

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE COMMISSIONER OF HEALTH

In the Matter of Karlstad Healthcare Center;
Survey Exit Date: April 11, 2013

RECOMMENDED DECISION

This matter was the subject of an independent informal dispute resolution (IIDR) conducted by Administrative Law Judge Barbara L. Neilson on September 25, 2013. The OAH record closed at the conclusion of the conference that day.

Christine Campbell, Division of Compliance Monitoring, appeared on behalf of the Minnesota Department of Health (MDH or Department). Mary Cahill, Planner Principal with the Division of Compliance Monitoring; Pam Kerssen, Assistant Program Manager; and Vienna Andresen, Surveyor, also participated in the conference on behalf of the Department.

Susan Voigt, Attorney at Law, Voigt, Rode & Boxeth, LLC, appeared on behalf of Karlstad Healthcare Center (Facility). Emily Straw, Administrator; Susan Dahlin, Assistant Director of Nursing Services and Care Coordinator; Joyceln Englund, L.P.N., Care Coordinator; and James Surdy, M.D., also participated in the conference on behalf of the Facility.

Based on the exhibits submitted and the arguments made and for the reasons set out in the Memorandum below, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

As discussed more fully below, the Administrative Law Judge concludes that the Tag F 323 deficiency is not supported by the facts with respect to Resident 33 and should be rescinded. The Administrative Law Judge further finds that the Tag F 323 deficiency is supported with respect to Resident 29 at a severity level of 2, but a typographical error in the Form CMS 2567 should be corrected.

Dated: October 13, 2013

s/Barbara L. Neilson
BARBARA L. NEILSON
Administrative Law Judge

Reported: Digitally recorded (no transcript prepared).

NOTICE

In accordance with Minn. Stat. § 144A.10, subd. 16(d)(6), this recommended decision is not binding on the Commissioner of Health. As set forth in Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the Facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within ten calendar days of receipt of this recommended decision.

MEMORANDUM

Introduction

In April of 2013, surveyors for the Minnesota Department of Health concluded a recertification survey at the Karlstad Healthcare Center (the Facility). Following the completion of the survey on April 11, 2013, the surveyors issued a Form CMS-2567 Summary Statement of Deficiencies to the Facility.¹ In this proceeding, the Facility challenges the deficiencies identified by Tag F 323 relating to Residents 29 and 33.

Tag F 323 alleges a violation of the standards set forth in 42 C.F.R. § 483.25(h). The Department contends that the Facility failed to implement interventions to minimize the risk of injuries and accidents related to independent wheelchair mobility outside the facility for Resident 33 and failed to address wheelchair positioning for Resident 29.² Before deciding that the violation pertaining to Resident 33 occurred, the surveyors reviewed records, observed the Resident, and interviewed Resident 33 and certain Facility staff, including the Director of Nursing, the Occupational Therapist, and the Physical Therapist.³ Before deciding the violation pertaining to Resident 29 occurred, the surveyors reviewed records, observed the Resident, and interviewed the Assistant Director of Nursing.⁴ The F 323 deficiency was cited at a scope and severity level of Immediate Jeopardy (IJ), based upon the Department's conclusion that Resident 33 was in a situation of immediate jeopardy (i.e., the Department found that the deficiency, while isolated in scope, resulted in a situation in which immediate corrective action is necessary because the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility).

In this IIDR proceeding, the Facility asserts that the F 323 tag should be rescinded because the Facility was in substantial compliance with the applicable federal regulations. Among other things, the Facility criticizes the failure of the surveyors to discuss on the Form CMS-2567 the Resident's right to self-determination, his level of cognition, his history of independence, or what the Resident wanted, and asserts that it is necessary to find a balance between the rights of a resident and the need to keep that resident safe. The Facility also emphasizes that the surveyors did not find any

¹ Exhibit (Ex.) E.

² *Id.* at E-4 – E-12.

³ *Id.* at E-4 – E-10.

⁴ *Id.* at E-10 – E-11.

deficient practice with respect to care planning (F 280 and F 281) or assessment (F 272 and F279) and argues that those are the deficiencies that indicate whether an assessment or intervention is lacking. Finally, the Facility contends that the survey findings do not support an IJ level of severity.

Factual Background

Resident 33

Resident 33 is a 78-year-old retired farmer who currently resides at Karlstad Healthcare Center in Karlstad, Minnesota (a town in northwestern Minnesota with a population of approximately 800 people). He had a stroke in approximately 1994, which left him with weakness and impairment on his right side. He continued to live alone with some assistance from his brother until he suffered a fall at home that left him with a broken bone. He was admitted to the Facility on September 1, 2009.⁵ Resident 33's diagnoses include hypertension, hyperlipidemia, cerebrovascular accident (stroke), hemiplegia, glaucoma, and macular degeneration.⁶ He wears glasses for reading and working on jigsaw puzzles, but the Facility has determined that he does not have any functional limitations related to his vision problems.⁷ The Resident's physician commented during the IIDR session that the Resident's visual acuity is quite acceptable for distance.

