Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL334582783M
Compliance #: HL334584605C

Date Concluded: June 26, 2023

Name, Address, and County of Licensee Investigated:
Claddagh Senior Living
508 Kruckow Ave. N.
Caledonia, MN 55921
Houston County

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

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

Finding: Inconclusive

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 alleged perpetrator (AP) neglected a resident when the AP incorrectly placed an indwelling urinary catheter. The resident had bleeding from his penis, was admitted to the hospital, and developed a septic infection as a result of the incident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The residents medical record indicated the AP inserted the foley (urinary catheter) without complications. Approximately three hours later the resident was transferred to the emergency department and the resident had bright red blood in his urine. A urology consultation the following day indicated the emergency department (ED) had multiple failed attempts while replacing the residents foley, and a cystoscopy procedure (a procedure to look inside the bladder with a camera) and sensor guide was required to replace the foley. During the procedure a significant urethral tear

was identified. It could not be determined if the residents urethral tear injury occurred from placement of the foley catheter at the facility, or if trauma occurred with failed attempts to replace the foley in the ED. The resident was diagnosed with bacteremia (presence of bacteria in the blood) and septic shock (a life-threatening infection causing organ failure) due to chronic foley catheter use.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of facility records, physician's orders, progress notes, vital signs, service agreement, care plan, assessments, service delivery records, AP personnel files, and facility policies and procedures. In addition, observations were completed of resident and staff interaction.

The resident resided in an assisted living facility with diagnoses including mild memory disturbance, benign prostate hyperplasia/hypertrophy (enlarged prostate), and urge incontinence of urine.

The resident's care plan indicated the resident had a urinary foley catheter and received catheter assistance daily and as needed.

The residents progress note indicated one day the AP documented the resident's foley catheter was changed using sterile technique without difficulty. The progress note indicated a small amount of blood-tinged urine was noted. A follow up note indicated the resident had low urinary output, low blood pressure, and was transferred to the ED by ambulance.

The resident's hospital and ED record indicated the resident had bloody discharge present at the urinary meatus (the opening to the urethra) and in the urinary foley catheter drainage bag on admission. The following day a urology consultation note indicated multiple failed attempts were made to replace the resident's foley catheter in the ED. The note indicated a cystoscopy procedure using a sensor guide was performed at bedside to place a new foley catheter. During the procedure it was identified the resident had a significant tear in the urethral bulb (an area in the urethra leading up to the prostate prior to entering the bladder). It is unknown if the urethral tear injury occurred when the foley was placed at the facility, or if trauma could have occurred during failed attempts to replace the foley in the ED. The record indicated the resident's labs and vital signs identified the resident had a urinary tract infection which caused sepsis and septic shock as a result of chronic foley catheter use. There was no indication the infection was caused by improper foley placement or the urethral tear.

When interviewed the AP indicated the resident's foley catheter was inserted using sterile technique with no difficulty or concerns.

When interviewed the resident stated he recalled no issues when the AP changed his foley catheter.

In conclusion, it was inconclusive whether neglect occurred.

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:
(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: Yes

Action taken by facility:
The resident no longer receives foley catheter changes at the facility.

Action taken by the Minnesota Department of Health:
No further action taken.

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
	33458	A. BUILDING: _____ B. WING _____	C 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLADDAGH SENIOR LIVING	508 KRUCKOW AVENUE NORTH CALEDONIA, MN 55921

(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 On May 16, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL334584605C/#HL334582783M . No correction orders are issued.	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.	