

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

In the Matter of the Independent Informal  
Dispute Resolution for Barrett Care  
Center

**RECOMMENDED DECISION**

The above-entitled matter came before Administrative Law Judge Jim Mortenson for an independent informal dispute resolution review (conference) on December 11, 2015.<sup>1</sup> This matter arose out of a standard survey of Barrett Care Center conducted by the Minnesota Department of Health in August 2015. The record of the Office of Administrative Hearings closed on December 11, 2015, at the conclusion of the conference.

Holly Kranz, Nurse Evaluator, appeared on behalf of the Minnesota Department of Health (Department). Mary Cahill, Director's Office; Christine Campbell, Unit Supervisor; Beth Nowling, Nurse Evaluator; and Gail Anderson, Unit Supervisor, also participated on behalf of the Department.

Jeanine Junker, Administrator, appeared on behalf of Barrett Care Center (Barrett Care or facility). Linda Williams, Director of Nursing; Kim Drews, R.N.; and Dr. Larry Rapp, Medical Director, also participated on behalf of Barrett Care.

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

**SUMMARY**

1. Because the findings support the F 241 deficiency citation in full, the scope and severity assigned to the F 241 deficiency citation should not be changed.
2. Because the findings of fact do not support severity level 4, but rather severity level 2, for the F 371 deficiency citation, this deficiency determination should have originally been severity level 2.

---

<sup>1</sup> The matter was handled, at the request of the Department, as an informal review, not as a contested case hearing or arbitration pursuant to Minn. Stat. § 144A.10, subd. 16 (2014).

Based on the conference and records submitted, the Administrative Law Judge makes the following:

### FINDINGS OF FACT

1. The Department conducted a standard survey of Barrett Care on August 3 through August 6, 2015.<sup>2</sup>

2. Based on the survey, a Statement of Deficiencies, Centers for Medicare and Medicaid Services (CMS) Form 2567, was completed and signed August 27, 2015.<sup>3</sup>

3. The survey resulted in two deficiency citations: a violation of 42 C.F.R. § 483.15(a) (2015) for failing to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality;<sup>4</sup> and a violation of 42 C.F.R. § 483.35(i) (2015) for failing to prepare food under sanitary conditions.<sup>5</sup>

4. The Department called Barrett Care on August 28, 2015, and revisited the facility on September 23, 2015.<sup>6</sup>

5. The facility was found in substantial compliance (both deficiencies corrected) as of September 9, 2015.<sup>7</sup>

#### Deficiency Tag F 241

6. Deficiency Tag F 241 was issued to Barrett Care for violating 42 C.F.R. § 483.15(a). This was a failure to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<sup>8</sup>

7. In summary, the deficiency was based on the failure to ensure Resident 23's (R23) bed linens were changed in a dignified manner, and because Residents 8, 13, and 28 (R8, R13, R28) were not provided a dignified dining experience when transfer belts were not removed from them during the evening meal.<sup>9</sup>

8. The scope and severity of Tag F 241 was determined to be E.<sup>10</sup> This means it was determined that the deficiency was part of a pattern, and that there was no actual

---

<sup>2</sup> Exhibit (Ex.) E (Statement of Deficiencies, CMS 2567).

<sup>3</sup> *Id.*

<sup>4</sup> *Id.*

<sup>5</sup> *Id.* at 9.

<sup>6</sup> Ex. 3.3; Testimony (Test.) of Jeanine Junker.

<sup>7</sup> Ex. 3.3.

<sup>8</sup> Ex. E (Statement of Deficiencies, CMS 2567).

<sup>9</sup> *Id.* at 2.

