Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL361171100M **Date Concluded:** December 12, 2022
Compliance #: HL361171746C

Name, Address, and County of Licensee Investigated:
Rise Home Health Care
547 Continental Drive
New Brighton, MN 55112
Ramsey County

Facility Type: Assisted Living Facility (ALF) **Evaluator's Name:** Lissa Lin, RN
Special Investigator

Finding: Inconclusive

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

Initial Investigation Allegation(s):
The facility neglected the resident when the resident had a change in condition and the physician was not contacted. The resident was hospitalized with sepsis.

It is also alleged an unknown alleged perpetrator (AP) emotionally abused the resident when the AP asked the resident to conceal her face to satisfy the religious views of other resident's living in the home.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Unlicensed staff notified the nurse on the resident's change in condition. The nurse monitored and assessed the resident's condition but did not document all the cares and communication provided. Interviews with the resident and staff members produced conflicting information regarding the illness.

The Minnesota Department of Health determined abuse was inconclusive. An AP could not be identified. The resident and nurse had conflicting accounts regarding how staff interacted with the resident.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigation included review of the resident record, policies and procedures, and hospital records.

Change in Health Condition:
The resident resided in an assisted living facility. The resident's diagnoses included post-traumatic stress disorder (PTSD), adrenal insufficiency, gastrostomy, ileostomy, anxiety, and depression. She received liquid nutrition (trans parenteral feeding or TPN) as well as solid foods. The resident's service plan included assistance with bathing, medication management and meals. The resident's assessment indicated she had a history of bowel incontinence and urinary tract infections. She was able to make her needs known.

One day, the nurse documented the resident appeared bloated in the belly area and there were streaks of blood in her ileostomy (an opening in the abdominal wall used to collect digested food in an external pouch.) The nurse documented she would make an appointment for the resident the following day. The was no additional documentation on the appointment.

Over the next few days, the resident had a temperature of 100 plus degrees. Unlicensed staff communicated this to the nurse with texts and phone calls. The nurse instructed staff to monitor the resident and keep her updated on the resident's condition. At one point during the weekend the nurse texted to her other employer she had to leave work to take a very ill homecare resident to the emergency room (ER) because of high fever and cognition changes.

During an interview, the nurse said the resident had several in person and virtual visits with her care team a few days prior to her illness. The nurse could not recall if she scheduled any of those appointments for the resident. The nurse said she asked the resident about the blood in her ileostomy and the resident said that happened sometimes and it was not abnormal. The nurse said she wanted the resident to see her primary physician about that. When the resident became ill that weekend, the nurse said the resident declined going to the ER and tried to call her physician, but he was not available. The nurse said she could not force the resident to go to the ER. The nurse said she should have documented more of the cares and communication interventions she did for the resident that weekend.

During an interview, the resident said she had had office visits and virtual visits with her physician several consecutive days before she became ill. The resident said the facility nurse did not call her physician or offer to take her to the ER her when she was ill. The visiting nurse called the physician and sent the resident to the ER. She admitted to the hospital with sepsis.

During an interview, the owner said the nurse called her about the resident's condition but the resident refused to go to the ER.

After her hospitalization, the resident was discharged back to the facility at her baseline health and discharged to another facility a few months later.

Alleged Emotional Abuse:
During an interview, the resident said the nurse asked her to wear a headscarf during Ramadan because the other residents living there were Muslim. The resident said she did not feel welcomed having meals upstairs.

During an interview the nurse said no staff asked the resident to wear a headscarf during Ramadan. The nurse said the only issue with clothing that came up was the resident's ileostomy pouch was clear, so the digested food waste was visible and that made one resident uncomfortable at mealtimes. The nurse said she asked the resident if they could find solid color ileostomy pouches for her to use. The resident agreed and told her she preferred the solid color pouches because they were reusable.

The visiting nurse did not respond to multiple interview requests.

In conclusion, it was inconclusive whether neglect or abuse occurred.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Not Applicable. Resident was her own person.
Alleged Perpetrator interviewed: Not Applicable. The AP was listed as unknown for one complaint.

Action taken by facility:
Staff communicated the resident's change in condition to the nurse. The nurse documented some nursing interventions for the resident.

