

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

In the Matter of the Independent Informal  
Dispute Resolution Bigfork Valley  
Communities

**FINDINGS OF FACT,  
CONCLUSIONS OF LAW,  
AND RECOMMENDATION**

The above-entitled matter came before Administrative Law Judge Jeanne M. Cochran for an independent informal dispute resolution (IIDR) on August 5, 2015. This IIDR arose out of a recertification survey conducted by the Minnesota Department of Health in March 2015. The record of the Office of Administrative Hearings closed on August 5, 2015, at the conclusion of the IIDR conference on that day.

Holly Kranz, HFE Nursing Evaluator II, appeared on behalf of the Minnesota Department of Health (MDH or Department). Mary Cahill, Principal Planner; Christine Campbell, Unit Supervisor; Pamela Kerksen, Assistant Program Manager; and Vienna Andresen, Surveyor and R.N., also participated on behalf of the MDH.

Samuel Orbovich and Katherine Ilten, Fredrikson & Byron, P.A., appeared on behalf of Bigfork Valley Communities (Bigfork). Aaron Saude, Chief Executive Officer, Bigfork Valley Communities; Kyle Hedlund, Director of Senior Services and Acting Administrator, Bigfork Valley Communities; Melissa Christie, LPN, Bigfork Valley Communities; JoAnn Jacobson, RN, Bigfork Valley Communities; and Paul David Meek, Founder of the National Institute for Elopement Prevention & Resolution, also participated on behalf of Bigfork.

Based on the exhibits submitted, the statements of party representatives during the IIDR, and for the reasons set forth more fully in the attached Memorandum, the Administrative Law Judge makes the following:

**RECOMMENDED DECISION**

1) The F323 deficiency is supported by the facts and should be affirmed, but the severity level 4 (immediate jeopardy) is not supported by the facts and should be reduced to severity level 2 (no actual harm with potential for more than minimal harm that is not immediate jeopardy).

2) The F490 deficiency is supported by the facts and should be affirmed, but the scope of “widespread” is not supported by the facts and should be changed to “pattern.”

Dated: August 19, 2015

s/Jeanne M. Cochran  
JEANNE M. COCHRAN  
Administrative Law Judge

Reported: Digitally Recorded;  
No transcript prepared

### NOTICE

Under Minn. Stat. § 144A.10, subd. 16(d)(6) (2014), this recommended decision is not binding upon 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 10 calendar days of receipt of this recommended decision.

### MEMORANDUM

#### I. General Regulatory Background

Skilled nursing facilities participating in the Medicare program must meet certain requirements, which are set forth in 42 C.F.R. Part 483, Subpart B (2014). Compliance with these requirements is determined through regular surveys conducted by state agencies, such as MDH, under agreement with the federal Center on Medicare and Medicaid Services (CMS). The state agency conducting the survey reports any “deficiencies” to CMS on a standard form called a “Statement of Deficiencies.”<sup>1</sup>

A “deficiency” is a failure to meet a participation requirement in 42 C.F.R. Part 483 (2014).<sup>2</sup> Deficiency findings are organized in the Statement of Deficiencies under alpha-numeric “tags,” with each tag corresponding to a regulatory requirement in Part 483.<sup>3</sup> The facts alleged under each tag may include a number of survey findings, which (if upheld) would support the conclusion that a facility failed to meet the regulatory standards.

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<sup>1</sup> See, e.g., Exhibit (Ex.) E (Statement of Deficiencies, CMS 2567).

<sup>2</sup> See, 42 C.F.R. § 488.301 (2014).

<sup>3</sup> CMS State Operations Manual, Appendix PP, Section IV.

A survey agency's findings also include a determination as to the “seriousness” of each deficiency.<sup>4</sup> The seriousness of a deficiency depends upon both its “scope” and its “severity.”<sup>5</sup>

When citing deficiencies, state surveyors use the CMS Guidance on Deficiency Categorization. The range of deficiencies is set out on a three-column, four-level grid. Each square on the grid has a letter designation. “A” is the least serious and “L” is the most serious. The fourth level of the grid (including designations J, K, and L) is reserved for the most serious deficiencies which place residents in “immediate jeopardy.”<sup>6</sup> The phrase “immediate jeopardy” means “a situation in which the provider’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.”<sup>7</sup>

If a facility disputes a deficiency citation in a survey conducted by a state agency, the facility may request an opportunity for an IIDR.<sup>8</sup> Pursuant to Minnesota law, the IIDR is conducted by an Administrative Law Judge.<sup>9</sup> After the IIDR is completed, the Administrative Law Judge makes findings and a recommendation to the Commissioner of MDH regarding each deficiency the facility has challenged.<sup>10</sup> The Commissioner in turn makes a recommendation to CMS, which makes the final determination.<sup>11</sup>

A facility is considered to be in “noncompliance” with one or more requirements of 42 C.F.R. Part 483 if there is deficiency that “causes a facility to not be in substantial compliance.”<sup>12</sup> “Substantial compliance” is “a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.”<sup>13</sup> If a facility is found to be in “noncompliance” based on the results of a state survey, various remedies can be imposed including civil monetary penalties.<sup>14</sup>

In this IIDR, Bigfork challenges two of the deficiencies cited by MDH during a recertification survey conducted from March 22-27, 2015.

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<sup>4</sup> See 42 C.F.R. § 488.404 (2014).

<sup>5</sup> Ex. C-1.

<sup>6</sup> *Id.*

<sup>7</sup> 48 C.F.R. § 488.331 (2014).

<sup>8</sup> *Id.*

<sup>9</sup> Minn. Stat. §144A.10, subd. 16 (2014).

<sup>10</sup> *Id.*, subd. 16(d).

<sup>11</sup> See Ex. A-3.

