Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL327646283M
Compliance #: HL327641846C

Date Concluded: July 21, 2023

Name, Address, and County of Licensee Investigated:
Cherrywood of South St. Cloud
3325 Cooper Ave South
St. Cloud, MN 56303
Stearns County

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

Evaluator's Name:
Jana Wegener, 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.

Initial Investigation Allegation(s):
The facility neglected a resident when they failed to provide indwelling urinary catheter care and urinary catheter changes as ordered. The resident was admitted to the emergency department (ED) with a urinary tract infection (UTI), then admitted to hospice for end-of-life care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to provide urinary catheter care and/ or change the resident's urinary catheter monthly as ordered for three months and 16 days. The resident was transferred to the ED and diagnosed with a UTI.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included a review of the resident's medication and treatment orders, progress notes, point of care documentation, and provider communication. In addition, the investigator reviewed outside medical records including hospital, ED, urology records, discharge summaries, history and physical, and provider notes. In addition, the investigator observed staff providing care to resident in the facility.

The resident resided in an assisted living facility with diagnoses including dementia, UTI, chronic kidney disease, and heart failure.

An outside medical record indicated the resident was hospitalized with a UTI. The medical record indicated an internal scan of her abdomen and pelvis identified the resident also had a bladder tumor.

The facility re-admission assessment indicated the resident was returning from the hospital with a UTI and had an indwelling urinary catheter. The assessment indicated the resident required staff assistance with obtaining and ordering urinary catheter supplies and indicated the facility would provide catheter cares and change the urinary catheter per provider orders.

The facility record included orders from her primary care provider to leave the residents urinary catheter in place until after a urology follow up, with orders received to change the resident's catheter as needed for malfunction. The facility Medication and Treatment Administration Record (MAR/TAR) lacked orders to change the resident's catheter for malfunction.

A outside medical record urology after visit summary (AVS) indicated two weeks later the resident had a follow up after a cystoscopy procedure (a small tube and camera used to look inside the bladder) and transurethral resection of a bladder tumor (TURBT) procedure. The AVS indicated pathology identified the resident had bladder cancer. The AVS included orders to continue with the indwelling urinary catheter and change monthly.

The same day a facility nurse's note indicated the resident was seen by urology for a follow up with orders received change the resident's urinary catheter monthly. The facility MAR/TAR lacked the providers orders.

One month and 18 days after the urology follow up with orders to change the urinary catheter monthly, a provider rounding form and facility nurses note indicated the resident was seen by her primary care provider on rounds with orders received for catheter supplies and instructions to change the catheter monthly and as needed. The facility MAR/TAR lacked the providers orders, or documentation of the facility changing the resident's catheter.

A physician rounding form indicated the facility informed the primary care provider they had issues obtaining catheter supplies but failed to notify the provider the resident's urinary

catheter had not been changed as ordered for two months by that time. The resident record indicated no action was taken to ensure the resident's catheter was changed.

About a month later, an outside medical record indicated the resident was seen in the ED and treated for a urinary tract infection. The resident record indicated the facility failed to communicate to the ED the resident's urinary catheter had not been changed.

Two days later a nurse's progress note indicated the resident had increased confusion, weakness, and fever. The nurses note indicated the resident was transferred to the ED and communicated to the ED the resident's urinary catheter needed to be replaced. A follow up nurses note indicated the resident was admitted with a UTI, and her urinary catheter was changed at the hospital (three months and 16 days after it was placed by urology following the procedure).

A hospital AVS indicated the resident was hospitalized and received intravenous antibiotics for a UTI then discharged back to the facility four days later.

Three days after being readmitted to the facility the resident was admitted to hospice.

The resident record, progress notes, and MAR/TAR had no documentation of the facility ever changing the resident's urinary catheter prior to the hospital changing it. The resident's (MAR/TAR) lacked any orders to change the resident's catheter in the event of malfunction and failed to include the providers orders to change the resident's catheter monthly prior to being admitted to hospice. The point of care (POC) documentation contained no documentation of daily catheter cares including cleansing the insertion site and urinary catheter tubing being completed daily.

Email and text correspondence with the resident's provider, facility, and family indicated the provider was unaware the facility had not changed the resident's catheter as ordered. The communication indicated while hospitalized for a UTI, the facility was unable to provide a date of when the resident's urinary catheter was last changed.

During interviews, several facility licensed staff stated they went by the resident's task list in the resident plan of care and did not routinely review resident physician orders. Since the facility failed to implement urology or providers orders, staff were not alerted the indwelling urinary catheter was due to be changed.

During an interview the resident's family member stated facility leadership told family the resident's urinary catheter had not been changed at the facility.

When interviewed facility leadership stated they had problems obtaining urinary catheter supplies for the resident for three months and verified there was no documentation the resident's urinary catheter was changed prior to her admission to hospice.

In conclusion, 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:
(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: No - deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility identified signs of infection and sent the resident to the ED for evaluation and treatment.

