Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Presbyterian Homes of Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, Minnesota 55112
Ramsey County

Report #: H5424024

Date: January 14, 2009
Revised February 11, 2009
Revised: May 8, 2009

Date of Visit: June 2, 2008
Time of Visit: 7:40 a.m.

By: Diane Williams, 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 April 16, 2008, resident #1 complained of a severe headache. The following day she had episodes of vomiting as well as a severe headache. On April 19, 2008, staff noted a large raised area on the back of the resident's head and the resident complained of lethargy. She was transferred to a hospital where a cervical (C2) fracture was diagnosed. Bruising was noted on the resident's back, arms and thumbs. The facility indicated there was no evidence that the resident had fallen. The resident returned to the facility, was enrolled in a hospice program, and expired a short time later.

Investigative Findings:
All employees and persons were interviewed in private as desired and given the Tennessen Statement.

During the course of the investigation, the following was reviewed: resident #1's medical records from the facility and the hospital; five additional medical records; facility policies and procedures in regard to the Vulnerable Adults Act; documentation guidelines for acute illness and injury, and fall risk data collection; the facility's internal investigation file; staff schedules and assignments for April 13, 14, 15, 16, 17, and 18, 2008; bathing schedules for the weeks of March 31, April 7, and April 14, 2008; incident and accident reports from second floor North for March, April and May, 2008; and inservice records for the facility's Vulnerable Adults Act training.

Resident #1's medical record was reviewed and established the following:
Resident #1 was admitted to the facility in August, 2006. A dictated note from resident #1's physician, dated March 6, 2008, indicated that resident #1 had advanced osteoarthritis of her knees, shoulders, and ankles, with impaired gait and general skeletal failure. The note indicated that resident #1 had not

walked for some time, required assistance with transfers, had no recent falls and was occasionally resistive with cares. An assessment, dated March 17, 2008, indicated that resident #1 had short and long-term memory loss. A resident assessment protocol (RAP) summary, also dated March 17, 2008, indicated that resident #1 was able to participate in turning and repositioning in bed with the use of both upper half side rails but needed staff reminders and assistance. The RAP summary indicated resident #1 could walk with a wheeled walker and assistance but was resistive when staff attempted to walk her. She could propel her own wheelchair short distances but usually told her husband to push her wheelchair. She required assistance with other activities of daily living. The plan of care, dated March 24, 2008, indicated she had a low bed and a sensor alarm in her wheelchair. A note written by the nurse practitioner, on April 2, 2008, indicated that staff reported that resident #1 was hitting, kicking, and screaming with all cares. The resident had no agitation or behavior problems when cares were not being administered. The note indicated that family member (T) volunteered to come in to help resident #1 with baths, the facility would try to provide female caregivers and facility staff would work on approach.

The first documentation in the interdisciplinary progress notes, in regard to the injury, was written by employee (F)/nurse, on April 17, 2008 at 1:00 p.m. The entry indicated that resident #1 complained of a "right stiff neck" and headache "once up" for breakfast. A cold pack was administered and she was given Tylenol. After breakfast she wanted to go back to bed. She refused lunch. She "felt better" lying in bed. The next entry, written by employee (F) on April 18, 2008, at 9:45 a.m., indicated that the resident said her neck was still sore, and she had an emesis while at the table. Individual (W)/nurse practitioner was notified and orders for a warm pack and Tylenol were given. The progress notes written by employee (X)/nurse, on April 18, 2008 at 8:50 p.m., indicated that while eating supper, resident #1 complained of a headache and not feeling well. Vitals signs were taken and were within normal limits. Progress notes written by employee (E)/nurse, on April 19, 2008, at 11:30 a.m., indicated resident #1 had a "swelling and bruise" measuring 10 by 7 centimeters on the left side of her head and she had a bruise on her right thumb. The progress notes indicated resident #1's oxygen saturation level was 86% on room air. Oxygen was administered. The resident complained of a headache. The resident denied falling or bumping her head. A neuro-check flow sheet, dated April 19, 2008, indicated that at 11:00 a.m., resident #1 was alert, her hands grips were equal, and her right pupil was reactive to light. The resident's pulse was 105. An on-call nurse practitioner was notified and gave an order to send the resident to the hospital. At 12:45 p.m., resident #1 was transported to the hospital.