<sup>12</sup> See, 42 C.F.R. § 488.301.

<sup>13</sup> *Id.*

<sup>14</sup> See 42 C.F.R. §§ 488.402, .406, .412 (2014).

## II. Factual Background

### A. Bigfork Valley Communities' Facility

Bigfork Valley Communities<sup>15</sup> is a critical access hospital and senior living campus in Big Fork, Minnesota.<sup>16</sup> Bigfork Valley Communities includes assisted living residences and a skilled nursing facility. The skilled nursing facility (Facility) at Bigfork has a total of 47 beds, 20 of which are in a memory care unit known as the Aspen Unit. The Aspen Unit was first occupied by residents in the second week of January 2015 after Bigfork obtained the necessary approval from MDH and other governmental entities.<sup>17</sup> Prior to that time, Bigfork's memory care patients resided in another unit on the campus.<sup>18</sup>

The Aspen Unit was specifically designed to allow residents to move freely within the unit and to facilitate staff supervision.<sup>19</sup> The Aspen Unit is a large open unit with resident rooms on either side.<sup>20</sup> The nurses' station is in the center of the unit. On either side of the nurses' station is an activity area and a garden area.<sup>21</sup> The walls around the nurses' station, activity area, and garden area are approximately hip height.<sup>22</sup> The combined area is oval in shape, and is designed to provide a track for residents who have a need to walk around continuously.<sup>23</sup> From the nurses' station, the view of the rest of the Aspen Unit is mostly unobstructed.<sup>24</sup>

At the east end of the Aspen Unit is the main entrance with a foyer area and sliding doors. The main entrance is locked after 9:00 p.m.<sup>25</sup> At the west end of the unit is a glass-enclosed dining area. The dining area is approximately 50 feet from the nurses' station. There are two sets of glass doors that lead into the dining area. Just to the south of the dining area is a door leading to a fire exit. Just to the north of the dining area is a set of doors that leads into an adjoining nursing unit in the Facility, known as the Tamarack Unit.<sup>26</sup>

The glass-enclosed dining area in the Aspen Unit has a counter and kitchen area, along with tables. In addition, just outside the dining area is a patio that can be accessed by exiting out a set of French doors at the far west end of the dining area.<sup>27</sup>

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<sup>15</sup> Bigfork Valley Communities is the business name of North Itasca Hospital District, which is a hospital taxing district. Statement of Kyle Hedlund.

<sup>16</sup> Statement of Kyle Hedlund.

<sup>17</sup> *Id.*; Ex. N (Bigfork marketing brochure).

<sup>18</sup> Statement of Kyle Hedlund.

<sup>19</sup> *Id.*

<sup>20</sup> Ex. E-71; Ex. M; Statement of Kyle Hedlund.

<sup>21</sup> Statement of Kyle Hedlund.

<sup>22</sup> *Id.*

<sup>23</sup> *Id.*; Ex. M.

<sup>24</sup> Statement of Kyle Hedlund.

<sup>25</sup> Ex. E-71; Ex. M; Statement of Kyle Hedlund.

<sup>26</sup> Ex. E-71; Ex. M; Ex. 20-1, 20-3; Statement of Kyle Hedlund.

<sup>27</sup> Ex. E-71; Ex. M; Ex. 20-2; Statement of Kyle Hedlund.

The wall between the dining area and the patio is made primarily of glass, as are the French doors between the dining area and patio.<sup>28</sup>

At the time the Aspen Unit opened in January 2015, all the doors in the Aspen Unit were equipped with an alarm system except for the patio doors in the dining area. The Facility did not equip the patio doors with an alarm system because it planned to build a fence around the patio area.<sup>29</sup> The fence was to be installed by the time the Aspen Unit opened in January 2015, but due to weather issues the fence was not done when the Unit opened. As of the time of the survey, the construction of the fence had not started. Ultimately, the fence was not completed until summer 2015.<sup>30</sup>

In March 2015, when MDH conducted the survey of the Facility, the French doors to the patio did not lock from the inside; they only locked from the outside. Thus, the patio area could be accessed by a resident simply pushing on the patio door. At the time of the survey, the patio area consisted of a cement slab under a covered awning. The ground past the cement slab was uneven because the landscaping had not yet been completed. Beyond the patio area is the Facility driveway and a large forested area.<sup>31</sup>

## **B. Staffing at the Facility**

Between 6:30 a.m. and 10:00 p.m., the Aspen Unit typically is staffed with a Registered Nurse (RN) Floor Manager, a Licensed Practical Nurse (LPN), and two to three Certified Nursing Assistants (CNAs) during a shift. From 4:30-8:30 p.m., one of the CNAs floats between the Aspen Unit and the Tamarck Unit. In addition, during the day time hours, there are housekeepers, a laundry aide, and a dietary aide, who are all CNAs. The dietary aid works for 10 hours a day in the dining and kitchen area covering all three meal times.<sup>32</sup> From 10:00 p.m. to 6:30 a.m., the Unit is typically staffed by one LPN and one CNA. At night, there are times when there is only one staff person on the floor while the other staff person is attending to a resident. If there is a situation that requires both staff, the Facility has the ability to call the assisted living staff and hospital staff for assistance.<sup>33</sup>

In addition, the staff overlap for a half-hour between all shifts to allow incoming and departing staff an opportunity to discuss any issues, such as changes in care plans.<sup>34</sup> During shift changes, the Facility has the dietary aid or housekeepers, who are also CNAs, cover the floor. If those staff are not available, the Facility keeps one of the designated CNAs out of the shift change meeting to cover the floor.<sup>35</sup>

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<sup>28</sup> Ex. 20-2.

<sup>29</sup> Statement of Kyle Hedlund.