According to the Resident's care plan dated February 22, 2012 (which was in effect at the time of the Department's survey), the Resident is "stubborn," "very strong willed and likes ind[ependence] and things done his way."⁸ In his leisure time, Resident 33 prefers to work on jigsaw puzzles, listen to the jukebox, watch television in his room, spend time outdoors, and "venture uptown in his [wheelchair]."⁹ The Resident's care plan identified the Resident as being at risk for falls and also having impaired physical mobility.¹⁰ Although he uses a wheelchair inside and outside the facility, he is fairly independent at wheelchair level and with wheelchair transfers.¹¹ He requires very little assistance from Facility staff with his activities of daily living (ADLs).¹² The Resident is able to use the grab bar on his bed to assist with positioning, propel his wheelchair with his left side, and transfer himself to the toilet and other surfaces at wheelchair level.¹³ He is "considered a vulnerable adult secondary to age, placement and diagnosis," but is "able to communicate his need for help and can report incidents or conflicts with staff or

⁵ Ex. 1; Ex. 6 at 3; Comments of James Surdy, M.D.; Comments of Joyceln Englund.

⁶ Ex. 1 at 1; Ex. 2 at 15; Ex. 5.

⁷ Ex. 1 at 7; Ex. 5 at 1, 2; Ex. J-10.

⁸ Ex. J at J-4, J-11; Comments of Emily Straw, Susan Dahlin, and J. Englund, see also Ex. 5 at 12 (noting that Resident "is alert and stubborn and likes to have his own space" and "propels his own w/c about"); Ex. 6 at 1 (noting that the Resident is "very independent"); and Ex. 7 at 3 (noting that the Resident is "very strong willed" and "likes his independence").

⁹ Ex. J at J-11.

¹⁰ Ex.J at J-2, J-3; The Resident's more recent care plan dated April 15, 2013, contains similar information. See Ex. 1 at 2, 3.

¹¹ Ex. J at J-2, J-3, J-4; Ex. 1 at 2, 3, 4.

¹² Comments of J. Englund.

¹³ Ex. J at J-3, J-9; Ex. 1 at 1, 2, 3, 5.

residents.”¹⁴ Although his care plan indicates that the Resident “needs the assistance of staff to avoid a potentially dangerous situation due to limited mobility,”¹⁵ this statement was intended to encompass emergency situations where evacuation from the Facility would be required, such as a fire.¹⁶

The Facility assessed the Resident’s fall risk in March of 2013. As part of the assessment, the Facility reviewed the Resident’s diagnoses, sensory impairments, medications, physical function and devices he uses. According to the assessment, the Resident fell at home prior to admission to the Facility but had not had any recent falls since residing at the Facility. No changes in interventions were put in place.¹⁷

According to the quarterly assessment of Resident 33 which was conducted by the Facility on March 15, 2013, the Resident has adequate vision and hearing, can speak clearly, is able to express his ideas and wants, and is able to understand others.¹⁸ He scored a fifteen out of fifteen on the Brief Interview for Mental Status (BIMS) that was given to him at that time.¹⁹ During prior assessments in December 2012, September 2012, June 2012, and March 2012, the Resident also scored a fifteen out of fifteen on the BIMS.²⁰ The Facility’s determination that the Resident has no cognitive impairments was consistent with medical records from the Resident’s physician dated September 26, 2012, in which the Resident was found to be stable and no concerns were noted with his clinical condition or cognition, as well as medical records from his physician assistant dated January 23, 2013, in which the Resident was noted to be alert and oriented as to person, place, and time, and his mood, affect, judgment, thought content, and behavior were characterized as “normal.”²¹

The March 2013 quarterly assessment also noted that Resident 33 was independent with most ADLs. He required physical assistance with some bathing activities and required set-up assistance with dressing, eating, and personal hygiene.²² The Resident had experienced falls prior to his admission to the Facility, but had not fallen since his last assessment by the Facility in December 2012.²³

The Resident has exercised his right to make his own decisions on several occasions while living in the Facility. For example, on October 10, 2009, Resident 33 signed a Negotiated Risk Agreement in connection with his refusal to accept thickened liquids. The Agreement formally noted that the Resident had a right to make this choice and had been warned of the possibility that he would aspirate liquids and possibly die as a result of his decision. The Agreement also indicated that, after discussing the risks and alternatives offered to decrease the risks, the Resident had decided that he wanted

¹⁴ Ex. J at J-7; Ex. 1 at 12.

