OAH 71-0900-35858

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HEALTH

In the Matter of the IIDR of St. John's Lutheran Home

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

This matter came before Administrative Law Judge Jessica A. Palmer-Denig for an independent informal dispute resolution (IIDR) process on March 19, 2019, at the Office of Administrative Hearings in Saint Paul, Minnesota. The record closed on April 5, 2019, upon the filing of the parties' post-hearing written submissions.

Becky Wong, Registered Nurse (R.N.), appeared on behalf of the Minnesota Department of Health (Department). Matthew Heffron, Investigative Supervisor, Office of Health Facility Complaints (OHFC), also participated in the conference on behalf of the Department.

Aaron Sagedahl and Rebecca Coffin, Voigt, Rodè & Boxeth, LLC, appeared on behalf of St. John's Lutheran Home (Facility). Shannon Herman, R.N., Robin Phelps, Certified Nursing Assistant (CNA), Elaine Wieser, R.N. and Director of Nursing, Scot Spates, Administrator, and Sandy Nelson, former Director of Nursing, also participated in the conference on behalf of the Facility.

## STATEMENT OF THE ISSUES

The following deficiency citations, or Tags, were submitted to the Administrative Law Judge for consideration in this matter:

1. Tag F689, scope and severity level G; and

2. Tag F656, scope and severity level G.

## SUMMARY OF RECOMMENDATION

The citation to Tag F689 is supported in substance, as the Facility failed to provide adequate supervision to R1. The finding that R1 did not know how to call for help and lacked the normal means to summon help is not supported by the record and should be

deleted.[1] The citation to Tag F656 is supported in substance, as the Facility did not follow R1's plan of care by monitoring factors contributing to falls. The finding that R1 did not have a call light within reach, however, is not supported by the record and should be deleted.[2] The scope and severity level of G is supported by the record for each citation. As such, the Commissioner of the Department of Health (Commissioner) should **AFFIRM** the Department's determination that the Facility had deficiencies at Tags F689 and F656.

Based on the evidence in the hearing record and the arguments and submissions of the parties, the Administrative Law Judge makes the following:

## FINDINGS OF FACT

### I. Regulatory Framework

1. The Social Security Act mandates the establishment of minimum health and safety standards that must be met by providers and suppliers participating in the Medicare and Medicaid Programs.[3] Participation requirements for skilled nursing and long-term care facilities are set forth in 42 C.F.R. Part 483, subpart B (2018).

2. The Centers for Medicare and Medicaid Services (CMS) is a federal agency within the U.S. Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid.[4]

3. CMS assures compliance with the participation requirements through surveys conducted by state agencies, which have been delegated the responsibility for such action.[5] In Minnesota, the state survey agency is the Department. The state survey agency reports any deficiencies to CMS on a standard form called a Statement of Deficiencies, Form CMS-2567.[6]

4. A deficiency is a failure to meet a participation requirement set forth in 42 C.F.R. Part 483.[7] Deficiencies are cited as alpha-numeric tags, which correspond to a regulatory requirement in 42 C.F.R. Part 483.[8] The citations are commonly referred to as F-Tags because they relate to the survey enforcement provisions set forth in 42 C.F.R. Part 488, Subpart F.

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[1] *See* Exhibit (Ex.) E at 14 (Statement of Deficiencies).
[2] *Id*. at 2.
[3] 42 U.S.C. §§ 1302, 1320a-7(j), 1395hh (2018); *see also* 42 C.F.R. § 483 (2018).
[4] See 42 C.F.R. §§ 400-498 (2018).
[5] *See, e.g.,* 42 U.S.C. § 1864 (2018); 42 C.F.R. § 488.11.
[6] *See, e.g.,* Ex. E.
[7] 42 C.F.R. § 488.301.
[8] *See* Ex. E.

5. To assist state agencies in conducting surveys, CMS publishes a State Operations Manual (SOM).[9] The SOM provides guidance to state survey agencies, as well as regulated facilities, as to how CMS interprets the various rules and regulations.[10]

6. When a violation of a rule or a deficiency is identified, the state survey agency must make a determination as to the seriousness of that deficiency. The seriousness of the deficiency determines the remedy or the sanction imposed. The seriousness of the deficiency depends upon its scope and its severity. [11]

7. Guidance on scope and severity is set forth in the SOM at Appendix P, Deficiency Categorization.[12] Pursuant to 42 C.F.R. § 488.404 and the SOM, there are four levels of severity (Levels 1 through 4), with Level 1 being the lowest level of severity and Level 4 the highest.[13]

8. A Level 1 deficiency involves no actual harm to any resident in the care of a facility but has the potential to cause minimal harm. A Level 2 deficiency involves no actual harm to any resident, but has the potential to cause more than minimal harm but does not indicate a situation of immediate jeopardy. A Level 3 deficiency involves actual harm but does not pose an immediate jeopardy. A Level 4 deficiency involves an immediate jeopardy to a resident's health or safety.[14]

9. Scope has three levels: isolated, pattern, and widespread.[15]

10. Other factors may be considered in choosing a remedy within a remedy category, such as "the relationship of the one deficiency to other deficiencies resulting in noncompliance" and the facility's "prior history of noncompliance in general and specifically with reference to the cited deficiencies."[16]

11. Scope and severity are represented by a Scope and Severity Grid in the SOM (Grid). The Grid is a three-column, four-row table with the scope indicated by the column and the severity by the row. The left-most column is for deficiencies that are isolated while the right-most indicates a widespread deficiency and the middle column indicates the deficiency is observed in a pattern. The bottom-most row of the Grid indicates a Level 1 or least severe deficiency, and the severity of a deficiency increases through Level 4, the top row of the Grid.[17]

12. Each cell of the Grid is given a letter, starting at the bottom left-most corner of the Grid with "A," and continuing across the row with the next cells being labelled "B,"

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[9] *See* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html.
[10] *See* Ex. A (SOM Chapter 7).
[11] 42 C.F.R. § 488.404.
[12] Ex. D (SOM Appendix P).
[13] *Id.*; 42 C.F.R. § 488.404(b)(1).
[14] Ex. D at 1-2.
[15] *Id.* at 2; 42 C.F.R. § 488.404(b)(2).
[16] 42 C.F.R. § 488.404(c).
[17] Ex. C.

