OAH 84-0900-36035

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HEALTH

In the Matter of the IIDR of Walker Rehabilitation and Healthcare Center

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDED DECISION

This matter came before Chief Administrative Law Judge Tammy L. Pust for an independent informal dispute resolution proceeding on May 14, 2019. The record for the proceeding remained open to allow the Department to file relevant documents. When the Department filed those additional records on May 24, 2019, the record closed on that date.

Becky Wong, Nurse Evaluator, appeared on behalf of the Minnesota Department of Health (Department). The following individuals also participated in the IIDR on behalf of the Department: Lyla Burkman, Registered Nurse and Unit Supervisor of the Bemidji District Office; Pam Kerssen, Assistant Program Manager; Vienna Andresen, Registered Nurse and Nurse Evaluator; and Lisa Carey, Registered Nurse and Nurse Evaluator.

Samuel Orbovich, Frederickson & Byron, appeared on behalf of Walker Rehabilitation and Healthcare Center (Facility). Latonya Davis, Regional Nurse at Superior Health Care, also appeared on the Facility's behalf.

DISPUTED DEFICIENCY CITATIONS (TAGS)

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

- Tag F880, scope and severity level L; and
- Tag F689, scope and severity level K.

RECOMMENDATION

The Chief Administrative Law Judge recommends that the Commissioner **REDUCE** Deficiency Tag F880 to Level E because the Department's survey findings do not support scope and severity level L, and **REDUCE** Deficiency Tag F689 to Levels D, H, A, and A, with the two A-Level deficiencies reduced in timeframe, as set forth in the Conclusions of Law below, because the Department's survey findings do not support scope and severity level K.

Based on the submissions of the parties at the IIDR, the Chief Administrative Law Judge makes the following:

FINDINGS OF FACT

I. Regulatory Background

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.[1] Participation requirements for skilled nursing and long-term care facilities are set forth in 42 C.F.R. § 483, subp. 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.[2]

3. CMS assures compliance with the participation requirements through surveys conducted by delegated state agencies.[3] In Minnesota, the Department is the state survey agency. The state survey agency reports any deficiencies to the CMS on a standard form called a Statement of Deficiencies.[4]

4. Deficiency findings are organized in the Statement of Deficiencies under alpha-numeric tags, with each tag corresponding to a regulatory requirement in Part 483.[5] 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.

5. A facility is considered to be noncompliant 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."[6] "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."[7] If a facility is found to be noncompliant based on the results of a state survey, various remedies can be imposed including civil monetary penalties.[8]

6. To assist state agencies in conducting surveys, CMS publishes a State Operations Manual (SOM).[9] The SOM provides guidance to state survey agencies and

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[1] 42 U.S.C. §§ 1302, 1395hh (2012). *See also* 42 C.F.R. § 483 (2018).
[2] Department Statement.
[3] *See, e.g.,* 42 U.S.C. § 1864(a) (2012); 42 C.F.R. § 488.11 (2018).
[4] *See, e.g.,* Exhibit (Ex.) C.
[5] CMS State Operations Manual, Appendix PP.
[6] *See* 42 C.F.R. § 488.301.
[7] *Id.*
[8] *See* 42 C.F.R. §§ 488.402, .406, .412.
[9] *See* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html.

regulated facilities regarding how the CMS interprets various applicable rules and regulations.[10]

7. 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]

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

9. 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]

10. The scope of each cited deficiency is assigned to one of three levels reflecting whether the deficiency is isolated, constitutes a pattern, or is widespread.[15]

11. Scope and severity are represented by a Scope and Severity Grid in the SOM (Grid).[16] The Grid is a three-column, four-row grid 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," 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

[10] Department Statement.
[11] 42 C.F.R. § 488.404 (2018).
[12] Ex. D.
[13] *Id*.
[14] 42 C.F.R. § 488.404 (2018); Ex. D.
[15] *Id.*
[16] Ex. C.
[17] *Id.*

immediate jeopardy to a resident's safety or health.[18] Levels F through L are considered to represent a substandard quality of care.[19]

13. An illustration of the Grid is provided below.[20]

[redacted] 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

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

[redacted] 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

[18] *Id.*
[19] *Id.*
[20] *Id.*

II. The Facility, Investigation, Penalty, and Procedural History

14. Walker Rehabilitation and Healthcare Center (Walker or Facility) was a skilled nursing facility in Walker, Minnesota.