<sup>30</sup> *Id.*

<sup>31</sup> Ex. E-71; Ex. O; Statement of Vienna Andresen; Statement of Kyle Hedlund.

<sup>32</sup> Statement of Kyle Hedlund; Ex. 17.

<sup>33</sup> Statement of Kyle Hedlund; Ex. 17.

<sup>34</sup> Statement of Kyle Hedlund.

<sup>35</sup> *Id.*

Prior to the fence being installed around the patio, staff at the Facility were aware that the door to the patio did not lock from the inside and had no alarm. Staff understood that the floor of the Unit must always be covered and were keenly aware that they needed to monitor the residents.<sup>36</sup>

### **C. Resident 63 and his Exit-Seeking Behavior**

Resident 63 (R63) was admitted into the Aspen Unit on February 27, 2015 from a behavioral unit.<sup>37</sup> R63's Minimum Data Set (MDS) prepared on March 5, 2015 indicates that R63 was admitted with diagnoses including dementia, anxiety, insomnia, and Wernicke's Syndrome (alcohol induced dementia).<sup>38</sup> His care plan dated February 28, 2015, indicates that he was disoriented as to place and had impaired safety awareness.<sup>39</sup> In addition, at the time of the March 2015 survey, R63's medical records showed he had severe cognitive loss, but good ambulatory skills. The MDH survey staff also observed that his gait was steady without any limitations. He was able to walk on and off the nursing unit without any assistance.<sup>40</sup>

#### **i. February 28, 2015**

During the morning of February 28, 2015, the day after R63 was admitted, he went out the patio door in the dining room onto the patio and was directed by staff to come back inside because of the cold weather.<sup>41</sup> In a progress note at 10:14 a.m., Deb Porter, the MDS Coordinator, wrote that R63 "eloped out of the [dining room] door . . ." and returned back in as requested.<sup>42</sup>

Because R63 exited out of the building, Ms. Porter did an elopement risk assessment for R63 that morning. In answering the questions in the risk assessment, Ms. Porter indicated that R63 had a "history of leaving the facility without supervision," "had a history of elopement at home," and had "express[ed] a desire to go home." The risk assessment showed that R63 was at high risk for elopement. To address this risk, Ms. Porter indicated that the following interventions had been initiated for R63: secured unit, frequent monitoring, and recreational activities.<sup>43</sup>

As part of the planned interventions, R63 was fitted with a Wanderguard bracelet on the morning of February 28, 2015.<sup>44</sup> The Wanderguard system is a radio frequency technology used to lock doors and sound alarms. If a resident wearing a Wanderguard bracelet tries to open a door equipped with the system, the door locks. If the resident is able to breach the lock, like in the case of an emergency exit, the alarm goes off. The system then pages the staff, letting them know which door has the alarm going off and

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<sup>36</sup> *Id.*

<sup>37</sup> Ex. E-69; Ex. 13 at BVC000088.

<sup>38</sup> See Ex. 13 (Minimum Data Set dated 3/5/2015); Ex. 14 at BVC000160; Ex. E-69.

<sup>39</sup> Ex. 14 at BVC000135.

<sup>40</sup> Ex. E-71; Ex. L-55, L-58, L-90; Ex. 13 at BVC000099.

<sup>41</sup> Ex. L-88.

<sup>42</sup> *Id.*

<sup>43</sup> Ex. L56 through L-58.

<sup>44</sup> Ex. L-59.

which resident is breaching the door. At all times relevant to this matter, all of the exit doors in the Aspen Unit were equipped with the Wanderguard system except for the French doors in the dining room that lead to the patio.<sup>45</sup>

Later that same day, at 2:37 p.m., Ms. Porter stated in a progress note that R63 “has eloped outside X 3 today.” In the 2:37 p.m. progress note, Ms. Porter did not indicate the time of each “elopement,” which door or doors R63 exited, or how far from the door he was on each occasion. She did, however, state that R63 was “[r]edirected with verbal request to come back in” and was “cooperative with request.”<sup>46</sup> In an addendum to the original progress note, Ms. Porter provided more detail. She wrote: “[R63] exited the [dining room] via the door to the patio. Observed by staff to take two steps outside, staff immediately redirected [R63] to return inside with no difficulty.”<sup>47</sup>

Deb Porter also prepared an incident report on February 28, 2015 regarding R63’s wandering behavior. In the report, Deb Porter indicated that R63 “eloped outside via the Dining Room door and eloped to Tamarack via the Aspen door” and was “[r]edirected ... back inside.” The report also indicates that no injuries were observed.<sup>48</sup> Finally, the incident report indicates that Ms. Porter informed the Director of Nursing and Facility Administrator of the incident.<sup>49</sup>

## **ii. March 3, 2015**

On March 3, 2015, R63 was up early and tried several times to exit but was unable to do so because of the Wanderguard bracelet. He became frustrated and asked staff to help him take the bracelet off.<sup>50</sup> That morning, he asked staff to help him leave the building.<sup>51</sup> Later that day, after dinner, he packed his basket of clothes and brought it to the “west doors by the kitchen area.” He told staff that he was going to get his car and leave the facility. R63 was redirected and did not exit the building.<sup>52</sup>

## **iii. March 5, 2015**

On March 5, 2015, the Facility staff prepared a Minimum Data Set for R63, which indicated that he exhibited wandering behavior and was at “significant risk for getting into potentially dangerous places (e.g., stairs, outside of the facility).”<sup>53</sup> The Facility staff also conducted a Cognitive Care Assessment (CAA) on March 5, 2015, which noted that R63 has exit-seeking behavior. The CAA also specified that “Staff must anticipate

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<sup>45</sup> Statement of Kyle Hedlund.

<sup>46</sup> Ex. L-90.

<sup>47</sup> Ex. 10 at BVC000072 (Addendum on 4/24/2015).