and "C." The second row of the Grid is assigned "D," "E," and "F"; the third row: "G," "H," and "I;" and the fourth row: "J," "K," and "L." Thus "A" represents an isolated deficiency that did not cause any actual harm and has a potential to cause only minimal harm while an "L" indicates a deficiency that is widespread and poses an immediate jeopardy to a resident's safety or health. Levels F through L are considered to represent a substandard quality of care. Below is a copy of the Grid.[18]

| | Isolated | Pattern | Widespread |
|---|---|---|---|
| Immediate jeopardy to resident health or safety | J PoC<br>Required: Cat. 3<br>Optional: Cat. 1<br>Optional: Cat. 2 | K PoC<br>Required: Cat. 3<br>Optional: Cat. 1<br>Optional: Cat. 2 | L PoC<br>Required: Cat. 3<br>Optional: Cat. 1<br>Optional: Cat. 2 |
| Actual harm that is not immediate jeopardy | G PoC<br>Required* Cat. 2<br>Optional: Cat. 1 | H PoC<br>Required* Cat. 2<br>Optional: Cat. 1 | I PoC<br>Required* Cat. 2<br>Optional: Cat. 1<br>Optional: Temporary Mgmt. |
| No actual harm with potential for more than minimal harm that is not immediate jeopardy | D PoC<br>Required* Cat. 1<br>Optional: Cat. 2 | E PoC<br>Required* Cat. 1<br>Optional: Cat. 2 | F PoC<br>Required* Cat. 2<br>Optional: Cat. 1 |
| No actual harm with potential for minimal harm | A No PoC<br>No Remedies<br>Commitment to Correct<br>Not on HCFA-2567 | B PoC | C PoC |

Substandard quality of care in any deficiency in 42 CFR 483.13 Resident Behavior and Facility Practices, 42 CFR 483.15 Quality of Life, or 42 CFR 483.25, Quality of Care that constitutes immediate jeopardy to resident health or safety; or, a pattern of or widespread actual harm that is not immediate jeopardy; or, a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm.

Substantial compliance

## II. Background Facts

13. The Facility is located in Albert Lea, Minnesota and provides skilled nursing care to its residents as well as other services.[19]

[18] *Id.*
[19] Ex. I at 1.

14. R1 was admitted to the Facility on October 3, 2017, following a hospitalization.[20] At the time of her admission, R1 was one week shy of her 82nd birthday.[21] R1 was admitted to the Facility's short stay unit to receive therapy services for gait, balance and strengthening.[22]

15. R1's diagnoses included syncope and collapse, muscle weakness, unsteadiness on feet, chronic kidney disease, and anxiety disorder.[23] R1 also had impaired vision, impaired mobility, a history of self-transferring, and a history of multiple falls.[24]

16. The Facility conducted an assessment of R1 upon her admission.[25] R1 was found to be "alert and oriented" with "[n]o communication problems noted."[26] The Facility also noted R1's diagnoses of anxiety and depression, and her history of falls.[27]

17. The Facility assessed R1 as requiring the assistance of one staff person for all transfers and ambulation.[28] On October 19, 2017, nursing staff noted that R1 "remains unsteady; walks with a scissor gait; and runs into objects when walking."[29]

18. R1's admission Minimum Data Set (MDS) Assessment, completed October 10, 2017, indicates R-1 was cognitively intact and able to express herself and comprehend others.[30] Likewise, R1's 14-day MDS Assessment, dated October 16, 2017, found R1 cognitively intact with the ability to make herself understood and to understand others.[31] However, nursing staff also noted R1's forgetfulness and her need for reminders.[32]

19. R1's care plan required the following interventions: call light within reach; environment free of obstacles; bed in low position; proper shoe gear; reminders to ask for assistance with transfers; monitor factors contributing to falls.[33]

20. R1 was independent with toileting but required assistance to transfer on and off the toilet.[34] So long as a call light was within reach, R1's care plan did not require staff to stay with her in the bathroom.[35]

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[20] *Id.*; Ex. 1 at 1.
[21] Ex. 6.
[22] Ex. 1 at 1; Ex. 2 at 18.
[23] Ex. 1 at 2; Ex. I at 3.
[24] Ex. 1 at 2; Ex. 6 at 11.
[25] Ex. 1.
[26] *Id.* at 1; Testimony (Test.) of Shannon Herman.
[27] Ex. 1 at 2.
[28] Ex. 2 at 1; Ex. 6 at 5; Test. of Herman.
[29] Ex. 2 at 11.
[30] Ex. 3; Test. of Elaine Wieser.
[31] Ex. 4; Test. of Wieser.
[32] Ex. I at 18; Ex. E at 9-11.
[33] Ex. 6 at 11; Test. of Herman.
[34] Test. of Herman.
[35] *Id.*; Test. of Wieser; Ex. 6 at 10.

## III. The Facility's Call Light System

21. The Facility has a call light system allowing a resident to alert staff that the resident needs assistance.[36] The call light system may be triggered from the resident's bedroom or bathroom.[37]

22. The Facility installed a "new" call light system approximately ten years ago.[38] The new call lights are moveable wireless boxes that may be attached to a wall. Each resident's room has a new call light by the resident's bed and in the resident's bathroom.[39] The call light is triggered by pulling a cord that hangs down from the unit, or by pressing a large button on the front of the unit.[40] When the resident uses the new call light, an alert is sent directly to the nursing staff via walkie-talkies.[41] An alert also scrolls along a digital marquee at the nurse's station.[42] When this system is triggered, a record of the call is created and recorded on a log, which shows the time the call light was triggered and the time of the response.[43]

23. Staff are expected to answer call lights within three minutes.[44]

24. In addition to the new call light system, resident bedrooms and bathrooms remain equipped with the Facility's "old" call light system.[45] The old call light systems are hard-wired into the walls. In the bathroom, the old call light is a dark light switch on the wall. Some of the old call light systems have a cord hanging down that the resident may pull.[46] When activated, the old call light system turns on a bright red light above the door of the resident's room to alert staff.[47] Unlike the new call light system, the old system does not alert staff directly and is not recorded in a log when activated.[48] Instead, staff are required to remain attentive to the lights above residents' doors as they go about their work.[49]

25. Nursing notes indicate that R1 was "call light appropriate."[50] During her time at the Facility, R1 used both the old and new call light systems to request assistance.[51]

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[36] Test. of Herman, Test. of Scot Spates.
[37] Test. of Herman.
[38] Test. of Spates.
[39] Test. of Herman; Test. of Spates; Ex. E at 11.
[40] Ex. 7 (photo of call lights in R1's bathroom).
[41] Test. of Herman; Ex. E at 13.
[42] Test. of Herman; Ex. E. at 13.
[43] Test. of Herman; Test. of Spates; Ex. J at 2.
[44] Test. of Wieser.
[45] Throughout this recommendation, the wireless call lights are referred to as the new call light system, while the hard-wired call lights are referenced as the old call light system.
[46] Test. of Herman; Test. of Spates; Ex. I at 23; Ex. 7.
[47] Test. of Herman; Ex. E at 6.
[48] Test. of Herman.
[49] Ex. E at 7.
[50] Ex. 2 at 2.
[51] *Id.*; Test. of Herman; Test. of Robin Phelps.

