.m., R1 arrived at facility via EMT (emergency medical technicians) transport on w/c (wheelchair) accompanied by son. R1 was A & O x4 (alert and oriented times four), forgetfulness noted. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-on [DATE] at 10:30 p.m., administered Acetaminophen oral tablet 500 mg (milligrams) two for sign of mild pain. -on [DATE] at 11:30 p.m., PRN (as needed) administration of Acetaminophen was effective, follow up pain scale was 0 out of 10. -on [DATE] at 1:17 a.m. replace and re-insert pulled out Foley catheter. Send patient to emergency if resistance is met. -on [DATE] at 6:22 a.m. R1 pulled out indwelling catheter together with the water balloon that anchored it in place. Some bleeding noted, R1 was washed up and a brief was offered to patient pending an order from provider for further action. Writer put a call into provider and waited to be called back. (PN lacked detail on when R1 pulled out catheter and when call was made to provider). Later, nurse practitioner (NP)-A called back and after a thorough explanation of the situation, an order was given to re-insert catheter. R1 was approached for re-insertion but refused. Writer suspected pain and administered Tylenol then let R1 be for a while, leaving her door open for easy monitoring. At 12:30 a.m. patient was okay talking and breathing without any sign of impending doom. By around 1:00 a.m. writer saw patient lying across bed and was not responding to any stimulus and looked lifeless lying her head in vomited food and fluid with some in her mouth. Writer quickly called the other nurse who also noted that patient was lifeless and then left the room immediately. Writer then turned patient to her right side while the water was still oozing out. CNA [certified nursing assistant] then noted that patient had passage of bowel movement and quickly cleaned it. As more fluid was oozing out after the second nurse left. CNA left to go answer call light while writer let out the water in patient's mouth and raised head of bed [HOB] and went to the nursing station to check patient's code status. Have noted code status RESUSCITATION, writer dashed back and asked the other CNA for help with putting patient down and CPR initiated immediately. No time was wasted. Patient was on the floor with fluid oozing from the mouth and POLST status had to be ascertained. All these were satisfied in a short time, couple of minutes then CPR was started: 911 was called. Patient was not able to be resuscitated. Family was informed and family came and arranged funeral home. Patient has long been deposited in funeral home. R1's treatment administration record (TAR) documentation of urinary output entered per shift (a.m. , d+[DATE], p.m. ,d+[DATE], night shift ,d+[DATE]. [DATE] evening output 350 cubic centimeters (cc) and night output 700 cc. [DATE] Evening output 500 cc and night output 300 cc. R1's electronic medical record did not identify R1's urinary output on [DATE] day shift. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of NP-B visit dated [DATE], identified R1's advanced directives: Full Code. R1 had been hospitalized from [DATE], through [DATE], due to vaginal bleeding and concern for urinary source bleeding which resulted in increasing lightheadedness, dyspnea (shortness of breath), and a low hemoglobin 5.9 hemoglobin (Hgb) grams per deciliter (g/dL) (normal range 11.5 to 15). R1 received two units of red packed blood cells (RBC) upon admission and Hgb improved to 7.9, 8.4, and 8.3. On [DATE], R1 underwent D & C (dilation and curettage) (removed tissue from uterus), cystoscopy with fulguration of vessels (heat derived from an electrical current to destroy atypical /cancer tissue), and 50% removal of the bladder tumor. Additionally, on [DATE], R1 had an inferior vena cava filter placed due to unable to restart anticoagulant. R1 had an indwelling foley catheter placed to have remained in while at TCU. R1 was seen today [DATE], for an admission visit in the TCU. R1 had just finished up therapy and reported she was worn out from therapy. Appetite fair and no further bleeding. R1's vital signs ,d+[DATE], 97.3 Fahrenheit (F), pulse 86 per minute, 16 breathes per minute, and oxygen saturation level (Sa02) 98% (normal range 90 to 100%). R1's last Hgb on [DATE], was 8.9 g/dL. The facility's Incident Report submitted to the State Agency (SA) on [DATE] at 9:44 p.m., identified incident occurred on [DATE] at 1:00 a.m., administrator was notified of incident on [DATE] at 2:36 a.m. Nursing staff noted R1 had cessation of pulse and respirations on the morning of [DATE] at 1:00 a.m. The timeline of events from nurse progress notes were not conclusive as to when CPR (Cardiac pulmonary resuscitation) was initiated. Registered Nurse (RN)-A was suspended pending further investigation. Investigation was started. The facility's investigation submitted to the MDH on [DATE] at 9:17 a.m., identified this was an isolated incident, resident expired. The facility findings were inconclusive due to inconsistencies with staff statements and inability to establish and verify timeline of events. The resident's primary nurse resigned from her position effective immediately [DATE]. Review of [NAME] St. [NAME] Police Incident Report with a creation date and time of [DATE] at 5:43 a.m. revealed the following: [RN-B] was agitated and noted that [R1] had been unconscious for an extended period and that [RN-A] had failed to provide or render proper aid for an extended period. [RN-B] alleged that [R1] had been unconscious since midnight, approximately one hour before the call for service. [RN-B] was upset and contacted the state because of the neglect. I spoke with Mhealth's supervisor, who noted