<sup>48</sup> Ex. L-59.

<sup>49</sup> *Id.*

<sup>50</sup> Ex. I-86 (entry for 3/3/2015 at 05:58).

<sup>51</sup> *Id.* (entry for 3/3/2015 at 06:54).

<sup>52</sup> Ex. L-85.

<sup>53</sup> Ex. 13 at BVC000096.

his needs and be aware of the need to redirect and give him one to one attention when his behaviors are happening.”<sup>54</sup>

**iv. March 9, 2015**

On March 9, 2015, Melissa Christie, LPN, stated in a progress note at 6:04 p.m., that R63 “eloped” out the patio door during dinner. The note further indicates that “[R63] wanted to call his wife to see if she would come and pick him up. Elder eloped out the doors x 1 this pm.”<sup>55</sup> In the “Action” section of the progress note, she wrote that “Staff shut the double doors after supper to deter him from going out here again. Staff one to one to visit [with] him and to keep him busy.”<sup>56</sup>

At the IIDR conference, Ms. Christie acknowledged that she wrote “eloped” but stated that R63 was never out of the vision of staff on that day. She clarified that she should not have written that he “eloped” because R63 was supervised by staff when he exited.<sup>57</sup> She should have used the phrase “exit-seeking” instead.<sup>58</sup>

**v. March 13, 2015**

On March 13, 2015, Ms. Christie wrote in the progress notes that R63 “eloped out the door x 2 today. He was looking for a DMV and he wanted to get his car registered.” Under the “Action” section, she specified that “Staff redirected back inside and called his wife so that she could let him know his car is at home. Shut the double doors to the kitchen as soon as possible.”<sup>59</sup> She noted that she typically used the word “eloped” when referring to R63’s exit-seeking behavior, but in each instance staff was watching R63 when he exited or attempted to exit the Aspen Unit.<sup>60</sup>

**vi. March 15, 2015**

On March 15, 2015, R63 pushed the emergency panel on the front door and was able to get outside. Another resident accompanied R63 outside. According to the progress note by RN JoAnn Jacobson, “Staff noticed elders immediately, called for assistance and assisted elders back inside.”<sup>61</sup> At the IIDR conference, Ms. Jacobson explained that a nursing assistant witnessed R63 and the other resident go out the front door, and immediately came to get Ms. Jacobson. Ms. Jacobson stated that R63 was in the staff’s vision the entire time.<sup>62</sup>

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<sup>54</sup> Ex. L-18 and L-36 through L-38.

<sup>55</sup> Ex. L-83 through L-84 (entry for 3/9/2015 at 18:04 p.m.).

<sup>56</sup> *Id.*

<sup>57</sup> Statement of Melissa Christie; *see also*, Ex. 10 at BVC00053.

<sup>58</sup> Statement of Melissa Christie.

<sup>59</sup> Ex. L-83 (3/13/2015 entry at 13:12).

<sup>60</sup> Statement of Melissa Christie.

<sup>61</sup> Ex. L-82 (3/15/2015 at 05:11).

<sup>62</sup> Statement of JoAnn Jacobson.

**vii. March 19, 2015**

On March 19, 2015, the progress note at 8:24 p.m. indicates that R63 “eloped x 4 this pm, he got out the door x 2 this pm.” The note further states that “Staff asked him to come back in and he did come back in right away.” This progress note was written by Melissa Christie. At the IIDR conference, Ms. Christie indicated that even though she used the word “eloped,” R63 was always within sight of staff during these exit-seeking incidents.<sup>63</sup> She also indicated that she sent emails to the Director of Senior Services, the Director of Nursing, and the floor manager informing them of R63’s exit-seeking behavior. She did not state the specific date on which the emails were sent or whether she sent such emails after each incident that she noted in the progress notes.<sup>64</sup>

**viii. March 21, 2015**

On March 21, 2015, the progress note at 11:07 p.m. indicates that R63 had been up for more than 24 hours and “is constantly trying to get out the doors.” There is no indication, however, that R63 actually made it out any door.<sup>65</sup>

**ix. March 24, 2015**

On March 24, 2015, R63 was observed by MDH survey staff attempting to leave the Aspen Unit by pushing the exit door that leads to the Tamarack Unit. R63 was approached by a cook who redirected R63 back to the nurses’ station. The nurse informed R63 that he needed to stay in the unit and he responded that he was trying to find his children. Later that day, after dinner, R63 again attempted to leave by exiting through the doors to the Tamarack Unit. A nursing assistant (NA-C) approached him and redirected him back to his room. Another nursing assistant (NA-B) told MDH surveyors that R63 has a history of attempting to leave the facility via the unlocked patio door, but when R63 exited onto the patio he was easily redirected back into the building.<sup>66</sup>

**D. Bigfork Management’s Awareness of and Response to R63’s Exit-Seeking Behavior**

As part of the survey, the MDH team reviewed records relating to R63 and interviewed staff about R63. The surveyors completed their record review and interviews related to R63 on March 25, 2015.<sup>67</sup>

Through these interviews, the MDH survey team determined that the Facility management was aware that the patio door was not locked and that R63 had exited the facility on February 28, 2015.<sup>68</sup> The MDH notes also indicate that the RN Manager of the Aspen Unit knew that R63 had exited the Facility on February 28, 2015, but she was not aware that he had made multiple attempts to leave the building after February 28,

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<sup>63</sup> Statement of Melissa Christie; *see also*, Ex. 10 at BVC000069-70.

<sup>64</sup> Statement of Melissa Christie.

<sup>65</sup> Ex. L-80 (entry for 3/21/2015 at 23:07).

<sup>66</sup> Ex. E-72.

<sup>67</sup> Ex. E-72 through E-78.