¹⁵ *Id.*

¹⁶ Comments of S. Dahlin.

¹⁷ Ex. 3.

¹⁸ Ex. 2 at 6.

¹⁹ Ex. 2 at 7.

²⁰ Ex. 4 at 7; Ex. J at J-8..

²¹ Ex. 6 at 2.

²² Ex. 2 at 12, 13; Comments of J. Englund.

²³ *Id.* at 19; Ex. 3 at 1.

regular liquids in the dining room but would have thickened water when he was alone in his room.²⁴ On July 29, 2010, the Resident entered into another Negotiated Risk Agreement with the Facility relating to the choices he was making relating to safety with transfers, wheelchair mobility, and not following his plan of care. The Agreement stated that he had been formally warned that the risks associated with these choices included falls, broken bones requiring surgery, and death, and indicated that the Resident's final choice was that he "wants his independence."²⁵ On January 17, 2011, the Facility's nursing staff noted that the Resident performed several ADLs independently and referred him to Occupational Therapy/Physical Therapy (OT/PT) for a re-evaluation of his abilities and safety issues. After the evaluation was completed, OT determined that the Resident was able to be independent in all ADLs (dressing, toileting, transfers) at wheelchair level in his room.²⁶

During the time that he has lived at the Facility, the Resident has frequently chosen to sign himself out of the Facility to go home with his brother or wheel himself "uptown" in his wheelchair to various locations in the town of Karlstad.²⁷ The Resident indicated during a care conference on July 5, 2012, that he buys lottery tickets and eats in local restaurants during his outings, and stated that he enjoys being independent and it makes him happy.²⁸ The Resident goes to medical appointments and also receives regular massages at his clinic when he leaves the Facility in his wheelchair.²⁹ He told Facility staff in December 2012 that it is very important to him to be able to go outside to get fresh air when the weather is good.³⁰ When he leaves the Facility, he typically signs out on a "Release for Responsibility" form that includes the following notation at the bottom: "This is to Certify that I, [Resident's name], a resident at the Karlstad Healthcare Center have been [sic] informed of the risk involved and I hereby release the attending physician, the Nursing Center and its [sic] employees from any responsibility for any ill effects which may result from this action."³¹ Between April 13, 2011, and April 9, 2013, the Resident has signed himself out to go into town and/or to his medical clinic on at least sixty-eight occasions.³² The distance from the Facility to the gas station where the Resident frequently buys lottery tickets is one-half mile; the distance from the Facility to the clinic is less than that (approximately three blocks).³³

The Department surveyors were present at the Facility on April 9, 2013. The weather that day was dry and sunny, with temperatures ranging from a low of five degrees to a high of twenty-four degrees. The wind was eleven to seventeen miles per hour, gusting to twenty-two miles per hour.³⁴ Snow was still piled up in some areas

²⁴ Ex. 11 at 3.

²⁵ *Id.* at 1.

²⁶ Ex. 10.

²⁷ Ex. J at J-11; see also Exs. 8, 12, 28.

²⁸ Ex. 7 at 1, 2.

²⁹ Ex. 9 at 10, 12, 13.

³⁰ Ex. 4 at 13.

³¹ Ex. 12.

³² *Id.*

³³ Exs. 13, 25.

³⁴ Ex. G at G-2 and G-3.

along Washington Avenue in Karlstad.³⁵ When the surveyors were driving to lunch shortly after noon, they saw Resident 33 independently propelling his wheelchair backwards down Washington Avenue, against traffic. The Resident was near the middle of the traffic lane, and was propelling backwards using his left leg. He did not have a flag or a slow moving vehicle sign on his wheelchair. As Resident 33 approached the intersection of Washington Avenue and Main Street/U.S. Highway 59, he turned around and faced forward in his wheelchair and went with the flow of traffic. After a few more feet, the Resident turned around again and propelled his wheelchair backwards down Main Street, near the middle of the lane, against traffic.³⁶

There are no sidewalks on Washington Avenue. There are sidewalks along the east side of Main Street and along a portion of the west side of Main Street.³⁷ U.S. Highway 59 is the main highway between Thief River Falls, Hallock and Canada. In the town of Karlstad, Main Street/Highway 59 has a thirty miles-per-hour speed limit and a four-way stop sign. Main Street is a two-lane roadway, with room for cars to park.³⁸

The lead surveyor, Vienna Andresen, went back to the Facility to notify staff of the observation. She spoke to Emily Straw, the Facility Administrator. Ms. Straw said that Resident 33 often signed himself out of the facility and independently traveled to different destinations in town.³⁹ According to Ms. Andresen and the Form CMS 2567,⁴⁰ Ms. Straw said that “[s]he knew that R33 propelled the wheelchair backwards and against oncoming traffic;” however, Ms. Straw clarified during the IIDR session that she did not, in fact, know of that behavior. Ms. Straw did tell Ms. Andresen that Resident 33 was cognitively intact and had a care plan for going out into the community.⁴¹ At approximately 12:15 p.m. on April 9, 2013, the surveyors again observed Resident 33 on Main Street, still traveling backwards into oncoming traffic.⁴²