he asked [RN-B] if she had contacted first responders to assist with the medical, and she said she had not because it was not her patient. I spoke with [RN-A], who noted she was in [R1]'s room around 00:40. Around 01:00, she walked past the room and saw [R1] lying across the bed, so she entered the room to assist her. [RN-A] found another employee to help with moving [R1] when she realized she had been vomiting. [RN-A] ran and found [RN-B] and advised her of the situation. [RN-B] followed her to the room and eventually left. [RN-A] saw food in [R1]'s mouth, so she moved her to the floor to begin to render aid. While speaking with [RN-A], [RN-B] approached and began to allege she was lying about what had occurred. I separated the two and asked [RN-B] to provide us with some privacy. After speaking with [RN-A], I found [RN-B] and learned the following: anytime the facility has a death, nurses will request a second nurse to verify the information. This includes checking the heart, checking the pupils, and confirming the individual is deceased . (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[RN-A] called [RN-B] to the room at 00:30 hours, where she checked the pulse and pupils. [R1] showed no pupillary response and had no heartbeat; however, she was still warm. [RN-B] asked if this was an expected death, which is frequent due to the facility's nature, and [RN-A] advised it was. [RN-A] and the nursing assistant began straightening the body and cleaning the bed. Around 01:00, [RN-A] asked for the nursing assistants help, entered [R1]'s room, and began to perform CPR. According to [RN-B], before requesting the nursing assistant to perform aid, there were no resuscitation attempts, and aid took 35 minutes before [RN-A] began to render assistance. But there should have been. [RN-B] stated she tried to contact management, but they had not contacted her, and she needed to contact the state within two hours since R1 was a vulnerable adult. Medics continued to render assistance, but [R1] was eventually declared deceased at 01:47 hours . Due to the neglect and serious allegations, I contacted on-duty investigators and informed them of the situation. I also called the Hennepin County Coroner's Office and explained the situation. They said they would not respond to the location based on what they had learned. During a telephone interview on [DATE] at 10:30 a.m., RN-B indicated at 12:30 a.m. on [DATE], RN-A walked over to the 400 Wing of the nursing home; did not appear frantic or hurried and stated to her, 300 just died , come over to verify the death. RN-B stated she grabbed her stethoscope and one minute later entered R1's room. RN-B stated nursing assistant (NA)-A and RN-A were in R1's room, stood together one side of R1's bed, had repositioned R1's bed sheets, there was no sign of emesis on or around R1, and no CPR was being done. RN-B indicated she checked R1's apical pulse, with no pulse response, then both pupils (nonresponsive), skin was pale but remained warm, no breathing noted, and unresponsive. RN-B stated she asked RN-A if R1's death was expected, and she replied yes. RN-B stated an expected death only meant one thing which was a hospice death, so no code status was checked, and RN-A never requested and further help so she exited R1's room. RN-B stated she informed NA-B there had been a death because now many resident call lights had gone off. RN-B stated then at 12:55 a.m. she observed RN-A walking down the 400 hallway again and asked where NA-B was, so she informed her NA-B was at the end of the 400 hallway. RN-A indicated RN-A walked down to end of 400 hallway yelling out NA-B's name loudly three times. RN-A stated NA-B and RN-A walked together into R1's room and closed the door. RN-A stated right before 1:08 a. m. RN-A exited R1's room and right after that she received a text message from NA-B that said, not sure what was going on but RN-A had us place [R1] on the floor and we are doing CPR . she was already dead . adding, then she looked up from her computer and NA-B was frantically waved at her and she looked scared, so RN-B indicated she got up and went over to NA-B immediately and into R1's room. RN-B stated NA-B informed her RN-A completed some compressions, then left the room, to call EMS, adding NA-B stated she was not comfortable doing CPR by herself, then turned around, and RN-A had returned to R1's room with no exchange of conversation and just started chest compressions on R1 again. RN-B stated when EMS arrived shortly after and entered R1's room, RN-A mislead the entire R1 situation. RN-B stated when EMS had taken her statement, she informed them at 12:30 a.m. she confirmed with RN-A that R1 had died , body was warm, and RN-A informed her it was an expected death. RN-B stated there was no crash cart or ambu bag in R1's room. RN-B stated at 2:23 a.m. she called DON, but got no response, then called floor manager licensed practical nurse (LPN)-D and reviewed the events with her, which most likely met state notification, and unexpected death of a vulnerable adult (VA). RN-B received a call back at 2:47 a.m. from LPN-D who had informed the administrator. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 3:40 p.m., NA-A stated RN-A stood in front of R1's door and asked for help, R1 needed to be repositioned. NA-A verified both of us entered R1's room as she laid on her back across the bed with her feet on the floor and head towards the window. NA-A stated as they walked closer to R1 they realized she was dead, color was [NAME]/yellow and unresponsive. RN-A indicated as they repositioned and boosted R1 up into the bed throw up came out of her mouth. NA-A also stated RN-A checked R1's hear rate and said out loud no heart rate. RN-B also entered R1's room, assessed R1's pupils and confirmed she was not breathing, and left R1's room. NA-A stated no CPR was started and she changed R1's sheets twice with RN-A's assistance due to the throw up and bowel. NA-A confirmed R1's body was still warm and stated she said out loud to RN-A that this must have just happened. NA-A stated RN-A told her she had to call 911, her son, and the DON and left the room. NA-A stated she left her room after 10 or more minutes and answered other call lights. During an interview on [DATE] at 10:36 a.m., NA-B stated at about 12:30 a.m. RN-B informed her R1 had passed away. NA-B stated she walked down to R1's room, peaked into the room and R1 looked white, was not moving, and appeared deceased . NA-B stated there was no one in the room with R1. NA-B stated at about 12:45 a.m. she heard hollering in the hallway, and it was RN-A yelling for her to come help her. NA-B stated she followed RN-A to R1's room and was told to hurry, R1 needed to be placed on the ground. NA-B stated she was confused as to what was going on as she was previously told R1 was deceased . NA-B verified she assisted RN-A and lifted R1 from the bed with a lift sheet located underneath her and placed her onto the floor, her body was still warm and R1 was unresponsive the entire time. NA-B stated she felt very uneasy with the situation, but RN-A was very confrontational and not easy to work with, so she did what she asked. NA-B indicated RN-A and RN-B do not get along and she felt that was why she walked past RN-B and had chosen her go to R1's room. NA-B verified RN-A started chest compressions on R1 and stopped after one minute at around 1:05 a.m. NA-B stated RN-A instructed her to keep doing the compressions, and she had her CPR certification so she started compressions when RN-A left the room stating she was going to call 911. NA-B stated nothing had been put in place for CPR, no crash cart, no oxygen, no ambu bag and RN-A had not completed an assessment on R1's heartbeat/pulse while she was in the room. NA-B stated she was left in the room alone with R1 and completed chest compressions until she got tired, then stopped, opened R1's door, waved down RN-B and informed what they were doing (CPR/chest compressions only). NA-B stated RN-A had not returned to R1's room to help with CPR until she saw RN-B in R1's doorway. NA-B indicated at that time she heard the EMS sirens and went to front door and let them in. EMS went directly into R1's room and stated CPR. NA-B indicated unsure if or when RN-A checked R1's code status but felt like she panicked when she realized she was a full code. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 11:07 a.m., RN-A stated on [DATE] between 6:30 p.m. and 7:00 p. m. she was notified R1 had pulled out her indwelling catheter. RN-A she stated she decided to wait to call provider, checked another resident's orders, completed a wound dressing changed, and finished up with her medication pass. RN-A stated it was later in the evening NP-A provided an order: re-insert and if resistance was met send to ER. RN-A stated she entered the order into the electronic health record and finished a few other things, then went to R1's room. RN-A stated R1 refused to have catheter re-inserted, denied pain but could see her face frown so she administered Tylenol between 10:00 p.m. and 11:00 p.m. RN-A stated she returned back to R1's room at 12:30 a.m. and again she refused re-insertion of the catheter. After finishing up a few things, RN-A stated she was then going to call 911 and send her to the ER but at 1:00 a.m. she noticed R1 laid across her bed with her feet on the floor, quickly went to room [ROOM NUMBER] and got a NA-A. RN-A stated both staff entered R1's room and she was lifeless and so quiet. RN-A stated she removed fluid from R1's mouth three times, turned her onto her side, and within a few seconds called RN-B and she rushed into R1's room. RN-A stated RN-B placed a stethoscope on her chest over her heart and stated she's dead. RN-A stated she shouted out, I had just talked to her. RN-A verified she checked as soon as she could R1's carotid and apical pulses and no heartbeat, skin color had not changed, and R1's body was still warm. RN-A stated RN-B rushed out of room, adding voluntarily, we are enemies, she had been fighting with all of us, accused me of things, and liked to control people. RN-A indicated R1's mouth continued to drain a cloudy fluid that smelled like undigested food with particles in it. RN-A stated she assisted NA-A to clean R1 up (brief change) and change her sheets twice. RN-A stated she had left R1's room and checked her POLST for code status and confirmed she was a full code. RN-A stated NA-A had left R1's room. RN-A indicated RN-B sat at the 300 nurse's station, she saw NA-B down the hallway and said come, come, come and together they entered R1's room. RN-A stated she chose NA-B because she was stronger and RN-A would not have helped immediately, said R1 was already dead, and asked a lot of questions. RN-A stated together with NA-B they lifted R1 off the bed with a lift sheet located underneath her and placed her onto the floor. RN-A stated no urine output was noted and unsure of what time this had been done. RN-A stated she started CPR without assistance, two minutes after she found her, I did not keep track of time, completed 30 chest compressions, stopped, checked neck pulse and no pulse then asked NA-B to complete chest compressions. RN-A stated she left the room called 911 and planned on grabbing ambu bag. RN-A stated she called DON first, didn't answer, left message, adding R1 was confirmed not breathing and like she was dead. RN-A verified