Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL373622062M
Compliance #: HL373623638C

Date Concluded: May 8, 2023

Name, Address, and County of Licensee Investigated:
Brooklyn Park Assisted Living – The Lodges
7711 Humboldt Avenue North
Brooklyn Park, MN, 55444
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Christine Bluhm, RN
Special Investigator

Finding: Substantiated, individual 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) neglected the resident when the AP did not follow the resident's plan of care and inserted the wrong size urinary catheter. This resulted in severe pain, bleeding, and injury. The resident was hospitalized and required surgical repair of the urethra.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP used a urinary catheter which was too large causing the resident pain and bleeding. The resident required hospitalization and treatment for a torn urethra (the tube through which urine leave the body).

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of facility incident reports, resident records, policies, and protocols. Employee backgrounds and training were requested. The investigator interviewed other residents with indwelling urinary catheters.

The resident resided in an assisted living facility. The resident's diagnoses included spinal cord injury with quadriplegia and neurogenic bladder (dysfunction of the bladder). The resident's service plan included assistance with activities of daily living and instructions for nursing staff to replace the urinary catheter monthly using a 16 French (Fr) catheter per physician's orders ("French" is a measure of the size of the catheter). The resident's assessment indicated he was alert and oriented and able to make his needs known.

One day the AP changed the resident's his indwelling catheter but used a size that was too large. The resident told the AP it was the wrong size started but the AP proceeded with the catheter change anyway. During the catheter change the resident complained of excruciating pain but the AP continued to insert the catheter and told the resident the pain was normal. Afterward the resident continued to complain of pain and blood was visible in his urine collection bag. Two hours later the bleeding and pain continued so the resident was transported to the hospital and diagnosed with a torn urethra which required surgical repair.

The resident's nursing progress notes indicated the resident complained of pain after the AP placed a 24 Fr catheter when the resident's order was for placement of a 16 Fr. catheter. Approximately two hours after the procedure, the output was blood and no urine.

The resident's emergency room summary indicated that the resident had a one-centimeter laceration of the urethra. The resident underwent a bladder examination, removal of blood clots, extensive fulguration of bleeders (procedure to control bleeding), bladder irrigation, and new catheter placement.

During an interview, the resident stated he told the AP he had the wrong size catheter, a 24 Fr instead of a 16 Fr, but the AP said he would make it work. The resident stated he screamed when the AP inserted the catheter, and then inflated the balloon while it was still in the urethra. The resident stated there was pain and bleeding and he almost passed out. The resident stated he told the AP to stop, but the AP said the pain and bleeding was normal. The AP then told the resident to wait a couple of hours to see what would happen. The resident stated another nurse came into his room, saw the blood in the urinary bag, and called 911 right away.

During an interview, a member of management stated the AP was a temporary agency nurse and was not allowed to return to the facility to provide care for residents after the incident.

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: Yes.
Family/Responsible Party interviewed: Not applicable.
Alleged Perpetrator interviewed: The AP did not return requests for an interview.

Action taken by facility:
The facility transferred the resident to the emergency room and received treatment.

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
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37362	A. BUILDING: _____ B. WING _____	C 03/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKLYN PARK ASSISTED LIVING	7711 HUMBOLDT AVENUE NORTH BROOKLYN PARK, MN 55444

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0 000	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: #HL373624708C/#HL373622882M #HL373628577C/#HL373624984M #HL373624944C/#HL373623023M #HL373629929C/#HL373625784M #HL373629836C/#HL373625644M #HL373624379C/#HL373622525M #HL373623638C/#HL373622062M On March 20, 2023, through March 22, 2023, the Minnesota Department of Health conducted complaint investigations at the above provider, and the following correction orders are issued. At the time of the complaint investigations, there were 29 residents receiving services under the provider's Assisted Living license. No correction orders are issued for #HL373624708C/#HL373622882M, HL373624944C/#HL373623023M, #HL373629929C/#HL373625784M, and #HL373629836C/#HL373625644M.	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 The following correction orders are issued for #HL373628577C/#HL373624984M and #HL373624379C/#HL373622525M, tag identification 1760. The following correction order is issued for #HL373623638C/#HL373622062M, tag identification, 2360.	0 000		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure medications and gastrostomy tube (tube into the stomach for liquid nutrition) feedings were administered as ordered for two of three residents (R1, R7) reviewed for medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01760		

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01760	Continued From page 2 safety but had the potential to have harmed a resident's health or safety) 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 medical record indicated R1 admitted to the facility on December 26, 2022. R1 diagnoses included multiple sclerosis (paralysis of both arms and legs.) R1's assessment dated February 10, 2023, indicated R1 required gastrostomy tube (tube through the abdomen to stomach for feedings) for nutrition and received medications through the gastrostomy tube (G-tube). Staff were to administer all medications according to the prescriber's orders. R1's Individualized Medication Management Plan dated March 13, 2023, indicated nursing staff or delegated unlicensed personnel were responsible for monitoring the supply of medications, reordering, and updating the RN with any concerns on written orders, medication availability, or problems receiving medications. R1's medication administration record (MAR) for February 2023, indicated the following medications were not administered: -Santyl Ointment (ointment used on a wound bed to remove dead skin cells) apply to affected areas daily, was not provided to R1 on February 22, 23, 25, 27, and 28, 2023. R1's MAR for March 1, through March 19, 2023,	01760		