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

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

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36117	A. BUILDING: _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISE HOME HEALTH CARE	547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: **REVISED** HL361171100M/HL361171746C On November 16, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there was one (1) residents receiving services under the provider's Assisted Living license. Correction orders with a period to correct that are not immediate are issued. On November 21, 2022, the immediacy for HL361171746C/HL361171100M, tag identification 320, was removed. However, non-compliance remains at a level F. The following non-immediate correction orders	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 are issued for #HL361171746C/#HL361171100M, tag identification: 0470, 0720, 0730.	0 000		
0 320 SS=F	144G.30 Subdivision 1 Regulatory powers (a) The Department of Health is the exclusive state agency charged with the responsibility and duty of surveying and investigating all assisted living facilities required to be licensed under this chapter. The commissioner of health shall enforce all sections of this chapter and the rules adopted under this chapter. (b) The commissioner, upon request to the facility, must be given access to relevant information, records, incident reports, and other documents in the possession of the facility if the commissioner considers them necessary for the discharge of responsibilities. For purposes of surveys and investigations and securing information to determine compliance with licensure laws and rules, the commissioner need not present a release, waiver, or consent to the individual. The identities of residents must be kept private as defined in section 13.02, subdivision 12. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to provide ability for a Minnesota Department of Health (MDH) surveyor to access to the facility and records for a complaint investigation. At the time, the licensee was serving one resident. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety), and was issued at a	0 320	Home Care Provider 144A. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the	

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0 320	Continued From page 2 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). Findings include: On November 16, 2022, at 9:1 a.m., an MDH surveyor arrived unannounced at the licensee to conduct a complaint investigation. The MDH surveyor knocked at the front door and rang the doorbell. When no one answered the door, the MDH surveyor knocked at the door and rang the door bell three more times and waited approximately five minutes. No one answered the door. On November 16, 2022, at 9:24 a.m. the MDH surveyor received authorization to contact the licensee owner (OW)-A and try to speak to someone or leave a message. On November 16, 2022, at 9:27 a.m. the MDH surveyor called a contact number. An unidentified voicemail message picked up and the MDH surveyor left a message for a call back regarding access to the facility. The MDH surveyor also called a second contact number. An unidentified voicemail message picked up and the MDH surveyor left a message for a call back regarding access to the facility. The MDH surveyor walked to the back yard of the facility and knocked on the patio doors. There was no answer and all the curtains were drawn on the windows and patio doors. On November 16, 2022, at 9:53 a.m. the MDH surveyor received a voicemail from the first contact number; the person identified herself as a previous resident and said she did not live at the	0 320	"Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2). Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This	

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0 320	Continued From page 3 licensee any longer. On November 16, 2022, at 12:06 p.m., the MDH surveyor called a phone number listed as a third facility contact number. The unidentified voicemail message indicated the mailbox was full and could not accept any new voice messages but a short message (SMS) could be sent with a call back phone number. The MDH surveyor sent an SMS message to the owner/agent. On November 16, 2022, at 12:18 p.m., the MDH surveyor received a call from the third contact number. A male called and said he was not part of Rise Home Health Care, he had a different home care company. He gave his first name but declined to give his last name. The MDH surveyor asked if he knew anyone at Rise Home Health Care because this was a number linked as contact information for the licensee. He said the owner was his wife. He did not know why this was the phone number used, and said to call the second contact number to reach the OW-A. On November 16, 2022, at 12:24 p.m., OW-A called the MDH surveyor ad said she just saw the missed phone call from earlier. OW-A said the licensee was not closed but they only had one resident and he was out at an appointment all morning and no one was home. The staff person took the client to the appointment every Monday, Tuesday, Wednesday and Thursday. She was not sure about Friday. The MDH surveyor asked if other staff members were on site during the week, and OW-A said the nurse supervisor was usually there on Tuesdays and Wednesdays but not today. OW-A said she was out ill and the nurse could help if OW-A cannot be at the facility due to illness.	0 320	Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 320	Continued From page 4 TIME PERIOD TO CORRECT: Immediate INITIAL COMMENTS: #HL361171746C/#HL361171100M On November 21, 2022, the Minnesota Department of Health conducted a visit for correction order 0320 issued for complaint #HL361171746C/#HL361171100M. Immediacy of tag 320 removed, however non-compliance remained at a level of F. On November 21, 2022 at 2:00 p.m., registered nurse (RN)-B said the facility made a sign to post at the front door when staff and the resident were away. The handwritten sign read: Staff are curently away, please call 612-998-0906. RN-B said the phone number on the sign was her cell phone and she would take calls if someone came to the facility and no one was home.	0 320		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster	0 470		

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0 470	Continued From page 5 situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, record review and interview, the licensee failed to develop and post a staffing plan as required. This had the ability to impact all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). Findings include: During an observation on November 21, 2022 at 12:00 p.m., the Minnesota Department of Health (MDH) surveyor observed unlicensed personnel (ULP)-C wipe clean a white board posted in the kitchen. ULP-C said he had just wiped it clean because there was old information on it from the	0 470		