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 651-201-4890 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
The Office of Ombudsman for Mental Health and Developmental Disabilities
Stearns County Attorney
St. Cloud, MN City Attorney

St. Cloud, MN Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32764	A. BUILDING: _____ B. WING _____	C 06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF SOUTH ST CLOUD	3315 COOPER AVENUE SOUTH SAINT CLOUD, MN 56301

(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: #HL327641846C/#HL327646283M, On June 14, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 16 residents receiving services under the provide's Assisted Living with Dementia Care license. The following correction orders are issued for #HL327641846C/#HL327646283M,, tag identification 1940, and 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 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.	
01940 SS=G	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of	01940		

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01940	Continued From page 1 ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure indwelling urinary catheter care and changes were completed per physician orders and failed to notify the physician when the facility was not able to change the catheter for one of one resident's (R1) reviewed. R1 was harmed when the urinary catheter was not changed for three months and 16 days. The	01940		

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01940	Continued From page 2 resident was transferred to the emergency department and required treatment for a urinary tract infection (UTI). This practice resulted in a level three violation (a violation that harmed a resident's 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). The findings include: R1 was admitted to the facility on December 21, 2017, with diagnoses including dementia, UTI, chronic kidney disease- stage 4, and heart failure. On October 31, 2022, R1's re-admission assessment indicated R1 was re-admitted to the facility after being hospitalized for a UTI with an indwelling urinary catheter placed on October 30, 2022. The assessment indicated R1 required assistance with obtaining and ordering urinary catheter supplies and indicated the facility would provide catheter care and change the catheter per provider orders. R1's service plan included tasks for monitoring urine output each shift. The service plan tasks included urinary catheter care on day shift, and evening shift, with instructions for staff to change R1's leg bag and rinse daily with vinegar and swab the connection openings with alcohol. The service plan tasks lacked instructions for catheter care to include cleansing of the urinary catheter insertion site and tubing.	01940		

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01940	Continued From page 3 A physicians rounding form dated November 3, 2022, included orders to leave R1's indwelling urinary catheter in place until seen by urology for a follow up. The rounding form included orders to change R1's urinary catheter as needed (PRN) due to malfunction. R1's facility nurse progress note dated November 3, 2022, at 5:24 p.m. indicated registered nurse (RN)-A acknowledged the providers orders. R1's medication and treatment administration record (MAR/TAR) for November 2022, failed to include the providers orders to change R1's urinary catheter PRN due to malfunction. A outside medical record after visit summary (AVS) dated December 8, 2022, indicated R1 was seen for a cystoscopy procedure (a procedure to look inside the bladder with a small tube and camera) and transurethral resection of a bladder tumor. It is likely R1 had a new catheter placed at that time. A outside medical record AVS follow up dated December 22, 2022, included orders for R1 to continue using an indwelling urinary catheter, change it monthly, and follow up in three months. R1's facility nurse progress note dated December 22, 2022, at 2:39 p.m. LPN-D acknowledged the providers orders. R1's MAR/TAR for December 2022, and January 2023, failed to include the providers orders to change R1's catheter monthly. A physicians rounding form dated February 9, 2023, included orders for urinary catheter supplies, and orders to change R1's catheter	01940		

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01940	Continued From page 4 monthly and PRN. R1's facility nurse progress note dated February 9, 2023, at 2:41 p.m. indicated LPN-E acknowledged the providers orders to change R1's catheter monthly and PRN, and indicated the order was sent to pharmacy. R1's MAR/TAR for February 2023, failed to include the providers orders to change R1's catheter monthly. On March 1, 2023, a physician rounding form indicated the facility informed the primary care provider they had issues obtaining catheter supplies, however, the facility failed to notify the provider the resident's urinary catheter had not been changed as ordered and had not been replaced for two months and 21 days at that point. The resident record indicated no action was taken to ensure the resident's catheter was changed. On March 21, 2023, an Emergency Department AVS indicated the resident was seen and treated for a urinary tract infection then discharged back to the facility. The AVS indicated the facility failed to notify the ED R1's catheter had not been changed. On March 22, 2023, a facility nurses note indicated a call was placed to home medical for urinary catheter supplies. A facility nurse progress note dated March 24, 2023, at 8:14 a.m. LPN-C indicated the resident had increased confusion, weakness, fever, and was not doing well. The nurses note indicated the resident was again transferred to the ED for evaluation. The progress note indicated LPN-C	01940		

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01940	Continued From page 5 notified the ED R1's catheter needed to be replaced. A follow up nurses note dated March 24, 2023, at 1:29 p.m. indicated R1 was admitted for a UTI, and her catheter was changed at the hospital. R1's hospital discharge summary dated March 28, 2023, indicated R1 was discharged to the facility with an indwelling urinary catheter in place, with orders for the catheter to be replaced monthly, and specific instructions for daily catheter care cleansing including cleaning the catheter tubing and insertion site with a washcloth and soap, rinse with warm water, and dry the area thoroughly. The orders included instructions to help prevent infection such as not disconnecting tubing more than needed, checking for kinks, keeping the drainage bag below the level of the bladder, and when to notify the provider. R1's MAR/TAR for March 2023 included orders for R1's urinary catheter to be changed monthly implemented on March 28, 2023. R1's nursing progress notes and provider communication failed to indicate R1's catheter was changed monthly as ordered from the time it was placed December 8, 2022, until it was replaced during a hospital admission on March 24, 2023, three months and 16 days later. The notes and communication failed to indicate the facility communicated to the provider R1's catheter had not been replaced as ordered. R1's point of care (POC) task list (directs staff on specific care needs of residents) included catheter care instructions for connecting/disconnecting R1's leg bag in the morning, and drainage bag in the evening, with	01940		

