



KLUA

*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 #: H5187037

Date: 3/23/2009

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: On 9/9/2008, resident #1 was admitted to the hospital. He was found to be toxic, dehydrated, malodorous, and wet with gastric juices on arrival. Resident #1 had several deep foul smelling pressure ulcers on his bilateral extremities. He also had necrotic tissue on both feet, in multiple areas, on the left lower extremity and purulent material in between his penis and swollen foreskin.

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 record; staff schedules and assignments for 9/4/2008 through 9/9/2008; policies and procedures regarding the Vulnerable Adult Act, physician and family notification of changes, wound prevention and management. Three personnel files and medical records for three additional residents were reviewed. Several residents were interviewed during the course of the investigation and interaction between residents and staff was observed.

Conclusion:

**Neglect of healthcare is inconclusive** in connection with the allegation that resident #1 was admitted to the hospital with deep pressure ulcers on his bilateral extremities, necrotic tissue on both feet in multiple areas and purulent material in between his penis and foreskin.

A review of resident #1's medical record indicated that he was admitted from another nursing home on 9/4/2008. Resident #1 requires total assistance for all activities of daily living (ADL's) and he is noted to be non-verbal. He has a tracheostomy with oxygen, a Foley catheter, a PEG tube, and a rectal tube. He has severe upper and lower extremity contractures and at times it is difficult to take a blood pressure because of his contractures. Resident #1 has wounds on bilateral feet and the back of his left hand.

A Wound Documentation Record from his previous facility, dated 8/19/2008, documented multiple wounds on right and left lower extremities and his penis. Resident #1 has severe upper and lower extremity contractures. Upon discharge, there was no documentation indicating overall general appearance.

Resident #1's medical records indicated that a care plan was implemented and a treatment record documented Foley catheter care every shift, tracheostomy care two times a day, dressing changes every day and application of antifungal ointment to his peri area two times a day.

Resident #1 was transported to the hospital due to low hemoglobin on 9/9/2008. Resident #1 returned to the facility after a four day hospital stay.

Employee (A) stated that on admission resident #1 was non responsive, appeared clean and his dressings were fresh. He had multiple pressure ulcers on both feet and one of his shins. Resident #1 had bilateral arm and leg contractures. He stated there was redness on his penis and scrotum.

Employee (D) stated that he discharged resident #1 to the hospital on 9/9/2008 and that his overall appearance looked clean, his dressings were clean and he did not notice a foul smell from resident #1's wounds. Resident #1 "had a lot going on, but he looked clean" and "based on everything he had going on", resident #1 looked well cared for.

Several employees were interviewed and indicated that resident #1 got good care at the facility and his cares were completed.

xc: Division of Compliance Monitoring - Licensing & Certification

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

PRINTED: 03/24/2009  
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>03/23/2009</b>
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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>
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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	INITIAL COMMENTS	F 000		
	An abbreviated standard survey was conducted to investigate H5187037. No deficiencies were issued.			

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.