she then called 911 but knew she should have called 911 prior to starting CPR and this was all completed in two seconds. RN-A indicated she returned back to R1's room and RN-B stood outside her bedroom door and said you are doing CPR on someone that has died , while NA-B continued chest compressions alone. RN-A stated EMS arrived, entered R1's room and took over. RN-A verified she should have asked RN-B to check R1's code status, would have saved time then CPR could have been started sooner. RN-A stated if this situation happened again, would do it differently and after no pulse, started CPR even if code status was not verified, to avoid something like this happening again. RN-A stated, it would have been a good idea to start CPR right away. RN-A also indicated she would have checked the code status for each resident at the beginning of the shift so that there would be no wasted time to go look. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 4:00 p.m., family member FM-A stated on [DATE], R1 was a little sluggish, tired, refused to eat lunch and supper which was rather odd for her. FM indicated around 6:00 p.m. requested bathroom and he stepped out of room while staff assisted her. FM stated a few minutes later RN-A came out of the room looking flustered and informed him R1 had pulled out her urinary catheter, if they could get the bleeding under control, they would reinsert catheter and if not, she would be transferred back to the hospital. FM stated did not get a sense that this was an everyday event but none of the staff seemed concerned, requested to be called with an update that evening, and left facility to go back home. FM stated had not heard received a call from the RN-A, called and talked to her and was informed my mother was doing fine, had not gotten a chance to re-insert the urinary catheter. FM stated then at 1:15 a.m. on [DATE], received a call from RN-A and was informed R1 was unresponsive and medical emergency had done CPR on her. FM stated RN-A had informed him they had packed a pullup with a hand towel used to prevent her from bleeding. FM stated R1 had not moved to TCU to die and was expected to have returned to the hospital in two weeks for the remainder of the tumor to be removed. During an interview on [DATE] at 2:20 p.m., director of nursing (DON) verified interviews were completed with all staff working the night shift the evening of R1's passing. DON indicated timelines varied, staff were unable to identify times things occurred, events were not consistent with RN-A's interview, and verification of consistencies was challenging. DON stated certain aspects aligned with RN-A's interview but what stood out was when the staff NA completed chest compressions, she indicated the body was warm. DON stated RN-A informed her she removed fluid from her mouth, cleaned her up and applied a new brief. DON stated a code status should have been checked, CPR started immediately instead, and another staff should have brought the crash cart into the room with suction machine on it, which would have helped remove R1's secretions out of her mouth. DON verified CPR should only be completed by certified licensed staff to assure the resident was getting high quality CPR, timing, and document the incident. DON also verified the staff NA should not be asked to complete chest compressions, especially after RN-A left the room. DON indicted R1's cause of death was not identified, and her death was unexpected. During a telephone interview on [DATE] at 5:00 p.m. medical director (MD) stated there were poor nursing decisions made throughout the night regarding R1. MD stated after review of the incident, it was identified CPR should have been initiated sooner and was not completed in a timely manner. MD stated R1's death appeared to be unexpected, could have been a cardiac arrest or maybe threw a big blood clot and had a PE (pulmonary embolism), this is unknown, but chance of survival would be about 80% and with her type of diagnoses could still have lived for another 6 months. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility policy Emergency Response Cardiopulmonary Resuscitation (CPR) dated [DATE], basic life support including initiation of CPR to a resident who experiences cardiac arrest (cessation of respirations and/or pulse) in accordance with the resident's advance directives or in the absence of advance directives or a Do Not Resuscitate (DNR) order. The facility will ensure that properly trained personnel and certified in CPR for Healthcare Providers are available immediately 24 hours a day to provide basic life support, including CPR to residents requiring emergency care prior to the arrival of emergency medical personnel, and subject to accepted professional guidelines, the advance directives and physician orders. All licensed nurses are required to maintain current CPR BLS certification through certification through training that includes hands-on practice and in person skills assessment. Per American Heart Association (AHA) recommendations, all potential rescuers initiate CPR unless: 1. A valid DNR is in place. 2. Obvious signs of clinical death (e.g. rigor mortis, dependent lividity, decapitation, transection, or decomposition) are present. Continue CPR until emergency personnel arrive and take over. The licensed nurse will run the code, instruct staff to obtain the medical record to verify the code status prior to initiating CPR. Once the code status is verified, the licensed nurse will give further directions to staff. The IJ which began on [DATE], was removed on [DATE], when the facility successfully implemented a removal plan which included: -All nursing staff will be retrained on CPR policy, responding to unresponsive residents, code status and any revisions made to the policy. -All facility staff will be trained on who in the facility should and should not perform CPR -Include the necessity for an immediate response -Outline how those who may not participate in performing CPR should assist to expedite emergency procedures (such as call 911, assist with timely repositioning for CPR preparation .etc.).

