DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303606405M **Date Concluded:** February 5, 2025
Compliance #: HL303609559C

Name, Address, and County of Licensee Investigated:
Cornerstone Residence of Fosston
115 1st Street East
Fosston, MN 56542
Polk County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The alleged perpetrator (AP), a licensed practical nurse (LPN) at the facility, failed to change the resident's catheter as ordered. The AP/LPN documented she had changed it, but a facility investigation indicated the AP/LPN never entered the resident's room. The resident was hospitalized with a urinary tract infection (UTI) and sepsis.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The AP was responsible for completing catheter changes for the resident but failed to do so. However, facility staff failed to report and take action on observed changes to the condition of the catheter, including after mold was observed in the collection bag. The resident was hospitalized for a septic UTI due to a catheter associated infection and hospital paperwork indicated the catheter did not "appear to have been changed in a significant amount of time."

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the primary care provider. The investigation included review of the resident's record, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed care and services at the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included traumatic brain injury, cognitive impairment, and memory loss. The resident's service plan included assistance with all activities of daily living, including toileting. The resident had an indwelling foley catheter and received catheter care three times per day, along with a monthly catheter change to be completed by a licensed nurse. The resident's assessment indicated the resident depended on facility staff to perform all cares and had impaired cognition.

Progress notes indicated staff observed the resident's behavior to be abnormal and that he wasn't responding to questions appropriately, so 911 was called and he was sent to the emergency room. The facility nurse who assessed the resident did not document concerns related to the catheter bag or tubing. Hospital staff raised concerns about the condition of the resident's catheter, but documentation indicated the AP/LPN had changed the catheter as ordered. Facility management initiated an internal investigation related to the catheter being changed as ordered.

The internal investigation indicated facility management were notified of concerns with the resident's catheter by hospital staff after he was admitted to the hospital. The facility internal investigation indicated during a routine audit, one month prior to the resident's hospitalization, it was noted the catheter change was not signed off as completed by the AP/LPN. Text messages between facility management and the AP/LPN indicated the AP/LPN was contacted to see if she changed the resident's catheter as ordered. The AP/LPN wrote that she did it last week. The AP/LPN completed a late entry marking the catheter change as completed. The last month's catheter change was also marked as completed by the AP/LPN. The catheter change prior to that was completed by a registered nurse and the AP/LPN.

During the investigation, the facility reviewed documentation and surveillance camera footage and did not observe the AP/LPN entering the resident's room during the time she documented she had changed the catheter. The facility also reviewed the resident's supply order and emails between facility management and the medical supply company indicated supplies were neither ordered nor sent to the facility in the two months leading up to the hospitalization, despite the AP/LPN being responsible for monthly supply ordering. The internal investigation indicated ULP reported they had observed mold in the resident's catheter and had reported it to the LPN.

Hospital records indicated the resident was brought to the emergency room due to concerns the resident was having a panic attack. Documentation indicated the resident had a chronic indwelling foley "that does not appear to have been changed in a significant amount of time." The resident was diagnosed with sepsis and bacteremia secondary to catheter associated

urinary tract infection. The resident was treated with intravenous antibiotics and spent seven days in the hospital.

During an interview, facility management stated another registered nurse did complete a catheter change with the AP/LPN to make sure she was comfortable doing it and the AP/LPN didn't raise any concerns and said she had completed many catheter changes previously. Facility management stated the AP/LPN was responsible for the catheter changes and ordering supplies and while she didn't order the resident's catheter supplies, she still ordered other supplies from the same supplier for the facility over the course of several months with no issues. Facility management stated after they started their investigation and began to realize it was possible the AP/LPN never changed the catheter, they asked her a few times but the AP/LPN maintained she changed the catheter as ordered.

During an interview, a facility nurse stated she had shown the AP/LPN how to complete the catheter change and the AP/LPN said she didn't have any problems with changing the catheter or ordering the necessary supplies each month. In the weeks leading up to the resident's hospitalization, staff reported they changed the resident's collection bag as they thought mold was growing in it, but they didn't suspect the tubing and catheter had not been changed.

During an interview, the AP/LPN stated she had changed the catheter as ordered and had ordered supplies for the resident's catheter changes. The AP/LPN stated the facility had additional catheter supplies that she used to complete the changes. The AP/LPN stated she was not sure why the supply company would have no record of her ordering catheter supplies and was not sure why facility surveillance footage did not show her entering the resident's room but reiterated she had completed the catheter changes as ordered and other staff would have seen her doing so.

During an interview, a ULP stated she had been off over a weekend and when she came back later that week, she noticed the collection bag was full of mold, so they threw it away and told a nurse that the bag was moldy.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means 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: Unable due to cognitive impairment.
Family/Responsible Party interviewed: No, declined.
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility investigated the incident and made a MAARC report. The AP/LPN was terminated. The facility made changes to its internal policies and procedures related to catheter care.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Polk County Attorney
Fosston City Attorney
Fosston Police Department
Minnesota Board of Nursing

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30360	A. BUILDING: ______ B. WING ______	C 11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE FOSSTON	**115 1ST STREET EAST FOSSTON, MN 56542**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER 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: #HL303606405M/#HL303609559C On November 27, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 33 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL303606405M/#HL303609559C, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State 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 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE FOSSTON	**115 1ST STREET EAST FOSSTON, MN 56542**

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	