DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL33435001M
Compliance #: HL33435002C

Date Concluded: October 5, 2021

Name, Address, and County of Licensee Investigated:
Walker Methodist
3737 Bryant Avenue South
Minneapolis, MN 55409
Hennepin County

Name, Address, and County of Housing with Services location:
Walker Methodist Levande
2011 6th Lane Southeast
Cambridge, MN 55008
Isanti County

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

Investigator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, facility responsibility

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.

Allegation(s):

It is alleged that the Alleged Perpetrator (AP) neglected a resident when they failed to provide assistance with individualized cares which resulted in a large penile wound and a groin rash.

Investigative Findings and Conclusion:

Neglect is substantiated. The facility was responsible for the maltreatment. The facility had no system in place to ensure the resident's catheter cares were completed or changes made to the resident's plan of care when the wound developed. The resident had an indwelling catheter and developed a large open wound in the skin at the catheter insertion site. The unlicensed personnel who were responsible for cleaning the resident's catheter insertion site and penis did not document cleaning or observing the resident's catheter insertion site. Unlicensed personnel contacted a facility nurse on three occasions over two months to look at the catheter insertion

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site due to redness, irritation, bleeding, and pain. No changes were made to ensure appropriate cares were completed to the resident's catheter insertion site.

The investigation included interviews with facility staff, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted family and medical providers. The investigator observed staff/resident interactions, reviewed medical records, facility documents, policies and procedures related to staff training, catheter cares, and maltreatment of vulnerable adults.

The resident moved into the memory care unit of the facility due to diagnoses that included Parkinson's Disease and benign prostatic hypertrophy (a condition in which the flow of urine was blocked due to the enlargement of the prostate creating difficulty urinating and increased frequency at night). The resident received services from the assisted living facility that included bathing, behavioral instruction, dressing, grooming, vital signs, housekeeping, daily room cleaning, laundry, medication administration, medication management, escorts, transfers, nursing service, bathroom, catheter assistance, and therapeutic exercise.

The resident's service plan indicated unlicensed personnel (ULPs) provided the resident with assistance brushing his teeth, shaving, combing his hair and cleaning his glasses twice daily. The service plan indicated ULPs emptied and recorded urine output from the resident's indwelling catheter six times per day.

Over the course of two months, ULPs who provided cares to the resident informed nursing on three separate occasions the resident had redness, irritation, and/or bleeding from the catheter insertion site. All three times a nurse observed the area but did not do an assessment or make changes to the resident's services.

One day a home health nurse came to do an assessment for skilled nursing services and discovered the resident had a large tear on his penis from the catheter. The home health nurse recommended wound cares and specific cleansing of the area. Facility nursing did not change the resident's service plan to include the recommendations to ensure the staff was providing the necessary care to the resident's catheter.

During an interview, the director of health services stated ULPs should be completing the resident's catheter care with AM and PM cares. However, there was no documentation indicating if catheter cares were being completed.

During interview a facility nurse stated ULPs were trained to provide catheter care and the ULPs would contact a nurse if they had a concern regarding a resident's catheter. The nurse said the home health nurse showed her the resident's skin breakdown when she changed the catheter. The nurse stated it appeared the catheter had eroded the skin on the penis opening and

created a tear. The nurse believed the skin erosion was due to the resident pulling on the catheter. The nurse said that home health was in charge of the catheter and would be responsible for doing an assessment if there were skin breakdown concerns as facility nurses did not routinely participate in hands on care of residents.

During interview the home health nurse said they came into the facility for an initial assessment when the wound was discovered. The home health nurse said that she could not tell how long the tear had been there. She said that she expected the facility staff cleansed the area daily and with assisting with toileting, however, it appeared to not have been done. The home health nurse completed an assessment and ordered weekly wound care and monthly catheter changes.

In conclusion, neglect occurred. The facility failed to ensure the resident received the necessary care and services to prevent skin breakdown from the indwelling urinary catheter.