The hospital emergency room (ER) records indicated that resident #1 complained of neck and head pain and pain in her thumb (doesn't say which thumb). The ER note indicated the nursing home staff suspected a fall, resident #1 did not recall falling, and resident #1 had a contusion on the back of her head. The examination revealed a left scalp hematoma and "various healing contusions" on her arms. Resident #1 could not say what caused the bruises. A computed tomography (CT) scan of resident #1's head indicated a left parietal and occipital scalp hematoma "minimally present." There was no acute intracranial hemorrhage. The CT scan of resident #1's cervical spine indicated that the resident #1 had "fractures of the bilateral C2 pedicles and posteroinferior aspect of the C2 body, consistent with a hangman's fracture, with generalized osteoporosis and multilevel degenerative change of the cervical spine." Family members, in consultation with physicians, decided against surgical intervention. The resident was treated with a cervical collar. Hospital records indicated staff had difficulty keeping the collar on (related to resident #1's dementia).

Resident #1 returned to the facility on April 20, 2008 at 5:00 p.m. The re-admission assessment, completed by employee (Z)/nurse, indicated resident #1 had purplish-yellowish bruises on her right mid back, her left and right thumb, and her left forearm and hand. A note written by individual (W)/nurse

practitioner, indicated that resident #1 was examined on April 21, 2008, and found to have a raised lump on the left side of her head with a purple bruise over the lump, the resident's right thumb was bruised, the resident had multiple bruises on her forearms and the resident had a bruise on her left back.

Resident #1 experienced a steady decline and expired on April 29, 2008. The death certificate indicates that resident #1 died of hypertensive cardiovascular disease with other contributing factors of osteoporosis and a C2 neck fracture.

***Internal Investigation*:** During interviews conducted by the facility's administrative staff, two registered nurses and two nursing assistants stated that resident #1 was "fine" on the evening shift of April 16, 2008. Employee (S)/nursing assistant, who worked the night shift, stated that nothing unusual happened during the night and the resident did not experience any trauma. Employee (J)/nursing assistant stated that resident #1 complained of pain while her hair was being combed during the morning of April 17, 2008.

Interviews:
Employee (J) was interviewed on June 2, 2008, at 1:20 p.m. and June 13, 2008 at 10:50 a.m., and stated that, prior to injury, resident #1 would stand but she wouldn't walk. When he combed resident #1's hair on April 17, 2008, between 8:30 a.m. and 9:00 a.m., he did not notice any bruises or "lumps." The resident was complaining of pain in her head, not her neck. He did not think the resident was capable of getting herself up off the floor. He did not think resident #1's husband could lift her.

Employee (F)/nurse was interviewed on June 5, 2008 at 11:00 a.m., and stated that on the morning of April 17, 2008, resident #1 complained of a stiff neck on her right side and a headache. Employee (F) did not see "anything" (no bruises or bumps) where the resident indicated she had pain. Employee (F) stated that resident #1 had an emesis after breakfast on April 18, 2008. The resident repeated, "My neck, my neck." Employee (F) notified individual (W)/nurse practitioner. Employee (F) did not notice any "bumps" on resident #1's head prior to the resident's hospitalization. She thought the resident's fracture was acquired by the resident losing her balance, tipping over, and striking her head on the headboard of her bed.

Employee (Q) was interviewed on June 24, 2008 at 1:10 p.m., and stated that when he was combing resident #1's hair on the morning of April 19, 2008, he found a "bump" on her head. He could tell by the expression on resident #1's face that she was in pain. He brought the resident to employee (E).

Employee (E)/nurse, who worked the day shift on April 19, 2008, was interviewed on June 2, 2008 at 2:35 p.m., and stated that when employee (Q) found an area on resident #1's head (on April 19, 2008) the area looked purple, with yellow bruising around the area, towards the top and side of resident #1's head. Resident #1 complained of pain in the head and neck area. Employee (E) called the on-call nurse practitioner who gave an order to send the resident to the hospital.