<sup>68</sup> *Id.*

2015 and that he had exited the building. The RN Manager also stated that there were eight other residents in the Aspen Unit who also displayed wandering behaviors and had the potential to exit the Facility. Finally, she confirmed that the Aspen Unit is to be operated as a secured memory care unit.<sup>69</sup>

Similarly, RN-A/Minimum Data Set coordinator said she was aware of one occasion on which R63 had exited the building. According to the MDH interview notes, RN-A stated that any time a resident has “exited/eloped” from the facility, the staff are to ensure the resident’s safety, escort them back to the building, document the incident in the progress notes, and complete an incident report.<sup>70</sup>

The Interim Director of Nursing (IDON), JoAnn Jacobson, was also interviewed by MDH surveyors. The IDON stated that she was aware of the incident on March 15, 2015, when R63 exited the building by pushing the emergency panel on the front door. She stated that she was the nurse working that shift and had notified the Director of Senior Services about the incident. She confirmed that she did not complete an incident report regarding that incident.<sup>71</sup>

MDH surveyors also interviewed the Director of Senior Services, Kyle Hedlund, and the Facility Administrator, James Blum.<sup>72</sup> According to the MDH surveyor notes, both management officials indicated that “they were not aware of a pattern of R63’s behaviors in which he would attempt to elope.”<sup>73</sup> At the IIDR conference, Kyle Hedlund, who was Director of Senior Services at the time of the MDH survey, stated that he was informed of R63’s exit seeking behavior on February 28, 2015.<sup>74</sup> He stated that the Facility’s plan to address the exit risk posed by the unsecured patio door in the dining room was to monitor the residents by having the floor covered at all times.<sup>75</sup>

Mr. Hedlund also noted that the Facility had an Unsafe Elder Wandering Policy in effect at the time R63 was admitted to the Facility. That Policy required staff to notify the Administrator and Director of Nursing if an elder is missing from the facility. According to Mr. Hedlund, staff never notified management that R63 was missing or left the facility without being noticed.<sup>76</sup>

Mr. Hedlund also stated that because R63 was observed by staff when he exited or attempted to exit, and was redirected back into the Unit each time, staff should not have used the term “eloped” in their notes. Instead, staff should have recorded that

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<sup>69</sup> Ex. E-74 through E-75.

<sup>70</sup> Ex. E-75 through E-76.

<sup>71</sup> Ex. E-76.

<sup>72</sup> James Blum was the Facility Administrator at the time. Kyle Hedlund is now the Acting Facility Administrator. Statement of Kyle Hedlund.

<sup>73</sup> Ex. E-77.

<sup>74</sup> Statement of Kyle Hedlund.

<sup>75</sup> Statement of Kyle Hedlund.

<sup>76</sup> Statement of Kyle Hedlund; Ex. 5.

R63 was “exit-seeking.”<sup>77</sup> He noted that there was some confusion among staff as to the meaning of the term “elope.”<sup>78</sup>

He stated that the Facility has since adopted a policy on “Eloperments” that clarifies that an “elopement” occurs “when an elder (resident) who is cognitively, physically, mentally, emotionally, and/or chemically impaired; wanders away, walks away, runs away, escapes, or otherwise leaves the facility or environment unsupervised, unnoticed, and/or prior to their scheduled discharge.” The policy also provides that “[i]f an elder is observed leaving the building or safe area, this is not considered an elopement since they are under supervision.”<sup>79</sup>

#### **E. Weather in March 2015**

The weather in Big Fork, Minnesota, in March is generally cold and is often below freezing.<sup>80</sup> As a result, R63 was exposed to cold weather when he exited the Facility’s front door and when he went onto the patio in February and March 2015.

#### **F. Statement of Deficiencies, CMS 2567**

The MDH issued a Form CMS-2567 Statement of Deficiencies to the Facility based on the results of the survey.<sup>81</sup> The statement designated a number of “F Tags.” These tags set forth areas in which the Department asserts that the Facility fell below the federal requirements for participation in the Medicare and Medicaid programs.<sup>82</sup> In this proceeding, the Facility challenges the deficiencies identified by the F323 Tag (Accidents and Supervision) and the F490 Tag (Administration), both of which relate to R63 and the Facility’s response to his exit-seeking behavior.

### **III. Tag F323 Analysis**

#### **A. Applicable CFR Part and Relevant SOM Provisions**

Tag F323 is based upon an alleged violation of 42 C.F.R. § 483.25(h) (2014). That regulation requires:

The facility must ensure that—

- (1) The resident environment remains as free from accident hazards as is possible; and

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<sup>77</sup> Statement of Kyle Hedlund.

<sup>78</sup> *Id.*

<sup>79</sup> *Id.*; Ex. 7 (emphasis in the original).

<sup>80</sup> Statement of Vienna Andresen; see also, <http://www.accuweather.com/en/us/bigfork-mn/56628/march-weather/2087673?monyr=3/1/2015>.

<sup>81</sup> Ex. E (Statement of Deficiencies, CMS 2567).

<sup>82</sup> See *id.*; 42 C.F.R. §§ 488.301, .325(a) (2014); Ex. F.

- (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), (2) is to ensure that the facility "provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents."<sup>83</sup> 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.<sup>84</sup>

The term "hazard" is defined in the SOM to refer to "elements of the resident environment that have the potential to cause injury or illness." In addition, the SOM specifies that "[h]azards over which the facility has control' are those hazards in the resident environment where reasonable efforts by the facility could influence the risk for resulting injury or illness."<sup>85</sup> The SOM notes that the resident environment can present hazards, and specifies that "disabled locks or latches" and "nonfunctioning alarms," among other things, can be hazards to residents at a facility.<sup>86</sup>

The SOM defines "risk" as "any external factor or characteristic of an individual resident that influences the likelihood of an accident."<sup>87</sup> The SOM specifies that "unsafe wandering and elopement" present a risk to residents of a facility. "Unsafe wandering may occur when the resident at risk enters an area that is physically hazardous or that contains potential safety hazards...."<sup>88</sup>

The SOM further specifies that "[e]lopement occurs when a resident leaves the premises or a safe area without authorization ... and/or any necessary supervision to do so. A resident who leaves a safe area may be at risk (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle."<sup>89</sup> The SOM also provides that if the

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<sup>83</sup> Ex. F-1.