26. The new call lights occasionally require repairs.[52] On these occasions, the malfunctioning unit is removed from a resident's room and left at the nurse's station for the Facility's maintenance staff to repair.[53]

27. When a resident's bathroom call light is being repaired, staff will sometimes move the resident's bedside call light into the bathroom while the resident is in the bathroom.[54] Depending on the level of assistance and supervision required for the resident, staff might also remain with the resident in the bathroom if the resident's new bathroom call light is missing.[55]

## IV. R1 Falls in the Bathroom

28. On or about November 12, 2017, Facility staff removed R1's new call light system from her bathroom for repairs.[56] The call light had become submerged in water and had stopped working.[57]

29. R1's bathroom new call light box was left at the nurse's station for maintenance staff to repair and test.[58] Maintenance staff examined and tested R1's bathroom call light on the morning of November 13, 2017.[59]

30. R1's bathroom had an old call light switch installed in the wall but it did not have a pull cord.[60] The only way to activate the old call light in R1's bathroom was to flip the switch on.[61]

31. On November 13, 2017, R1 got up at approximately 7:45 a.m.[62] After getting washed up and dressed, R1 was assisted to the dining room for breakfast.[63]

32. After breakfast, R1 was assisted back to her room.[64] At 9:40 a.m., R1 turned on her bedside call light.[65] Shannon Herman responded to the call at 9:42 a.m.[66] Herman observed R1's mental status to be anxious and forgetful, which was fairly typical for R1.[67]

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[52] Test. of S. Spates; Ex. E at 9.
[53] Test. of Herman.
[54] *Id.*; Test. of Spates; Ex. E at 7-9.
[55] Ex. E at 7.
[56] Test. of Herman; Ex. E at 3, 10.
[57] Ex. E at 10, 12.
[58] *Id.* at 3.
[59] Test. of Herman; Ex. 9 at 2; Ex. E at 10-12.
[60] Test. of Spates; Ex. I at 23.
[61] Ex. I at 23.
[62] Ex. 9 at 3.
[63] *Id*.
[64] *Id*.
[65] Ex. J at 2.
[66] *Id*.
[67] Ex. E at 23-24; Ex. 9 at 2.

33. At 9:48 a.m., Herman entered a nursing note regarding R1's condition indicating "[s]he is currently in her room resting in her chair."[68]

34. R1's new bathroom call light was triggered at 9:45 a.m.[69] Because R1's new call light was not in her bathroom at that time, it was not activated by R1 in her bathroom; rather, it most likely was activated by maintenance staff testing the unit.[70]

35. Sometime after 10:00 a.m. and prior to 10:35 a.m., CNA Robin Phelps responded to a call light from R1's bedroom. This call light was triggered from the old system in the bedroom and did not create a call log entry.[71]

36. R1 activated the call light because she wished to be taken to the bathroom.[72] Phelps responded to the call light and assisted R1 into the bathroom.[73] Phelps transferred R1 onto the toilet, reminded her to use the call light when she was done, and left.[74]

37. The removal of R1's new call light system from her bathroom was not reported to Phelps.[75] Phelps did not notice that R1's new call light was missing when she left R1 sitting on the toilet.[76] As a result, Phelps assumed she would receive a notification on her walkie-talkie when R1 was ready to leave the bathroom.[77]

38. Approximately ten minutes after bringing R1 to the bathroom, Phelps checked on R1.[78] R1 was not done toileting.[79] About this time, Phelps received a call light notification regarding another resident.[80] Phelps told R1 that she was going to check on the other resident and would come back to help R1 when she was finished.[81]

39. Because of R1's forgetfulness, history of self-transferring, and history of falls, staff was expected to check on R1 multiple times when she was on the toilet.[82] R1 had a history of transferring herself even when a call light was available.[83]

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[68] Ex. 2 at 1; Test. of Herman.
[69] Ex. J at 2.
[70] Test. of Herman: Ex. I at 23.
[71] Ex. E at 8; Ex. J at 2; Test. of Phelps.
[72] Test. of Phelps.
[73] *Id*.
[74] *Id*.; Ex. E at 8.
[75] Ex. E at 9 and 14.
[76] Test. of Phelps; Ex. E at 8-10.
[77] Ex. E at 8-9.
[78] Test. of Phelps.
[79] *Id*.
[80] *Id*.
[81] *Id*.; Ex. E at 8.
[82] Test. of Herman.
[83] Ex. 17 (Statement of Elaine Wieser).

40. R1 waited for Phelps to return to assist her off the toilet.[84] When Phelps did not return, R1 began yelling for help. R1 did not turn on the old call light switch. Ultimately, R1 attempted to transfer herself off the toilet. In the process, R1 lost her balance and fell, striking her left side against the edge of the toilet.[85] R1 managed to crawl to the door and was located by a dietary aide.[86] The dietary aide called out for help when she saw R1.[87]

41. Herman was at the nurse's station when she heard the dietary staff member call out that R1 had fallen.[88] Herman wrote the time, 10:45 a.m., on her hand in order to begin establishing a record.[89]

42. Herman found R1 on her knees in the bathroom.[90] R1 was shaking and upset.[91] R1 stated she had hit her left breast and rib area on the toilet when she fell.[92] R1 said she was she was using the bathroom and went to reach for the call light, but found it was not there.[93] She said she called out for help, "became shaky" and fell.[94] R1 complained of rib pain and had a 3 x 3 cm bruise on left chest/rib area.[95] R1 declined to go to the emergency room.[96]

43. Herman contacted R1's son and reported that R1 had fallen.[97]

44. The Facility immediately reported R1's fall to the OHFC.[98] In the report, the Facility stated that R1 "fell trying to get assistance as there was no call light in her BR. It was being repaired."[99]

45. Herman conducted a fall investigation for the Facility.[100] Herman determined that R1's call light had been removed from her bathroom for repairs and that R1 had been left in the bathroom without access to a call light.[101] Herman concluded that R1's fall was preventable and was due to staff's failure to follow R1's plan of care.[102]