<sup>10</sup> *Id.* at 1.

harm with potential for more than minimal harm that is not immediate jeopardy (severity level 2).<sup>11</sup>

## **R23**

9. Review of records for R23 by Department staff included: R23's quarterly Minimum Data Set (MDS), dated May 13, 2015; R23's Communication Care Area Assessment (CAA), dated February 18, 2015; R23's Activities of Daily Living (ADL) CAA, dated February 18, 2015; and R23's care plan, dated September 18, 2014.<sup>12</sup>

10. Department staff also observed and interviewed R23 and facility staff.<sup>13</sup>

11. R23's diagnoses included: Parkinson's disease; depression; anxiety; and moderate cognitive impairment.<sup>14</sup>

12. R23 required extensive assistance with bed mobility, dressing, toilet use, personal hygiene, and was unable to maintain balance without physical support from facility staff.<sup>15</sup>

13. R23 was able to verbalize needs, had clear speech, and was able to be understood by others.<sup>16</sup>

14. R23 required extensive assistance with all ADLs.<sup>17</sup> R23 ambulated with help of one person and used a walker because of problems with balance and risk of falls.<sup>18</sup>

15. R23 was classified as a vulnerable adult as a result of physical limitations.<sup>19</sup>

16. The care plan for R23 required R23 to be treated with respect and dignity.<sup>20</sup>

17. On August 4, 2015, from 9:45 a.m. to 10:00 a.m., R23 was lying on a blue plastic mattress on his/her bed with a transfer belt around his/her waist.<sup>21</sup> R23's head was resting on a bedspread on the footboard of the bed.<sup>22</sup>

---

<sup>11</sup> Ex. Ca1.

<sup>12</sup> Ex. E (Statement of Deficiencies, CMS 2567) at 2.

<sup>13</sup> *Id.* at 3-4.

<sup>14</sup> *Id.* at 2.

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

<sup>16</sup> *Id.*

<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

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

<sup>20</sup> *Id.*

<sup>21</sup> Ex. E (Statement of Deficiencies, CMS 2567) at 3.

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

18. During this time, a facility staff person entered R23's room, placed a stack of linens in the room, told R23 that housekeeping staff would come by to make the bed, and then immediately left the room.<sup>23</sup>

19. Next, a housekeeping staff person briefly appeared in the doorway of R23's room, and then left without entering the room or speaking with R23.<sup>24</sup>

20. R23 had been lying on the un-made bed with his/her head on the footboard since he/she had returned from breakfast. He/she had been instructed to have staff help him/her when getting up or down, and so he/she had been waiting for such assistance.<sup>25</sup>

21. R23 was uncomfortable in the position he/she was left in and was bothered by the fact people were walking past him/her without assisting.<sup>26</sup>

22. Two facility staff assisted R23 at 10:00 a.m. when one person helped R23 stand while the other person made the bed.<sup>27</sup> R23 was then assisted into the bed.<sup>28</sup>

## **R8**

23. Review of records for R8 by Department staff included R8's quarterly MDS, dated May 5, 2015, and R8's care plan, dated September 15, 2014.<sup>29</sup>

24. Department staff also observed and interviewed R8 and facility staff.<sup>30</sup>

25. R8's diagnoses include: dementia; chronic kidney disease; hypoglycemia; and severe cognitive impairment.<sup>31</sup>

26. R8 does not have behavioral problems, but is a vulnerable adult due to physical limitations.<sup>32</sup>

27. The care plan for R8 required R8 to be treated with respect, dignity, and for R8's given name to be used when communicating.<sup>33</sup>

---

<sup>23</sup> *Id.*

<sup>24</sup> *Id.*

<sup>25</sup> *Id.*

<sup>26</sup> Ex. E (Statement of Deficiencies, CMS 2567) at 3.

<sup>27</sup> *Id.*

<sup>28</sup> *Id.*

<sup>29</sup> Ex. E (Statement of Deficiencies, CMS 2567) at 6.

<sup>30</sup> *Id.* at 6-7.

<sup>31</sup> *Id.* at 6.

