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Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:

Robbinsdale Rehab and Care Center
3130 Grimes Avenue North
Robbinsdale, MN 55422
Hennepin County

Report #: H5417140

Date: 8/4/2009

Date of Visit: 1/26/2009

Time of Visit: 8:30 a.m.

By: Jolene Bertelsen, 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. On 12/27/2008, resident #1 was found by a visitor to have several deep scratches on her left shin, just above her foot, that had become infected. Staff should have noted these wounds as she has cream applied to her legs every day for her neuropathy. The wounds required an antibiotic. Resident #1 is often found with sugar packets which may compromise the care of her diabetes.

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; the facility's internal investigation; staff schedules and assignments for December 2008 and January 2009; policies and procedures in regard to the Vulnerable Adults Act. A tour of resident #1's unit was conducted and observations of staff and resident interactions. Several residents and facility staff were interviewed during the course of the investigation.

Medical Record:

According to her care plan, resident #1 is alert and oriented, has short term memory loss, and modified independence in her decision making. She requires assist, as needed, with her activities of daily living, and is independent in her mobility.

An e mail sent to the facility on 2/4/2008 by a family member identified concerns that need to be addressed at the facility for resident #1. The concerns included "hoarding" which is a major issue that needs to be addressed at the facility. She needs rigid boundaries, and a system set up to prevent her

hoarding. The email also documented phone numbers for family including home, work, and cell phone numbers, phone numbers for resident #1's social worker, his assistant, and a number the social worker can be reached when not at work. The email also documented an email address for the family.

Interviews:

Individual (H) was interviewed on 1/28/2009 at 1:18 p.m. and stated the following:

- Resident #1 was admitted to facility on 1/30/2008. On 2/20/2008, the initial care conference was held. Individual (H) expressed concerns regarding "hoarding things" He stated that she needs strict boundaries for her hoarding, and what she can and cannot have in her room." He also felt that her diet and blood sugars needed to be monitored more closely.
- An email was sent to the facility in May regarding concerns of lack of supervision. Resident #1 was not eating appropriately, her room was always unkempt, and the clock on the wall was blinking the wrong time for over a month. "She was not being supervised. We found open sugar packets on the floor in her room, on a regular basis."
- He was notified in May of a scheduled care conference; he was unable to attend and emailed the social worker to set up another time for the conference. He was never contacted by the facility for a different date for the conference.
- When he visited the facility in November, there were urine stains, and opened sugar packets on the floor in her room, and she was dressed inappropriately. He felt that a care conference was needed. He stated that there was not a conference from 2/20/2008 to now 11/2008.
- He contacted the social worker several times, and a conference was not scheduled until 12/23/2008. When concerns were expressed at the conference, the social worker stated "your mom slipped through the cracks." It was discussed at the care conference that resident #1 is not independent, and is not able to dress herself appropriately. He stated that the facility staff expected resident #1 to be more independent that she was able. He emphasized that there were no notes from the social worker in regard to resident #1 for six months.
- On a 12/27/2008 visit, resident #1 complained of pain in her legs, and they were "very red." He had to bring it to the attention of the staff how red and painful resident #1's legs were. The nurse assessed her legs and then called the physician. She was started on antibiotics for possible cellulitis.

Individual (K) County Social Worker was interviewed on 3/3/2009 at 9:17 a.m. and stated the following:

- He stated that resident #1 was transferred to the facility from another facility. The expectations of her care were discussed including: incontinence, problems with her feet, and problems with pain, hoarding issues, falling, and some memory problems.
- He expressed that resident #1 is not independent in toileting. She is able to dress herself, but needs assistance to dress appropriately. He noted that he was at the facility shortly before she was discharged, and resident #1 had on clothes where one of her breasts was showing, and he suggested to staff that they put some appropriate clothes on her.
- Over last couple of years resident #1 has been deteriorating, and she has now been diagnosed with dementia. He mentioned to the staff at the facility to have her evaluated for dementia, he did not believe this was done. When she was transferred to her new facility in 2/2009, she was evaluated, and placed on a dementia unit.
- He was never invited to a care conference at the facility. He stated that because he is the County Social Worker, he should be getting something in the mail, or a phone call to let him know of a scheduled care conference. He stated that he never received a call or a letter from the social worker at the facility