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[84] These events were recounted to the investigator by a family member of R1 based upon statements R1 made to the family member. Ex. E at 13. R1 was also interviewed during the survey, but she did not provide the same level of detail in her own interview. *See id*. at 7-8.
[85] *Id.* at 13.
[86] Test. of Herman; Ex. E at 10.
[87] Test. of Herman.
[88] *Id*.
[89] *Id*.
[90] Ex. 2 at 1.
[91] Ex. E at 23.
[92] Ex. 2 at 1; Test. of Herman.
[93] Ex. 2 at 1; Ex. 9 at 2.
[94] Ex. 2 at 1.
[95] *Id.*; Test. of Herman.
[96] Ex. 2 at 1; Ex. I at 23; Test. of Herman.
[97] Ex. 2 at 1.
[98] Ex. 10 (OHFC Report submitted Nov. 13, 2017).
[99] *Id*. at 2.
[100] Ex. 9; Ex. I at 17-21.
[101] Ex. 9.
[102] *Id*. at 4.

46. On November 14, 2017, the Facility issued a written warning to Phelps for failure to follow R1's plan of care.[103] The written warning stated that Phelps transferred a resident to the bathroom and failed to verify that the resident had a call light within reach.[104] Phelps was directed to: "always visualize and orient resident to where the call light is [and] never leave resident without a means of accessing assistance."[105] The written warning was signed by Phelps, her supervisor, and the Facility's director of human resources.[106]

47. On November 15, 2017, R1 was taken to urgent care because of continued complaints of pain in her left breast and rib area.[107] An examination revealed that R1 had sustained two fractured ribs on her left side as a result of her fall.[108]

48. On November 16, 2017, the Facility submitted an investigation report to the OHFC.[109] Based on its investigation, the Facility concluded that an employee had left R1 in the bathroom without access to a call light.[110] The Facility noted that the employee had received a written warning for failure to follow R1's plan of care.[111]

49. At some point after R1 fell, R1's daughter called Elaine Wieser, the nurse manager of the Facility's short stay unit.[112] R1's daughter was very upset.[113] She told Wieser that R1 said she had been left alone on the toilet for about 45 minutes.[114]

50. On November 20, 2017, Wieser left a voice mail message with R1's daughter apologizing for R1's injury.[115] Wieser stated that a nursing assistant had left R1 on the toilet for approximately 45 minutes without verifying that R1 had a call light within reach.[116] Wieser explained that the nursing assistant was waiting for the call light notification, got busy with another resident, and did not return before R1 had fallen.[117]

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[103] Ex. 13.
[104] *Id*.
[105] *Id*.
[106] Test. of Spates.
[107] Ex. 11; Ex. I at 23.
[108] Ex. 9 at 1 and 4; Ex. 11.
[109] Ex. 11.
[110] *Id*.
[111] *Id*.
[112] Test. of Wieser.
[113] *Id*.
[114] *Id*.
[115] Ex. E at 6, 13; Test. of Wieser.
[116] Ex. E at 6.
[117] *Id*.

## V. The Department's Investigation

51. The OHFC conducted an abbreviated survey in response to the Facility's report of R1's fall.[118] On January 5, 2018, the surveyor interviewed eleven staff members and R1.[119] The surveyor also interviewed a family member of R1 on January 12, 2018.[120]

52. During her interview, Phelps stated that she helped R1 to the bathroom on the morning of November 13, 2017, and did not notice that the new call light was missing.[121] Phelps stated that she assumed the new call light was in R1's bathroom and that she would receive an alert on her walkie-talkie when R1 was ready to leave the bathroom.[122] Phelps stated that she checked on R1 after ten minutes and again five minutes later, before learning that R1 had fallen.[123] Phelps conceded that R1 sat on the toilet "for a long time."[124]

53. When interviewed, R1 stated she was sure Phelps told her the bathroom call light was not available and that she would come back to help R1 after assisting another resident.[125] R1 stated that normally the bathroom call light "just hangs there."[126]

54. When interviewed, nursing staff stated generally that R1 is anxious, forgets easily, and needs frequent reminders.[127]

55. The investigator observed the old and new call light systems at the Facility, noting how each system works.[128] The investigator stated that "there remains an old light switch on the bathroom wall that, if flipped, turns on a red light outside of the resident's room; however, it does not produce any sounds. The third-tier backup switch on the bathroom wall looks like a light switch."[129]

## VI. The Department Finds Deficiencies

56. The Department exited the survey on May 21, 2018.[130] The Department issued a Statement of Deficiencies identifying two deficiencies with respect to R1: F656 (care plan) and F689 (supervision).[131]

57. Based upon its investigation of R1's fall and its review of the Facility's policies, the Department concluded the Facility violated 42 CFR § 483.21(b)(1), which

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[118] Ex. E; Test. of Matt Heffron.
[119] Ex. E at 6-13.
[120] *Id*. at 13-14.
[121] *Id*. at 8-9.
[122] *Id*.
[123] *Id*.
[124] *Id*.
[125] *Id*. at 7-8.
[126] *Id*.
[127] *Id*. at 7-11.
[128] *Id.* at 6.
[129] *Id.*
[130] *Id.* at 1; Test. of Heffron.
[131] Ex. E; Test. of Heffron.

requires facilities to develop and implement a comprehensive person-centered care plan for each resident. [132]

58. The Department determined the Facility failed to ensure R1 received care according to her written care plan.[133] One of the interventions for fall risk listed on R1's care plan, dated October 17, 2017, was "call light within reach."[134] The Department determined R1's fall was due to the Facility's failure to follow R1's care plan and ensure a call light was within reach.[135]

59. Based on its investigation, the Department also concluded the Facility violated 42 CFR § 483.25(d)(2), which requires facilities to provide "adequate supervision and assistance devices to prevent accidents."[136]

60. The Department determined the Facility failed to ensure R1 received adequate staff supervision and assistance to prevent an accident. Specifically, the Department found: (1) a staff person failed to communicate to other staff that R1's call light had been removed, and (2) a staff person transferred R1 to the toilet and left her sitting there for 45 minutes without having the "normal means for summoning help."[137]

61. The Department assigned both deficiencies a severity level of G. The Department determined the scope of the deficiency was isolated and while there was actual harm to a resident, there was no immediate jeopardy.[138]

62. Without admitting to the deficiencies, the Facility proposed a plan of correction that included educating and updating maintenance and nursing staff on call light protocols through the Employee Newsletter on June 15, 2018.[139] The Facility also proposed to monitor call light reports daily through the month of June 2018 and review the findings for additional call light protocol recommendations.[140]