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01760	Continued From page 3 indicated the following medications were not administered: -Amoxicillin/Clavulanic acid (antibiotic for bacterial infections) 875/125 milligram (mg), 1 tablet twice daily for 10 days was not administered four of the ten days on March 4, 7, 8 (two doses), and 11, 2023. R1's documentation for those days were blank. -Santyl Ointment 250/gram (Gm)was not provided to R1 on March 4, 7, 8, 17, 18, and 19, 2023. Staff documentation was left blank. R1's February and March 2023, MAR indicated R1 had orders for Sodium Chloride Injection 0.9% 10 ml (milliliters) daily flush of the nephrostomy catheter (a tube that drains urine directly from kidney into a bag outside of the body) for patency. R1's MAR for February 2023, indicated R1 did not receive the Sodium Chloride nephrostomy catheter flushes on February 1, 2, 6, 7, 9, 11, 12, 13, 14, 15, 16, 20, 21, 25, 26, 27 and 28, 2023. On five occasions staff left the documentation blank, on 10 occasions the medication was not available, and on two occasions staff indicated they did not have the appropriate supplies available for R1's flushes. R1's MAR for March 1, through March 19, 2023, indicated R1 did not receive the nephrostomy catheter flushes on March 1, 2, 6, 7, 11, 12, 13, 14, 15, 16, and 19, 2023. On seven of the occasions staff left the documentation blank, on two occasions the medication was not available, on three occasions staff did not have the appropriate supplies available for R1's flushes. R1's Interventional Radiology Procedure notes	01760		

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01760	Continued From page 4 dated March 20, 2023, at 2:30 p.m., indicated R1's urostomy/nephrostomy catheter was occluded. During an interview on April 14, 2023, at 11:03 a.m., the radiology technician (RT)-I stated when R1's nephrostomy catheter occluded, R1's kidney could not drain causing urine to pool in the kidneys. R1 had previously developed sepsis (blood infection) in the past from an occluded nephrostomy catheter and R1 could become septic quickly with catheter occlusions. RT-I stated although R1's nephrostomy catheter was occluded on R1's March 20, 2023, appointment, R1 was not septic. R7's record indicated R7 was admitted to the licensee on August 31, 2021. R7's diagnoses included myoclonic muscular dystrophy (a disease that causes increased muscle weakness), dysphagia (difficulty swallowing), and attention deficit hyperactivity disorder. R7's assessment, medication, and treatment plan dated March 21, 2022, indicated R7 required assistance with medications including storage, administering, and monitoring of medications. R7 received bolus (single larger) feedings for nutrition, and medications and treatment supplies were monitored by nursing staff weekly and as needed. R7's MAR dated April 2022, indicated the following medications were not administered: R7's MAR for April 2022, indicated orders for Jevity (nutrition formula) give 180 milliliters (mL) through the G-tube with a bolus (single large amount) as the resident tolerated without nausea. The order directed staff to provide R1 a total of	01760		

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01760	Continued From page 5 360 mL daily (two bolus feedings daily). R7 ' s MAR indicated Jevity was not documented as provided to R7 on April 24, 2022. R7's MAR for May 2022, indicated the following medications were not administered: -Methylphenidate HCl (stimulant) 20 mg, two tablets daily was not documented as administered on May 27, 28, 29, 30, 31, 2022, (5 doses). R7's MAR for May 2022, indicated Jevity was not documented as provided to R7 on May 17, 18, 24 and 25, 2022. R7's MAR for June 2022, indicated the following medications were not administered: -Methylphenidate HCl not documented as administered on June 1, 2, 3, 4, 5, 7, 2022 (6 doses). R7 ' s MAR for June 2022, indicated Jevity was not documented as provided to R7 on June 1, 3, 4, 5, 7, 8, and 13, 2022. R7's MAR for July 2022, indicated the following medications were not administered: -Provigil was not documented as administered to R7 on July 9, 10, 11, 12, 2022 (4 doses). -Methylphenidate was not documented as administered on July 7, 8, 9, 10, 11, 12, 2022, (6 doses). R7's MAR for July 2022, indicated Jevity was not documented as provided to R7 on July 1, 11, 18,	01760		

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01760	Continued From page 6 20, and two feedings on July 26, 2022. During an interview on April 18, 2023, at 10:00 a.m., registered nurse (RN)-A stated staff were expected to provide every resident with their medications as ordered and if not administered to document a reason and to notify the RN. RN-A stated staff were expected to document medication administration and not leave blank documentation on the MAR. RN-A stated staff were required to communicate to the nurse when medications were not in stock. RN-A stated R1 had nephrostomy flushes and supplies were available in February and March 2023. During interview on April 26, 2023, at 2:30 p.m., RN-D stated the licensed practical nurses (LPN)'s, were responsible for ensuring medications were refilled and reordered. The licensee's policy titled Documentation of Medication, Treatment and Therapy Management Services, undated, indicated the nurse would document actions to implement prescriptions when it was received, and actions to request and obtain needed refills for residents, including communications with the prescriber, pharmacy, resident and/or resident's representative or family. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		
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.	02360		

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02360	Continued From page 7 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R6) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the individual alleged perpetrator is responsible for the maltreatmnet, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	