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0 470	Continued From page 6 other day. ULP-C said staff write their names on the white board during their shift. ULP-C said there is no staff schedule posted. During an on-site visit November 21, 2022, at 12:40 p.m., registered nurse (RN)-B said the licensee does not have any staff schedules, it was "one of the things we got wrong with survey." RN-B said she did not have a schedule from April, 2022, but she could tell the MDH surveyor who worked what days and shifts because they only have 2 staff scheduled to work each day. The licensee lacked a policy on staffing and schedules. Time Period to Correct: Twenty-one (21) Days	0 470		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure appropriate records were readily available to the Minnesota Department of Health (MDH) surveyor during an on site investigation. Registered nurse (RN)-B was unable to provide staff schedules. RN-B was unable to access sections of the electronic medical record for one of one resident (R1)	0 720		

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0 720	Continued From page 7 reviewed. RN-B was unable to email, screenshot or print R1's medication administration records (MARs). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). Findings include: R1's intake assessment form, dated April 4, 2022, included diagnoses of post traumatic stress disorder (PTSD), anxiety, depression and adrenal insufficiency. R1's service plan, dated April 4, 2022, indicated R1 received medication administration, assistance with grooming, bathing and self feeding, and continence cares. R1's service plan addendum for treatment and therapy services indicated R1 received home infusion services, gastrostomy and jejunostomy tube feedings. During an on-site visit November 21, 2022, at 12:40 p.m., RN-B said the licensee does not have any staff schedules, it was "one of the things we got wrong with survey." RN-B said she did not have a schedule from April, 2022, but said she could tell the MDH surveyor who worked what days and shifts because they only have 2 staff scheduled. RN-B said R1's MAR was stored electronically and she could not print her April-July, 2022 MARs. During an observation November 21, 2022, at	0 720		

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0 720	Continued From page 8 1:40 p.m., RN-B was unable to print R1's MARS and progress notes from April - July. 2022. RN-B said she would need to call owner (OW)-A or her husband to see why the records won't print. At 3:30 p.m. R1's electronic MAR was still not accessible. During the on-site visit November 21, 2022 at 3:47 p.m., RN-B said she needed to leave the licensee for another appointment. During an interview November 29, 2022 at 3:02 p.m., OW-A said they entered medications, cares, nursing notes, and vital signs in the electronic MAR (EMAR), but they never had to print out anything. OW-A said she would call a woman she knows to help access the EMAR and she would work on that during the week. During a phone interview on December 5, 2022 at 9:30 am, RN- B said R1 took 20 plus medications daily so taking cell phone screenshots of just one day of R1's MAR would take 5 or 6 pages. It would be hard to read. RN-B said she thought OW-A was working on getting copies of R1's MARs for the MDH surveyor. An undated policy titled Resident Records, read: resident records are legal documents containing comprehensive, accurate and organized information concerning the resident's health, emotional status, treatments and services. The facility will ensure the appropriate records are readily available to employees and contractors authorized to access the records. Records will be maintained in a manner that allows for timely access, printing or transmission. Time Period to Correct: Seven (7) Days	0 720		

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0 730	Continued From page 9	0 730		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36117	A. BUILDING: _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISE HOME HEALTH CARE	547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112

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0 730	Continued From page 10 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure the resident's record included documentation of significant changes in her status and actions taken in response to the needs of the resident, including reporting to the appropriate health care professional for one of one resident (R1) records reviewed. Staff documented R1 was ill for a few days but did not provide follow up documentation on nursing interventions, communications with R1 or her physician or how often R1 was hospitalized during her four months at the licensee. R1 admitted to hospital for sepsis. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1's intake assessment form, dated April 4, 2022, included diagnoses of post traumatic stress disorder (PTSD), anxiety, depression and adrenal	0 730		