<sup>32</sup> *Id.*

<sup>33</sup> *Id.*

28. On August 3, 2015, from 5:00 p.m. to 6:18 p.m., R8 was seated at a table in the facility dining room with a transfer belt attached to his/her waist, over colored slacks.<sup>34</sup>

29. At 5:48 p.m. a nursing assistant sat next to R8 and assisted R8 with eating the evening meal.<sup>35</sup>

30. At 6:18 p.m. R8 was assisted in exiting the dining room, with the transfer belt still in place.<sup>36</sup>

31. It is unknown whether R8 was unable to remove the transfer belt on his/her own.<sup>37</sup>

### **R13**

32. Review of records for R13 by Department staff included R13's annual MDS, dated June 24, 2015, and R13's care plan, dated September 3, 2014.<sup>38</sup>

33. Department staff also observed and interviewed R13 and facility staff.<sup>39</sup>

34. R13's diagnoses include: dementia; anxiety; psychotic disorder; and severe cognitive impairment.<sup>40</sup>

35. R13 required extensive assistance with ADLs and was categorized as a vulnerable adult.<sup>41</sup>

36. The care plan for R13 required R13 to be treated with dignity, respect, and to keep R13's environment and daily activities "homelike."<sup>42</sup>

37. On August 3, 2015, at 3:41 p.m., R13 was seated in a recliner chair in the common area of the facility with a transfer belt secured around his/her waist, over clothing.<sup>43</sup>

38. On August 3, 2015, at 5:17 p.m., R13 was seated in a recliner chair in his/her room with a transfer belt secured around his/her waist, over clothing.

---

<sup>34</sup> *Id.* at 7.

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

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

<sup>37</sup> *Id.*

<sup>38</sup> Ex. E (Statement of Deficiencies, CMS 2567) at 5.

<sup>39</sup> *Id.* at 5-6.

<sup>40</sup> *Id.* at 5.

<sup>41</sup> *Id.*

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

<sup>43</sup> *Id.*

39. On August 3, 2015, at 5:33 p.m., R13 was assisted to ambulate to the dining room by a nursing assistant.<sup>44</sup> After being seated, R13's transfer belt was not removed.<sup>45</sup>

40. On August 3, 2015, at 5:51 p.m., a nursing assistant sat down with R13 and assisted R13 with eating the evening meal, without removing the transfer belt from R13.<sup>46</sup> The transfer belt remained on R13 throughout the meal.<sup>47</sup>

## **R28**

41. Review of records for R28 by Department staff included R28's quarterly MDS, dated June 10, 2015, and R28's care plan, dated May 22, 2014.<sup>48</sup>

42. Department staff also observed R28 and interviewed facility staff.<sup>49</sup>

43. R28's diagnoses include: dementia; esophageal reflux; cardiac dysrhythmias; and severe cognitive impairment.<sup>50</sup>

44. R28 does not have behavioral problems, but is a vulnerable adult due to physical limitations and cognitive impairment.<sup>51</sup>

45. The care plan for R28 required R28 to be treated with dignity and respect.<sup>52</sup>

46. On August 3, 2015, from 4:50 p.m. to 6:32 p.m., R28 had a transfer belt secured to his/her waist, over clothing, for the entire evening meal.<sup>53</sup>

## **Deficiency Tag F 371**

47. Deficiency Tag F 371 was issued to Barrett Care for violating 42 C.F.R. § 483.35(i). This was for failing to prepare food under sanitary conditions.<sup>54</sup>

48. In summary, the deficiency was based on the failure to ensure unpasteurized eggs were properly prepared for residents, in order to prevent infection from Salmonella Enteritidis.<sup>55</sup>

---

<sup>44</sup> *Id.*

<sup>45</sup> *Id.*

<sup>46</sup> *Id.* at 6.

<sup>47</sup> *Id.*

<sup>48</sup> Ex. E (Statement of Deficiencies, CMS 2567) at 7.

<sup>49</sup> *Id.* at 8.

<sup>50</sup> *Id.* at 7.

<sup>51</sup> *Id.*

<sup>52</sup> *Id.* at 8.

