Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202647303M
Compliance #: HL202642501C

Date Concluded: February 25, 2025

Name, Address, and County of Licensee Investigated:
Meadow Woods Assisted Living Facility 1301 E 100th St
Bloomington, MN 55425
Hennepin County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Julie Serbus, RN
Special Investigator

Finding: Not Substantiated

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

Initial Investigation Allegation(s):
The facility neglected the resident when proper catheter care was not provided.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility was not responsible for the maltreatment. While it was true the resident had an indwelling foley catheter the facility was not responsible for the maintenance or changing of the catheter as this was managed by a home care agency.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member and a home care agency staff. The investigation included review of the resident record(s), provider record, facility nursing notes, hospital record, related facility policy and procedures. Also, the investigator made a visit to the facility staff interactions with facility residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included chronic kidney disease, urinary retention, benign prostatic hyperplasia, history of urinary tract infections, indwelling foley catheter, and dementia. The resident's service plan included the resident was independent with mobility in his wheelchair, required stand by assistance with transfers in and out of bed, cues for dressing, and medication administration.

The resident's assessment indicated the facility coordinated care with outside home health provider. The home health agency was responsible for catheter management including changing of the catheter. However, the unlicensed caregivers to change out catheter bag and clean per homecare orders.

One morning the resident displayed facial grimacing with bed mobility and an unlicensed caregiver noticed there was no urine output in the resident's catheter bag and immediately notified nursing. The resident's medical provider was at the facility that morning, the facility updated the medical provider, and the send the resident into the emergency department for evaluation.

The progress notes indicated the resident had been found on the floor the night before and, at the time, there were no apparent injuries aside from some back pain.

The hospital emergency department record indicated the resident fell the previous evening and medical imagine indicated the indwelling foley catheter was not properly placed.

During an interview, nurse #1 stated the facility contracted with an outside home care agency managed catheter change, provided the supplies for the catheter, and managed any concerns with the catheter. The unlicensed caregivers emptied the catheter bag five times a day, but the facility did not monitor urine intake or output on the resident nor was it care planned to do so. Nurse #1 stated it was possible the catheter was displaced because of the fall.

During an interview, an unlicensed caregiver stated she observed the resident's catheter bag was empty upon entering to give medications, so she notified the nurse immediately.

During an interview, nurse #2 stated the resident lying in bed and resident complained of back pain and voice was a lower tone. Nurse #2 attempted to roll the resident, but his face grimaced and she noticed catheter bag contained no urine. Nurse #2 stated the medical provider, who was in the facility, was updated and the resident was sent to the emergency department.

During an interview, a homecare employee stated the resident received services to manage foley catheter care. The homecare employee stated homecare agency managed catheter supplies, scheduled and as needed catheter changes, along with skin checks. Due to medical diagnosis the catheter change was difficult but could be completed at the facility by the homecare agency and it was not usually necessary for this to be done in a clinic or hospital. The

homecare employee stated the resident had a history of pulling at the catheter tubing and frequent urinary tract infections.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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.

Vulnerable Adult interviewed: No
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: NA

Action taken by facility:
No action taken.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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
	20264	A. BUILDING: _____ B. WING _____	C 02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW WOODS ASSISTED LIVING	1301 EAST 100TH STREET BLOOMINGTON, MN 55425

(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 On February 6, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL202642501C/#HL202647303M. No correction orders are issued.	0 000		