



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 #: H5187044

Date: 4/22/2010

Date of Visit: 2/4/2010
Time of Visit: 12:00 p.m.

By: Deb Neuberger, 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: Resident #1 was neglected during the night shift of January 9, 2010 when his oxygen saturation rate was noted to be 77% at 1:30 a.m. Although the resident's respiratory status did not improve with suctioning, no other interventions were provided and the resident was found not breathing at 1:45 a.m.

Investigative Findings:

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

Investigative activities included a review of: medical records, the internal investigation, policies and procedures related to respiratory care and assessment, incident and accident logs, nursing assistant care guides, 24 hour reports, training, and personnel files. Observations and interviews with staff and residents were also conducted.

Medical Record:

Resident #1's medical record was reviewed and revealed:

- Resident #1 was admitted in December 2009 with diagnoses that included chronic airway obstruction and aftercare for fractured vertebrae.
- Resident #1 had a tracheostomy.
- Resident #1 had elected no resuscitation (DNR).
- Resident #1's respiratory plan of care dated 12/09 indicated Resident #1 used oxygen and required suctioning and the goal was to keep his oxygen saturation level at 90% or greater.

- On 1/9/2010 Resident #1 was experiencing labored breathing and was receiving suctioning of thick, yellow mucus.
- With suctioning, Resident #1's oxygen saturation level was staying at approximately 95%.
- Employee (B)'s nursing notes dated 1/10/2010 at 1:30 a.m. indicated Resident #1's oxygen saturation was 77% and she attempted to suction him of thick secretions. After the suctioning his oxygen saturation was unchanged.
- Employee (B)'s next note dated 1/10/2010 at 1:45 a.m. indicated she came back into the room to suction Resident #1 again, and was unable to get an oxygen saturation level and he was not breathing and did not have a pulse, and Resident #1's physician was paged.
- Employee (B) also added a "late entry" note for 1/10/2010, dated 1/15/2010. In this note Employee (B) indicated that she was notified of Resident #1's shortness of breath at 1:30 a.m. and she checked his oxygen saturation level and it was 77%. She documented that she then elevated the head of his bed, and rechecked and it was still 77%. She indicated she then asked another staff member to call Resident #1's physician while she suctioned him. She then indicated that he stopped breathing.
- Resident #1's cause of death was listed as respiratory complications of head and neck injuries.

Internal Investigation:

Employee (A) and Employee (D) conducted the internal investigation and Employee (A) stated:

- Employee (B) was the nurse on Resident #1's unit on 1/9/2010 when Resident #1 experienced difficulty breathing.
- Resident #1's condition was deteriorating.
- Employee (B) was late on 1/9/2010 and actually arrived for her shift at about 12:00 a.m. on 1/10/2010.
- Employee (B) received a report from the previous shift indicating that Resident #1 was requiring suctioning and oxygen to maintain his oxygen saturation levels near 95%.
- Employee (B) was left with 2 sets of suctioning supplies in Resident #1's room.
- Employee (B) told Employee (A) that she checked Resident #1 at about 1:00 a.m. and his oxygen saturations were in the 70% range. Employee (B) stated she then suctioned Resident #1 and his oxygen saturation came up into the 80% range. She then stated she changed the oxygen tank. She then stated she left the room to hang an IV and get suctioning kits. Employee (B) then stated that she came back to Resident #1's room at about 1:45 a.m. When she got back to the room at 1:45 a.m. Resident #1 was not breathing. At 1:45 when she got to the room, the nursing assistants were turning and changing him. She then called the physician. (Inconsistent with her nursing notes above.)
- Employee (B)'s version of the events of 1/9/2010 did not make sense to Employee (A).
- At some point Resident #1's oxygen saturation went in the 70% range.
- Employee (A) could not determine which kind of suctioning Employee (B) performed, and Resident #1 would have required endotracheal suctioning, not oral suctioning.
- Employee (B) had experience with suctioning tracheostomies, she should have known how to care for Resident #1 and nursing manuals are also available if there are questions.
- Resident #1 stopped breathing and died on 1/10/2010.
- Resident #1's physician indicated that Resident #1's death was not unexpected.

Employee (D) stated:

- The first time she interviewed Employee (B), Employee (B) stated that she suctioned resident #1 and got sputum up, but did not have all the right equipment available.

- The second time Employee (B) stated that she used oral suctioning around the tracheostomy and did not have tracheostomy suctioning equipment available to her in the resident's room.
- Employee (B) did not document any vital signs taken during Resident #1's respiratory episode, and would not give any answers about taking any vital signs, then later said she tried, but it was too late.
- Employee (D) would expect that at the beginning of a shift, staff members should check to see that they have all the equipment that they will need for the shift.
- Employee (D) would have expected Employee (B) to call 911 or the resident's physician if the employee attempted suctioning and the resident was not responding with increased oxygen saturation levels.
- Employee (D) stated that just because a resident is "DNR" does not mean that they would not be hospitalized, if necessary.