The survey team thereafter reviewed Resident 33’s records and conducted interviews with the Director of Nursing, an Occupational Therapist, a Physical Therapist, and the Resident. They also reviewed Appendix Q of the State Operations Manual. The surveyors noted that the care plan did not identify the Resident’s risky behavior of going into town in his wheelchair backwards and failing to use sidewalks. They also noted that the care plan did not describe the interventions that had been offered by the Facility to keep the Resident safer but refused by the Resident. During her interview, the Facility’s Director of Nursing informed the surveyors that Facility staff were aware of the Resident’s independent wheelchair travel to the uptown area located several city blocks away from the Facility; however, she did not know that the Resident propelled the chair backwards in the roadway, or that he traveled against the traffic.⁴³ She

³⁵ Comments of Vienna Andresen; Ex. H.

³⁶ Ex. E at E-5 – E-6; Comments of V. Andresen.

³⁷ Comments of E. Straw; Comments of V. Andresen; Ex. 13.

³⁸ Comments of E. Straw.

³⁹ Ex. E at E-6; Comments of V. Andresen.

⁴⁰ Comments of V. Andresen; Ex. E at E-6.

⁴¹ Comments of E. Straw.

⁴² Ex. E at E-6.

⁴³ In summarizing the interview with the Director of Nursing, the Form 2567 noted that the “DON stated she did not know that R33 propelled the chair backwards in the roadway, or that he traveled against the

pointed out that the Resident was required to notify staff and sign a sign-out sheet that functioned as a waiver of liability for injuries sustained during the outing, just like any other resident leaving the building. The Director of Nursing also stated that the Resident had been allowed to travel by wheelchair independently for approximately the last year, was not cognitively impaired, and should have the right to travel about town independently if he wished. She agreed that the Facility had not conducted a comprehensive assessment of the Resident's vision, mobility or safety with independent wheelchair mobility in the community.⁴⁴ The OT interviewed by the team said that, although wheelchairs are "meant to go forward," they could go backwards if the individual could turn his head to visually see where he is going.⁴⁵ The PT told the surveyors that she would not recommend propelling the wheelchair backwards, and said that there had not been a PT assessment of the Resident's wheelchair mobility.⁴⁶

The materials provided by the Department indicated that the Resident was interviewed on April 9, 2013, at 3:15 p.m. At that time, the Resident said that he had gone uptown that day to buy lottery tickets at the gas station, and stated that he had propelled the wheelchair both forward and backward. He said that propelling it backwards was "easier to do" and "better if it's windy." He stated that he could see where he was going by turning his head. When asked to demonstrate, the Resident rotated his head about ninety degrees to the left and right. The Resident verified that there was no way for him to communicate with the Facility if he had a problem, and said that he would "[j]ust lay there and try to flag down a car" if he fell out of the chair. The survey team believed that, when the Resident propelled himself backwards in his wheelchair, there would be no way for him to remove himself from danger in time because he could not rotate his head sufficiently to see what was behind him.⁴⁷

The survey team reviewed relevant portions of the State Operations Manual and conferred with Pam Kerksen, Assistant Program Manager with the Department of Health. Ms. Kerksen, in turn, discussed the situation with unit supervisors from the Department's district offices. The Department decided that a violation of F-Tag 323 had occurred and that the Resident had been placed in an immediate jeopardy situation.⁴⁸ The Facility was notified of the IJ determination related to the lack of safety assessment and interventions for the Resident's independent wheelchair travel in the community at 4:00 p.m. on April 9, 2013.⁴⁹

On April 9, 2013, after learning of the Department's immediate jeopardy determination, the Facility formulated a Plan of Correction that included providing a Therapy Evaluation for Resident 33 to assess the safety of his wheelchair handling skills and traffic/street and weather conditions for outdoor use of his wheelchair; offering

traffic." Ex. E at E-8. However, the Form 2567 later contains a contradictory statement that the "DON knew R33 went backwards in the wheelchair sometimes." Ex. E at E-10.

⁴⁴ Department's Pre-IIDR Submission at 7-8.

⁴⁵ *Id.* at 8.

⁴⁶ *Id.*

⁴⁷ Comments of V. Andresen.

⁴⁸ Comments of V. Andresen; Comments of Pam Kerksen.