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F 0684 Level of Harm - Minimal harm or potential for 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 provide the necessary care and services for 1 of 3 residents who was recovering from bladder surgery, had pulled out their indwelling catheter and the provider was not contacted timely, provider orders to replace catheter or send to Emergency Department were not followed and ongoing assessment and monitoring for bladder retention, bleeding, or change of condition were not completed. Findings include: R1's diagnoses list dated [DATE], identified: neoplasm (growth of abnormal cells) of bladder, aftercare following surgery for neoplasm, acute post hemorrhagic anemia (excess bleeding), abnormal uterine and vaginal bleeding, heart failure, presence of coronary angioplasty implant and graft, diabetes mellitus (type II), history of venous thrombosis and embolism (blood clot), and gross hematuria (visible blood in urine). R1's orders from [DATE], through [DATE] included: -Code Status - Full Resuscitation order date [DATE]. -Patient Instruction for urinary retention: If you are unable to urinate 6 to 8 hours after discharge, return to emergency room with your discharge instructions order date [DATE] -Discharge potential: length of stay less than 30 days order date [DATE]. -Urology: call for any questions if your catheter is not draining well. If you begin to notice more blood or large clots. Order date [DATE]. -Skilled Medicare charting. Document findings in progress not: Vital signs (VS), ADL (activities of daily living) functioning, pain status, neuro status, skin issues, respiratory status (especially SOB [shortness of breath] and any oxygen/CPAP used), any special care items for patient (e.g. IV, drains, etc.), and any changes in condition including hospitalization s and returns, MD (medical doctor) appointments and return. Use your nursing judgement to add pertinent additional information. Order date [DATE]. -[DATE], Patient instruction for Urinary Retention: If you are unable to urinate in ,d+[DATE] hours after discharge, return to emergency room with your discharge instructions. -[DATE], Minnesota Urology: Call for any questions if your catheter is not draining well or if you begin to notice more blood or large clots. -[DATE] at 11:59 p.m. replace and re-insert pulled out Foley catheter. Send patient to emergency if resistance is met. (order received after delay in contacting physician on [DATE], catheter never replaced, and resident never sent to emergency) (continued on next page)

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	245618	A. Building B. Wing	09/12/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's care plan dated [DATE], identified resident had Foley catheter due to bladder tumor diagnosis. Interventions directed staff to monitor/record/report to MD (medical doctor) for s/sx (signs and symptoms) UTI (urinary tract infection): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased [NAME], temperature, and urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns. R1's progress notes (PN) dated [DATE], through [DATE], identified: -on [DATE] at 5:23 p.m., R1 arrived at facility via EMT (emergency medical technicians) transport on w/c (wheelchair) accompanied by son. R1 was A & O x4 (alert and oriented times four), forgetfulness noted. -on [DATE] at 10:30 p.m., administered Acetaminophen oral tablet 500 mg (milligrams) two for sign of mild pain. -on [DATE] at 11:30 p.m., PRN (as needed) administration of Acetaminophen was effective, follow up pain scale was 0 out of 10. -on [DATE] at 1:17 a.m. replace and re-insert pulled out Foley catheter. Send patient to emergency if resistance is met. -on [DATE] at 6:22 a.m. R1 pulled out indwelling catheter together with the water balloon that anchored it in place. Some bleeding noted, R1 was washed up and a brief was offered to patient pending an order from provider for further action. Writer put a call into provider and waited to be called back. (PN lacked detail on when R1 pulled out catheter and when call was made to provider). Later, nurse practitioner (NP)-A called back and after a thorough explanation of the situation, an order was given to re-insert catheter. R1 was approached for re-insertion but refused. Writer suspected pain and administered Tylenol then let R1 be for a while, leaving her door open for easy monitoring. At 12:30 a.m. patient was okay talking and breathing without any sign of impending doom. By around 1:00 a.m. writer saw patient lying across bed and was not responding to any stimulus and looked lifeless lying her head in vomited food and fluid with some in her mouth. Writer quickly called the other nurse who also noted that patient was lifeless and then left the room immediately. Writer then turned patient to her right side while the water was still oozing out. CNA [certified nursing assistant] then noted that patient had passage of bowel movement and quickly cleaned it. As more fluid was oozing out after the second nurse left. CNA left to go answer call light while writer let out the water in patient's mouth and raised head of bed [HOB] and went to the nursing station to check patient's code status. Have noted code status RESUSCITATION, writer dashed back and asked the other CNA for help with putting patient down and CPR initiated immediately. No time was wasted. Patient was on the floor with fluid oozing from the mouth and POLST status had to be ascertained. All these were satisfied in a short time, couple of minutes then CPR was started: 911 was called. Patient was not able to be resuscitated. Family was informed and family came and arranged funeral home. Patient has long been deposited in funeral home. R1's medication administration record for month of [DATE] identified acetaminophen oral tablet 500 mg two tablets by mouth every 6 hours as needed for mild pain was administered to R1 on [DATE] at 10:30 p.m. and pain level determined was 4 out of 10 (a numerical scale ranging from zero to 10: zero indicates no pain and 10 represents pain so severe that an individual loses consciousness). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's treatment administration record (TAR) documentation of urinary output entered per shift (a.m. , d+[DATE], p.m. ,d+[DATE], night shift ,d+[DATE]). -[DATE] evening output 350 cubic centimeters (cc) and night output 700 cc. -[DATE] evening output 500 cc and night output 300 cc. R1's electronic medical record did not identify R1's urinary output on [DATE] day shift. NP-B visit note dated [DATE], identified R1's advanced directives: Full Code. R1 had been hospitalized from [DATE], through [DATE], due to vaginal bleeding and concern for urinary source bleeding which resulted in increasing lightheadedness, dyspnea (shortness of breath), and a low hemoglobin 5.9 hemoglobin (Hgb) grams per deciliter (g/dL) (normal range 11.5 to 15). R1 received two units of red packed blood cells (RBC) upon admission and Hgb improved to 7.9, 8.4, and 8.3. On [DATE], R1 underwent D & C (dilation and curettage) (removed tissue from uterus), cystoscopy with fulguration of vessels (heat derived from an electrical current to destroy atypical /cancer tissue), and 50% removal of the bladder tumor. Additionally, on [DATE], R1 had an inferior vena cava filter placed due to unable to restart anticoagulant. R1 had an indwelling foley catheter placed to have remained in while at TCU. R1 was seen today [DATE], for an admission visit in the TCU. R1 had just finished up therapy and reported she was worn out. Appetite fair and no further bleeding. R1's vital signs ,d+[DATE], 97.3 Fahrenheit (F), pulse 86 per minute, 16 breathes per minute, and oxygen saturation level (Sa02) 98% (normal range 90 to 100%). R1's last Hgb on [DATE], was 8. 9 g/dL. During a telephone interview on [DATE] at 4:00 p.m., family member (FM) stated R1 had a bladder tumor and only half could be removed during the surgery because the bladder walls were very thin. FM stated the urologist wanted the urinary catheter left in place because if the bladder got too full and was not constantly draining, the bladder could rupture. FM stated R1 was to be discharged from hospital on [DATE] initially but had started to bleed again. FM stated once discharged from hospital they had planned on going back in a couple of weeks for the remainder of the bladder tumor to be removed. FM stated he was visiting on [DATE] and R1 was a little sluggish, tired, refused to eat lunch and supper, which was rather odd for her. FM indicated around 6:00 p.m. R1 requested the bathroom, and he stepped out of room while staff assisted her. FM stated a few minutes later RN-A came out of the room looking flustered and informed him R1 had pulled out her urinary catheter, if they could get the bleeding under control, they would reinsert catheter and if not, she would be transferred back to the hospital. FM stated he did not get a sense that this was an everyday event, but none of the staff seemed concerned. FM indicated he had requested to be called with an update that evening, and left facility to go back home. FM stated when he had not received a call from the RN-A, at 9:15 p.m. FM he called and talked to her and was informed R1 was doing fine, but they had not gotten a chance to re-insert the urinary catheter. Adding, then at 1:15 a.m. he received a call from RN-A and was informed R1 was unresponsive and medical emergency had done CPR on her. FM stated RN-A had informed him they had packed a pullup with a hand towel used to prevent her from bleeding. FM express, R1 had not moved to the TCU to die, but to recover and go on to finish the rest of her surgery. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 4:40 p.m., NA-C stated between 5:30 p.m. to 6:00 p.m. she went to take R1 to the bathroom but R1 had already gotten herself up and was almost to the bathroom. NA-C stated R1 informed her she had to go bad and then noticed blood on the floor where her feet had walked through it. NA-C indicated she looked around room and noticed the urinary catheter bag hung on the side of R1's bed with tubing attached to it that was no longer attached to R1. NA-C indicated she asked RN-A to assess R1 and see where the blood was coming from. NA-C stated RN-A entered R1's room as she cleaned up the drops of blood off the floor and suggested a brief be placed on R1. NA-C stated she noticed a dime sized blood clot stuck to the side of the toilet bowl when she flushed the toilet. NA-C also stated RN-A had picked up the catheter bag, held it up and looked at it. NA-C verified she was unsure as to where the blood came from, however there was approximately 300 cc of pink tinged urine in the collection bag. NA-C stated R1 appeared more confused. During a telephone interview on [DATE] at 11:07 a.m., RN-A stated on [DATE] between 6:30 p.m. and 7:00 p. m. a licensed practical nurse (LPN) informed her R1 was bleeding and she asked if it was R1 and she indicated yes. RN-A stated she immediately went