15. This proceeding arises from the Department's compliance survey of the Facility that began on March 19, 2018 and was exited on March 27, 2018.[21]

16. The survey resulted in the issuance of a Statement of Deficiencies (also known as a "2567") on November 30, 2018 that cited several deficiencies, among them Tags F880 and F689,[22] which are disputed in this IIDR process.

17. Tag F880 is based on 42 C.F.R. § 483.80 and concerns the prevention and control of infectious disease — in this instance, influenza.[23]

18. Tag F689 is based on 42 C.F.R. § 483.25(d), which requires that facilities remain as free of accident hazards as possible, and that each resident receive adequate supervision and assistance devices to prevent accidents.[24]

19. In this proceeding, Walker disputes three different incidents that the Department cited as deficiencies under Tag F689: one involving elopements; one involving the fall risk of a patient who used a wheelchair; and one involving the injury risk to a patient who required the use of a lift.[25]

20. Based on the Statement of Deficiencies, the Centers for Medicare and Medicaid Services ("CMS") imposed a $350,800 penalty against Walker.[26]

21. The parties do not dispute that, on or about October 5, 2018, Walker filed a Notice of Closure with the Department; that, on or about November 9, 2018, Walker's relocation plan for its residents was approved by the Department; and that all the Facility's residents were transferred before Walker received notice of the CMS penalty. The Facility remains closed.

22. Pursuant to law, CMS afforded Walker an opportunity for independent informal dispute resolution (IIDR) review of the Statement of Deficiencies.[27] Walker timely filed its request for IIDR review.

23. An IIDR proceeding was held on May 14, 2019. The Chief Administrative Law Judge held open the record until May 24, 2019 so that the Department could file supplementary documents. Upon receipt of those filings, the record closed on May 24, 2019.

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[21] Ex. 1 at 0023.
[22] Ex. E.
[23] *Id.* at 39-40.
[24] *Id.* at 1.
[25] *See id.*
[26] Ex. 3 at 0015-21.
[27] *Id.* at 0021.

III. Tag F880: Influenza Controls

A. Deficiency Identified

24. Tag F880 concerns a cited deficiency for failure to control influenza in the Facility. According to the citation, Immediate jeopardy began on January 5, 2018, and was lifted on March 27, 2018, at 12:00 p.m., although the Facility remained at scope and severity level F at that time.[28]

B. Interpretive Guidelines

25. The CMS interpretive guidelines relating to infectious disease controls provide these relevant definitions:[29]

> Airborne precautions: actions taken to prevent or minimize the transmission of infectious agents/organisms that remain infectious over long distances when suspended in the air. (These precautions can involve isolation or restriction of movement.[30])
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> Contact precautions: measures that are intended to prevent transmission of infections agents which are spread by direct or indirect contact with the resident or the resident's environment.
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> Droplet precautions: actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions.
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> Hand hygiene: a general term that applies to hand washing, antiseptic hand wash, and alcohol-based hand rub.
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> Hand washing: the vigorous, brief rubbing together of all surfaces of the hands with plain (i.e., nonantimicrobial) soap and water, followed by rinsing under a stream of water.
>
> Personal protective equipment (PPE): protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-transmission.

26. The interpretive guidelines provide guidance as to a facility's development of an infection prevention and control program (IPCP). The guidelines state that a facility must establish and maintain an IPCP designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. An IPCP must include, at minimum, a system

[28] Ex. E at 42.
[29] Ex. G at 2-4.
[30] *Id.* at 5-6.

for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, and visitors.[31]

27. Pursuant to developing an IPCP, a facility must develop and implement written policies and procedures for the provision of infection prevention and control. At minimum, these policies need to include: (1) at least annually, and as necessary, a review and revision of the IPCP based on facility assessment; (2) an ongoing system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (3) when and whom possible incidents of communicable disease or infection should be reported within the facility; (4) which communicable diseases are reported to local/state public health authorities; (5) how to use standard precautions and when to use transmission-based precautions such as contact, droplet, or airborne isolation precautions, and consideration of specific precautions such as hand hygiene, PPE, facemasks, and isolation precaution by room assignment or restriction of movement.[32]

C. Influenza A Outbreak

28. The deficiency cited under Tag F880 relates to an outbreak of influenza A that began when resident R12 was diagnosed on January 5, 2018.[33] Between that date and January 15, 2018, residents R125, R124, and R6 also tested positive for influenza and eight other residents experienced flu-like symptoms.[34]

29. Walker offered flu shots about three months before the outbreak.[35] The four residents who tested positive for influenza A had been offered and refused flu shots.[36] There is no dispute that the residents were within their rights to refuse the flu shot.