⁴⁹ Ex. E at E-10; Department's Pre-IIDR Submission at 8.

a flag for the Resident's wheelchair; reviewing the plan of care for all other residents who leave the Facility unattended; and adopting a policy regarding Resident Outdoor Safety While Unattended. If the Resident left the building prior to the completion of the Therapy Evaluation/Assessment, Facility staff would be in attendance with him to ensure safety.⁵⁰

When Resident 33 was questioned later the same day by the Facility MDS Coordinator, the Resident said that he had turned backwards because a cold wind was blowing in his face and went against traffic because he was taught to do that and he wanted to see what was coming. He declined the Facility's offers to try to obtain an electric wheelchair for him and place a flag on his wheelchair. When the risks were discussed with him, he said "he wants his freedom to go uptown and do the things that he wishes." He signed another Negotiated Risk Agreement in which he acknowledged that the possible consequences associated with going uptown in his wheelchair in the manner observed by the surveyors included falls, broken bones, being hit by a vehicle, frost bite, or severe bodily injury up to and including death. The Agreement noted that the Resident had chosen to refuse interventions offered by the Facility to reduce his risk (carrying a cell phone, use of an electric scooter, and attaching a raised flag or orange "slow moving vehicle" triangle to his wheelchair).⁵¹

On April 10, 2013, a Functional Mobility Evaluation was performed with respect to the Resident. The Resident informed the evaluator that he propels his wheelchair within the Facility and also propels it to his clinic and "uptown" about twice a month when it is nice outside. Among other things, the evaluator noted that the Resident's vision at the time of his last exam on March 29, 2013, was 20/25 (right eye) and 20/30 (left eye). The Resident's range of motion on his left side was found to be within normal limits, but he had a deficit on his right side (apparently due to right side hemiparesis following his stroke). The Resident indicated that he was not interested in a power wheelchair or a scooter because he felt he would become weaker if he used one. He signed a document indicating that he had spoken with the OT about safety in the community when propelling his wheelchair and agreed to wear an orange hat; increase the visibility of his wheelchair; propel the wheelchair forward in order to see oncoming traffic; and participate in a community outing with the OT on a quarterly basis. He also agreed that he would not go out at night and would notify the Facility where he was going and how long he would be gone. The Resident further acknowledged that he understood "the risks involved with not following these recommendations could result in injury to [himself] or others." He agreed that he would raise any questions or concerns with Facility staff and that he would use his own safety judgment when in the dynamic environment such as streets, parking lots, and stores.⁵² The Resident's care plan was also revised to incorporate this information.⁵³

Later on April 10, 2013, the Resident informed Facility staff that he did not want anyone following him or making him "do all this stuff," and indicated that he would move

⁵⁰ Ex. 24.

⁵¹ Ex. 9 at 4-5; Ex. 11 at 2.

⁵² Ex. 21.

⁵³ Ex. 1 at 8.

out of the Facility if it continued.⁵⁴ He also said that he would buy his own orange cap and assured them that he knew what he was doing and could take care of himself. He again refused an electric scooter.⁵⁵

The Department removed the IJ on April 10, 2013, at 3:20 p.m. after the development of the safety plan for Resident 33 and a determination that no other residents were unsafe in the community.

After a short time, the Resident refused to follow most of the safety interventions that had been brought to his attention. On May 14, 2013, the Resident informed Facility staff that he was “very sick of all this and all of us [Facility staff]” and stated, “I know what I am doing and will do as I like.”⁵⁶ According to Facility records, the Facility’s Executive Director spoke with a police deputy on May 22, 2013, about the Resident’s safety and wheelchair use outside of the Facility. When she asked the officer to visit with the Resident to discuss his non-compliance with flags, signs and other safety measures, the officer declined to do so in the absence of citizen complaints that the Resident was displaying dangerous behavior. According to the May 22, 2013, Progress Note, the Resident had not been observed going backwards or in the middle of the street since the surveyors reported this behavior in April 2013.⁵⁷ The Resident has consistently refused to use an electric scooter,⁵⁸ and has been offended and insulted when Facility staff have reminded him of potential risks.⁵⁹ Facility personnel participating in the IIDR indicated that the only intervention that is sometimes used by the Resident is a slow moving vehicle sign that he places on the back of his wheelchair.⁶⁰

An additional BIMS assessment was performed on June 13, 2013, and Resident 33 was again found to be cognitively alert and oriented.⁶¹

The Resident’s brother provided a statement dated September 13, 2013, in which he supported the Resident’s ability to wheel himself into town independently and declared that the Resident “is fully capable of taking care of himself.” He indicated that the Facility had explained the safety concerns to him as well as to the Resident, and stated that they understand those concerns but both feel the Resident has the ability to decide for himself if he is able to go into town without supervision. He emphasized that the Resident had been going out for a long time and had never had any incident or sustained any injury.⁶²

⁵⁴ Ex. 9 at 3.