<sup>53</sup> *Id.*

<sup>54</sup> *Id.* at 10.

<sup>55</sup> *Id.*

49. The scope and severity of the F 371 deficiency was determined to be K.<sup>56</sup> This means it was determined that the deficiency was part of a pattern, and that there was immediate jeopardy to resident health and safety.<sup>57</sup>

50. The findings supporting the deficiency were based on observations, review of records, and interviews with facility staff and residents.<sup>58</sup>

51. As of August 3, 2015, all eggs used at the facility were unpasteurized, except for some liquid pasteurized eggs.<sup>59</sup>

52. The facility had difficulty obtaining pasteurized shell eggs, and the dietary manager of the facility reported to the Department staff on August 3, 2015, that no soft cooked eggs were being prepared at the time.<sup>60</sup> The dietary manager advised Department staff on August 5, 2015 that this was in error, but that she had advised staff that when unpasteurized eggs were cooked over easy, the whites had to be set and the yolks had to be cooked to 140° Fahrenheit (F).<sup>61</sup>

53. On Wednesdays, the facility implemented the “Sunny Day Café” program wherein residents could order eggs any way they wanted them.<sup>62</sup>

54. Unpasteurized eggs had been used by the facility and cooked over easy for approximately three weeks prior to August 5, 2015.<sup>63</sup> No pasteurized eggs had been purchased since at least those purchased June 14, 2015.<sup>64</sup>

55. On August 5, 2015, at 8:48 a.m., during the breakfast meal, R31 was seated at a table in the facility’s dining room and had finished eating.<sup>65</sup> R31’s plate had yellow runny egg yolk residue and small white particles of egg.<sup>66</sup> The eggs had been cooked over easy.<sup>67</sup>

56. On August 5, 2015, at 9:05 a.m., R26 left behind a plate in the dining room with yellow, thin, runny egg residue all over it.<sup>68</sup> The eggs had been cooked over easy.<sup>69</sup>

57. On August 5, 2015, 20 unpasteurized eggs were cooked over easy and, in addition to R26 and R31, were served to ten additional residents (R4, R6, R13, R14, R15,

---

<sup>56</sup> *Id.* at 9.

<sup>57</sup> Ex. Ca1.

<sup>58</sup> Ex. E (Statement of Deficiencies, CMS 2567) at 9-18.

<sup>59</sup> *Id.* at 10-11.

<sup>60</sup> *Id.* at 11.

<sup>61</sup> *Id.* at 13.

<sup>62</sup> *Id.* at 11.

<sup>63</sup> *Id.* at 12.

<sup>64</sup> *Id.* at 17; Ex. J.

<sup>65</sup> Ex. E (Statement of Deficiencies, CMS 2567) at 11.

<sup>66</sup> *Id.*

<sup>67</sup> *Id.*

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

<sup>69</sup> *Id.*

R33, R35, R39, R46, and R50).<sup>70</sup> The temperature of the over easy eggs was not checked.<sup>71</sup>

58. On August 5, 2015, following being advised about the undercooked unpasteurized eggs, the facility administration had the remaining unpasteurized eggs thrown out.<sup>72</sup>

59. It was estimated in the 1990s that 1 in 20,000 eggs are contaminated with Salmonella Enteritidis, or .005 percent.<sup>73</sup> No more recent authoritative data on these statistics was presented during the arbitration.

60. To ensure the safety of unpasteurized eggs, they must be cooked until both the whites and yolks are firm, or 160°F.<sup>74</sup>

61. It was the facility's policy to cook unpasteurized eggs to at least 140°F.<sup>75</sup>

62. No illness resulted from serving under-cooked unpasteurized eggs to residents at Barrett Care.<sup>76</sup>

63. On August 6, 2015, all dietary staff were informed of a new policy of Barrett Care to use only pasteurized eggs.<sup>77</sup>

64. On August 6, 2015, the facility had 15 dozen pasteurized eggs in storage, a carton of liquid pasteurized eggs, and no unpasteurized eggs.<sup>78</sup>