to R1's room and observed her on toilet in bathroom. RN-A stated nursing assistant (NA)-A informed her R1 started to take herself to the bathroom when she entered the room, saw the catheter was pulled out with balloon still inflated and intact, and bleeding. RN-A stated she checked catheter tubing, bag, no blood identified, and approximately 250 milliliters (ml) of tea colored urine noted in collection bag. RN-A indicated this must have caused R1 some trauma, but she denied pain. RN-A confirmed there was a small amount of blood in the toilet. RN-A verified at 7:00 p.m. she instructed the NA to place a brief on R1 and indicated she would contact the provider for instruction possibly re-insert the catheter or send R1 to the ER. RN-A stated she decided to wait to call provider because she had to check another resident's orders, complete a wound dressing changed, and finish up with her medication pass, so it was later in the evening when she placed a call to the on-call provider. RN-A indicated she had to leave a message and when the NP-A called her back she informed her that R1 pulled out her catheter, no additional bleeding noted, and was resting in bed. RN-A indicated she asked NP-A what she should do and received an order to re-insert catheter now as she must have one in. RN-A stated she informed NP-A there was trauma and suggested R1 be sent to the ER, as she was concerned if she reinserted the catheter, it could possibly push a blood clot back into R1's bladder. RN-A indicted NP-A provided an order: re-insert and if resistance was met, send to ER. RN-A stated she entered the order into the electronic health record (order shows it was entered at 1:17 a.m. [DATE] after R1's passing in record) and finished a few other things, then went to R1's room. RN-A stated R1 refused to have catheter re-inserted and denied pain. RN-A stated she returned to R1's room at 12:30 a.m. and again she refused re-insertion of the catheter, so she finished up a few things and was then was going to call 911 and send her to the ER. RN-A stated at 1:00 a.m. she noticed R1 was laying across her bed with her feet on the floor, so she quickly went to room [ROOM NUMBER] and got NA-B (without assessing R1). RN-A stated both staff entered R1's room and she was lifeless, quiet, and body was still warm. RN-A verified with RN-B, no heartbeat, no respirations, and unresponsive. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview via telephone on [DATE] at 12:11 p.m., RN-A stated called the on-call provider around 9:00 p.m., passed medications around that time also, time was not checked when she called back or documented in progress notes. RN-A stated was extremely busy that evening, resident with wound dressing change, new admission, and administered medications. RN-A stated DON was there, indicated those tasks needed to be completed first, wound cares around 8:30 p.m. and informed DON there was the whole night to get that catheter placed back in and DON indicated that was ok. RN-A stated she wanted R1 to have time to calm down, when catheter was pulled out sometimes it was hard on the resident especially when the balloon was still intact, and again stated she was in no hurry to contact provider. RN-A verified she did not document assessments completed as she was too busy, and no noted changes. RN-A indicated she was unsure what she told the triage and on-call provider but told them only what they asked for and they should have asked for more information. RN-A did confirm she should have told provide the catheter had been out for hours prior to the call, past medical history of bleeding and recent bladder surgery. RN-A stated the order that was given indicated to contact provider back if resistance was met and that did not happen because R1 refused. RN-A indicated she planned on sending R1 into ER but had medications to administer to other residents first. During a telephone interview on [DATE] at 9:24 a.m., on call NP-A stated RN-A first contacted triage on [DATE] at 10:02 p.m. (approximately 4 hours after R1 pulled out her catheter) NP-A indicated she had returned the call to RN-A on [DATE] at 10:16 p.m. NP-A verified RN-A had informed the triage nurse R1 had a recent bladder resection, pulled out indwelling catheter, bleeding had stopped, blood only noted when the peri area was wiped, and wore incontinent product. NP-A stated RN-A asked if R1's catheter could be replaced. NP-A stated the conversation was very short with triage nurse and was surprised she had not provided more information. NP-A stated she was the overnight on call provider and relied on what the nurse told the triage nurse. NP-A also stated the responsibility/burden lied with RN-A to have explained the situation to the triage nurse such as her history of bleeding issues. NP-A indicated she was not made aware R1 had gross hematuria (visible blood in the urine), anemia with Hgb of 5.9 g/dL, and a bladder tumor. NP-A stated she had given RN-A orders to replace, and re-insert pulled out Foley catheter and send to emergency if resistance was met. NP-A verified R1 had been seen earlier in the day by her primary provider NP-B. NP-A stated after R1 refused to have the catheter reinserted that would have fallen under an identified problem and would have expected RN-A to have called back right away with an update, re-assessed, and would have sent to emergency room to be assessed. NP-A verified she was not aware R1 had been without the catheter for over 4 hours, and was not contacted by RN-A after their initial conversation at 10:16 p.m. During an interview on [DATE] at 10:49 a.m., primary provider NP-B stated she would have expected RN-A to have sent R1 into the emergency room (ER) or call triage