⁵⁵ *Id.* at 2-3; *see also* Ex. 20.

⁵⁶ Ex. 9 at 3.

⁵⁷ *Id.*

⁵⁸ *Id.* at 1.

⁵⁹ Comments of J. Englund, S. Dahlin.

⁶⁰ Comments of S. Dahlin, J. Englund; *see* Exs. 29, 30 (videotape of the Resident traveling in his wheelchair into the town of Karlstad).

⁶¹ Ex. 9 at 2.

⁶² Ex. 27.

Resident 29

Resident 29 is a 90-year-old man who has resided in the Facility since August of 2008. His diagnoses include Chronic Obstructive Pulmonary Disease, diabetes, Alzheimer's disease, anxiety disorder, depression, and hypertension. He uses a wheelchair and a lift for transfers, and needs the assistance of two or three individuals with all of his ADLs.⁶³

A PT functional mobility assessment of Resident 29 that was conducted on June 11, 2012, determined that the Resident needed the assistance of two individuals with transfers to and from his wheelchair. The therapist did not make any recommendation to nursing staff about the need for foot rests.⁶⁴ Moreover, the Resident's care plan that was in effect at the time of the survey (which was last reviewed on January 4, 2013) did not include a direction for the use of foot rests when he was being pushed in his wheelchair.⁶⁵

On April 8, 2013, the Department surveyors observed a nursing assistant pushing Resident 29 in his wheelchair with his feet skimming the floor. When the nursing assistant rounded the corner of the hallway, the Resident's feet caught the carpet and his feet were pushed back under the chair. Resident 29 said, "Ugh!" and pulled his feet a bit higher to keep them from dragging under the chair. The nursing assistant told the surveyors that Resident 29 did not need foot rests on the wheelchair during transport. When the surveyors interviewed the Assistant Director of Nursing, she said that the nursing assistant should have reported Resident 29 was having difficulty holding his feet up during transport, and confirmed that the nursing assistant had not done so.⁶⁶ The Form CMS- 2567 states that the Facility violated F 323 with respect to Resident 29 because he was not provided foot rests for wheelchair positioning and safety.⁶⁷

An OT evaluation was conducted regarding Resident 29 on April 12, 2013 (after completion of the survey and issuance of the deficiency). Based on the evaluation, it was determined that wheelchair foot rests were to be used at all times.⁶⁸

⁶³ Ex. 14 at 12, 13, 15-16; Ex. 15 at 1, 6, 8, 9,

⁶⁴ Ex. 16.

⁶⁵ Ex. 15 at 6, 8; Ex. E at E-11.

⁶⁶ Ex. E at E-11.

⁶⁷ *Id.* at E-10.

⁶⁸ Ex. 15 at 1, 6, 8.

Discussion

Tag F 323 is based upon an alleged violation of 42 C.F.R. § 483.25(h). That regulation requires:

The facility must ensure that—

- (1) The resident environment remains as free from accident hazards as is possible; and
- (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

As reflected in Appendix PP of the State Operations Manual (SOM), the intent of 42 C.F.R. § 483.25(h)(1) and (2) is to ensure that the facility "provides an environment that is free from accident hazards over which the facility has control and provide supervision and assistive devices to each resident to prevent avoidable accidents."⁶⁹ This includes the following:

- Identifying hazard(s) and risk(s);
- Evaluating and analyzing hazard(s) and risk(s);
- Implementing interventions to reduce hazard(s) and risk(s); and
- Monitoring for effectiveness and modifying interventions when necessary.⁷⁰

Among other things, the term "avoidable accident" is defined in the SOM to encompass situations in which an accident occurred because the facility failed to identify "individual resident risk of an accident, including the need for supervision;" or failed to "[i]mplement interventions, including adequate supervision, consistent with a resident's needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident."⁷¹ The term "risk" is defined to refer to "any external factor or characteristic of an individual resident that influences the likelihood of an accident."⁷² The SOM contains the following discussion of the supervision requirement:

"Supervision/Adequate Supervision" refers to an intervention and means of mitigating the risk of an accident. Facilities are obligated to provide adequate supervision to prevent accidents. Adequate supervision is defined by the type and frequency of supervision, based on the individual resident's assessed needs and identified hazards in the resident

⁶⁹ Ex. F-1.

⁷⁰ *Id.*

⁷¹ *Id.* at F-1, F-2.

⁷² *Id.* at F-3.

environment. Adequate supervision may vary from resident to resident and from time to time for the same resident.⁷³

The overview of F 323 set forth in the SOM includes the following discussion:

The facility is responsible for providing care to residents in a manner that helps promote quality of life. This includes respecting residents' rights to privacy, dignity and self determination, and their right to make choices about significant aspects of their life in the facility.