65. The Department determined that residents were in immediate jeopardy beginning on August 5, 2015, and that this ended on August 6, 2015. This was because staff had by then been trained regarding the use of unpasteurized eggs and facility policy was revised to allow the use only of pasteurized eggs.<sup>79</sup> In addition, a plan for auditing eggs served made-to-order was adopted.<sup>80</sup> The scope and severity level of the deficiency was changed to "E" that day, meaning that there was a pattern and the deficiency resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.<sup>81</sup>

---

<sup>70</sup> *Id.* at 12, 14.

<sup>71</sup> *Id.* at 12; Ex. H at 4.

<sup>72</sup> Ex. E (Statement of Deficiencies, CMS 2567) at 10; Ex. 1.

<sup>73</sup> Ex. P.

<sup>74</sup> *Id.*; Ex. F at 2.

<sup>75</sup> Ex. E (Statement of Deficiencies, CMS 2567) at 17.

<sup>76</sup> *Id.* at 10.

<sup>77</sup> *Id.* at 17; Ex. 1.1.

<sup>78</sup> Ex. E (Statement of Deficiencies, CMS 2567) at 17.

<sup>79</sup> *Id.*

<sup>80</sup> *Id.*

<sup>81</sup> *Id.*; Ex. Ca1.

66. The Department determined there was immediate jeopardy because the preparation of the undercooked unpasteurized eggs for 12 residents on August 5, 2015, placed them “at risk for the development of the food borne illness, Salmonella Enteritis [sic].”<sup>82</sup> The Department also reasoned: “The practice of serving the undercooked eggs had the potential to cause Salmonella. . . .”<sup>83</sup>

Based on these Findings of Fact, the Administrative Law Judge makes the following:

### RECOMMENDED DECISION

- 1) Deficiency Tag F 241 is supported in full, with no deletion of findings and no change in the scope or severity assigned to the citation.
- 2) The original severity of deficiency Tag F 371, immediate jeopardy, is not supported. The citation should have been severity level 2 (no actual harm with potential for more than minimal harm that is not immediate jeopardy).

Dated: December 24, 2015

s/Jim Mortenson  
\_\_\_\_\_  
JIM MORTENSON  
Administrative Law Judge

Reported: Digitally Recorded;  
No transcript prepared

### NOTICE

Based on direction from the Department of Health this recommended decision is not binding upon the Commissioner of Health. As set forth in Department of Health Information Bulletin 04-07, the Commissioner will 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.

---

<sup>82</sup> Ex. E (Statement of Deficiencies, CMS 2567) at 10.

<sup>83</sup> *Id.* (Gail Anderson and Beth Nowling also testified about the “potential” of the hazard of the eggs.)

## 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 (2015). Compliance with these requirements is determined through regular surveys (inspections)<sup>84</sup> conducted by state agencies, such as the Department, under agreement with CMS, pursuant to 42 C.F.R. Part 488 (2015). The state agency conducting the survey reports any “deficiencies” to CMS on a standard form called a “Statement of Deficiencies.”<sup>85</sup>

The standards by which the state agency determines compliance are found at 42 C.F.R. § 488.26:

- (b) The decision as to whether there is compliance with a particular requirement, condition of participation, or condition for coverage depends upon the manner and degree to which the provider or supplier satisfies the various standards within each condition. Evaluation of a provider's or supplier's performance against these standards enables the State survey agency to document the nature and extent of deficiencies, if any, with respect to a particular function, and to assess the need for improvement in relation to the prescribed conditions.
- (c) The State survey agency must adhere to the following principles in determining compliance with participation requirements:
  - (1) The survey process is the means to assess compliance with Federal health, safety and quality standards;
  - (2) The survey process uses resident and patient outcomes as the primary means to establish the compliance process of facilities and agencies. Specifically, surveyors will directly observe the actual provision of care and services to residents and/or patients, and the effects of that care, to assess whether the care provided meets the needs of individual residents and/or patients.
  - (3) Surveyors are professionals who use their judgment, in concert with Federal forms and procedures, to determine compliance;
  - (4) Federal procedures are used by all surveyors to ensure uniform and consistent application and interpretation of Federal requirements;
  - (5) Federal forms are used by all surveyors to ensure proper recording of findings and to document the basis for the findings.