## VII. The Facility Changes Its Assessment of the Cause of R1's Fall

63. Herman has changed her opinion as to the cause of R1's fall.[141] Contrary to the conclusion she reached in the November 13, 2017 fall investigation report, Herman now believes staff did not violate R1's care plan.[142] Herman notes that the old bathroom call light was in reach of R1 on the morning of her fall.[143] Because the old call light was

[132] Ex. E; Test. of Heffron.
[133] Ex. E; Test. of Heffron.
[134] Ex. E; Ex. 6 at 11.
[135] Ex. E; Test. of Heffron.
[136] Ex. E; Test. of Heffron.
[137] Ex. E at 14; Test. of Heffron.
[138] Ex. E at 1, 14.
[139] *Id.* at 2-3.
[140] *Id.*
[141] Ex. 18 (Statement of Shannon Herman).
[142] *Id.* Compare Ex. 18 with Ex. 9.
[143] Ex. 18.

within reach of R1, Herman now maintains the fall was an accident that could not have been prevented.[144]

64. In a statement dated March 8, 2019, Administrator Spates concurred with Herman and concluded that R1's fall was not due to staff's failure to follow her care plan.[145] Based on this conclusion, Spates rescinded the disciplinary action issued by the Facility against Phelps related to this incident.[146]

65. Wieser also offers a different conclusion in a statement dated July 3, 2018, noting that during her original investigation she "forgot to consider the old call light system that we use as backup."[147] Weiser has concluded that Phelps should have ensured that the hanging cord was attached to the old call light, but that a call light was still within reach of R1, consistent with her care plan.[148]

66. Phelps has also provided a new statement as well, dated July 3, 2018, stating that she assisted R1 to the toilet at 10:35 a.m. on the morning of November 13, 2017.[149] Phelps states that she "reminded R1 that her main call light was being repaired and she should use the old call light system, which was located on the bathroom wall, when she was done."[150] Phelps states that R1 was capable of understanding and following instructions, but that "she just at times chose not to."[151]

67. The Facility timely filed a request for an IIDR proceeding pursuant to Minn. Stat. § 144A.10, subd. 16 (2018), and contests both deficiency citations.

## VIII. Incorporation

68. Any conclusion of law more properly considered a finding of fact is incorporated herein.

69. Any fact identified in the Memorandum below is incorporated as a finding of fact.

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

## CONCLUSIONS OF LAW

1. The Commissioner and the Administrative Law Judge have jurisdiction in this matter, pursuant to Minn. Stat. §§ 14.57, 144A.10 (2018).

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[144] *Id*.
[145] Ex. 19 (Statement of Scot Spates).
[146] *Id*.
[147] Ex. 17.
[148] *Id.*
[149] Ex. 16 (Statement of Robin Phelps).
[150] *Id.*
[151] *Id.*

2. The Facility is subject to the federal Social Security Act and 42 C.F.R. Parts 483 and 488.

3. The Administrative Law Judge must issue one or more of the following findings with regard to the deficiency in dispute:

a. Supported in full. No deletion of Department findings and no change in the scope or severity assigned to the deficiency citation;

b. 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;

c. Deficient practice cited under wrong requirement of participation. The citation is amended by moving it to the correct requirement of participation;

d. Scope not supported. The citation is amended through a change in the scope assigned to the citation;

e. Severity not supported. The citation is amended through a change in the severity assigned to the citation; or

f. 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 are not binding on the commissioner.[152]

4. A regulated facility is subject to remedial action if it is not in "substantial compliance" with one or more regulatory standards.[153] A facility is not in substantial compliance if there is a deficiency that creates at least the "potential for more than minimal harm" to one or more residents.[154] If a deficiency poses no greater risk to a resident's health or safety than the potential for causing minimal harm, the facility is in substantial compliance.[155]

5. Under 42 C.F.R § 483.25(d)(1), (2), which is the basis of Tag F689, a facility must ensure that the resident environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance devices to prevent accidents.[156]

[152] Minn. Stat. § 144A.10, subd. 16(d).
[153] 42 C.F.R. § 488.400.
[154] 42 C.F.R. § 488.301.
[155] *Id*.
[156] *See* Ex. F at 1.

6. An "accident" is an "unexpected or unintentional incident, which may result in injury or illness to a resident."[157] "Hazards" are elements of the environment "that have the potential to cause injury or illness."[158] "Free of accident hazards as possible" means "free of accident hazards over which the facility has control."[159]

7. An "avoidable accident," means that an accident occurred because a facility failed to:

> • Identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision and/or assistive devices; and/or
>
> • Evaluate/analyze the hazards and risks and eliminate them, if possible, or, if not possible, identify and implement measures to reduce the hazards/risks as much as possible; and/or
>
> • Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and, if not, reduce the risk of an accident; and/or
>
> • Monitor the effectiveness of the interventions and modify the care plan as necessary, in accordance with current professional standards of practice.[160]

8. "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," including supervision of residents and of identified hazards within the residents' environment.[161]

9. Adequacy of supervision is defined by type and frequency, and is based in part on the individual resident's assessed needs. The level of supervision that is "adequate" may vary from resident to resident and from time to time for the same resident.[162]

10. Tag F656 is based upon 42 U.S.C. § 483.21(b)(1), which provides that the facility must develop and implement a comprehensive person-centered care plan for each resident.[163]

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[157] *Id*.
[158] *Id.* at 2.
[159] *Id.*
[160] *Id.* at 1.
[161] *Id.* at 2, 5.
[162] *Id.* at 5.
[163] Ex. G at 1.

11. A facility is required to identify objectives to meet resident goals and implement interventions to meet that objective.[164] Interventions are actions, treatments, procedures, or activities designed to meet an objective.[165]

12. Determining whether a facility is in "compliance with 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."[166]

13. A "deficiency" is a failure of a facility to meet a participation requirement specified by applicable law and regulation relating to skilled nursing facilities and nursing facilities.[167]

14. Deficiencies are assigned to the Grid according to a determination of scope and severity.[168] Relevant here is level G, which may be assigned when a deficiency is isolated, but it creates actual harm that is not immediate jeopardy.[169]

15. The Administrative Law Judge determines that the Department has shown the Facility has a deficiency at Tag F689 and that the deficiency is properly categorized at a scope and severity level of G, because the incident was an isolated event in which R1 suffered actual harm that was not immediate jeopardy.