Interviews:

Employee (C)/nurse was interviewed on 2/19/2010 at 10:40 a.m. and stated:

- He worked the evening shift on 1/9/2010.
- Resident #1 had required suctioning at the tracheostomy site and oxygen throughout the shift to maintain his oxygen saturation levels at around 96 – 97 %.
- He gave the night shift report and left at approximately 12:30 p.m.
- When Employee (C) left, Resident #1's oxygen saturation levels were in the 90% range and his respirations were "okay."
- When Employee (C) left, he left 3 suctioning supply kits on the room and the oxygen tank was at about 25% full, so he reported to the next shift that they would need to monitor that and change it as needed.
- If Resident #1 had not responded to suctioning with elevated oxygen saturation levels, Employee (C) would have increased the resident's oxygen and if that did not work, he would have called 911 and the resident's physician.
- Employee (C) stated he was aware of how to suction residents who have tracheostomies.

Employee (B)/nurse was interviewed on 2/22/2010 at 12:37 p.m. and stated:

- On 1/9/2010 Employee (B) was late, and arrived to work at about 12:00 a.m. on 1/10/2010.
- Employee (B) got report from Employee (C) and then he handed her the keys.
- Employee (B) was about to go through the books to see what she needed to get done, when Employee (G) told her at 12:45 or 1:00 a.m. that Resident #1's oxygen saturation was 77%.
- Employee (B) went to Resident #1's room with Employee (G) to make her own assessment of resident #1's condition.
- Employee (B) initially stated that she looked at Resident #1's oxygen level and it was 77%, she also (later in the interview) stated that when she got to the room Resident #1 had no oxygen saturation registering.
- Employee (B) found Resident #1 in his bed with his eyes closed.
- Employee (B) initially stated she could not tell if Resident #1 was breathing and later stated he was not breathing when she checked him the first time.
- Employee (B) listened to his chest and did not hear a heart beat.
- Although Employee (B) could hear no heartbeat and Resident #1 was not breathing, she thought she should suction Resident #1, because he had secretions around his tracheostomy.
- Employee (B) had to leave the room to find a suction kit.

- Employee (B) raised the head of Resident #1's bed and she and the other staff changed his oxygen tank because the old one was empty.
- Employee (B) suctioned Resident #1 from his Tracheostomy.
- During this time Resident #1 did not have a heart beat.
- Although Employee (B) stated she did lung sounds and she did not hear any, she also stated she heard "gurgling secretions", which are lung sounds.
- Resident #1's oxygen saturation was not going up, and she asked Employee (G) to get the nurse from the 2nd floor.
- Employee (H)/LPN came to the room.
- Resident #1's oxygen saturation was not registering at all.
- Employee (H) asked if Employee (B) checked his chest to see if he was breathing.
- Employee (B) stated that she was not getting anything, and Employee (H) took the stethoscope from her.
- Employee (H) said she was not getting anything either.
- Employee (B) said to go call the doctor.
- Employee (H) said she did not think he was breathing.
- Employee (B) did not call 911 because Resident #1 was "DNR."
- Employee (B) left Resident #1 for approximately 1 minute to get a suctioning kit; otherwise she stayed with Resident #1.
- Employee (B) had cared for residents with tracheostomies before and felt comfortable care for residents with tracheostomies.

Employee (E)/nurse was interviewed on 2/12/2010 at 1:55 p.m. and stated:

- Employee (E) was working on 1/9/2010.
- She was called down to first floor to assist with orders and other activities between 12:30 and 1:00 a.m.
- Employee (E) saw Employee (B) was standing in the hall holding an IV.
- Employee (E) went to the south hall and assisted with call lights, and feedings.
- Employee (E) was in the south hall for at least ½ hour.
- Employee (E) was walking to the nursing station, when Employee (G) asked her to come to Resident #1's room to check Resident #1's condition after 1:00 a.m.
- Employee (G) told Employee (E) that they were changing his oxygen.
- Employee (E) came to room to find Employee (G) changing Resident #1's oxygen tank because Employee (G) thought his oxygen tank was empty.
- Resident #1 looked pale, lethargic and when Employee (E) checked his oxygen saturation and it was 75%.
- After the tank was changed, the oxygen saturation was about 77%.
- Employee (B) was not in the room at that time.
- Employee (E) asked where Employee (B) was, and she was told that Employee (B) had already been told about Resident #1's condition, but she was working on another resident's IV and would come when she was finished.
- Employee (E) was told that Employee (B) was planning to suction Resident #1.
- About 5 minutes later, Employee (E) went to nursing station to see what Resident #1's orders included and Employee (B) started toward Resident #1's room.
- At that time, Employee (B) was looking for a suctioning kit, or tubing and Employee (E) asked Employee (B) if they should call the physician.

- Employee (G) called Employee (B) back to Resident #1's room, and Employee (E) called Employee (H).
- Employee (E) went back into Resident #1's room and thought she noted Employee (B) suctioning Resident #1 using the suctioning tube used to suction the mouth and not the tube used for the tracheostomy, but she could not be sure.
- Employee (E) asked if she should call the physician, and she believes that Employee (B) told her to call the family.
- Employee (E) thought she should call the physician or 911, but Employee (B) was her supervisor, so she did not know what to do.
- Employee (B) was in Resident #1's room for 5 or 10 minutes, when she came back out and said he was no longer breathing.
- Employee (E) went to Resident #1 room and he was not breathing.
- Employee (E) stated that if she had been suctioning a resident and his oxygen saturation levels did not rise, she would call 911 and the resident's physician immediately.

