



Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:

Golden Valley Rehab. & Care Center
7505 Country Club Drive
Golden Valley, MN 55427
Hennepin County

Report #: H5186149

Date: January 9, 2009

Date of Visit: 8/26/08
Time of Visit: 8:15 a.m.

By: Rita Lucking, RN
Special Investigator

Nature of Visit:

An unannounced visit was made in order to investigate the following allegation of neglect of health care in accordance with federal regulations for long term care facilities at 42 CFR Part 483, Subpart B. In conjunction with the federal investigation, an investigation was also conducted in accordance with the Vulnerable Adults Act (VAA), Minnesota Statutes §626.557 and state nursing home licensure rules, Chapter 4658.

The allegation is: On August 8, 2008, when resident #1 came from the facility for a routine neurosurgery clinic halo check, a large (30 cm. by 40 cm.) foul smelling reddened area was noted on the resident's back (from scapula to upper lumbar area). The area was bleeding and had purulent drainage with multiple open areas from pinpoint to 5 cm. by 7 cm. Also, residue and scaling were noted on the halo pin sites on the resident's head, and the resident was in need of oral hygiene. The resident indicated that he had not gotten out of bed and had not received any therapy (PT or OT) since admission to the facility on July 21, 2008.

Investigative Findings:

All employees and persons were interviewed in private as desired and given the Tennessen Statement.

During the course of the investigation, the following was reviewed: resident #1's nursing home record; resident #1's 6/16/08 hospital record; staffing; facility's internal investigation; written statements; incident reports and re-education provided to licensed staff on 8/20/08. In addition, the second floor was toured, and staff and other persons were interviewed.

Documentation and interviews provided the following information:

- Resident #1 was admitted to the facility on 7/21/08. The resident was hospitalized on 6/16/08 following a fall in May 2008 that resulted in a traumatic brain injury, cervical fracture and quadriplegia. The resident was hospitalized at two hospitals prior to his admission to the nursing home. Resident #1 was wearing a halo neck brace that was attached to a tight fitting vest when he was admitted to the facility.
- Resident #1's admission orders did not identify any skin concerns and did not include orders for skin care, halo care or vest care. The orders indicated resident #1 had a follow-up appointment with his

neurosurgeon on 8/22/08. The hospital did not send the resident's discharge summary, history and physical and consultations to the facility until 8/4/08.

- Nurse practitioner (H's) 7/22/08 progress note did not indicate that she noted any skin problems or concerns when she conducted her initial examination of the resident.
- On 7/27/08, resident #1 was sent to the hospital for evaluation of cardiac symptoms and was admitted to the cardiac unit. Resident #1 returned to the facility on 7/29/08. The hospital's discharge documentation indicated resident #1's vest was not removed and his back was not examined. The documentation did not identify any skin concerns or contain orders pertaining to skin care.
- On 8/7/08, facility staff noted drainage on resident #1's sheets and observed that the drainage was coming from under resident #1's vest that was attached to his neck brace and halo. Staff were unable to assess the resident's skin and the origin of the drainage because the vest was tight and could not be removed. Nurse practitioner (H) was contacted related to the drainage, and she ordered an antibiotic and directed staff to make an appointment for resident #1 to be seen by his neurosurgeon on 8/8/08.
- On 8/20/08, nurse (B)/DON provided re-education for licensed nurses that included the following reminders: 1) Conduct a comprehensive review of all documentation when a resident is admitted to the facility 2) Ensure that all pertinent information is addressed and that information when a resident is admitted to the facility 3) Contact the discharging facility if there are concerns and questions about admission documentation and a resident's ongoing care.
- Nurse practitioner (H) was interviewed by phone on 8/28/08, and she stated resident #1 was under her care while he was at the facility. She stated she was not aware that resident #1 had a history of skin problems related to wearing the vest. The hospital did not send a discharge summary, orders or consultations that revealed resident #1 had prior skin problems. Nurse practitioner (H) denied that she noted any drainage coming from under resident #1's vest when she examined him. She indicated she did not remove the vest and view the skin on his back. She stated she did not observe any residue on resident #1's halo pin sites. Nurse practitioner (H) denied that she noted any problems with resident #1's oral hygiene. She stated the staff routinely got resident #1 out of bed. In addition, she stated resident #1 received physical therapy and occupational therapy while he was at the facility.

Conclusion:

Neglect of health care is inconclusive in connection with the allegation that the facility failed to provide resident #1 with appropriate care related to resident #1 developing skin breakdown on his back, having residue on his halo pin sites and poor oral hygiene on 8/8/08. Documentation and interviews revealed that resident #1 had a prior history of skin breakdown on his back related to wearing the vest. The hospital did not provide the nursing home with a discharge summary, history and physical, and consultations related to resident #1's prior skin problems. In addition, the hospital did not provide the facility with orders related to skin care, halo care or vest care when resident #1 was admitted to the facility on 7/21/08. The facility contacted nurse practitioner (H) on 8/7/08 when the drainage was noted and an antibiotic was ordered. Resident #1 was seen by his neurosurgeon on 8/8/08 related to the skin breakdown and drainage. Documentation and interviews indicated resident #1's halo pin sites were routinely cleaned, he was provided with oral care, staff routinely got him out of bed, and he received physical therapy and occupational therapy while he was at the facility.

xc: Division of Compliance Monitoring - Licensing & Certification

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245186	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/27/2008
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NAME OF PROVIDER OR SUPPLIER GOLDEN VALLEY REHABILITATION AND CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427
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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) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>An Abbreviated Standard Survey was conducted to investigate complainant #H5186149. No deficiencies were noted.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.