Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H51194783M
Compliance #: H51195214C

Date Concluded: October 7, 2024

Name, Address, and County of Licensee Investigated:
Aitkin Health Services
301 Minnesota Ave S
Aitkin, MN 56431
Aitkin County

Facility Type: Nursing Home

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Inconclusive

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 resident was neglected when the alleged perpetrator (AP) failed to properly insert an indwelling foley catheter as ordered causing urethral trauma, pain, and persistent bleeding to the resident's penis resulting in sepsis (a severe life-threatening infection) and hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the AP inserted the incorrect foley size, the resident utilized that size prior to and following the incident. The resident had a history of pulling on and pulling out his foley catheter causing bleeding. The resident's foley was inserted 4 times the night of the incident by multiple staff, as a result there is no way to determine which catheterization attempt could have caused trauma. In addition, the resident had a history of urinary tract infections related to chronic indwelling foley catheter use prior to the incident, as a result it could not be determined if the incident caused the resident's infection.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record(s), hospital records, facility internal investigation, personnel files, staff schedules, and related facility policy and procedures.

The resident resided in a skilled nursing facility with diagnoses including benign prostate hyperplasia (enlarged prostate), vascular dementia, advanced dementia, chronic urinary retention, neurogenic bladder (lack of bladder control due to a brain, spinal cord or nerve problem), history of bladder cancer, and urinary tract infections associated with chronic indwelling urethral catheter use.

The resident's service plan identified the resident was at a risk for bleeding related to anticoagulant use, and at risk for urinary tract infections related to indwelling foley catheter use. The service plan indicated the resident needed his foley catheter and drainage bag changed every 28 days using a 14 french 10 (milli liter) ml balloon catheter.

The resident's July medication and treatment administration (MAR/TAR) record included orders for Aspirin (ASA) 81 mg daily, and 325 mg daily (ASA can increase the resident's risk for bleeding). The MAR/TAR included orders for the resident's foley catheter to be changed every 28 days with a 14 french 10 ml balloon foley catheter.

The resident's provider orders included both 16 and 14 french 5 ml balloon catheters prior to the incident. Following the incident the resident's orders were changed to a 20 french 10 ml foley catheter (a larger size than a 14 or 16 french). Indicating although the AP selected a 16 french instead of a 14 french foley catheter, the error was not likely to have caused the resident trauma.

The facility investigation included handwritten statements, and interviews with the AP and other facility nurse which indicated both nurses used appropriate technique when inserting the foley catheters, and had urine return prior to inflating the foley catheter retention balloon. The AP completed the initial foley catheter change and indicated she met resistance with bloody return when the first foley catheter was inserted. The AP pulled back and immediately removed the foley then notified nursing leadership. The AP was informed bleeding with catheter insertion for this resident was normal and the AP was instructed to reinsert the foley. The AP's statement indicated when she reinserted a 16 french foley she noted bloody urine return. Another nurse's statement indicated the nurse removed the catheter inserted by the AP due to no output and increased pain. The nurse noted the resident had a large amount of bloody urine with clots when the catheter was removed, and the resident's pain was decreased following reinsertion of a new foley catheter. The nurse indicated the resident again expressed discomfort later that evening, but the pain resolved and the foley drained 50 ml of bloody urine in the drainage bag. The nurse indicated the resident was resting without discomfort from 11:15 p.m. until 3:30 a.m. when the nurse checked on him during routine rounds. At that time

the nurse noted the resident's urinary output had not changed, and the resident again began to complain of pain. The nurse assessed the resident's vital signs, and the resident had a low blood pressure. The nurse notified the provider and the resident to the emergency department (ED) for evaluation.

The resident's hospital record indicated the resident was admitted to the hospital with sepsis. The resident's catheter was changed at the facility with bleeding and no urinary output and was brought to the ED where an ED nurse removed the foley that was previously inserted at the facility. The ED nurse documented noting a blood clot was clogging the end of the foley when it was removed. The ED nurse documented re-inserting a 22 french 3-way foley catheter with mild irrigation at 5:45 a.m. The record indicated at 7:53 a.m. the resident had a CT scan of his chest abdomen and pelvis. A radiology report of the CT scan identified the resident's foley catheter inserted by the ED nurse was mispositioned with the retention balloon inflated within the resident's penile urethra. The hospital record indicated urology was consulted and at 9:20 a.m. a urology procedure note indicated a cystoscopy procedure was done using a guide wire to place a 16 french foley catheter with irrigation. As a result, there is no way to know if the foley catheter placed by the AP and then replaced by the other facility nurse caused any trauma to the resident.

A review of the resident's progress notes indicated the resident had a history of urinary tract infections related to chronic use of an indwelling foley catheter prior to the incident. As a result, there was no way to determine if the infection was caused by recurring catheterization attempts by the AP or subsequent nurses. The record indicated the resident had a history of pulling on and pulling out his catheter, as a result there is no way to know if the resident could have pulled on the catheter to contribute to the bleeding noted.

The resident's urology orders following the incident indicated the resident utilized urology for all foley catheter changes using cystoscopy to place the resident's foley catheter due to history of bladder cancer.

When interviewed the AP stated she had changed the resident's catheter previously using a 16 french foley catheter. The AP stated she met resistance and had bloody return on the first catheterization attempt, immediately removed the catheter, and consulted nursing leadership. The AP stated nursing leadership informed her some bleeding was normal for this resident and instructed the AP to re-insert the catheter. The AP stated she re-inserted a new catheter with bloody urine return noted.

When interviewed a facility nurse stated the AP reported the concerns with the resident's catheter replacement and she observed bloody urine return in the resident's foley collection bag indicating the resident's foley was properly placed by the AP. The nurse stated later that evening she observed clots in the resident's bag, no more urinary output, and the resident reported increased discomfort, so the resident's catheter was removed. The nurse stated the resident voided a large amount of bloody urine with clots and she placed a new foley catheter

without difficulty with a small amount of bloody urine return. The nurse stated the resident woke up in pain around 11:00 p.m. but the pain subsided, and the resident rested comfortably without complaints of pain until routine rounds around 3:00 a.m. During rounds the resident had no further urine output, increased pain, and low blood pressure so the nurse called the provider, and the resident was transferred to the ED.

Leadership nursing staff stated the resident's catheter placed by the facility nurse was removed and replaced at the ED. Leadership stated the mispositioned catheter could have been placed by ED staff and not the AP or other facility nursing staff.

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

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.

Vulnerable Adult interviewed: No, not interviewable
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility assessed the resident and transferred the resident to the ED for evaluation and treatment.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility 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. You may also call 651-201-4200 to receive a copy via mail or email.

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

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
	00002	A. BUILDING: _____ B. WING _____	C 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H51194783M/#H51195214C, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000		

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2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		