- He was not aware of the issue of resident #1 spreading shampoo or other things on her legs. "If we had care conferences, we could relay concerns back and forth."
- Her room was "filthy," it smelled like incontinence. There were hoarding issues at the previous facility, but her room was "orderly." He stated that if they had issues with her room at the previous facility, they would call, and we would come a help her get rid of things. He never received a call from this facility. He stated that it was an "overall feeling of general disregard" for resident #1.

Employees (A) and (B)/Administrative Staff were interviewed on 1/26/2008 at 9:00 a.m. and stated the following:

- Resident #1 has a history of taking sugar packets from the dining room, and eating the packets of sugar. She will grab a handful of the packets and is resistive when staff tries to get them back. She is a diabetic, and her Hemoglobin A1C (identifies the average plasma glucose concentration over a period of time) was checked. Her hemoglobin A1C was noted to be 6.8% on 11/13/2008 (normal range is less than 7 %.)
- Resident #1 is always scratching at her legs. She has lotion ordered two times a day

Employee (M)/Nursing Assistant was interviewed on 4/9/2009 at 3:49 p.m. and stated the following:

- Resident #1 would take off her brief, and go to the dining room, and she would sit down, and urinate. Resident #1 "didn't realize" that she was urinating or that she was even wet. She was wet two to three times a day. She would frequently change her clothes five times before breakfast, and frequently change her briefs. Her bed was soaked every night, because she would also take her brief off in bed.
- Resident #1 would go into the dining room, and take sugar packets. She would go into the bathroom, and empty the sugar packets into her mouth. She stated that this occurred daily.
- The housekeeper would go in daily and clean her room, and the resident #1 would go into the room and "mess it up." She stated that this was daily also.
- Resident #1 was not able to make decisions. She would go into other rooms and take watches and earrings, and we would find them in her room. Resident #1 would state that another resident gave it to her. She stated that this occurred "once in a while."
- She kept scratching her legs, and the sugar would get into her foot sometimes, and she would complain they itched. She was always scratching at her legs.

Employee (D)/nurse was interviewed on 1/26/2008 at 9:30 a.m. and stated the following:

- Resident #1 was alert, confused, and "liked to believe she was independent." She was hard to redirect, and "she liked to make her own decisions." She stated that resident #1 did not make "appropriate decisions." She required assistance with toileting, and she received assistance in the morning with basic activities of daily living. She has a history of changing her clothes three to ten times a day.
- The sugar packet incidents were frequent. She liked to go into the dining room, and she would take the sugar packets, and didn't like to give them back. Resident #1 would open the sugar packets, and eat them at the table. It was usually an exchange of cereal for the sugar packets that would work, but a lot of times that was not effective. The dietician was involved, and did request a prealbumen, the physician declined the lab draw.
- Resident #1's legs were always discolored. She had a lot of irritation with her lower extremities.
- She had cream ordered, but she was always scratching them. She stated that staff would frequently find her rubbing anything she could get a hold of on her legs--like shampoo or bar

soap. She was "obsessive" with putting something on her legs everyday, and scratching her legs. She stated that resident #1 never complained about pain in her legs.

- She did not note swelling in resident #1's legs, but she had a lot of surface scratches. She was started on Keflex in December, for "presumed cellulitis." Resident #1 had neuropathy, and she was obsessed with her legs. Her legs have been painful and discolored since admission.

Employee (G)/nurse was interviewed on 1/28/2009 at 12:53 p.m. and stated the following:

- On 12/27/2008, a family member asked her to look at resident #1's legs. She stated that they were very red. The family stated that she was complaining of pain, and that her legs itched. Her legs were warm and painful to the touch. The physician was notified, and an antibiotic was ordered. She stated that resident #1 always complained of leg pain.