For various reasons, residents are exposed to some potential for harm. Although hazards should not be ignored, there are varying degrees of potential for harm. It is reasonable to accept some risks as a trade off for the potential benefits, such as maintaining dignity, self-determination, and control over one's daily life. The facility's challenge is to balance protecting the resident's right to make choices and the facility's responsibility to comply with all regulations.

The responsibility to respect a resident's choices is balanced by considering the potential impact of these choices on other individuals and on the facility's obligation to protect the residents from harm. The facility has a responsibility to educate a resident, family, and staff regarding significant risks related to a resident's choices. Incorporating a resident's choices into the plan of care can help the facility balance interventions to reduce the risk of an accident, while honoring the resident's autonomy.

Consent by resident or responsible party alone does not relieve the provider of its responsibility to assure the health, safety, and welfare of its residents, including protecting them from avoidable accidents. While Federal regulations affirm the resident's right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, legal surrogate, or representative to demand the facility use specific medical interventions or treatments that the facility deems inappropriate. The regulations hold the facility ultimately accountable for the resident's care and safety. Verbal consent or signed consent forms do not eliminate a facility's responsibility to protect a resident from an avoidable accident.⁷⁴

Applicability of F 323 to Resident 33

The Department contends that it properly found the Tag F 323 deficiency with respect to Resident 33 and assigned a severity level of IJ. It argues that the Facility "had knowledge of the repeated occurrence of R33 traveling against traffic, backwards at times, on the highway in his wheelchair downtown."⁷⁵ The Department asserts that

⁷³ *Id.*

⁷⁴ *Id.* at F-3 – F-4.

⁷⁵ Department's Pre-IIDR Submission at 3.

the Facility assessed the Resident as having a visual field deficit and needing staff assistance to avoid “potentially dangerous situations due to limited mobility,” and maintains that the Resident was placed at risk for significant injury, harm, impairment, or death because:

- the facility had not conduct an assessment of R33’s ability to safely travel the busy roadways to downtown Karlstad;
- the facility had not provided individualized education and a risk/benefit analysis to R33 to review his ability to safely navigate his manual wheelchair independently downtown;
- the facility had not enabled R33 to provide informed consent;
- the facility had not supervised his travels downtown thus enabling a comprehensive assessment for safety; and
- the facility had not implemented interventions to maximize R33’s independence and minimize his risk for injury, harm, impairment or death.⁷⁶

In response, the Facility argues that the citation should be removed with respect to Resident 33 because no deficient practice was demonstrated or, in the alternative, that the level of severity should be lowered to “no actual harm with potential for more than minimal harm that is not immediate jeopardy.” The Facility contends that it did properly assess Resident 33’s functional mobility, cognition, fall risk and vision; balanced the Resident’s request for independence and his desire to make his own choices against the results of those assessments; discussed potential risks with the Resident; determined that the Resident was willing to assume the risks and take responsibility for himself in the community; and allowed him to venture out into the community independently.

After careful review of the record and the arguments of the parties, the Administrative Law Judge concludes that the Tag F 323 deficiency should be deleted with respect to Resident 33 because the findings do not support the citation. The record shows that the Facility conducted proper assessments of Resident 33’s functional mobility, cognition, fall risk, and vision. Based on these assessments, the Facility concluded, among other things, that the Resident did not have any cognitive deficits and his vision did not impair or limit his functional mobility. There were no changes in his condition that triggered a new risk assessment between 2010 and 2013. The Resident’s physician ordered that the Resident could go on leaves of absence with medications, and the Administrative Law Judge agrees that this order logically supports the Resident’s ability to leave the facility and go out into the community on his own. The Resident’s physician, Dr. Surdy, confirmed during the IIDR session that the Resident’s distance vision is satisfactory despite his glaucoma and macular degeneration and he is

⁷⁶ *Id.*

physically able to use his wheelchair. Dr. Surdy described the Resident as “very independent, to the point of obstinance.” He believes that the Resident is capable of making his own decisions about leaving the Facility and understands the risks. In Dr. Surdy’s view, the Resident’s quality of life is directly tied to his limited independence.⁷⁷ Facility staff participating in the IIDR session emphasized that the Resident has wanted to be as independent as possible throughout his stay at the Facility and that he is cognitively intact and aware of the risks in his surroundings. According to Facility personnel, Resident 33 is very intelligent and able to retain information. He reads the newspaper and brings articles to the attention of staff. There has not been any change in his status or needs since he came to the Facility.⁷⁸

There is no evidence that any Facility personnel knew prior to the surveyors’ reported observations on April 9, 2013, that the Resident ever propelled his wheelchair in the street backwards against traffic or did anything else unsafe inside or outside the Facility. When they have seen the Resident in the community, he has been traveling on side streets, sidewalks, or in store parking lots.⁷⁹ Contrary to statements to the contrary made by the surveyor and set forth in the Form CMS 2567, neither the Facility Administrator nor the Director of Nursing knew that the Resident propelled the wheelchair backwards and against oncoming traffic prior to being informed of the surveyors’ observations.