16. The Administrative Law Judge determines that the Department has shown the Facility has a deficiency at Tag F656 and that the deficiency is properly categorized at a scope and severity level of G, because the incident was an isolated event in which R1 suffered actual harm that was not immediate jeopardy.

17. Any finding of fact more properly considered a conclusion of law is incorporated herein.

18. Any portion of the Memorandum below constituting a conclusion of law is incorporated as such.

Based upon these Conclusions of Law, and for the reasons explained in the accompanying Memorandum, the Administrative Law Judge makes the following:

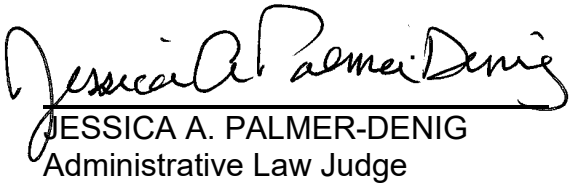
## RECOMMENDATION

The citation to Tag F689 is supported in substance at a scope and severity level of G. The finding that R1 did not know how to call for help and lacked the normal means to summon help is not supported by the record should be deleted. The citation to Tag F656 is supported in substance at a scope and severity level of G. The finding that R1 did not have a call light within reach, however, is not supported by the record and should

[164] *Id.*
[165] *Id.*
[166] 42 C.F.R. § 488.26(b).
[167] 42 C.F.R. § 488.301.
[168] Ex. C
[169] *Id.*

be deleted. Therefore, the Administrative Law Judge recommends that the Commissioner **AFFIRM** the deficiency citations at Tags F689 and F656.

Dated: April 19, 2019



JESSICA A. PALMER-DENIG
Administrative Law Judge

Reported: Digitally Recorded
No transcript prepared

## NOTICE

This Report is a recommendation, not a final decision. The Commissioner will make the final decision after a review of the record. The Commissioner may adopt, reject or modify the Findings of Fact, Conclusions of Law, and Recommendations. Under Minn. Stat. § 14.61 (2018), the final decision of the Commissioner shall not be made until this Report has been made available to the parties to the proceeding for at least ten days. An opportunity must be afforded to each party adversely affected by this Report to file exceptions and present argument to the Commissioner. Parties should contact Jan Malcolm, Commissioner, Minnesota Department of Health, 85 East Seventh Place, P.O. Box 64975, St. Paul, MN 55164, to learn the procedure for filing exceptions or presenting argument.

If the Commissioner fails to issue a final decision within 90 days of the close of the record, this Report will constitute the final agency decision under Minn. Stat. § 14.62, subd. 2a (2018). The record closes upon the filing of exceptions to the Report and the presentation of argument to the Commissioner, or upon the expiration of the deadline for doing so. The Commissioner must notify the parties and the Administrative Law Judge of the date on which the record closes.

Under Minn. Stat. § 14.62, subd. 1 (2018), the agency is required to serve its final decision upon each party and the Administrative Law Judge by first class mail or as otherwise provided by law.

## MEMORANDUM

The Facility challenges the Department's decision to issue Tags under two federal regulatory standards. The Administrative Law Judge determines that both Tags were correctly cited, and that the scope and severity assigned to them is supported by the record, though with regard to both tags, certain findings should be deleted. As the cited deficiencies are both supported in substance, the Administrative Law Judge recommends that the Commissioner affirm the two cited deficiencies.

## I. Legal Standard

An issue arose at the IIDR proceeding regarding the legal standard to apply in this case. The facility asserts that "substantial compliance" is all that is required of it.[170] According to the Facility's reasoning, if it substantially complied with a regulatory requirement, no deficiency can be found. The Administrative Law Judge disagrees.

Federal regulations provide definitions for several key terms. A "deficiency" is a failure of a facility to meet a participation requirement specified by applicable law and regulation relating to skilled nursing facilities and nursing facilities.[171] 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."[172] Noncompliance is "any deficiency that causes a facility to not be in substantial compliance."[173]

According to these definitions, a facility's level of compliance is assessed after determining that a deficiency exists. A facility may be cited for a deficiency, but so long as the deficiency has only the potential for causing minimal harm, the facility is still in substantial compliance. The Facility's argument here, that substantial compliance is the standard for ascertaining whether a deficiency occurred in the first place, contradicts the governing regulation by putting the question of the level of compliance before the determination that there has been a deficiency.

The Grid used to assign scope and severity levels supports this reading of the regulation, specifically identifying deficiencies cited at a scope and severity level of A, B, or C, as substantial compliance.[174] All of these categorizations involve deficiencies at Level 1, which is assessed for deficiencies involving "no actual harm with potential for minimal harm."[175]

Therefore, consistent with the regulations and guidance documents, the Administrative Law Judge utilizes a two-step process to analyze the issues in this case. The first step examines whether a deficiency existed and, if so, the second step assigns a scope and severity to the deficiency. If the scope and severity are assigned at levels A, B, or C, the Facility will still be in substantial compliance with program requirements.

## II. Tag F689: Supervision

The Department cited the Facility at Tag F689 at a scope and severity level of G. The Department contends that the Facility failed to provide adequate supervision to R1,

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[170] *See* Facility's Prehearing Statement at 5, 7 (Mar. 13, 2019); Facility's Written Closing at 1-2 (Apr. 5, 2019).
[171] 42 C.F.R. § 488.301.
[172] *Id.*
[173] *Id.*
[174] Ex. C.
[175] *Id.*

leading to her accident, and that R1 suffered actual harm that was not immediate jeopardy. The Facility argues that it adequately supervised R1 because she was independent as to toileting, had no cognitive impairments, knew how to use both call light systems, and had access to the old call light system within her reach. The Facility maintains that its actions and practices were not deficient. The Administrative Law Judge determines that the Department has substantiated the citation.

Under 42 C.F.R § 483.25(d)(1), (2), a facility must ensure that the resident environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance devices to prevent accidents.[176] An "accident" is an "unexpected or unintentional incident, which may result in injury or illness to a resident."[177] "Supervision/Adequate Supervision" refers to an "intervention and means of mitigating the risk of an accident."[178] The adequacy of supervision depends in part on the individual resident's assessed needs, and the level of supervision that will be adequate varies from one patient to another, and may vary for each patient over time.[179]

R1 was able to toilet independently, but needed one-to-one assistance to move anywhere, including on and off the toilet.[180] R1 had a history of falls and of self-transferring.[181] She also had a diagnosis of anxiety and the Facility deemed her normal state to be forgetful.[182]

On the morning of November 13, 2017, Phelps assisted R1 onto the toilet. There is no dispute that R1 was discovered on the floor at 10:45 a.m., in response to the dietary staff member's call that a fall had occurred.[183] There is a dispute between the parties as to how long R1 was left on the toilet.