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:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:

No action taken

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, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding.

cc: The Office of Ombudsman for Long-Term Care
Isanti County Attorney
Cambridge Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33435	A. BUILDING: ______ B. WING ______	C 09/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST LEVANDE LLC	**2011 6TH LANE SE CAMBRIDGE, MN 55008**

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0 000	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On September 24, 2021, the Minnesota Department of Health conducted an investigation at the above provider, and the following correction orders are issued. At the time of the investigation, there were 46 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL33435002C/#HL33435001M, tag identification 0730, 1640, and 2360.	0 000	The Minnesota Department of Health documents 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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. Per Minnesota Statute §144G.41, subd. 3, the home care provider must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.41, subd. 3.	
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the	0 730		

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0 730	Continued From page 1 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 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution;	0 730		

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(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 interview and document review, the facility failed to ensure documentation of catheter cares for one of one resident (R1) reviewed for skin breakdown, when R1 developed an open wound from the tip of his penis down the shaft that measured 4.8 centimeters (cm) long by 2.5 cm wide, and the facility lacked documentation of cleaning of the catheter insertion site.

This practice resulted in a level two violation (a violation that did not harm a residents health or safety but had the potential to have harmed a residents health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

Findings include:

R1's record was reviewed. R1 moved into the facility due to diagnoses that included Parkinson's disease and benign prostatic hyperplasia (BPH). R1 received services from the assisted living facility that included bathing, behavioral instruction, dressing, grooming, vital signs, housekeeping, daily room tidying, laundry, medication administration, medication management, escorts, transfers, nursing service, bathroom, catheter assistance, and therapeutic

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exercise.

R1's service plans dated May 4, 2021, and June 23, 2021, provided instruction to unlicensed personnel (ULPs) for grooming as follows: assist with brushing teeth (may need assistance with dentures), shaving, combing hair, and cleaning glasses at 7:45 a.m. and 7:45 p.m. The instruction did not list peri care or cleaning of R1's catheter insertion site.

R1's service plans dated May 4, 2021, and June 23, 2021, provided instruction to ULPs for bathroom service as follows: toileting with gait belt and pivot transfer using bedside commode at 1:00 a.m., 4:00 a.m., 6:45 a.m., 11:45 a.m., 3:00 p.m., and 8:00 p.m. The instruction did not identify peri care or cleaning of R1's catheter insertion site.

R1's service plans dated May 4, 2021, and June 23, 2021, provided instruction to ULPs for catheter assistance as follows: empty and record urine output from Foley catheter at 1:00 a.m., 4:00 a.m., 6:45 a.m., 11:45 a.m., 3:00 p.m., and 7:45 p.m. The instruction did not identify peri care or cleaning of R1's catheter insertion site.

R1's progress note dated June 11, 2021, at 1:47 p.m. written by director of health services (DHS)-B indicated R1's tip of penis was red and irritated from Foley catheter. R1 complained of mild discomfort.

R1's progress note dated June 16, 2021, at 2:08 p.m. written by registered nurse (RN)-F indicated a ULP requested nursing look at R1's catheter insertion site due to bleeding. RN-F indicated she noted bright red blood partially clotted at tip of R1's penis. RN-F indicated R1 complained of

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some pain.

R1's progress note dated July 10, 2021, at 5:05 p.m. written by licensed practical nurse (LPN)-H indicated a ULP reported R1 had small amount of bleeding from the end of his penis, and R1 complained of burning on the scrotum.

R1's progress note dated August 4, 2021, at 4:41 p.m. written by LPN-H indicated R1's end of his penis was partially torn by the catheter. LPN-H indicated R1 did not complain of pain.

R1's home health nursing progress note dated August 4, 2021, indicated R1 reported moderate to intense pain due to open area on penis. The progress note indicated the open area extended from the tip of R1's penis to half-way down the shaft, the wound was split open, the wound bed was beefy red with surrounding skin red and swollen. The home care nurse indicated she performed wound care, contacted a wound-ostomy-continence specialty nurse, and made a referral to urology. The wound was measured as 4.8 centimeters (cm) long and 2.6 cm wide.

During an interview on September 24, 2021 at 12:09 p.m., director of health services (DHS)-B stated unlicensed personnel (ULPs) were trained and deemed competent to complete catheter cares. DHS-B stated she observed R1's penis tip on June 11, 2021, to be red and irritated. DHS-B stated the facility standard was to use soap and water to cleanse R1's penis and catheter tubing during daily grooming. DHS-B stated she believed that R1's penis tear occurred slowly over time. DHS-B verified that the cleaning of R1's penis and catheter was not documented.