30. Walker disputes that resident R125 (whom Walker refers to by her initials, CDS) contracted influenza at the Facility. R125, a 72-year-old woman, died on January 19, 2018.[37] Her cause of death was reported as (a) respiratory distress, (b) influenza A, and (c) congestive heart failure, and the approximate interval of the onset of influenza A to death was listed as seven days.[38]

31. R125 was taken to the emergency room on January 11, 2018, after suffering a fall at 6:00 pm.[39] A note dated January 16, 2018, stated that R125 had been

[31] *Id.* at 4.
[32] *Id.* at 5-6.
[33] Ex. E at 42.
[34] *Id.* at 42, 43.
[35] Ex. L at 6.
[36] *Id.* at 6.
[37] Ex. E at 47.
[38] Department's Additional Documents.
[39] Walker Supplement at 1090.

diagnosed with influenza.[40] Walker's records indicate that the onset of R125's influenza symptoms were January 15, 2018, at a medical facility external to Walker.[41]

32. The Statement of Deficiencies includes Department facts on influenza placing the incubation period of the illness (the time between infection and the onset of symptoms) at between one and four days.[42]

33. Based on the onset of R125's symptoms on either January 15 or January 16, R125's infection with influenza likely occurred somewhere between January 11 or 12, 2018 and January 14, 2018. This accords with the death report, which estimates that the onset of influenza was seven days before January 19, 2018, which would be January 12 or 13, 2018.

34. Because it is likely that R125 became infected between January 11, 2018, and January 14, 2018, and R125 was not residing at Walker for most of that time, it is more likely than not that R125 was not infected with influenza at Walker.

35. In surveying the Minimum Data Sets (MDS) for R12 and R124, the Department found that both residents were instructed to remain in their rooms during their illness to prevent the spread of infection, but found no evidence that droplet precautions had been implemented.[43]

36. The Department's review of the infection control logs found a lack of indication that Walker implemented isolation precautions for the eight additional flu-symptomatic residents when they became symptomatic.[44]

D. QAPI and Survey Findings

37. The Department reviewed the log for the Facility's quality assurance performance improvement (QAPI) meeting dated January 16, 2018.[45] The log indicated the presence of influenza in the Facility but did not identify outbreaks or trends/patterns of infection, isolation or other precautionary measures taken, whether the infections had been reported to the health department, or ongoing monitoring systems.[46]

38. During the March 2018 survey, the Department's inspectors noted several deficiencies with the Facility's practices.

39. A licensed practical nurse at the facility reported that she could not recall using any type of isolation precautions at the facility despite a previous outbreak of

[40] *Id.* at 1091.
[41] Ex. L at 6.
[42] Ex. E at 44.
[43] *Id.* at 45-46.
[44] *Id.* at 48.
[45] *Id.* at 49; *see also* Department's Additional Documents (QAPI logs).
[46] Ex. E at 49; *see also* Department's Additional Documents (QAPI 22-23).

influenza.[47] A nursing assistant at the facility reported that she could not recall using infection control isolation gowns during the past six months.[48]

40. A registered nurse reported that gloves and masks were used by "some staff" during the influenza outbreak in January, but that isolation gowns were not used.[49]

41. The director of nursing reported that the facility had not implemented droplet precautions during the outbreak of influenza.[50]

42. A licensed practical nurse stated that, if residents required droplet or isolation protections, she would need to find PPE but she did not know where PPE was located in the Facility.[51]

43. The newly hired director of nursing reported that she was unaware of any type of infection control training completed in the past year, but training had been scheduled for April 2018.[52]

44. Inspectors reported seeing a registered nurse repeatedly administering medication by placing it in a hand before putting it in a cup.[53] The registered nurse was not observed washing hands during this practice.[54]

IV. Tag F689: Elopement

A. Deficiency Identified

45. Tag F689 includes an identified situation of immediate jeopardy concerning the elopement of Resident 226. The immediate jeopardy began on December 3, 2017, at 5:40 a.m., and was removed on March 27, 2018 at 12:00 p.m., at which time the Department identified continuing deficiency at scope and severity level D.[55]

