



SF

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 #: H5187038

Date: June 8, 2009

Date of Visit: January 2, 2009
Time of Visit: 7:10 AM

By: Laurel Baumann, R.N.
Special Investigator

Nature of Visit:

An unannounced visit was made in order to investigate the following allegation of abuse 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 §626.557 and state nursing home licensing rules, Chapter 4658.

The allegation is: On December 15, 2008, resident #1 was physically abused by a staff person. A spiral fracture was diagnosed. In addition, a partially healed right wrist fracture was noted as well as scabs and abrasions on the resident's head. The resident has indicated on several occasions that a man (limited physical description provided) "grabbed [his] arm and twisted it." The facility indicated an investigation was in progress. Approximately three weeks prior to December 15, 2008, the resident was noted to have large bruises on the side of his head.

Investigative Findings:

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

During the course of the investigation the following tasks were completed:

- Review of resident #1's medical record
- Review of incident reports for resident #1 from June-December 2008
- Review of incident reports for the Garden Terrace for October, November and December 2008
- Interviews of staff, residents [limited due to conducted on dementia unit], and other key individuals
- Observations of care provided to resident #1 and observations of staff to resident interaction on the Garden Terrace
- Review of policies and procedures for the Vulnerable Adult, and Incident Reporting
- Review of the facility's internal investigation of the alleged incident
- Review of pertinent nursing staff schedules
- Review of the personnel file of employee (P)

Medical Record and Additional Documentation:

- Resident #1 was admitted to the facility on 11/3/06. His diagnoses include [unspecified] dementia with behavioral disturbance. Resident #1 has long and short term memory problems. He resides on a secured dementia unit. He also had a diagnosis of arthritis of multiple joints of the right hand.
- He is dependent on staff assistance for his grooming, activity of daily living and mobility needs.
- Resident #1 has an identified target behavior of resisting care, which may include kicking and striking out at staff. His behavior is monitored. Interventions include a calm approach, explanation of actions, redirection and re-approaching at a later time. Resident #1's physician recently adjusted his medication related to increased sexual behaviors which included inappropriate advances toward other residents.
- Resident #1 has a history of falls. He has frequently attempted to self transfer from his bed and his wheelchair. A review of his incident reports for June-December 2008 reveals that he experienced six falls during this interim. The last fall occurred on 11/5/08. Each of these falls was reviewed by the interdisciplinary team with interventions put in place. Fall interventions include a personal alarm when in bed and in the wheelchair, a mat on the floor when he is in bed, hip protectors when up and a self releasing alarm belt for his wheelchair.
- On 11/5/08, resident #1 experienced a fall that resulted in a bruise to his left forehead. Following this fall, the self releasing alarm belt was implemented to be used in his wheelchair.
- On 12/14/08, resident #1 was found in bed fully clothed, when the night shift made their first rounds around 11:00 PM. When the night staff was removing his clothing to get him ready for the night, it was noted that he had pain in his right lower arm. The Progress Notes, dated 12/14/08 at 11:15 PM, noted that he had pain with movement of his right hand and it was swollen from his fingers to just below his elbow.
- A call was placed at 11:33 PM on 12/14/08 to notify the physician of the findings with an order for an x-ray the following morning. The x-ray, completed on 12/15/08, identified "an acute mid-shaft ulnar comminuted [broken or splintered into pieces] spiral-type fracture." A second ulnar fracture that showed callus formation was identified. A cast was placed and resident #1 returned to the nursing home.

At the time of the onsite visit on 1/2/09, resident #1 was observed to have a splint in place on his lower right arm. He did not appear to have any pain. Also noted, were two small well healed [no redness or signs or symptoms of infection] scabs on top of the resident's head.

Interviews:

Employee (S)/TMA was interviewed on 1/8/09 at 2:40 PM and stated the following:

- She passed meds for resident #1, during the evening shift on 12/14/08, in the Garden Terrace. She first saw him around 5:00-5:30 PM. He was in his wheelchair in the dining room. She gave the resident a beverage at that time. Resident #1 used his right hand to grab the beverage. He was smiling with no evidence of any pain.
- She assisted residents to eat during the evening meal at the same table where resident #1 dines. He ate his supper with his right hand with no difficulty.
- She gave the resident his medications at 7:00 PM on 12/14/08. He was still in the dining room. She did not note anything out of the ordinary with his right hand and arm.
- Nothing was reported to her regarding resident #1 by the AP on 12/14/08. She did not receive a report that the resident had pain or swelling in his right hand and arm.

Employee (L)/nurse was interviewed on 1/6/09 at 2:45 PM and stated the following:

- He worked the evening of 12/14/08 in the Garden Terrace. He was not passing medications for resident #1 that evening, but for the other team.
- It is not true that he received a report from the AP that resident #1 was having pain in his hand/arm during the evening shift on 12/14/08.

Employee (O)/NA was interviewed on 1/7/09 at 7:45 AM and stated the following:

- She worked the night shift, which begins at 10:30 PM, on 12/14/08-12/15/08 in the Garden Terrace.
- She has been an employee at the facility for eighteen years.
- She and employee (M) were making the first rounds of the night. When they came to resident #1, they found him fully dressed, with his shirt and pants on. Employee (O) got employee (N)/nurse to show her that the resident was fully dressed.
- Employee (N) left the room. When the two nursing assistants began removing resident #1's flannel shirt, he flinched and clutched his right arm. They saw that his arm was swollen from his elbow down to his fingers. He said his arm hurt.
- When they asked resident #1 what happened, he said that "Indian girl" twisted my arm. The resident used a descriptive term related to the AP's physical appearance.
- The nursing assistants again summoned the nurse to evaluate the residents arm.

