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Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:

Benedictine Community Living
1907 Kline Street
St. Peter, MN 56082
Nicollet County

Report #: H5501007

Date: April 27, 2009

Date of Visit: November 12, and 13, 2008
Time of Visit: 2:30 PM and 8:15 AM

By: Laurel Baumann, 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 §626.557 and state nursing home licensing rules, Chapter 4658.

The allegation is: Neglect occurred when, on September 8, 2007, resident #1 fell while being transferred by one staff without a transfer belt, instead of two as stated in her care plan. This fall resulted in a skin tear on her arm which required 23 staples to close the wound. On October 6, 2007, staff noted that the resident's buttock was bruised and she was sent to a hospital ED for evaluation. Later, during another transfer, the resident was "dropped" by staff into her wheelchair. On the morning of October 7, 2007, the resident was sent to the ED when staff was unable to arouse her. The resident was given transfusions in the hospital but she passed away later.

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 the medical record of resident #1
- Review of incident reports for resident #1 from April 2007 to October 2007
- Review of the facility's internal investigations of the incidents causing injury to the resident's arm and bruising of her hip
- Review of staff education on resident transfers
- A tour of the resident's former room and adjacent bathroom
- Interviews of staff and other key individuals
- Review of a DVD of a conference held on 2/12/08 [there was no audio portion to 50% of the DVD]

Medical Record: The medical record of resident #1 was reviewed and identified the following information:

- Resident #1 was admitted to the facility on 2/19/2007 with multiple diagnoses that included Heart Disease with a history of Congestive Heart Failure and Atrial Fibrillation, Pernicious Anemia, Stage III Chronic Renal Failure, Rheumatoid arthritis, Osteoporosis and Peripheral Vascular Disease. Resident #1 was ninety two years of age.
- The Minimum Data Set Assessment [MDS] dated 9/23/07 identified that resident #1 had some short term memory problems. She required staff assistance to meet her activity of daily living and mobility needs.
- Resident #1 experienced a fall on 9/8/07. When the fall occurred, the facility's internal investigation identified that the resident was transferred according to her care plan with the assist of one and a transfer belt. Following this incident, she was reassessed by physical therapy and it was determined that she should be transferred with the assist of two.
- Resident #1 was on the medication prednisone daily related to her rheumatoid arthritis, which may contribute to thin, fragile skin. Her care plan identified her to have the potential for skin breakdown with interventions in place.
- Resident #1 was also on Aspirin 325 mg. daily related to her disease process, which can predispose an individual to bruising more readily.¹
- Resident #1 was treated for severe stasis dermatitis on her legs, which was initiated on 9/13/07. This condition is caused by chronic venous insufficiency and usually coexists with edema, a brown stain like rash and dilation of superficial venules around the ankles. This dermatitis can be accompanied by itching, which may cause open areas when scratched.²

Incident #1:

- At approximately 8:15 PM on 9/8/07, resident #1 was being assisted by individual (H)/NA [supplementary agency staff] to ambulate to the bathroom to get ready for bed. A transfer belt was in use. The resident was using a walker. This transfer was in accordance with the care plan in effect on 9/8/07. When resident #1 became weak, individual (H) grabbed her by the transfer belt and arm to prevent the resident from falling.
- Individual (H) was interviewed by this investigator on 11/20/08 at 12:35 PM. She stated she was familiar with resident #1's care plan when she cared for her on 9/8/07. She chose to grab the resident's arm when the resident's knee gave out, to prevent the resident from hitting her head. She verified that she used a transfer belt.
- When the charge nurse entered the room after being summoned by individual (H), resident #1 had a transfer belt on.
- Resident #1 sustained a large skin tear on her the inner aspect of her upper right arm.
- Resident #1 was sent to the emergency room the evening of 9/8/07 where she was treated with multiple staples to the wound. She returned to the facility at 11:15 PM on 9/8/07. Individual (H) did not return to the facility to work again after 9/8/07.
- The facility reported this incident/injury according to state and federal law.
- The wound to her arm was treated with daily dressing changes. She was seen by a wound care specialist. The progress note authored by the wound specialist, dated 9/25/07 states, "Pt's skin tear is almost completely resolved....."

