Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL289631704M
Compliance Report #: HL289633253C

Date Concluded: October 31, 2022

Name, Address, and County of Licensee Investigated:

Progressive Care LLC
355 River Road
Grand Rapids, MN 55744
Itasca County

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

Evaluator's Name: Carol Moroney 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 facility neglected a resident when the residents' medications were not ordered timely, and the facility staff gave the wrong medication dose to the resident. In addition, the facility hung the resident's catheter bag upside-down and did not do catheter care as ordered which caused a urinary tract infection.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The evidence was conflicting of medications not being ordered timely nor the resident to have received the incorrect medications. It is unable to be determined how the resident acquired a urinary tract infection. There was conflicting evidence the facility staff neglected the resident by not providing catheter care or to have hung the urinary bag upside down.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's hospital and hospice records. The investigation included review of resident records, personnel files, training records and the resident's death record.

The resident resided in an assisted living facility. The resident's diagnoses included diarrhea, history of urinary tract infections, urinary retention, high blood pressure, and a previous stroke. The resident's service plan indicated the resident needed assistance with catheter care, including staff to change the bag twice daily from foley (night bag) to leg bag (daytime use), and cleaning when changed. Instructions were provided for staff to clean the urinary catheter bags when the bag were changed. The service plan also indicated staff applied compression stockings every morning and removed them every night.

The resident's assessment indicated the resident used a foley catheter, with catheter care to be done twice daily. It also indicated "see care plan" for directions. Resident had a dry mouth and trouble swallowing pills. The resident preferred to take pills with a teaspoon of applesauce. The resident had chronic diarrhea, possible bowel obstruction or colitis, and mega bowel.

The resident's nursing progress notes indicated hospice directed care and ordered medications in conjunction with the resident's family for the last month of care. The facility assessed the resident with changes. The hospice registered nurse (RN) changed the urinary catheter.

The resident's medication administration record (MAR) noted for two days the resident was out of vitamin D3. No other evidence was found of medications not being ordered or the wrong medications were given. In later months, documentation indicated the resident's family directed the resident's medications administration frequently.

The resident's services delivered documentation of catheter care indicated care was documented as provided when required.

The hospital records indicated the resident had a urinary tract infection and low potassium. The resident took his potassium supplements but had intermittent constipation and diarrhea. The resident admitted with a possible small bowel obstruction with no nausea or vomiting and no fever. The resident had chronic kidney disease, and chronic diarrhea. The resident had a history of bladder cancer.

The hospice records indicated diagnosis of cirrhosis of the liver, chronic kidney disease, a history of a stroke, and high blood pressure. The resident had multiple urinary tract infections in the past year. The hospice staff documented education was provided to each family member regarding care.

The death certificate indicated the cause of death was malignant neoplasm of the bladder, chronic kidney disease, and late effect of the stroke.

The facility reported the family ordered the resident's medications until hospice took over the medication ordering. The facility also confirmed the resident had requested medication to be given in applesauce.

During multiple facility staff member interviews, staff reported they cleaned the catheter twice daily as directed. The foley catheter was always hung correctly. Hospice changed the bag and catheter as needed. The resident enjoyed talking to staff and was generally happy. The facility staff stated the resident wanted his pills in applesauce to assist with getting his medications swallowed. The facility staff were not aware of a lot of medication error occurrences.

During an interview with the family, the family member reported the resident's catheter bag was not cleaned properly; the urinary catheter leg bag was hanging upside down at least once. The facility staff put his medication in applesauce, and he did not like it that way, so he did not take all his pills. The facility staff missed some of his medication to be administrated to the resident. The documentation provided by the family was reviewed.

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:
(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.

Vulnerable Adult interviewed: No, the resident is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility documented services were provided.

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

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
	28963	A. BUILDING: _____ B. WING _____	C 10/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER GRAND SENIOR LIVING	355 RIVER ROAD GRAND RAPIDS, MN 55744

(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 Initial comments On October 4, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL289631704M/HL289633253C. No correction orders are issued.	0 000		