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0 730	Continued From page 11 insufficiency. R1's service plan dated April 4, 2022, indicated R1 received medication administration, assistance with grooming, bathing and self feeding, and continence cares. R1's service plan addendum for treatment and therapy services indicated R1 received home infusion services, gastrostomy and jejunostomy tube feedings (TPN). R1's nursing note dated April 14, 2022 at 8:46 a.m., read "client very bloated with blood in ileostomy. Making an appointment for tomorrow." There was no follow up documentation on an appointment for R1. R1's progress note dated April 15, 2022 at 12:59 p.m., read: hydroxyzine 50 mg (Atarax) by ULP-F. Reason: generalized anxiety disorder. Follow up by ULP-F at 4:42 p.m. A text exchange dated April 16 [2022] at 8:33 a.m., RN-B with ULP-F: A picture showed a thermometer that read 101.2. The texts read: "remind her to do her TPN. And bring it out for her to her bed or something." "Her temperature is 101.2." "Is it still high? WTF. How is she feeling?" Another text, at 10:39 a.m. with ULP-F read: "give her some meds and check an hour later, Tylenol is in the morning meds. I'm coming now." A text exchange dated April 17 [2022] at 8:50 a.m., RN-B with ULP-F, read: "she has a fever, 101.6 ." "Again." "Yeah." "How is R1 doing?"	0 730		

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0 730	Continued From page 12 "Went back to sleep." Another text at 10:43 a.m., RN-B with RN-B's employer at another business: "my client at homecare is extremely sick. I need to take her to ER. High fever and she keeps passing out." R1's nursing note dated April 17, 2022, at 5:33 p.m., read: "client throwing up some of the food she takes", "client declined yesterday and today to be taken to ER saying she does not want to", "client needs antibiotics due to symptoms will talk to Doc [sic] tomorrow morning about", and "client looks like she might have an infection somewhere in body due to her high temp." R1's nursing note dated April 18, 2022, at 10:00 a.m., read: "client went to ER after talking with doc [sic] he said she needs to go to ER ASAP. Staff." R1's nursing note, dated April 21, 2022 at 11:43 a.m. read: "hospitalized". R1's nursing note, dated April 26, 2022 at 5:33 p.m., read: "client back from ER with multiple antibiotics and fluids through central line." R1's hospital discharge summary dated April 26, 2022, at 12:43 p.m., indicated R1 was admitted and treated for sepsis secondary due to numerous potential sources, enterococcus bacteremia, recurrent ileus, and recurrent small bowel obstructions. R1 presented to the emergency department (ED) 4/18 with 3 days of fever, chills, body aches and abdominal fullness. R1 was discharged with an intravenous (IV) antibiotic, an oral antibiotic and an IV antifungal. An email to the MDH surveyor from RN-B dated	0 730		

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0 730	Continued From page 13 November 29, 2022, at 9:46 a.m., read: attached are some phone screenshots that you might see as useful...I had to leave early due to R1's condition to take her to the ER but unfortunately R1 declined to be taken anywhere that weekend, said she would call her provider for an appointment on the 18th Monday instead." Five screenshots of texts from April were attached to the email. During an interview on November 21, 2022, at 1:30 p.m., RN-C said R1 was hospitalized multiple times while she lived at the licensee yet during the entrance conference with RN-B at 12:40 p.m. she said there had been no hospitalizations since April, 2022. During an interview on November 28, 2022, at 1:00 p.m., R1 said she had concerns about the facility being able to properly care for her. R1 said RN-B did not assess her or offer to take her to the hospital when she was ill. R1 said she got infections through her central line and those could have been prevented if there had been more support from the facility. During an interview on November 29, 2022, at 3:02 p.m., owner (OW)-A said R1 could make her needs known and she declined to go to the hospital that weekend after RN-B offered to take her to the hospital. During an interview on December 5, 2022, at 9:30 a.m., RN-B said staff updated her on R1's condition and she told staff to continue with her medications and continue to monitor her when R1 had a fever, nausea and vomiting on April 16 and 17. RN-B said R1 appeared "very bloated and looked like she was 9 months pregnant" that weekend, but refused to to go the ER because	0 730		

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0 730	Continued From page 14 she was usually admitted to the hospital for weeks and did not want that and she could not force R1 to go. RN-B said when the infusion nurse, RN-C, came to see R1 she got angry and wanted to know why R1 was not in the hospital. RN-B said she told RN-C that R1 declined to go in and wanted to speak to her physician on Monday. RN-C called R1's physician and sent R1 to the hospital. RN-B said she did not document as much or as often on R1 as she should have, but everything happened so fast (with R1's illness). RN-B said R1 was hospitalized a few times for infections because R1 did not always practice good hand hygiene while preparing her own TPN; she would touch her ileostomy line, then her gastric line and cross contaminate the two despite reminders to wash her hands between cares. An undated policy titled Resident Records, read: resident records are legal documents containing comprehensive, accurate and organized information concerning the resident's health, emotional status, treatments and services rendered by nurses, therapists and other health care team members. TIME PERIOD TO CORRECT: Seven (7) Days.	0 730		