Incident #2:

¹ Nursing 2008 Drug Handbook

² The Merck Manual of Geriatrics, pp.1264

Documentation review and interviews established the following:

- At approximately 9:45 PM on 10/6/07, the nurse on duty was called to the room of resident #1 because the resident was complaining of pain in her right hip. Documentation states that an eight cm. [centimeter] area of bruising and swelling was noted that was tender to touch. There is no indication that resident #1 was able to say what happened.
- The resident's physician was notified and ordered that resident #1 be transported to the emergency room for evaluation.
- The resident's hip was x-rayed and was negative for a fracture. She was diagnosed with a right hip contusion [bruise] and a right hip hematoma. The resident's hemoglobin was also noted to be 8.7 [normal female range 12-16] during her visit to the emergency room. Her hemoglobin on 9/3/07 had been 10.1, and the physician's order was that it should be re-checked in 24-48 hour following the ER visit on 10/6/07.
- Resident #1 returned to the facility at 11:30 PM. The nursing assistants on duty at the time of resident #1's return transferred her from the gurney to her wheelchair. During this transfer, the resident had a brief lapse of unresponsiveness with some jerking movement. Employee (F)/nurse was summoned to the resident. Resident #1 was transferred from the wheelchair to her bed and was able to respond verbally. Her vital signs were within normal limits. [B/P 128/58, T-97.2° F P-58 R-20] Family was with her.
- At 12:30 AM on 10/7/07, resident #1 complained of stomach discomfort and was given Mylanta. She slept the remainder of the night.
- At 8:15 AM on 10/7/07, the day staff attempted to awaken resident #1. She was noted to be breathing heavily and did not respond verbally. Her color was poor and she had some jerking movements. Her temperature was slightly elevated at 99.7, P-58, R-22, and B/P-112/46. Resident #1's oxygen saturation level was low at 75%. Oxygen was started, the physician was called and resident #1 was transported to the hospital at 9:00 AM on 10/7/07.
- Resident #1 was diagnosed with urosepsis. She died on 10/10/07.

The facility conducted an internal investigation and the following was identified:

- Individual (G)/NA provided bedtime care for resident #1 the evening of 10/6/07, around 8:00 PM. She was interviewed by employee (E)/nurse that same evening. Individual (G) admitted to employee (E) that she had transferred resident #1 alone. The care plan in effect on 10/6/07 directed that resident #1 was to be transferred with the assist of two. She denied that anything unusual happened during the transfers and said she did use a transfer belt for the transfers. Individual (G) said she did not leave resident #1 alone at any time during bedtime cares.
- Individual (G) was interviewed by employee (D)/LSW on 10/9/07. Individual (G)'s account of the evening of 10/6/07 was consistent with her original story given to employee (E) on 10/6/07. She told employee (D) that the transfers went "real good." Individual (G) also added that resident #1 told her that her hip hurt, but she did not see any bruising when she was assisting her with cares.
- There is no evidence that the bruising was observed prior to 9:45 PM on 10/6/07, when the nurse was summoned to look at resident #1's right hip.
- Individual (G) was a past employee of the nursing home. On 10/6/07, she was working at the nursing home as an employee of a temporary staffing agency. Individual (G) did not work at the nursing home again after 10/6/07.
- The injury of unknown origin was reported in accordance with state and federal law.

The following interviews were conducted during the course of this office's investigation, which was initiated on 11/12/08 with an onsite visit at the nursing home:

Employee (E)/nurse was interviewed on 11/20/08 at 10:30 AM and stated the following:

- She spoke to individual (G) after the bruise was discovered the evening of 10/6/07, in an attempt to determine what had happened. Employee (G) told her that she had used a transfer belt to transfer resident #1 and denied that there were any problems with the transfers.
- Individual (G) was a "good person."

Employee (C)/NA was interviewed on 11/13/08 and stated the following:

- She answered the resident's light the evening of 10/6/07 [around 9:45 PM] and found resident #1 to be in significant pain. She noted that there was bruising on resident #1's right hip.
- She proceeded to summon the nurse to check the resident.
- She worked with individual (G) before she started working as an agency staff person. She didn't believe that individual (G) would ever intentionally hurt a resident.