Employee (Z) was interviewed on August 13, 2008 at 2:45 p.m. and stated that she did not assess resident #1 before she was hospitalized. She completed an assessment when resident #1 returned from the hospital. Employee (Z) noted that resident #1 had several "old" bruises. There was a purplish bruise on the back of her head that was a little raised. She was uncertain of the dimensions of the bruise. There was a purplish bruise approximately 5 x 6 centimeters on the resident's right mid back. There were bruises on the resident's left and right thumbs that were yellowish. The bruises were in the middle of her thumbs and were approximately 3 to 4 centimeters long and were not raised. The resident's thumbs were

not swollen. The resident also had bruises on her left and right arm that employee (Z) thought were from intravenous therapy.

Employee (R) was interviewed on June 24, 2008, at 1:30 p.m., and stated that, in the past (prior to the injury), he had witnessed resident #1 trying to stand from a sitting position in her wheelchair. Her husband was trying to help her as she wanted to use the bathroom. He and another staff person helped resident #1 use the bathroom.

Employee (I) was interviewed on June 5, 2008 at 3:40 p.m., and stated that when staff sat resident #1 on her bed she would tip backwards if they were not holding onto her. In the past, employee (I) has witnessed resident #1 adjusting her television while she was standing. Employee (I) stated that the resident must have gotten out of her wheelchair by herself as no staff person had assisted her to stand. Resident #1's husband always wanted to help her. The resident often called out for her husband to help her. Employee (I) has witnessed resident #1's husband get out of his bed, walk over to resident #1's bed and reach out to try to help her. She has not witnessed resident #1's husband providing "hands on" cares to the resident. Employee (I) stated she thought resident #1's injury was acquired by her hitting her head on the side rail.

All employees [(A) through (S)], when interviewed by the investigator, stated they did not know how resident #1 sustained her fracture. They stated resident #1 often told her husband (they resided in the same room) to help her. He often pushed the resident about in her wheelchair.

Family member (T) was interviewed on June 10, 2008 at 1:15 p.m., and stated that resident #1 was "fine" when other family members visited with her on April 15, 2008 between noon and 1:00 p.m. Family member (T) did not think any family members visited resident #1 on Wednesday, April 16, 2008. Resident #1 was complaining of neck pain and a "bad headache" when she visited her the morning of Thursday, April 17, 2008. The resident complained of "horrible" pain with movement of her head and neck. The resident normally complained of shoulder pain but not headaches. Resident #1 was "screaming" in pain when she visited the resident the morning of Friday, April 18, 2008. She noticed the resident #1's hair was "nice and clean." The resident's usual bath day is Sunday. Family member (U) visited the resident on Friday evening, April 18, 2008. He said that resident #1 screamed with movement of her head. On Saturday, April 19, 2008, family member (T) received a phone call from the facility. She was informed that resident #1 had a "bump" on her head, her vitals signs were not normal and facility staff had called an ambulance. The resident was taken to the hospital emergency room. She and family member (U) went to the hospital. It was determined that resident #1 had a neck fracture. The emergency room physician felt resident #1 had been injured earlier in the week. She and family member (U) were told that the resident's neck fracture could "only happen" with a fall or a blow to the head. (Note: According to the Wikipedia, an encyclopedia, the mechanism of the injury for a C-2 hangman's fracture is "forcible hyperextension of the head," usually related to sports injuries, traffic accidents, or hanging). After the incident, family member (T) was given information by a neighbor that a staff member on third floor "heard" that there was an incident in the bathroom that resulted in resident #1's injuries. Family member (T) was reluctant to divulge the name of the staff member; consequently, the investigator was unable to follow-up on the information.

Family member (U) was interviewed on June 10, 2008, at 3:30 p.m., and stated that he first noticed bruising on resident #1's arms in March, 2008. According to a journal entry, given to the investigator by family member (U), when family members (T) and (U) visited resident #1 on March 16, 2008, they noticed bruising on resident #1's arms. Due to the size and location of the bruises, they immediately

wondered if resident #1 had been mishandled by staff. Family member (T) asked resident #1 how she acquired the bruises. The resident stated that "these bad people take me in the hallway and they beat me." When a staff member was asked about the bruises, she claimed that resident #1 and her husband (who was resident #1's roommate) were always fighting between themselves. Family members have not witnessed resident #1's husband mistreat the resident. The theory that resident #1 fell and her husband helped her off the floor is "laughable." Resident #1's death certificate indicated she had a bad heart. The resident did not have a bad heart.