<sup>84</sup> *Id.*

<sup>85</sup> Ex. F-3.

<sup>86</sup> Ex. F-9.

<sup>87</sup> Ex. F-3.

<sup>88</sup> Ex. F-11. The SOM also notes that "[w]hile alarms can help to monitor a resident's activities, staff must be vigilant in order to respond in a timely manner. Alarms do not replace necessary supervision."

<sup>89</sup> *Id.*

facility fails to maintain a secure environment for a resident who exhibits unsafe wandering and/or elopement behavior, there is an F323 deficiency.<sup>90</sup>

Surveyors are then to evaluate whether the facility has provided adequate supervision for such residents to ensure substantial compliance.<sup>91</sup> With regard to supervision required by this standard, the SOM contains the following discussion:

‘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 environment. Adequate supervision may vary from resident to resident and from time to time for the same resident.<sup>92</sup>

## **B. Tag F323 and the Parties’ Positions**

MDH found that the Facility had not met the requirements of 42 C.F.R. § 483.25(h)(1), (2) based on its determination that the Facility systematically failed to comprehensively assess R63’s risk of elopement, and failed to effectively implement interventions in order to minimize the risk of serious injury or death to R63 resulting from elopement.<sup>93</sup> As a result, MDH included the F323 Tag in the Statement of Deficiencies.

MDH issued the F323 Tag with a scope and severity of J, meaning the MDH determined that this deficiency is isolated in scope but is one that results in immediate jeopardy (IJ) to resident health and safety.<sup>94</sup> An IJ is the highest level of severity, or severity level 4.<sup>95</sup> MDH concluded that an IJ situation existed based on its determination that R63 was at high risk for serious injuries or death from elopement.<sup>96</sup>

MDH determined that the IJ began on February 28, 2015 when R63 first displayed wandering and exit-seeking behaviors, and continued until March 27, 2015. MDH notified the Director of Nursing and Administrator of the IJ on March 25, 2015 at 4:22 p.m. The IJ was removed on March 27, 2015 at 12:30 p.m., based on actions taken by the Facility to address the situation after the IJ notice including: (1) completion of a comprehensive assessment of R63; (2) updated care plan for R63; (3) establishment of a system in which the dining room doors were locked except during meal times; (4) an updated elopement policy; and (5) staff training on the new

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<sup>90</sup> Ex. F-24 and F-25.

<sup>91</sup> Ex. F-25.

<sup>92</sup> Ex. F-7.

<sup>93</sup> Ex. E-68.

<sup>94</sup> Ex. E-69; Ex. C. The MDH notified the Director of Nursing and Administrator of the IJ on March 25, 2015 at 4:22 p.m. The IJ was removed on March 27, 2015, based on actions taken by the Facility to address the situation after the IJ notice. The MDH determined, however, that non-compliance remained at the lower scope and severity level of E, which indicates a pattern of non-compliance and no actual harm but the potential for more than minimal harm that is not IJ. See Ex. E-69.

<sup>95</sup> Ex. C-1.

<sup>96</sup> *Id.*; Ex. L-56-58; Statement of Pam Kerksen; Statement of Vienna Andresen.

elopement policy and changes to R63's care plan.<sup>97</sup> MDH determined, however, that the F323 deficiency remained at the lower severity and scope level of E, which indicates severity level 2 (no actual harm but the potential for more than minimal harm that is not IJ) and a scope of "pattern."<sup>98</sup> MDH based its IJ determination for the period from February 28, 2015 to March 25, 2015 on interviews with staff, document review, and observation of R63 during the survey.<sup>99</sup> MDH noted that the SOM Guidelines clarify that actual harm as well as **potential** harm to one or more individuals can be grounds for an IJ.<sup>100</sup>

At the IIDR conference, MDH emphasized that the Facility administration knew that the Aspen Unit was not secure because the patio doors were unlocked, and the Facility failed to put in place adequate supervision and safeguards to address R63's exit-seeking behavior.<sup>101</sup> MDH noted that staff failed to fully document R63's exit-seeking behavior or report all of the details and asserted that this led to a breakdown in communication and interfered with the Facility's ability to analyze the root cause of R63's exit-seeking behavior.<sup>102</sup> MDH further asserted that the scope and severity level of J are proper given R63's exit-seeking behavior and the proximity of the uneven ground, the Facility driveway, and nearby forested area. MDH noted that there was the potential for R63 to exit without staff noticing given shift changes and lower staff levels at night, which put him at risk for serious injury or death.<sup>103</sup>

At the IIDR conference, the Facility challenged both the F323 deficiency itself, and in the alternative, the IJ determination for R63.<sup>104</sup> The Facility asserted that it was in substantial compliance with the requirements of 42 C.F.R. § 483.25(h) because R63 received adequate supervision to prevent elopements. The Facility maintains that as a result of the Aspen Unit's design, staffing policies, and specific interventions taken with respect to R63, R63 did not elope from the facility. The Facility noted that each time R63 exited a door in the Aspen Unit, he was observed by staff. On that basis, the Facility maintains R63 did not elope as the term is used by CMS. The Facility also emphasized R63 was redirected back into the Unit each time he exited and did not incur any injuries.<sup>105</sup> Finally, the Facility also asserted, even if a deficiency is found, that there was no showing of IJ because there is no evidence that R63 was likely to experience serious injury, harm, impairment or death as a result of the alleged deficiency.<sup>106</sup>

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<sup>97</sup> Ex. E-69 and E-78.