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01940	Continued From page 6 instructions to clean the bags with vinegar and tubing connections with alcohol. The task list included instructions for peri care twice daily but failed to include specific ordered catheter care instructions for cleaning the insertion site, and tubing. During an interview on June 14, 2023, at 11:55 a.m. licensed practical nurse (LPN)-C stated the provider was notified the facility had issues getting catheter supplies, but indicated she was not sure if R1's provider was aware her catheter had not been changed. During a interview on June 14, 2023, at 12:15 p.m. unlicensed personnel (ULP)-B stated she completed catheter cares by cleaning the area with warm soapy water. When asked how she knew what to do, ULP-B stated if the orders and instructions for catheter care were not in R1's POC she would just know it needed to be cleaned and would notify the nurse. During an interview on June 14, 2023, at 12:26 p.m. RN-A stated staff were expected to do daily catheter care. RN-A stated they had difficulty getting urinary catheter supplies to change R1's catheter for three months. RN-A stated she thought the provider was notified R1's catheter had not been changed due being unable to get supplies. During interview on June 29, 2023, at 2:09 p.m. LPN-D stated R1 was re-admitted to the facility with an indwelling urinary catheter. LPN-D stated if an order was received, she would put it into the computer, notify RN-A, then file the resident's paperwork for RN-A to review. During interview on June 28, 2023, at 1:49 p.m.	01940		

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01940	Continued From page 7 LPN-E stated R1's orders to change her urinary catheter monthly should have been on the MAR, then the order would have come up on the POC task list to be completed. LPN-E indicated if the order was not put into R1's MAR staff would not know R1's catheter was due to be changed because the nurses did not routinely review resident orders, and only went by the residents POC tasks assigned during their shift. LPN-E stated R1's catheter was not being changed every 30 days, it was overdue to be changed by at least two months, maybe longer, and R1 ended up getting a infection During interview on June 27, 2023, LPN-G stated in general an indwelling urinary catheter should be replaced every 30 days, and there should be orders for the catheter, how to care for it, and when to change it. LPN-G stated she did not recall hearing R1's catheter was ever replaced, and indicated she never saw orders to replace R1's catheter monthly. LPN-G stated although she provided catheter care and had no concerns staff had not completed catheter cares, R1's POC lacked specific instructions for completing the catheter cares including cleansing the insertion site and tubing. During interview on June 27, 2023, at 3:59 p.m. LPN-F stated she did not routinely review resident's orders and only went by a POC assigned task list during her shift. LPN-F stated in general an indwelling urinary catheter should be changed monthly. LPN-F indicated she was not aware R1 had no orders to change the urinary catheter and indicated she did not routinely review residents orders and would not have noticed R1's record lacked orders for changing the catheter.	01940		

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01940	Continued From page 8 During a follow up interview on June 29, 2023, at 11:09 a.m. RN-A stated although R1's orders were not implemented on the MAR/TAR, she recalled facility staff reporting they had changed R1's urinary catheter. RN-A stated there was no documentation in R1's record of staff changing the catheter. RN-A stated nurses should put orders into the MAR/TAR and POC when they receive them. RN-A indicated she did not know how orders to change R1's urinary catheter every month were missed. RN-A stated the residents MAR/TAR, service plan, progress notes, and POC should be accurate and match the providers orders. A facility policy and procedure titled "Catheter Care" dated August 1, 2021, included instructions for staff to provide catheter care using warm soap and water to clean the urethral opening and catheter tubing approximately four inches, rinsing frequently from front to back washing the genital area, document care provided, and report any concerns to the RN. The policy failed to indicate catheter care including instructions for cleaning the catheter insertion site and tubing would be on the resident's service plan and POC task for staff to complete and document. A facility policy and procedure titled "Medication and Supplies Reordering" dated August 1, 2021, indicated nursing staff would assist residents to ensure medications and supplies were ordered and available. The policy failed to indicate what the facility would do if supplies were not available, and when to notify the provider. A facility policy and procedure titled "Medication and Treatment Orders" dated August 1, 2021, indicated medication and treatment/therapy orders received must be implemented within 24	01940		

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01940	Continued From page 9 hours of receipt. The original signed order or faxed order would be placed in a designated area for the RN to review, and indicated when appropriate, changes would be made to the service plan. The procedure indicated a licensed nurse would review and audit the MAR/TAR regularly for compliance, and communicate with the prescriber. The policy failed to indicate staff would notify the provider if the orders were not completed as prescribed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
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 interview and record review, the facility failed to ensure one of one of one residents (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 (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

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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