---

<sup>84</sup> Minn. Stat. § 144A.10, subd. 2 (2014).

<sup>85</sup> See, e.g., Ex. E (Statement of Deficiencies, CMS 2567).

- (d) The State survey agency must use the survey methods, procedures, and forms that are prescribed by CMS.
- (e) The State survey agency must ensure that a facility's or agency's actual provision of care and services to residents and patients and the effects of that care on such residents and patients are assessed in a systematic manner.

A “deficiency” is a failure to a meet a participation requirement in 42 C.F.R. Part 483 (2015).<sup>86</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>87</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.

A survey agency's findings also include a determination as to the “seriousness” of each deficiency.<sup>88</sup> The seriousness of a deficiency depends upon both its “scope” and its “severity.”<sup>89</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>90</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>91</sup> “[T]he commissioner may not issue a finding of immediate jeopardy unless the specific event or omission that constitutes the violation of the requirement of participation poses an imminent risk of life-threatening or serious injury to a resident.”<sup>92</sup>

If a facility disputes a deficiency citation in a survey conducted by a state agency, the facility may request an opportunity for an independent informal dispute resolution (IIDR).<sup>93</sup> Pursuant to Minnesota law, the IIDR is to be conducted as a contested case hearing under Minn. Stat. §§ 14.57-.62 (2014), or an arbitration conducted by an Administrative Law Judge.<sup>94</sup>

In this case, only a short, informal review of the survey and deficiency findings was conducted by the Administrative Law Judge, at the request of the Commissioner. The

---

<sup>86</sup> See, 42 C.F.R. § 488.301.

<sup>87</sup> CMS State Operations Manual, Appendix PP, Section IV.

<sup>88</sup> See 42 C.F.R. § 488.404.

<sup>89</sup> Ex. C-2.

<sup>90</sup> *Id.*

<sup>91</sup> 48 C.F.R. § 488.331.

<sup>92</sup> Minn. Stat. § 144A.10, subd. 14 (2014).

<sup>93</sup> Minn. Stat. § 144A.10, subd. 16.

<sup>94</sup> Minn. Stat. § 144A.10, subd. 16.

Commissioner has requested that, consistent with an IIDR hearing or arbitration, that within ten working days of the close of the review the Administrative Law Judge issue findings and a recommendation regarding each of the deficiencies in dispute.<sup>95</sup> Following an arbitration, the Administrative Law Judge must make one or more of the following findings:

- (1) Supported in full. The citation is supported in full, with no deletion of findings and no change in the scope or severity assigned to the deficiency citation.
- (2) Supported in substance. The citation is supported, but one or more findings are deleted without any change in the scope or severity assigned to the deficiency.
- (3) Deficient practice cited under wrong requirement of participation. The citation is amended by moving it to the correct requirement of participation.
- (4) Scope not supported. The citation is amended through a change in the scope assigned to the citation.
- (5) Severity not supported. The citation is amended through a change in the severity assigned to the citation.
- (6) No deficient practice. The citation is deleted because the findings did not support the citation or the negative resident outcome was unavoidable. The findings of the arbitrator (Administrative Law Judge) are not binding on the commissioner.<sup>96</sup>

The Administrative Law Judge has adopted this approach for this recommended decision, with the exception of “(6) No deficient practice.” This is because the entirety of the report and decision here is a recommendation to the Commissioner, not only a finding of no deficient practice, had there been such a finding.

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>97</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>98</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>99</sup>

In this proceeding, Barrett Care challenges both of the deficiency tags cited by the Department during the survey conducted August 3-6, 2015.