Employee (G)/nursing assistant was interviewed on 2/23/2010 at 7:29 a.m. and stated:

- Employee (G) worked nights on 1/9/2010.
- During her rounds, Employee (G) called Employee (B) to come and check on Resident #1 between 1:00 a.m. and 1:30 a.m. because he seemed congested, but he was breathing.
- Employee (G) called Employee (B), and then went to get the oximeter to check Resident #1's oxygen saturation level.
- Employee (G) checked Resident #1's oxygen saturation level and it was 74% then it went to 78%.
- The nurses, Employees (B) and (E) came to check him, and Employee (G) checked the oxygen tank, and it was empty.
- Employee (G) began to change the oxygen tank.
- Resident #1 was still breathing at that time.
- Employee (B) came in and suctioned Resident #1.
- Employee (G) left Employee (B) to suction Resident #1.
- Employee (G) was not certain what kind of suctioning Employee (B) performed.
- Employee (G) left the room to go finish rounds and Employee (B) was with Resident #1 and he was breathing at that time.
- Employee (G) was at the other end of the hall, about 20 minutes later when Employee (B) called her down and stated that Resident #1 was no longer breathing.

Employee (H)/nurse was interviewed on 3/17/2010 at 12:36 p.m. and stated:

- Employee (B) called her down to confirm that Resident #1 had died.
- When Employee (H) got to the room, Resident #1 was not breathing and had no pulse.
- Employee (H) was not sure of the time, and did not document her involvement.

Personnel Files:

Employee (B)'s personnel file was reviewed and revealed:

- Employee (B) was hired on 1/31/1994.
- Employee (B) was an LPN with a current license.
- Employee (B)'s most recent background check was completed on 11/5/2005 indicating that she "may provide direct contact services."

- Employee (B) had a *Disciplinary Action Report* dated 9/1/09 for using vulgar and profane language with staff and intimidating staff.
- Employee (B) had a *Disciplinary Action Report* dated 1/10/10 for caring for another, less critical resident, when a resident in respiratory distress required her assistance.

Conclusion:

As defined by federal regulatory requirements at 42 CFR 483.13(c), and the current statutory definitions specified within Minnesota Statutes, §626.5572, the preponderance of evidence indicates that **neglect did occur** in connection with the allegation that Resident #1 was neglected during the night shift of January 9, 2010 when his oxygen saturation rate was noted to be 77% at 1:30 a.m. Although the resident's respiratory status did not improve with suctioning, no other interventions were provided and the resident was found not breathing at 1:45 a.m. Employee (B)'s version of the events of 1/9/2010 have been inconsistent each time she has written or been interviewed about it. Employee (B)'s version of the events also do not match the statements of the other staff members who were working that night.

- Employee (B) initially documented that she checked Resident #1 at 1:30 a.m. and suctioned him with no change noted. There is no documentation of any vital signs taken, any calls made to the resident's physician or any further intervention attempted. She then documented that at 1:45 a.m. she "came to suction patient" and was unable to get an oxygen saturation level.
- Although in the late entry note, written 5 days later, Employee (B) documented that she stayed with the resident at 1:30 a.m. and asked another staff member to call Resident #1's physician, no staff member remembers Employee (B) asking them to call Resident #1's physician, in fact Employee (E) believes she asked Employee (B) if she should call the physician and Employee (B) told her no, but to call the family. Since Employee (B) was her supervisor, she did not know what to do.
- During the internal investigation, Employee (B) stated she suctioned the resident at 1:00 a.m. with his oxygen saturation going up to the 80% range, left him for 45 minutes and came back to find him not breathing.
- During the interview for this report, Employee (B) stated that when she entered Resident #1's room at 12:45 or 1:00 a.m., he was not breathing and had no pulse, which does not agree with any other staff members version of the events, or either set of nursing notes that she generated.

The other nurses interviewed all were aware of what to do if a resident with a tracheostomy does not respond to suctioning, including calling 911 to get immediate assistance.

The "mitigating factors" in Minnesota Statutes, §626.557, subdivision 9c (c) were considered and it was determined that Employee (B) is responsible for the neglect. Although Employee (B) had training as a nurse, and had cared for residents with similar conditions before, she did not follow standard nursing judgment when she did not intervene appropriately to care for Resident #1 when he developed respiratory distress. The Employee will be notified of the right to request reconsideration and/or appeal the maltreatment finding. The facility was found to be in compliance with federal regulations and, therefore, no deficiencies were issued.

xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Board of Nursing
Hennepin County Medical Examiners
Hennepin County Attorney
St. Louis Park City Attorney

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: 245187	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/23/2010
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NAME OF PROVIDER OR SUPPLIER TEXAS TERRACE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426
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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 complaint H5187044. No deficiencies are issued.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.