The Department contends that R1 was left on the toilet for 45 minutes. The Department originally argued that Phelps placed R1 onto the toilet in response to the summons from the call light logged at 9:45 a.m., which had a response time of 9:52 a.m.[184] However, the call log shows that this call light notification was triggered from R1's new call light equipment, which was with maintenance for repair, and could not have been triggered from the bathroom.[185] R1 told a family member she was on the toilet for 45 minutes; while R1 may have felt that she was left without assistance for 45 minutes, there is no evidence to support R1's assessment of the timing.[186]

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[176] *See* Ex. F at 1.
[177] *Id.*
[178] *Id.* at 2, 5.
[179] *Id.* at 5.
[180] Ex. 2 at 1; Ex. 6 at 5; Test. of Herman.
[181] Ex. 2 at 1; Ex. 6 at 5; Test. of Herman.
[182] Ex. 1 at 2; Ex. I at 18.
[183] Test. of Herman; Ex. E at 10.
[184] Ex. J at 2; Test. of Heffron.
[185] Ex. J at 2; Test. of Herman.
[186] Ex. E at 13.

The Department now concedes that the exact time that Phelps assisted R1 to the toilet cannot be determined from the record.[187] Simultaneously, however, the Department posits that the most reasonable conclusion is that Phelps assisted R1 to the bathroom in response to the bedroom call light notification logged at 9:40 a.m., which had a response time of 9:42 a.m.[188] The record does not support concluding that R1 was placed on the toilet in response to that call. Herman responded to the 9:40 a.m. call light and assisted R1, entering a nursing note at 9:48 a.m. indicating that R1 was "currently in her room resting in her chair."[189]

The Facility contends that Phelps assisted R1 to the bathroom at 10:35 a.m.[190] This is also not supported by the record. The Fall Investigation Report and Phelps' most recent statement both cite 10:35 a.m. as the time Phelps placed R1 on the toilet.[191] Yet, Phelps has provided a variety of statements about what happened, including statements contradicting that timing. For example, Phelps stated in January 2017, that she checked on R1 after ten minutes and again five minutes later, and that R1 sat on the toilet for a long time.[192] R1's statements also suggest she was on the toilet for longer than ten minutes; R1 reported to her family member that she was on the toilet for so long that her legs became numb and that she yelled for help, but that no one heard her.[193] Only after that did she attempt to transfer herself.[194]

The Administrative Law Judge finds that, while the exact time R1 was placed on the toilet cannot be determined, the transfer occurred during a timeframe beginning around 10:00 a.m. and before 10:35 a.m. This is supported by several facts in the record that the Administrative Law Judge finds credible: (1) Herman's nursing note at 9:48 a.m. remarking that R1 was then resting in her chair; (2) Phelps's statement that she checked on R1 ten minutes after placing her on the toilet, but that R1 was on the toilet for a long time; and (3) R1's report that she was on the toilet long enough for her legs to go numb and to need to call for help.

The parties also have disputed whether R1 had a call light available allowing her to alert Phelps to assist her from the toilet. The Department determined that R1 was left without a call light to alert staff of her need to be assisted, and the Facility originally found this was true as well.[195] Subsequently, as explained in the findings of fact above, the Facility concluded it had erred in its assessment, and that R1 had a call light available because of her access to the old call light system hardwired into the bathroom wall, which R1 knew how to use.[196] The investigator's findings support that the old call light was

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[187] Department's Written Closing at 2 ("it is unable to be determined what time the transfer to the toilet occurred").
[188] Ex. J.
[189] Test. of Herman; Ex. 2 at 1.
[190] Ex. 9 at 3; Ex. 16.
[191] Ex. 9 at 3; Ex. 16.
[192] Ex. E at 9.
[193] *Id.* at 13.
[194] *Id.*
[195] Ex. E; Ex. 9; Test. of Heffron.
[196] Exs. 17, 18.

present, as the investigator observed the old call light system during the survey.[197] The Facility produced uncontroverted evidence at the IIDR proceeding that R1 used the old call light system and, in fact, the record supports a finding that the alert R1 used to summon Phelps to assist her to the bathroom came from the old call light system in R1's bedroom.[198]

The Administrative Law Judge finds that the presence of a call light in the bathroom is not determinative as the citation for Tag F689. Even crediting that R1 had a call light available, the Facility failed to provide R1 with supervision adequate to mitigate the risk of this accident. R1 was known to be at risk of falling and the Facility knew she transferred herself. The nursing notes created for R1 repeatedly state that she requires an assist of one person for all movement and that R1 was engaging in self-transfers.[199] Additionally, the Facility knew R1 had anxiety and was forgetful, and staff was expected to check on her multiple times in the bathroom.[200] Further, the Facility's evidence includes a statement from Wieser indicating that "[e]ven with a call light available, R1 has a history of trying to transfer herself.[201]

Under these circumstances, Phelps did not provide adequate supervision to R1 once she was on the toilet. The Administrative Law Judge determines, based upon the record, that Phelps assisted R1 onto the toilet and checked on her about ten minutes later, but then began assisting another resident and did not come back to check on R1. As discussed in further detail below, Phelps was waiting for a notification from the new call light system to return. As time passed without such a notification, however, Phelps should have returned to the bathroom to check in on R1, as Phelps herself assessed that R1 was on the toilet for a long time. While the exact length of time R1 was on the toilet cannot be determined, it was long enough for R1 to experience numbness in her legs and to begin calling for someone to help her.

The adequacy of supervision depends upon the patient's needs. With R1's history and known behaviors, the Facility was aware of the risk that R1 would transfer herself, even with a call light available, and should have had staff checking in on R1 more regularly.

Therefore, the Administrative Law Judge determines that the citation at Tag F689 is supported in substance based upon the Facility's failure to provide R1 with adequate supervision. The factual finding made by the Department to support the citation, that R1 did not know how to call for assistance and did not have the normal means for summoning help,[202] is not supported by the record and should be deleted. Additionally, as R1's fall broke two of her ribs, she suffered actual harm that was not immediate jeopardy, making

[197] Ex. E at 19.
[198] *Id.* at 8; Ex. J at 2; Test. of Phelps; Test. of Herman.
[199] *See* Ex. 2.
[200] Ex. 1 at 2; Ex. I at 18; Test. of Herman.
[201] Ex. 17.
[202] Ex. E at 14.

an assessment of the incident at a scope and severity level of G proper. Therefore, the Commissioner should affirm the citation at Tag F689.