Employee (M)/NA was interviewed on 1/7/09 at 7:15 AM. The following information was provided:

- Employee (M)'s account of the first rounds around 11:00 PM on 12/14/08 was consistent with that of employee (O).
- He has been an employee at the facility for sixteen years.
- When he and employee (O) came upon resident #1, he was fully clothed.
- The resident said "ow-ow" when his shirt was removed from his arm. He noted the lower right arm was puffy.
- Employee (M) also stated that the resident said his arm had been twisted by that "Indian girl", when they asked him what happened.

Employee (N)/nurse was interviewed on 1/7/09 at 7:30 AM and stated the following:

- She worked the night shift of 12/14/08-12/15/08 in the Garden Terrace.
- At the change of shift it was reported to her by the evening nurse that resident #1 was fine.
- She was summoned to resident #1's room first to see that he had been put to bed fully clothed and then to evaluate the resident's arm.
- Resident #1's arm was puffy from his fingers to above his wrist. She did not notice any redness or bruising.
- She elevated the resident's arm on a pillow, then called the doctor to obtain an order for an x-ray.

The AP was interviewed on 1/7/09 at 11:15 AM and stated the following:

- She worked the evening of 12/14/08 on Garden Terrace.
- Around 5:30 PM, she went to get resident #1 up for supper. When she stood him up he told her he was feeling pain in his left arm. She checked and saw swelling in his hand. *(During the facility's internal investigation, she said she had reported right arm pain.)*
- She proceeded to take him to the dining room for supper, at which time she reported to employee (L) that the resident was "feeling pain." Employee (L) nodded yes to her report. She went to the other dining room and does not know how employee (L) followed up.

- Around 7:00 PM, she took resident #1 to his room to get ready for bed. He refused to take his clothes off. He kept trying to kick her and told her "no". She did not recall that resident #1 was resistive or combative with his arms. She said "okay", left a gown in his room and told him she would be back. She managed to change his incontinent product and get his shoes off, but put him to bed fully clothed.
- She re-approached resident #1 during last rounds, about 10:15 PM and was able to change his incontinent product, remove his clothes and put a gown on him. *[During the facility's internal investigation, she reported that she had successfully removed only the resident's slacks when she approached him a second time.]*
- She did not know what caused the pain and swelling in the resident's arm.
- She reported to the nurse [employee L] and that was what her responsibility was.

Physician (R) who saw resident #1 in the emergency room on 12/15/08 was interviewed on 1/8/09 at 9:30 AM and stated the following:

- The spiral fracture sustained by resident #1 could be consistent with the arm being twisted. *[The emergency department record, dated 12/15/08, stated the fracture was related to trauma; a fall or a defensive blow to the arm were suggested.]*
- There is no way of knowing the age of the older fracture, identified when the resident's right arm was x-rayed on 12/15/08.

Internal Investigation:

- The facility initiated employee interviews on 12/16/08 with multiple employees. The facility reported the right arm fracture, identified on 12/15/08, according to state and federal regulations.
- The internal investigation was consistent with the interviews as above. Resident #1, who has a diagnosis of dementia with identified memory problems did, however, state the day after the incident that a man had twisted his arm.
- The AP was suspended during the internal investigation and subsequently terminated.

Personnel File:

The personnel file for the AP was reviewed and identified the following information:

- She began her employment with the nursing home on 12/17/07.
- Her file did not contain any disciplinary action prior to December 2008.
- Her employment was terminated on 12/24/08. The reason given for termination was "Dishonesty."

Conclusion:

As defined by federal regulatory requirements at 42 CFR 483.13(b), and the current statutory definition specified within Minnesota §626.5572, the preponderance of evidence indicates that **physical abuse did occur** in connection with the allegation that resident #1 sustained a fracture related to his arm being twisted. Staff interviews indicate that resident #1 had no discomfort or limitations using his right arm prior to his bedtime care on 12/14/08. The AP's credibility is called into question as her account of events was inconsistent with other employees, and varied with different interviews. She stated that she reported to employee (L) that the resident's hand was swollen and that he had pain, around 5:00 PM on 12/14/08. Employee (L) stated that he never received such a report. The resident was seen using his right hand during the supper meal and again around 7:00 PM without any difficulty. The AP admits that resident #1 was resistive to receiving care when she attempted to put him to bed. He wouldn't allow her to remove his clothing, was kicking and telling her "no" but she has no idea how he might have

sustained an injury. During the facility's internal investigation, the AP said she was able to remove the resident's pants when she put him to bed. When interviewed by this investigator, she stated that she had gone back into the room after her first attempt to put the resident to bed on 12/14/08 and removed his clothing, changed his incontinent product and put on a hospital gown. Three night staff employees found resident #1 fully clothed during first rounds [around 11:00 PM] on 12/14/08. The fracture sustained was consistent with the resident's account of what happened, "that Indian girl twisted my arm", which was his initial account when queried by the staff who found him at 11:00 PM.

The "mitigating factors" in Minnesota §626.557, Subdivision 9c (c) were considered and it was determined that the perpetrator is responsible for the abuse. The Employee will be notified of the right to request reconsideration and/or appeal the maltreatment finding.

There were no federal deficiencies or state licensing orders issued.

Since the allegation of abuse by an identified employee is substantiated, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements in State law. The employee will be notified of the right to request reconsideration and a hearing to challenge these findings.

xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Board of Examiners for Nursing Home Administrators
St. Louis Park City Police Department: Attention; Bryan Kruelle
Hennepin County Attorney
St. Louis Park City Attorney
Hennepin County Adult Protection: Attention; Tracy Allen

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

PRINTED: 01/13/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245187	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/13/2009
--	---	--	---

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

(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>INITIAL COMMENTS</p> <p>An Abbreviated Standard Survey was conducted to investigate complainant #H5187038. 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.