<sup>98</sup> Ex. E-69.

<sup>99</sup> *Id.*

<sup>100</sup> Ex. H-3.

<sup>101</sup> Closing Statement of Holly Kranz.

<sup>102</sup> Opening Statement of Holly Kranz.

<sup>103</sup> Closing Statement of Holly Kranz.

<sup>104</sup> Bigfork Valley Communities Memorandum in Support of IIDR (Memorandum) at 10-12, 14-15 (July 30, 2015).

<sup>105</sup> *Id.* at 10-12; Closing Statement of Katherine Ilten.

<sup>106</sup> Memorandum at 13; Closing Statement of Katherine Ilten.

### C. Legal Analysis

As set forth above, 42 C.F.R. § 483.25(h) requires the Facility to ensure that the resident environment remains as free from accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. The record in this case demonstrates that the Facility failed to comply with this requirement because it operated the Aspen Unit, a memory care unit, with an unlocked door from the dining room to the outside. The door also had no alarm system. Because R63 had known exit-seeking behavior, the unlocked door presented a hazard under the Facility's control that the Facility could have removed through reasonable efforts like installing a lock, Wanderguard wiring, or other alarm system.<sup>107</sup> In fact, because the door was not secured, R63 exited out this door several times and was unnecessarily exposed to the cold March weather. As a result of the Facility failing to address this situation, the Facility failed to provide the secured unit that R63's care plan required.<sup>108</sup> Because the Facility could have addressed this hazard through reasonable efforts, it failed to keep "the resident environment ... as free from accident hazards as is possible" as required by 42 C.F.R. § 483.25(h)(1).<sup>109</sup>

The Facility argues, nonetheless, that it was in substantial compliance with this requirement and should not be subject to a determination of noncompliance. The Administrative Law Judge finds this argument unpersuasive. To be in substantial compliance, there must be facts showing that the F323 deficiency posed "no greater risk to resident health or safety than the potential for causing minimal harm."<sup>110</sup> If the deficiency creates the "potential" for more than "minimal harm," then substantial compliance cannot be found.<sup>111</sup> Here, the unlocked patio door created the potential for more than minimal harm because, as the Facility staff acknowledged, there are times when there is only one nurse or staff person on the floor. In addition, there are times when there is no staff in the dining area. Given that the nurses' station is approximately 50 feet from the dining area, R63 could have exited with sufficient time to make it past the patio and onto the uneven terrain or even beyond during the time when the door was not fitted with a lock or alarm. With his impaired cognitive ability, he could have fallen and incurred more than minimal harm especially if he had exited after dark. Thus, the potential existed for more than minimal harm to R63 even with the supervision that the Facility put in place. The fact that this did not happen does not negate that the potential existed. For these reasons, the Administrative Law Judge concludes that

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<sup>107</sup> See Statement of Kyle Hedlund; Ex. 20-4 (showing a mesh alarm system on the patio doors that the Facility installed after the survey was completed).

<sup>108</sup> Ex. L-57.

<sup>109</sup> At the IIDR conference, the Facility noted that MDH had approved the Aspen Unit for occupancy in January 2015 knowing that the patio door did not lock and that the fence was not yet installed. Counsel for the Facility acknowledged, however, that the Facility has ultimate responsibility for its residents notwithstanding any certificate of occupancy that it received from MDH. In addition, even if the Facility was considered safe when it opened in January 2015, the Facility should have known that the door presented a hazard upon learning that R63 had exited the unsecured patio door on February 28, 2015, and the Facility should have taken reasonable steps to secure the door.

<sup>110</sup> See, 42 C.F.R. § 488.301.

<sup>111</sup> *Id.*; Ex. F-30 and F-31.

Facility was not in substantial compliance with 42 C.F.R. § 483.25(h) and the F323 deficiency should be affirmed.

Having made that determination, the next question is whether the Department properly classified the severity level for the F323 deficiency as IJ (severity level 4).<sup>112</sup> The federal rules provide that IJ means “a situation in which the provider’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.”<sup>113</sup> In addition, Minnesota law provides that MDH may not issue a finding of IJ “unless the specific event or omission that constitutes the violation of the requirements of participation poses an imminent risk of life-threatening or serious injury to the resident.”<sup>114</sup> Thus, to find an IJ there must be a determination that the deficiency is “likely” to cause “serious injury” and, similarly, that the deficiency “poses an imminent risk of ...serious injury.”

While the Facility’s F323 deficiency created the “potential” for more than minimal harm, the record fails to demonstrate that “serious injury” or serious “harm” was “likely” or that an “imminent risk” of serious injury existed. The Aspen Unit staff were all aware of R63’s exit seeking behavior and monitored his activity closely. As a result, each time he exited through a door, staff observed him and redirected him back into the Unit shortly thereafter. R63 was not injured as a result of any of these events. Staff’s close attention to R63’s exit-seeking behavior was sufficient to ensure that “serious injury, harm, impairment, or death to a resident” was not likely even though the potential existed for more than minimal harm. Under these circumstances, there is not sufficient evidence to support a finding of IJ. Instead, the Administrative Law Judge concludes that the deficiency rises only to Severity Level 2 (no actual harm with potential for more than minimal harm that is not immediate jeopardy).

