



Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:

Stillwater Good Samaritan Center
1119 Owens Street North
Stillwater, MN 55082
Washington County

Report #: H5207026

Date: May 26, 2006

Date of Visit: 11/30/05
Time of Visit: 10:00 a.m.

By: Jaime Hujanen, 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 Statute 626.557.

The allegation is: Resident #1 was in a weakening condition and on August 24, 2005 family was told her platelets were critically low and she would typically have a few weeks to six months to live. She was a known fall risk. On August 30, 2005 she fell from her chair and showed no apparent sign of injury. On August 31, 2005 at approximately 8:50 p.m., family was notified that she had fallen out of her wheelchair in the common area by the TV. She was the only resident that had not been returned to her room. When asked why a resident who was a known fall risk would be left alone in that area, staff acknowledged that she should not have been left there alone. The following morning the resident was found crying because her head hurt so much. She was severely bruised on the whole left side of her face. She was then taken to the emergency room where a CT scan identified bleeding on the outside of her brain. This was unlikely to stop due to the low platelets. She died on September 3, 2005, after going through a lot of pain waiting for the correct dose of morphine to be administered.

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, including the medical record from her hospitalization, the facility's internal investigation, staff schedules and assignments from August 24, 2005 through September 1, 2005, incident/accident reports for July 2005 through November 2005, personnel files and policies and procedures regarding falls, neurological examinations, significant changes and physician and family notification. Observations, resident interviews and staff interviews were conducted. Additional residents' medical records were reviewed.

Resident #1's medical record was reviewed and revealed the following: resident #1 was a long term care resident at the facility and had diagnoses including myelodysplastic disease with pancytopenia (a rare disease which would make resident #1 prone to bleeding), Alzheimer's dementia and osteoporosis. She required staff assistance with all of her activities of daily living and required stand by assistance with all of her mobility needs due to her unsteady gait, forgetfulness and history of falls. The care plan directed staff to

keep a bed and chair alarm (a device to alert staff when a resident attempts to transfer without assistance) on resident #1 at all times. On 8/22/05 physician (E)/resident #1's primary physician, ordered physical therapy for resident #1 to improve her overall strength, per request from the facility. Hospice care was initiated at the facility on 8/26/05 due to resident #1's bleeding disorder and weakening condition.

The facility incident/accident reports and fall records for July 2005 and August 2005 were reviewed and documented the following:

- During the month of July 2005, resident #1 did not have any documented falls or incidents.
- During the month of August 2005 two incidents occurred.
 - On 8/30/05 at 4:00 p.m., employee (G)/nurse documented that resident #1 was found by staff on the floor in her room in front of her wheelchair. She did not sustain any injuries. The action-plan after that incident was to check on the resident frequently and remind her to ask for assistance.
 - On 8/31/05 at 8:30 p.m., employee (C) documented that resident #1 was found lying on the floor after an unwitnessed fall. The report further documented that she landed on her left side, and the left side of her face hit the floor. She was bleeding from a puncture wound "from (her) glasses". Her chair alarm was attached to her shirt at the time of the fall, however "it did not go off". Resident #1's vital signs, neurological status and range of motion were all stable.

Employee (C)/nurse was interviewed on 12/9/05 at 10:17 a.m. and stated the following:

- She was familiar with resident #1 and indicated that resident #1 was unsteady on her feet and was at a high risk for falls. She indicated that resident #1 had a bed and chair alarm in place for safety.
- On 8/31/05, after dinner, resident #1 was in the dining room watching television with a small group of residents. At approximately 7:30 p.m. all the other residents went to their rooms and resident #1 was the only resident in the common area. The common area is a highly visible area by staff and she was able to check on resident #1 frequently because she was in the immediate area.
- At approximately 8:30 p.m. resident #1 was found lying on the floor on her left side. She had a puncture wound to her left eyebrow area that was bleeding and the area was swollen and bruised. Resident #1's vital signs, neurological status and range of motion were stable. She called resident #1's family and physician and notified them of the fall. The on-call physician directed the facility staff to monitor resident #1's condition, call with any changes and notify physician (E) in the morning.
- On 9/1/05 at approximately 1:30 a.m. she indicated that a nursing assistant (unknown name) notified her and employee (D)/nurse at the nursing station that resident #1 vomited in her room. They found that resident #1 had vomited a small amount (few tablespoons) of "greenish liquid".