## III. Tag F656: Care Plan

The Department determined that the Facility had a deficiency at Tag F656 for failing to develop and implement a care plan for R1. Specifically, the Department concluded that the Facility failed to implement a term of R1's care plan by keeping a call light within R1's reach in the bathroom on November 13, 2018

Tag F656 arises from a regulation requiring that a facility develop and implement a comprehensive person-centered care plan for each resident.[203] A facility is required to identify objectives to meet resident goals and implement interventions to meet that objective.[204] Interventions are actions, treatments, procedures, or activities designed to meet an objective.[205]

R1 had a care plan in place. R1's care plan required the following interventions: call light within reach; environment free of obstacles; bed in low position; proper shoe gear; reminders to ask for assistance with transfers; monitor factors contributing to falls.[206] R1 also needed more frequent checks while she was in the bathroom.[207]

The Facility initially found that it had failed to follow R1's care plan related to the call light, determining this was the cause of R1's accident.[208] The Facility subsequently revised its assessment and it now contends that it was in compliance with the care plan because R1 had access to the old call light switch, hardwired into the wall of her bathroom. The Facility explains this shift through several witnesses. Herman provided a statement indicating that she "realized that R1 did in fact have a call light available to her, as she did have the old call light system that we use as a backup."[209] Wieser similarly states: "when I did the investigation, I forgot to consider the old call light system that we use as back up."[210]

The Facility's evidence regarding the call light system contains some inconsistencies. According to the Facility, the old call light system is still in active use, with residents, including R1, regularly using the old call light system to summon staff for assistance. It is curious, then, that experienced and senior staff of the Facility, including Herman and Wieser, overlooked the presence of that system during the fall investigation.

Additionally, the story Phelps has told about the presence of the call light has changed over time. Phelps initially indicated that she did not realize that the new call system box was missing from R1's bathroom, noting that she "could swear" that the call

[203] Ex. G at 1; 42 U.S.C. § 483.21(b)(1).
[204] Ex. G at 1.
[205] *Id.*
[206] Ex. 6 at 11; Test. of Herman.
[207] Test. of Herman.
[208] Ex. 9; Ex. I at 17-21.
[209] Ex. 18.
[210] Ex. 17.

light was there, and stating another time that she felt the call light was there but was "not 100% sure."[211] In her interview with the Department investigator during the survey, Phelps stated that she reminded R1 that there were two call lights, telling her to put one on and that if it did not work, to put the other on.[212] Phelps left the bathroom assuming that the new call light apparatus, which would send an alert to her walkie-talkie, was present in the bathroom.[213] Phelps stated she found out that maintenance had R1's call light.[214] She noted, however, that the old call light system was also present and that she showed R1 how to use the switch.[215] Later, in her statement filed as an exhibit for the IIDR proceeding, Phelps asserts that, in fact, she did know that the new call light system was missing, noted that for R1, and reminded R1 to use the old call light system.[216] Finally, at the IIDR proceeding, Phelps testified that she transferred R1 to the toilet, noted for R1 that there were two call lights, and indicated that R1 should use the call light to summon her to return.[217] She testified she remembered checking on R1 after ten minutes, but was not sure about whether she checked on her again five minutes after that.[218] Phelps confirmed that she believed the new call light system was in place and she expected to get an alert to her walkie-talkie when R1 was finished toileting.[219]

Ultimately, the Administrative Law Judge determines that the Department cited the Tag at F656 properly, though the presence or absence of the call light is not the determining factor. Rather, the citation is appropriate due to the Facility's failure to ensure monitoring of factors contributing to falls. Therefore, this citation is supported in substance and should be affirmed, though the finding that the call light was absent should be deleted from the Statement of Deficiencies.

This determination is based upon several factors. First, R1 was known to be at risk of falls and self-transferring, even when a call light was available. Second, R1 had anxiety and was forgetful; she needed reminders to wait for assistance and more frequent checks while she was in the bathroom. Third, R1's care plan specifically addressed the risk of self-transferring and falls, requiring that R1 receive assistance when moving about, staff remind R1 not to self-transfer, and that factors contributing to falls be monitored. Fourth, among the different versions of events offered by both parties, the Administrative Law Judge finds most credible that Phelps did not realize that the new call light was missing, was waiting for an alert on her walkie-talkie, checked on R1 after ten minutes had passed, but then became busy with another resident and did not make it back to timely check on R1.

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[211] Ex. I at 23.
[212] Ex. E at 8. R1 had a different memory of this interaction, reporting that Phelps told her that the new call light was not present and then did not tell her what she should do to alert Phelps to return. *Id.* at 7-8. The Administrative Law Judge does not find this to be the most likely version of events based upon the entire record.
[213] *Id.* at 9.
[214] *Id.*
[215] *Id.*
[216] Ex. 16.
[217] Test. of Phelps.
[218] *Id.*
[219] *Id.*

The Facility's failure to implement the care plan does not depend upon whether R1 had access to a call light. There is no dispute that R1 did have access to the old system and had used it in the past.[220] The Statement of Deficiencies specifically states that the investigator observed the old call light system and noted how it worked.[221] Instead, the Facility's failure to follow the care plan arises because Phelps put R1 on the toilet without verifying whether the new call light was present, was waiting for an alert from the new call light system, and did not check in with R1 in a timely manner when she did not receive the alert. In this situation, and given R1's history and health concerns, the Facility failed to implement the care plan by monitoring factors contributing to falls.

As a result, the Tag at F656 was properly cited. Additionally, the scope and severity designation of G is also supported by the record because R1 suffered two broken ribs due to her fall, constituting actual harm that was not immediate jeopardy.

## IV. Conclusion

The Administrative Law Judge determines that the citations of Tag F689 and Tag F656 are supported in substance and that both were properly categorized at a scope and severity level of G. With respect to each tag, the Commissioner should delete the findings that a call light was not available from the Statement of Deficiencies, as these findings are not supported by the record. The Commissioner should **AFFIRM** the two citations as explained herein.

**J. P. D.**

[220] While the Administrative Law Judge finds it curious that the Facility failed to consider the old call light system in its initial investigation of R1's fall, the Facility provided evidence that the old call system was still in use and the Department's evidence is consistent with that. Therefore, the Administrative Law Judge has found that the system was still in use, including by R1.
[221] Ex. E at 6-7.