#### **IV. Tag F490 Analysis**

Tag F490 is based upon an alleged violation of 42 C.F.R. § 483.75. That regulation provides that:

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Based on interviews with staff and review of Facility documents, MDH determined that the Facility had not met this requirement because the Facility Administrator failed to ensure the safety of residents who are at risk for elopement.<sup>115</sup> MDH noted that the Facility management was aware that the door from the dining room to the patio was not secured and residents could exit without any alarm or other security system to alert staff. MDH also emphasized that the Facility did not take any measures to protect residents until the fence was completed even though the Aspen Unit was

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<sup>112</sup> Ex. E-69; Ex. C-1.

<sup>113</sup> 48 C.F.R. 488.331.

<sup>114</sup> Minn. Stat. § 144A.10, subd. 14.

<sup>115</sup> Ex. E-95.

designed to provide care to residents with dementia, who are at risk for elopement. In addition, MDH asserts that staff did not consistently prepare incident reports or inform the administration when a resident exited the facility through the patio door or other door.<sup>116</sup> Staff also did not have a clear direction as to what constituted elopement and, as a result, staff was unsure when and how to report exit-seeking behavior.<sup>117</sup>

The MDH issued the F490 Tag with a scope and severity of F, meaning the deficiency was considered to be widespread in scope and have a severity level 2 (no actual harm but the potential for more than minimal harm that is not IJ).<sup>118</sup> The MDH considered the deficiency to be widespread in scope based on its determination that there was a systemic failure by the Facility to assess and implement measures to ensure R63's safety as well as the safety of other individuals at risk for elopement in the Aspen Unit.<sup>119</sup>

The Facility challenges both the F490 deficiency and the classification of the deficiency as widespread in scope.<sup>120</sup> The Facility maintains that it is in compliance with 42 C.F.R. § 483.75 even though the door to the patio was not secured. The Facility argues that it adopted an effective alternative intervention strategy to ensure resident safety by making sure that a staff member was on the floor at all times.<sup>121</sup> The Facility also maintains that its staff communicated effectively with its administration regarding R63's exit-seeking behavior.<sup>122</sup> In the alternative, the Facility asserted that any deficiency was not widespread in scope because the alleged deficiency only related to the Aspen Unit, which is one of two units at the Facility.<sup>123</sup>

After carefully reviewing the record in this case, the Administrative Law Judge concludes that the record supports the F490 deficiency finding. The Facility administration's failure to secure the patio door unnecessarily placed R63 and the eight other residents in the Aspen Unit with a history of exit-seeking behavior at risk. This door could have been secured through reasonable measures such as installing a lock or Wanderguard wiring. As a result, the Facility failed to provide a secured facility to its memory care residents with exit seeking behaviors. This situation was compounded by the administration's failure to provide clear guidance on what constitutes elopement and exit-seeking behavior, and how to properly report such behavior. As a result, the administration did not have complete knowledge of the extent of R63's exit-seeking behavior and the risk posed to R63 and other residents by the unlocked patio door until the time of the MDH survey.<sup>124</sup> These facts demonstrate that the Facility's

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<sup>116</sup> Ex. E-96.

<sup>117</sup> Opening Statement of Holly Kranz.

<sup>118</sup> Ex. E-95; Ex. C-1.

<sup>119</sup> Ex. E-95 through E-96.

<sup>120</sup> Bigfork Valley Communities Memorandum in Support of IIDR at 12-15 (July 30, 2015).

<sup>121</sup> *Id.*; Closing Statement of Katherine Ilten.

<sup>122</sup> Closing Statement of Katherine Ilten.

<sup>123</sup> *Id.* at 15.

<sup>124</sup> Ex. E-99; Statement of Vienna Andresen (noting lack of detail in progress notes regarding incidents where R63 exited out a door); Statement of JoAnn Jacobson (stating that she did not prepare an incident report for March 15, 2015 exit by R63); Statement of Kyle Hedlund (stating that staff misused the term elope).

administration failed to use its resources effectively and efficiently to attain the highest practicable well-being of its residents with exit-seeking behaviors in violation of 42 C.F.R. § 483.75 (2014).

While the finding of a F490 deficiency is supported by the record, the widespread scope assigned by MDH is not supported by the record. The SOM provides that a deficiency is widespread “when the problems causing the deficiencies are pervasive in the facility and/or represent systemic failure that affected or has the potential to affect a large portion or all of the facility’s residents.”<sup>125</sup> The SOM specifically provides that “[w]idespread in scope refers to the entire facility population, not a subset of residents or one unit of a facility.” A deficiency may be identified as widespread in scope, however, if “a systemic failure in the facility (e.g., failure to maintain food at safe temperatures) would likely affect a large number of residents and is, therefore, pervasive in the facility.”<sup>126</sup> As discussed above, the Facility has two units: the Aspen Unit and the Tamarack Unit. The Aspen Unit has 20 beds, and the Facility has a total of 47 beds.<sup>127</sup> Because the deficiency affected only the Aspen Unit, the deficiency cannot be considered “widespread” as defined in the SOM.

Rather, it should either be characterized as “isolated” or “pattern.” The term “isolated” applies when “one or a very limited number of residents are affected....” The term “pattern” applies when “more than a very limited number of residents” are affected, including a subset of the facility’s population.<sup>128</sup> Here, the facts show that there were nine residents in the Aspen Unit who had exhibited wandering behavior, including R63.<sup>129</sup> Because the deficiency had the potential to affect at least nine residents in the Aspen Unit, in the view of the Administrative Law Judge, it is most properly characterized as “pattern” in scope. For these reasons, the Administrative Law Judge recommends that the F490 deficiency be retained, but the scope be reduced from “widespread” to “pattern.” This would place the F490 Tag in category E, rather than F.

### **J. M. C.**

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<sup>125</sup> Ex. C-3.

<sup>126</sup> *Id.*

<sup>127</sup> Statement of Kyle Hedlund; see *a/so*, Ex. M.

<sup>128</sup> Exs. C-3 and C-4.

<sup>129</sup> Ex. E-96.