---

<sup>95</sup> *Id.*, subd. 16(d); Department of Health Information Bulletin 04-07 (May 2004).

<sup>96</sup> Minn. Stat. § 144A.10, subd 16(d).

<sup>97</sup> *See*, 42 C.F.R. § 488.301.

<sup>98</sup> *Id.*

<sup>99</sup> *See* 42 C.F.R. §§ 488.402, .406, .412.

## II. Survey of Barrett Care Center

### A. Deficiency Tag F 241

Deficiency Tag F 241 is based upon the violation of 42 C.F.R. § 483.15(a). That regulation requires that “[t]he facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.” The Department issued Tag F 241 with a scope and severity of E, meaning the Department determined that this deficiency was based on a pattern of compliance issues, but that there was no actual harm with potential for more than minimal harm that is not immediate jeopardy.<sup>100</sup>

In summary, the Department found that by leaving transfer belts on residents during meal time and when the belts were not being used to help residents up or down, failed to maintain or enhance the dignity and respect of those residents.<sup>101</sup> The facility argued that a separate Department report showed there were little or no issues with dignity issues in the facility.<sup>102</sup> The facility also argued that transfer belts were left on the residents in question for their own safety. Finally, the facility argued that leaving transfer belts on residents is not prohibited by law.

There is no dispute about the facts in relation to this deficiency. Rather, the dispute is over the application of the law and the Department's interpretation of 42 C.F.R. § 483.15(a). The facility's argument that a separate report from the Department showed no dignity issues does not refute the findings made by the survey team. The report cited by the facility was created in February 2015, and the survey was conducted later, in August 2015. The survey was based on objective observations of residents, and the February report results were based on resident responses to questions about their perceptions of the care they received and the facility. So, even if the results of the report were a material fact, it would have no bearing on the observations made in August.

Department staff reasonably concluded that R23 was not positioned in a dignified manner when she was left upside-down on her bare bed, expressed discomfort by the situation, and staff did not immediately attend to her, despite knowing the position she was in. Department staff also reasonably concluded that residents who required transfer belts were treated in an undignified manner when the belts were left on them, over their clothing, when not being helped up or down. The transfer belts are assistive equipment needed at specific times. Based on examples from the Interpretive Guidelines for 42 C.F.R. § 483.15(a), issued June 12, 2009,<sup>103</sup> Department staff reasonably concluded that a transfer belt is not a dignified article of clothing to be worn in public except when assisting a person in a transition up or down, and not when ambulating. Thus, the Department's findings are supported with no deletions, and the determination is supported in both its scope and severity.

---

<sup>100</sup> Exs. Ca1; E at 1.

<sup>101</sup> Except for R23, whose dignity issue was based on a different set of facts.

<sup>102</sup> Ex. 11.1

<sup>103</sup> Ex. Fa at 1-3.

## B. Deficiency Tag F 371

Deficiency Tag F 371 is based upon an alleged violation of 42 C.F.R. § 483.35(i). That regulation provides: “The facility must- . . . (2) Store, prepare, distribute, and serve food under sanitary conditions; . . . .”

There is no dispute of fact that unpasteurized eggs were served undercooked. Rather, the dispute is whether the severity of the violation warranted a finding of immediate jeopardy. The facility argues that because the unpasteurized eggs were immediately thrown out when the issue was brought to the administration’s attention on August 5, 2015, that training was immediately provided to staff regarding the use of unpasteurized eggs, and that because Salmonella from eggs is rare and no one at the facility became ill from the undercooked unpasteurized eggs, there was no immediate jeopardy.

