



SF/JR

*Protecting, Maintaining and Improving the Health of Minnesotans*

Office of Health Facility Complaints Investigative Report  
PUBLIC

Facility:

Texas Terrace Care Center  
7900 West 28th Street  
St. Louis Park, MN 55426  
Hennepin County

Report #: H5187036

Date: 04/27/2009

Date of Visit: 9/18/2008

Time of Visit: 8:30 a.m.

By: Jolene Bertelsen, R.N.  
Special Investigator

Kim Jacobson, R.N.  
Special Investigator

Nature of Visit:

An unannounced visit was made in order to investigate the following allegation of neglect 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 licensing rules, Chapter 4658.

The allegation is: Neglect occurred when on 3/8/2008 resident #1 was transferred with a Hoyer lift by one staff person, rather than two staff, as required by the policy. The resident was dropped and fractured her left knee. In addition, the resident sustained pressure ulcers under her cast.

Investigative Findings:

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

The investigation included a review of the following: Resident #1's medical records; staff schedules and assignments for March 3<sup>rd</sup> through March 9th, 2008; policies and procedures regarding the Vulnerable Adults Act; falls, physician and family notification of changes, wound prevention and management, reporting of incidents; instructions on use of lift equipment; incident/accident reports for February, March and April 2008; three personnel files and medical records for three additional residents were reviewed. Resident #1 and staff were interviewed. Several residents were visited during the course of the investigation and resident cares were observed.

Conclusion:

Neglect of health care is **inconclusive** in regard to the allegation that resident #1 sustained a fall on 3/8/2008 (it was identified that the date of the incident was 3/6/2008) from a Hoyer lift (it was identified that the lift was actually a sit to stand lift) resulting in a fracture of her left knee and pressure ulcers under her cast. Resident #1 did sustain a fracture of her left knee and pressure ulcers under her cast,

however it was unable to be determined how or when the fracture occurred. Inconclusive means that there was less than a preponderance of evidence that neglect **did or did not** occur.

Documentation and interviews established:

- Resident #1 has diagnoses including multiple sclerosis and osteoporosis. She has bilateral hand contractures and is wheel chair dependent (uses a motorized wheel chair). Resident #1 is a paraplegic; she has no movement in her leg and her legs are quite rigid. Resident #1 requires the assistance of two people for transfers using the sit to stand lift or the Hoyer lift. Resident #1 is alert and oriented, but forgetful.
- Resident #1 has a history of knee pain prior to the 3/6/2008 transfer and took scheduled pain medication.
- On 3/6/2008, employee (F)/nursing assistant (NAR) transferred resident #1 to a standing position using the sit to stand lift. Resident #1 developed pain in her hands and knees and she was lowered to the floor using the sit to stand lift. Resident #1 was then lifted into bed using a Hoyer lift. Resident #1 was unable to identify what NAR's, or how many NAR's, transferred her using the sit to stand lift or the Hoyer lift. Resident #1 was assessed by employee (E)/nurse, who saw no injury. Resident #1 told employee (E) that she did not get hurt.
- Employee (F) stated employee (G)/NAR assisted him while transferring resident #1 with the sit to stand lift. Employee (G) stated he remembers he assisted employee (F) with transferring resident #1 from the floor to the bed using the Hoyer lift, but he did not remember assisting employee (F) with transferring resident #1 using the sit to stand machine.
- On 3/7/2008, resident #1 complained of bilateral leg pain that was not relieved by her scheduled pain medication. Resident #1's physician was notified and an x-ray of resident #1's legs showed a left distal femur fracture.
- Resident #1's physician stated that because of her neurological condition, resident #1 was fitted with a leg immobilizer. Resident #1's developed skin break down under the leg immobilizer. As soon as the skin breakdown was discovered she was assessed and treated by the wound clinic and her leg immobilizer was changed.
- Resident #1's Physician stated that her account to him on how the fracture happened was vague and the "confusing thing is that it might take a very trivial injury to cause a fracture in resident #1." Just being "bumped the wrong way" could have caused this type of injury to resident #1. He consulted an orthopedic surgeon regarding resident #1, and the surgeon was not surprised that this type of fracture happened without a clear cut history of severe trauma. Though the staff was not aware of any major injury to resident #1, "it could have been that she was lowered to the floor too quickly and that could have been enough to cause an injury of this type, without it being obvious to the staff at the time". Resident #1's physician stated her nursing home's response to the incident was appropriate.
- Although resident #1 verbalized the incident as being a "fall", interviews with resident #1 and staff, describe resident #1 being lowered to the floor using the sit to stand lift, not falling to the floor.

xc: Division of Compliance Monitoring - Licensing & Certification  
Ken Labore, Attorney

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

PRINTED: 10/27/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245187</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/16/2008</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>TEXAS TERRACE CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7900 WEST 28TH STREET</b> <b>SAINT LOUIS PARK, MN 55426</b>
--	--

(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
--------------------	--	---------------	---	----------------------

F 000	<p><b>INITIAL COMMENTS</b></p> <p>An Abbreviated Standard Survey was conducted to investigate complainant H5187036. No deficiencies were noted.</p>	F 000		
-------	---	-------	--	--

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.