Employee (I)/nurse was interviewed on 2/4/2009 at 3:17 p.m. and stated the following:

- Resident #1 "hoarded" sugar. "She did this the whole time she was at the facility." She stated that they would hide the sugar in the dining room, but during meal time they put the sugar down so the other residents would have access to it.
- Resident #1 had cellulitis, and her legs were scabbed. It wasn't long before she left (unsure of dates) that she was placed on an antibiotic. It came on "pretty suddenly." She stated that staff does skin checks on shower days.

Employee (C)/ Social Worker was interviewed 1/26/2009 at 10:20 a.m. and stated the following:

- The social worker informs the primary contact person of scheduled care conferences upon admission, quarterly, significant change, and at family request. She stated that she will contact the primary contact person, to let them know of a scheduled care conference. She stated that she may try to contact them a few times, and will call them after the care conference, if they do not attend.

Employee (J)/social worker was interviewed on 2/10/2009 at 12:25 p.m. and stated the following:

- The MDS triggers to schedule care conferences quarterly. The social worker will call the family members or whoever the resident would like invited to the care conference. The care conference is documented in the progress notes in the social service section of the chart.
- The contacts are made by phone to the families. The case worker should be included in the process, and invited to the conference.
- At the end of November, she received a letter stating that a care conference hadn't been done in awhile, and we needed to have a conference scheduled. The family was frustrated about the lack of communication and that a care conference had not been held for months. She stated that the family had nursing concerns, and concerns regarding the lack of communication.

Weekly skin assessment documentation indicated that resident #1 has weekly skin assessments scheduled for Monday evenings. An assessment was initiated on 12/1/2008, no initials on 12/8-12/15-12/22/2008, and initials indicating she refused a skin check on 12/29/2008.

- Resident #1 had Capsaicin cream ordered twice a day and documentation indicated that she received the cream every AM except 12/27/2008, and every evening except 12/12, 12/13, 12/19, 12/21, 12/24, and 12/29/2008. She also had Capsaicin cream ordered, as needed, and documentation that she received the as needed cream on 12/13 and 12/14/2008 for the month of December 2008.

- In January 2009, resident #1 did receive the Capsaicin cream two times a day from 1/1/2009 through 1/12/2009. She did not receive any as needed cream. Her weekly skin assessments documented that she refused a skin assessment on 1/5/2009 and no initials for 1/12/2009.

Social work notes document an assessment on 2/21/2008, and the next assessment was on 8/12/2008 which documented that "multiple attempts to have family meet for a care conference with (resident #1) with no response." The notes document that family did not respond in May or August. Notes dated 9/2008 document that "no contact with family this month."

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 of healthcare did occur** in connection with the allegation that resident #1 was not assessed properly by the facility, care conferences were not held on a regular basis, and her issues of "hoarding" (including sugar packets) were not addressed with specific interventions in place. She was also noted to have painful lower extremities, and would spread lotion, shampoo, etc on her legs to relieve the pain. Resident #1 had issues with incontinence, room cleanliness, and again, the facility did not have specific interventions in place so each staff is aware of how to address these behavioral issues.

In addition, the facility failed to evaluate resident #1 for a recent dementia diagnosis, and there was sufficient evidence to document that care conferences were not held on a regular basis.

During the course of this investigation, a re-certification survey was completed by MDH Licensing and Certification staff. Violations noted during that survey included: resident comprehensive assessment, notification of changes, dignity, housekeeping, urinary incontinence, sanitary conditions, quality of care, quarterly review assessments, and specific needs of the residents. The deficient practices identified during the investigation of resident #1's care were related to the same violations, therefore no federal deficiencies or state orders will be issued connected to this specific investigation.

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

xc: Division of Compliance Monitoring - Licensing & Certification

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

PRINTED: 08/11/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245417	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/04/2009
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NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422
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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 H5417140. No deficiencies were issued.</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.