It is evident that Resident 33 has fiercely insisted on being independent to the extent possible during the entire time he has lived in the Facility. The Facility has respected his right to make his own decisions, as it must.⁸⁰ There is no specific requirement in the applicable regulations that a facility assess a resident’s ability to travel safely in the community. The Facility appropriately has discussed risks with the Resident and had the Resident sign a Negotiated Risk Agreement. Since at least April 2011, the Resident has signed out of the Facility on a “Release for Responsibility” form that reiterates that he has been warned of the risk involved and releases the Facility from responsibility. To the knowledge of the Facility and his brother, he has not had any accidents or suffered any injuries during his outings since that time. Moreover, based on the information provided to the Facility by a local police officer, it does not appear that any member of the public has complained about the manner in which the Resident operates his wheelchair.

As the Facility argues, it is questionable whether F 323 was intended to cover a situation of this sort. A violation of F 323 occurs where a facility fails to ensure that the “resident environment remains as free of accident hazards as is possible” and “each resident receives adequate supervision and assistance devices to prevent accidents.” The Guidance to Surveyors defines the “resident environment” to include “physical

⁷⁷ Comments of J. Surdy.

⁷⁸ Comments of J. Englund, S. Dahlin.

⁷⁹ Comments of E. Straw, J. Englund, S. Dahlin.

⁸⁰ See, e.g., resident rights set forth under Tag F 150 and F 151, which recognize a resident’s right to “a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility” and prohibit facilities from limiting a resident’s autonomy or choice, “particularly in ways that affect independent functioning.”

surroundings to which the resident has access (e.g., room, unit, common use areas, and facility grounds, etc.)”⁸¹ and explains that the environment must be free from accident hazards “over which the facility has control,”⁸² which is further defined to mean “hazards in the resident environment where reasonable efforts by the facility could influence the risk for resulting injury or illness.”⁸³ These descriptions do not properly encompass a situation like the present one, in which an alert and oriented resident independently leaves the premises of the Facility on a frequent basis. In addition, F 323 recognizes that “[a]dequate supervision may vary from resident to resident and from time to time for the same resident” and states that “[t]he facility is responsible for providing care to residents in a manner that helps promote quality of life. This includes respecting residents’ rights to privacy, dignity and self-determination, and their right to make choices about significant aspects of their life in the facility.”⁸⁴

Of course, the behavior displayed by the Resident on April 9, 2013, is highly concerning. However, the Resident is well aware of the risks, and is entitled to exercise his right to make his own decisions. The deficiency and IJ with respect to Resident 33 should be rescinded.

Applicability of F 323 to Resident 29

The Department argues that Resident 29 was not assessed and provided appropriate interventions to ensure that he was safely transported in his wheelchair. According to the Department, a resident who is unable to hold his feet up during transport in a wheelchair is at high risk for injury to that extremity or even tumbling from the wheelchair if a foot is caught. The Department contends that F 323 requires facility staff to refer such residents for an appropriate assessment and implement proper interventions. The Department asserts that the Facility did not take these steps for Resident 29, resulting in a deficient practice. The Department contends that the severity with respect to Resident 29 should be level 2 (no actual harm with potential for more than minimal harm).

The Facility contends that Resident 29 had a minimal issue with use of wheelchair foot rests. It urges that, at most, the level of severity associated with his situation is low (no actual harm with potential for minimal harm).

Under the circumstances, the Administrative Law Judge finds that the Tag F 323 deficiency is supported with respect to Resident 29, and that the severity was properly cited at a level 2. The Guidance to Surveyors indicates that level 2 is appropriate where there is potential for a negative outcome such as bruising, minor skin abrasions, and rashes.⁸⁵ If a resident in a wheelchair catches his feet on carpeting, causing his feet to be pushed back under the wheelchair, it is possible that bruising, a rash, or a more significant injury could result.

⁸¹ Ex. 17 at PP-349.

⁸² *Id.* at PP 347.

⁸³ *Id.* at PP 349.

⁸⁴ *Id.*

⁸⁵ *Id.* at PP-387.

There is, however, a typographical error in the portion of the Form 2567 Statement of Deficiencies relating to Resident 29. The statement refers to a PT assessment dated "6/13/13."⁸⁶ This language should be changed to reflect the correct date of that assessment, which appears to be June 11, 2012.⁸⁷

B. L. N.

⁸⁶ See Ex. E at E-11.

⁸⁷ Ex. 16.