Salmonella Enteritidis is a serious infection. A person who has contracted Salmonella Enteritidis usually will develop a fever and suffer abdominal cramps and diarrhea within 12 to 72 after consuming contaminated food.<sup>104</sup> The illness usually lasts four to seven days, and most people will recover without antibiotics.<sup>105</sup> Hospitalization can be required when diarrhea is severe, however.<sup>106</sup>

The illness may be more severe in the elderly and those with impaired immune systems.<sup>107</sup> When these people suffer illness from Salmonella Enteritidis, the infection may spread from the intestines to the blood stream, and then to other locations in the body.<sup>108</sup> Death may result without prompt treatment with antibiotics.<sup>109</sup>

Fresh, or unpasteurized, eggs are a source of Salmonella Enteritidis.<sup>110</sup> Approximately .005 percent of unpasteurized eggs are contaminated with the bacteria in the United States.<sup>111</sup> Thoroughly cooking unpasteurized eggs until both the yolk and white are firm (160°F) will kill the bacteria and eliminate the threat of illness.<sup>112</sup>

After carefully reviewing the record in this case, the Administrative Law Judge concludes that the record supports the F 371 deficiency finding. The facility administration’s failure to ensure unpasteurized eggs were always thoroughly cooked to 160°F, until both yolks and whites were firm, left a risk of infection for Salmonella Enteritidis. Thus, 42 C.F.R. § 483.35(i) was violated because food was not prepared or served under sanitary conditions.

---

<sup>104</sup> Ex. P at 1.

<sup>105</sup> *Id.*

<sup>106</sup> *Id.*

<sup>107</sup> *Id.*

<sup>108</sup> *Id.*

<sup>109</sup> *Id.*

<sup>110</sup> *Id.* at 1-2.

<sup>111</sup> *Id.*

<sup>112</sup> *Id.*; Ex. F at 2.

While the finding of the F 371 deficiency is supported by the record, the severity assigned by the Department, immediate jeopardy, is not supported by the record. Immediate jeopardy is applied when a provider's noncompliance "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident."<sup>113</sup> Likewise, under state law, the commissioner is barred from issuing an immediate jeopardy finding unless the cited violation "poses an imminent risk of life-threatening or serious injury to a resident."<sup>114</sup>

Pursuant to the State Operations Manual (SOM) Appendix Q – Guidelines for Determining Immediate Jeopardy, the second component of the decision-making for immediate jeopardy is "immediacy."<sup>115</sup> "Is the harm or potential harm *likely to occur in the very near future* to this individual or others in the entity, if immediate action is not taken?"<sup>116</sup> The Department's position in this case was based on its determination that the undercooked unpasteurized eggs were "likely to cause" serious harm or even death to residents who ate them. While it is true an infected egg or eggs may be likely to cause such harm, no infected eggs were found. Furthermore, the evidence showed that the likelihood of coming across an infected egg was very small, a .005 percent chance. Thus, it does not follow that the facility's failure to prepare the eggs in a sanitary manner by not thoroughly cooking them was *likely* to cause serious injury, harm, or even death. The risk of a life-threatening or serious injury to a resident was quite small. Imminent risk of a life-threatening or serious injury to a resident was not in existence. Thus, the severity level must be adjusted.

This was not a case of actual harm, so severity level 3 is ruled out. Likewise, although there was no actual harm, if harm were to occur, it had the potential for much more than minimal harm. Thus, severity level 1 is ruled out.

This leaves severity level 2. Severity level 2 is defined as "[n]o actual harm with potential for more than minimal harm that is not immediate jeopardy."<sup>117</sup> Immediate jeopardy is ruled out in this case, because the risk of Salmonella Enteritidis contamination and resulting illness was so low. No one became sick from the undercooked eggs, so there was no actual harm. Yet, if there were a contaminated egg that was undercooked and consumed, there was a potential for significant harm or even death. Thus, severity level 2 was the correct level to use in the original calculation. Because there is no dispute that the violation that was found was a pattern, the categorization determination should have been "E."

**J. R. M.**

---

<sup>113</sup> 42 C.F.R. § 488.303.

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

<sup>115</sup> Ex. G at 13.

<sup>116</sup> *Id.* (Emphasis added.)

<sup>117</sup> Ex. Ca1.