Employee (D) was interviewed on 12/1/08 at 8:30 AM and stated the following:

- She conducted the internal investigation related to the bruising on resident #1's right hip.
- She questioned if something may have happened when individual (G) transferred resident #1 the evening of 10/6/07, but was not able to prove anything. She thought possibly that resident #1 may have sat down hard on the toilet.
- Individual (G) said she used a transfer belt when she transferred the resident. It was her [employee D] opinion that individual (G) was telling her the truth.

Individual (G)/NA, was interviewed by this investigator on 11/25/08 at 4:00 PM and stated the following:

- She provided bedtime care for resident # on 10/6/07.
- She used a transfer belt for the transfers. She knows that she did not hurt the resident.

Employee (F)/nurse was interviewed on 11/19/08 at 7:30 AM. A second interview was conducted on 3/3/09 at 7:10 AM, for purposes of clarification. She stated the following:

- She worked the overnight shift on 10/6/07-10/7/07. She was not present when the nursing assistants transferred resident #1 from the gurney to the wheelchair when the resident returned from the emergency room. She heard a commotion and went to the scene immediately. Resident #1 was unresponsive. The resident was then transferred to her bed.
- She believed the resident's episode of unresponsiveness was related to her position change from lying to sitting. The resident responded quickly once in bed, she spoke in her usual manner and her vital signs were within normal limits.
- Once the resident was sleeping, she looked in on her several times during the night and observed her respirations to be regular. She did not awaken her to check her vital signs because she felt she needed to rest after being transported to and from the emergency room and she recalled the family stayed very late.
- She did not have any report that resident #1 was dropped during her transfer from the gurney to the wheelchair.

Physician (J)/primary physician was interviewed on 11/21/08 at 11:50 AM and stated the following:

- Resident #1 was on Prednisone for a long period of time related to her diagnosis. She was also on Aspirin. Prednisone is notorious for causing bruising. It makes the skin very thin, so even taking someone by the arm can cause a bruise.

- She recalls seeing resident #1 with bruises often when she would visit her. She never considered the bruising to be related to any kind of maltreatment.

Interviews with individuals (I) on 11/19/08 and (K) on 11/20/08, family members of resident #1, verified the concerns as reflected in the allegation.

Conclusion:

As defined by federal regulatory requirements at 42 CFR 483.13(c), and the current statutory definitions specified within Minnesota §626.5572, the preponderance of evidence indicates that **neglect did not occur** in connection with the allegation that resident #1 fell on 9/8/07 because the nursing assistant was not following the care plan. Individual (H) was transferring the resident according to the care plan in place at the time the incident occurred. Resident #1 had very fragile skin. Individual (H) took hold of the resident's arm when the resident began to fall, in an effort to prevent more serious injury. This action resulted in a large skin tear. The facility intervened with appropriate treatment.

Neglect is inconclusive as it relates to the allegation that the bruise and contusion sustained by resident #1 were related to maltreatment. Individual (G) admittedly transferred resident #1 alone, which was not in accordance with the care plan in place on 10/6/07. She denied, however, that she had any problems with the transfers. There were no witnesses of maltreatment occurring on the evening of 10/6/07. Resident #1 had a propensity for bruising easily, related to medication that she was taking. It is not known what trauma may have caused the bruising and hematoma on the resident's right hip. Resident #1, who had a diagnosis of chronic renal failure, was hospitalized on 10/7/07 and was diagnosed with urosepsis, which is a urinary tract infection that has become systemic. According to hospital records, the family chose comfort measures only, and resident #1 died on 10/10/07. Therefore, there is less than a preponderance of evidence to show that maltreatment did or did not occur.

No federal or state deficiencies were issued related to the investigation. Appropriate transfer techniques were reviewed with the nursing staff during an inservice on 10/24/07.

xc: Division of Compliance Monitoring - Licensing & Certification

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: 245501	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/03/2008
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NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1907 KLEIN STREET ST PETER, MN 56082
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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 complainant #H5501007. No deficiencies were noted.</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.