Physician (V) was interviewed on July 7, 2008, and stated that resident #1's injury strongly suggested a fall. The resident had a history of imbalance and falls.

Physician (Y)/primary physician was interviewed on July 9, 2008, at 2:10 p.m., and stated that in this situation "we" don't have an explanation for the injury. He has no concerns "at all" about the care provided at the facility. He and/or the nurse practitioner are promptly notified of incidents, even ones without an injury.

Physician (AA)/neurosurgeon was consulted and stated that resident #1 could not have sustained a C-2 significant hangman's neck fracture without experiencing trauma.

Conclusion: ~~As defined by federal regulatory requirements at 42 CFR 483.13 (c), and the current statutory definitions specified within Minnesota Statutes, §626,557, the preponderance of evidence indicates that **maltreatment did occur** when resident #1 sustained a C2 neck fracture.~~ The information obtained during the investigation indicated that resident #1 neck fracture was the result of a traumatic injury. Although the facility's internal investigation and MDH's maltreatment investigation were unable to identify a specific incident, physical assessments and physician interviews ~~indicted~~ indicated that the injury resident #1 sustained could not have occurred without the resident experiencing trauma. Documentation and interviews indicated the following:

- According to family member (T) resident #1 was fine on April 16, 2008 when visited by family members.
- According to medical record documentation and staff interviews, resident #1 began complaining of a stiff neck and a headache on April 17, 2008. Employee (Q) found a "bump" while he was combing resident #1's hair on the morning of April 19, 2008.
- When resident #1's pain continued over the next two days and she had an episode of vomiting, decreased O2 saturation levels and a bruise was noted on the left side of her head, she was sent to the ED for evaluation on April 19, 2008.
- When evaluated at the hospital resident #1 was found to have a significant fracture of her cervical spine, (hangman's fracture and a scalp laceration.
- Physician (V) stated that the injury suggested that the resident fell.
- Physician (AA) stated that resident #1 could not have sustained a C-2 hangman's fracture without experiencing trauma.
- According to the literature reviewed by the investigator, a hangman's fracture is the result of significant trauma such as a sports injury, automobile accident, or a hanging.
- Employees (J) stated that, if resident #1 had fallen, she would not have been able to get herself up from the floor due to her medical condition and resident #1's spouse would not have been able to get resident #1 up due to his medical condition.

Prior to the on-site visit by the investigator, the facility had conducted a thorough internal investigation. The administrative staff conducted interviews in regards to resident #1's injury with direct care, housekeeping and maintenance staff persons. Facility staff were unable to identify the cause of resident#1's injuries (the fracture and bruising.) Facility staff were re-trained on the Vulnerable Adults Act and mandatory reporting. Staff were told that if they witnessed any incident with a resident, they must report it. During the course of the investigation incident/accident reports related to bruising and other injuries were reviewed. The review indicated that the incidents were thoroughly investigated and reported in accordance with state law. Therefore, no federal deficiencies or state licensing orders will be issued.

As defined by Minnesota Statutes, section 626.557, **maltreatment is inconclusive** as it relates to Resident #1's injuries. Although information gathered during the investigation supports the fact that trauma was the cause of Resident #1's serious neck fracture, the investigation was unable to determine whether or not the trauma was the result of maltreatment. Therefore, there is less than a preponderance of evidence to show that maltreatment **did or did not** occur.

xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Board of Examiners for Nursing Home Administrators
Minnesota Board of Nursing
Ramsey County Medical Examiner
Ramsey County Sheriff
~~Roseville Police Department~~
Ramsey County Attorney
Arden Hills City Attorney
~~Roseville City Attorney~~

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

PRINTED: 01/16/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING ____ B. WING ____	C 06/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF ARDEN HILLS	3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112

(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	INITIAL COMMENTS An Abbreviated Standard Survey was conducted to investigate complainant #H5424024. No deficiencies were noted.	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.