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During an interview on September 24, 2021 at 2:27 p.m., registered nurse (RN)-F stated the ULPs cleaned and emptied R1's catheter. RN-F verified that R1's service plan indicated catheter assistance was required six times per day. RN-F verified catheter assist, in R1's service plan, directed the ULPs to empty and record urine output from R1's Foley catheter. RN-F verified the service plan did not provide direction for cleaning the resident's penis or catheter. RN-F stated documentation indicated the number of times the ULPs delivered the service of emptying and measuring urine, however, there was no way of knowing when ULPs cleaned R1's penis and catheter tubing due to the lack of documentation.

During an interview on September 27, 2021, at 12:21 p.m., home care registered nurse (RN)-G stated she met with R1 on August 4, 2021, for the first time and completed an assessment. RN-G stated she observed R1's wound on his penis and could not tell how long it had been there. RN-G stated she believed the wound happened over time due to erosion from the catheter. RN-G stated she had concerns that the staff did not clean the catheter insertion site. RN-G stated she spoke with the nurse (LPN-H) who was not aware of R1's wound.

During an interview on September 27, 2021 at 3:45 p.m., LPN-H stated the nurses only observed R1's penis and catheter if a ULP called for the nurse to look at it. LPN-H stated she was called to look at R1 on July 10, 2021, and noted R1's penis had eroded skin at the opening and partway down the shaft with tearing of the skin. RN-H stated the only way to know if a service was completed was to see if the ULP sign off that they did it.

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The facility policy titled Catheter Care-Indwelling dated August 1, 2021, indicated catheter care was provided by a nursing assistant, resident assistant, or licensed nurse with AM and PM cares. The policy provided specific instructions on cleaning the catheter and penis that included the following: Apply soap and water to a washcloth and thoroughly clean around the meatus then rinse and pat dry, beginning at the top of the penis and wash downward toward the body; cleanse approximately 2-3 inches of the catheter tubing; gently pat dry with a clean towel.

The licensee did not provide a requested copy of the facility documentation policy

TIME PERIOD FOR CORRECTION: Seven (7) days.

01640 SS=G — 144G.70 Subd. 4 Service plan, implementation, and revisions t — 01640

(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.
(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care.
(c) The facility must implement and provide all services required by the current service plan.
(d) The service plan and the revised service plan

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must be entered into the resident record, including notice of a change in a resident's fees when applicable.
(e) Staff providing services must be informed of the current written service plan.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to revise services for one of one resident (R1) reviewed for a change in condition when staff reported to nursing that R1 had redness, irritation, and bleeding of his penis tip around the insertion site of his indwelling catheter. One month later, R1 had an open wound from the tip of his penis down the shaft that measured 4.8 centimeters (cm) long and 2.5 cm wide.

This practice resulted in a level three violation (a violation that harmed a residents health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

Findings include:

R1's record was reviewed. R1 moved into the facility due to diagnoses that included Parkinson's disease and benign prostatic hyperplasia (BPH). R1's service plan dated May 4, 2021, indicated R1 received services from the assisted living facility that included bathing, behavioral instruction, dressing, grooming, vital signs, housekeeping, daily room tidying, laundry, medication administration, medication

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management, escorts, transfers, nursing service, bathroom, catheter assistance, and therapeutic exercise.

R1's comprehensive health service assessment dated April 26, 2021, indicated R1's skin integrity was intact with some bruising from IV insertion. The assessment also noted that R1 had a indwelling Foley catheter.

R1's service plan dated May 4, 2021, provided instruction to unlicensed personnel (ULPs) for grooming as follows: assist with brushing teeth (may need assistance with dentures), shaving, combing hair, and cleaning glasses at 7:45 a.m. and 7:45 p.m.

R1's service plan dated May 4, 2021, provided instruction to ULPs for bathroom service as follows: toileting with gait belt and pivot transfer using bedside commode at 1:00 a.m., 4:00 a.m., 6:45 a.m., 11:45 a.m., 3:00 p.m., and 8:00 p.m.