Employee (G)/nurse was interviewed on 2/15/06 at 10:23 p.m. and stated the following:

- She was the second nurse working on resident #1's unit on the evening of 8/31/05.
- She was familiar with resident #1 and indicated that she was unsteady on her feet and required a chair and bed alarm for safety. On 8/31/05 after dinner, she saw resident #1 in the common area with a group of residents. Later in the evening, at approximately 8:00 p.m., resident #1 was still in the dining room with other residents. The common area is in a highly visible area by staff and she was being monitored frequently.
- Sometime between 8:00 p.m. and 9:00 p.m. another resident notified her that resident #1 was on the floor. She immediately went to check on resident #1 and notified employee (C), resident #1's primary nurse.
- There was adequate staff on that evening to meet the resident care needs.

Employee (D)/nurse was interviewed on 12/9/05 at 11:08 a.m. and stated the following:

- She is a full time employee and was assigned to resident #1's unit on the night shift that began on 8/31/05 at 10:30 p.m. and ended on 9/1/05 at 6:30 a.m.
- When she started her shift, resident #1 was quite bruised and swollen from the fall.

- She monitored and examined resident #1 every hour or more during the night including taking her vital signs and completing neurological examinations. At 1:30 a.m. resident #1 vomited a small amount and complained of dizziness. Resident #1 showed signs and symptoms of discomfort and complained of a headache intermittently during the night. At approximately 3:00 a.m. she gave resident #1 pain medication and notified the on-call physician regarding resident #1's complaints of dizziness, nausea and headache. The on-call physician directed her to continue to monitor resident #1's condition and notify physician (E) in the morning.

Employee (A)/Nursing Assistant, (NAR) was interviewed on 11/30/05 and stated the following:

- She was assigned to resident #1's unit on the day shift of 9/1/06. At approximately 8:00 a.m. employee (G)/NAR asked her to come and look at resident #1. The left side of resident #1's face was bruised, her left eye was swollen shut and she was complaining of a headache and nausea. She immediately notified the nurse. Resident #1's physician was notified and she was sent to the hospital.

Physician (E) was interviewed on 2/16/06 at 12:30 p.m. and stated that on the morning of 9/1/05, he was notified regarding resident #1's condition and after a discussion with resident #1's family transferred her to the hospital for further evaluation.

At the hospital resident #1 was diagnosed with bilateral subdural hematomas. Resident #1 returned to the facility on 9/1/05 at approximately 4:00 p.m. with orders for comfort care only. The facility staff administered Morphine (a narcotic pain medication) as needed, as directed by hospice recommendations and the physician's orders for comfort. She expired on 9/3/05.

According to the facility's DISCHARGE SUMMARY, dated 9/16/05 and signed by physician (E), the final diagnoses/cause of death was as follows:

1. Subdural hematomas status post head injury from a fall complicated by myelodysplastic disease with pancytopenia.
2. Alzheimer's dementia.

Conclusion: Neglect of health care is **inconclusive** as it relates to the allegation that resident #1 was neglected when she was left alone in the common area. Resident #1 was the only resident in the common area for approximately thirty minutes or less, prior to the incident on 8/31/05, however, she was in a highly visible area and, according to staff, she was monitored frequently. Documentation and interviews established that the facility staff initiated multiple interventions for resident #1's risk of falls, including but not limited to, frequent monitoring and a chair and bed alarm. Resident #1's falls had decreased in number after the alarm was initiated. Although it was determined that resident #1's chair alarm may not have been turned on at the time of the incident, it was unable to be determined if that would have prevented her fall.

xc: Division of Compliance Monitoring - Licensing & Certification

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

PRINTED: 05/30/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2006
--	--	--	---

NAME OF PROVIDER OR SUPPLIER STILLWATER GOOD SAMARITAN CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1119 OWENS STREET NORTH STILLWATER, MN 55082
---	--

(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

F 000

Ab Abbreviated Standard Survey was conducted to investigate complainant #H5207026. No deficiencies were noted.

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.