back when unable to reinsert the urinary catheter. NP-B indicated R1 just had a huge surgery and we wanted to avoid urinary retention. NP-B stated had seen R1 the morning of [DATE] around 9:00 a.m. to 10:00 a.m. while she made rounds at the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:20 p.m., director of nursing (DON) indicated she was at the facility later that evening but was unable to provide an approximate time she was onsite. DON stated prior to leaving the facility later during the p.m. shift on [DATE], she was made aware by RN-A and R1's son of R1's indwelling catheter being pulled out. DON stated she informed R1's son the provider would be contacted to get direction on what to do, and he requested a follow up call once that was completed. DON informed RN-A R1's son requested an update once provider was contacted. DON verified during the facility's investigation following R1's death, RN-A verified she contacted the provider, but no time was provided, and the facility did not ask for a specific time. DON indicated she would have expected RN-A to contact the provider immediately and follow the orders due to history of bladder cancer, recent bladder surgery. DON stated it was unknown if R1's bladder was empty or full due to a lack of assessment by RN-A, and she would have expected RN-A to have completed and documented abdominal assessments, bladder scans, output, and ongoing monitoring to demonstrate R1's nursing care needs were being met and she was not having a change in condition. DON stated she would have expected RN-A to have followed up with the provider as soon as possible to update the provider on R1's refusal for re-insertion along with her assessment information and to received further direction and orders. DON indicated it may had been concerning to have R1's catheter out over six hours with her history of current bladder surgery but was unable to determine without the assessments having been completed. DON stated she did not delegate as to what steps RN-A should have taken or prioritized during her shift. DON indicated RN-A was expected to ask for help if needed and communicate that to her. During an interview on [DATE] at 4:30 p.m., administrator stated he would have expected RN-A to follow up with the provider to get the order timely. Administrator also stated if R1 had any resistance and/or refused re-insertion, R1 should have been sent to the hospital and was not sure why Tylenol and monitoring was the plan of care when that was not what the physician's order stated. Administrator added, she was unable to speak to RN-A's judgment, but if RN-A indicated she monitored R1 then she would have expected documentation of that monitoring to be completed. Administrator stated monitoring this resident would have been important due to their acuteness when admitted to the facility. Administrator also stated RN-A did not demonstrate critical thinking regarding necessary care and treatment R1 was ordered and required and it was unfortunate but was unsure if that would have changed the outcome. During a telephone interview on [DATE] at 5:00 p.m. medical director (MD) stated the nurse should have completed assessments and bladder scans to helped determined if R1's bladder was full. MD stated no doubt the staff nurse should have contacted the provider and updated her when R1 refused to have catheter re-inserted and providers orders were not followed. MD stated there were some bad nursing decisions made regarding R1's care here. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on [DATE] at 3:20 p.m. medical doctor/urologist (MDU) stated R1 was diagnosed with bladder cancer with a very large tumor that occupied half of her bladder. MDU also stated R1 had bled for one month prior to her diagnosis and became very anemic. MDU verified on [DATE], he removed half of the R1's tumor, hospitalized for seven days, and was stable enough when discharged to TCU with an indwelling urinary catheter. MDU stated R1's son had informed him she had pulled out her catheter at the TCU prior to her death. It would have been important to have kept the urinary catheter in place due to the large resection of the bladder tumor, a very thin bladder, and history of bleeding that resulted in a Hgb of 5.9. MDU added, it would have also been important for nursing to monitor, assess, and document R1's urinary output amount and color of urine. MDU stated R1's bladder cancer extended into the neck of the bladder, when the catheter was pulled out, and the balloon remained intact, that could have caused bleeding, which in turn, could have caused R1's bladder to ruptured if she had urinary retention. MDU stated R1 most likely had something going on earlier in the day and could have been a DVT/PE (blood clots) or cardiac issues, ultimately, we do not know, but her death was unexpected. Facility policy Nursing Assessments dated [DATE], identified licensed nurses would conduct initial and periodic comprehensive, standardized, and accurate reproducible assessments for each resident's functional status and should contain sufficient information related to the resident's condition. In addition to direct observation and communication with the resident licensed nurses will use a variety of other sources and may include discussions with physicians and review of the clinical record. Facility policy Change in Resident Condition dated [DATE], identified physicians will be notified of acute changes in a resident's condition in health include but not limited to: bowel and bladder continence and refusal of treatment as soon as possible. Notifications to physicians/NP (nurse practitioners) and condition changes would be documented in progress notes in medical record.