R1's service plans dated May 4, 2021, and June 23, 2021, provided instruction to ULPs for catheter assistance as follows: empty and record urine output from foley catheter at 1:00 a.m., 4:00 a.m., 6:45 a.m., 11:45 a.m., 3:00 p.m., and 7:45 p.m.

R1's progress note dated June 11, 2021, at 1:47 p.m. written by director of health services (DHS)-B indicated R1's tip of penis was red and irritated from his Foley catheter. The progress note indicated R1 complained of mild discomfort.

R1's progress note dated June 16, 2021, at 2:08 p.m. written by registered nurse (RN)-F indicated a ULP requested a nurse look at R1's catheter insertion site due to bleeding. RN-F indicated she

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noted bright red blood partially clotted at tip of R1's penis. RN-F indicated R1 complained of some pain.

R1's service plan dated June 23, 2021, indicated R1 received services from the assisted living facility that included bathing, behavioral instruction, dressing, grooming, vital signs, housekeeping, daily room tidying, laundry, medication administration, medication management, escorts, transfers, nursing service, bathroom, catheter assistance, and therapeutic exercise.

R1's 90-day comprehensive health service assessment dated July 22, 2021, indicated R1 often had irritation in groin area and at tip of penis due to catheter. There were no changes made to R1's service plan.

R1's progress note dated August 4, 2021, indicated licensed practical nurse (LPN)-H observed a torn area on the end of R1's penis due to R1's catheter. There was no assessment completed, and no changes made to R1's service plan.

R1's home health skilled nurse evaluation summary dated August 4, 2021, indicated R1 had a traumatic wound on his penis that measured 4.8 cm by 2.6 cm. The summary indicated the open area extended from the tip of R1's penis half-way down the shaft. The wound was observed as split open with a beefy red wound base with swelling.

R1's urologist progress note dated August 9, 2021, indicated a recommendation of a suprapubic catheter placement (a tube placed directly into the bladder, while the patient is under

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(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
01640	Continued From page 10 anesthesia) due to R1's penile injury. R1's progress note dated August 24, 2021, at 7:12 a.m. indicated R1 to follow up with primary care physician in two more weeks for pre- op for suprapubic catheter placement with R1's urologist. During an interview on September 24, 2021, at 12:09 p.m., director of health services (DHS)-B stated she observed R1's penis tip on June 11, 2021, to be red and irritated. DHS-B stated she was not sure if a nurse revised the service plan. DHS-B stated she felt it was the responsibility of the home care company nurse to complete an assessment and get new orders to change the service plan. During an interview on September 24, 2021, at 2:27 p.m., registered nurse (RN)-F stated she was notified of R1's wound on June 16, 2021. RN-F stated wrote a progress note about what she saw and actions taken. RN-F stated she advised staff to provide more slack on the catheter tubing but did not conduct an assessment or change the service plan. During an interview on September 27, 2021, at 12:21 p.m., home care registered nurse (RN)-G stated she met with R1 on August 4, 2021, for the first time and completed an assessment. RN-G stated she observed R1's wound on his penis and could not tell how long it had been there. RN-G stated she believed the wound happened over time due to erosion from the catheter. RN-G stated she had concerns that the staff did not clean the catheter insertion site. RN-G stated she spoke with the nurse (LPN-H) who was not aware of R1's wound. RN-G stated she wrote orders for the area to be cleansed daily with peri-care and if	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33435	A. BUILDING: ______ B. WING ______	C 09/24/2021

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01640	Continued From page 11 R1 soiled his brief. RN-G stated that after her assessment the home health agency provided monthly catheter changes for R1 and weekly wound care to the catheter insertion site. During an interview on September 27, 2021, at 3:45 p.m. LPN-H stated she was called to look at R1 on July 10, 2021, and noted R1's penis had eroded skin at the opening and partway down the shaft with tearing of the skin. LPN-H stated she again saw R1 with a home health nurse on August 4, 2021, and R1's penis had a significant tear from the tip down the shaft. LPN-H stated a nurse should have done an assessment and changed the service plan. The Resident Assessments policy dated July 27, 2021, indicated an assessment would be completed with a change of condition and based on changes in the needs of the resident the director of health services or designee would update the service plan. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, 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: Based on observations, interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was neglected.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

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02360	Continued From page 12 Findings include: On September 24, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360		