B. Interpretive Guidelines

46. The CMS interpretive guidelines regarding accident prevention state that facilities can take a systemic approach to address and mitigate the risk of accident.[56] Systems to address the risk of accident include the identification of hazards; the

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[47] Ex. E at 49.
[48] *Id.*
[49] *Id.* at 49-50. It is unclear from the survey report whether the Department used the term "PPE" to refer exclusively to isolation gowns, or if the term also encompassed gloves and masks. At various points in the report, the Department reported statements indicating that PPE were not used in the facility, which conflicts with the report that gloves and masks had been used.
[50] *Id.* at 49.
[51] *Id.* at 54.
[52] *Id.* at 54-55.
[53] *Id.* at 55.
[54] *Id.* at 55-56.
[55] *Id.* at 2.
[56] Ex. F at 3.

evaluation of hazards; the implementation of individualized, resident-centered interventions; and monitoring for the effectiveness and modification of interventions when necessary.[57]

47. The guidelines state that elopement occurs when a resident leaves the premises or a safe area without authorization and/or the necessary supervision to do so.[58] Residents who elope may be at risk of heat or cold exposure, dehydration or other medical complications, drowning, or being struck by a motor vehicle.[59] Policies that clearly define the mechanisms and procedures for assessing or identifying, monitoring, and managing residents at risk for elopement can help facilities minimize the risk of resident elopement.[60] Residents at risk should have interventions in their comprehensive plan of care to address the potential for elopement.[61]

C. Resident 226's Elopement

48. R226, a 90-year-old man, was taken to Sanford Medical Center after suffering an accident while hunting on November 4, 2017.[62] R226 was treated at Sanford for a hematoma and a spinal compression fracture likely resulting from a fall while hunting.[63] Notes from Sanford indicate that R226 was "oriented to person, place, and time," "appears well-developed and well-nourished," and had "[n]o distress."[64]

49. From Sanford Medical Center, R226 was admitted to Walker to recuperate. Walker's intake records indicate that R226 did "not exhibit" wandering behavior, did not have a neurological impairment condition such as dementia, and was expected be discharged back into the community.[65] R226 scored a 12 of 15 on a brief assessment meant to assess mental status.[66]

50. In intake material dated November 13, 2017, there was only one box marked "yes" in a section that assessed R226's "risk for elopement"; that box asked if the resident "[e]xperienced a recent move in room or facility," which is a condition experienced by any person who is admitted to a new facility.[67] The bottom of the section says, "If 'YES' is marked for #1 and 2 and any other (#3-8), consider a prevention plan of care for elopement."[68] For R226, Boxes #1 and 2 were marked "no."[69]

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[57] *Id.* at 3.
[58] *Id.* at 10.
[59] *Id.*
[60] *Id.*
[61] *Id.*
[62] Walker 0157.
[63] Walker 0156, 0180.
[64] Walker 0162.
[65] Walker 0048, 0058, 0078.
[66] Walker 0043.
[67] Walker 0153.
[68] Walker 0153. The Department's 2567 incorrectly states that "[t]he directive for this section indicated for any question marked 'yes' the rater should consider a prevention plan of care for elopement." Ex. E at 5.
[69] Walker 0153.

51. The Chief Administrative Law Judge finds that R226 did not present an identifiable elopement risk upon his admission to the Facility.

52. Once admitted to the Facility, R226 exhibited some confusion, which got worse as the day progressed such that he occasionally would not know where he was or would wander into the hallways and talk or yell confusedly.[70]

53. R226 was scheduled to be transferred to an assisted living facility on December 8, 2017.[71]

54. In the early morning of December 3, 2017, R226 was talking about going home and asked if there was a bus that could take him home.[72] At approximately 5:40 a.m., a staff member was unable to locate R226; staff searched the facility and grounds and were unable to find him.[73] Staff called 911 and learned that R226 was at the police station.[74] R226 was returned to the Facility at 6:30 a.m., a temporary "wanderguard" monitoring device was put on him, and staff implemented checks at 15-minute intervals to ensure that he remained at the Facility.[75]

55. Despite continuing to exhibit some confusion about his situation and whereabouts, R226 was successfully transferred to an assisted living facility on December 8, 2017, as scheduled.[76]

56. According to comments that Facility staff made to surveyors, between R226's admission to the Facility on November 13, 2017 and his elopement on December 3, 2017, R226 tried to or had successfully eloped on other occasions. A registered nurse reported that R226 tried to leave the facility on several occasions but was always caught before he could succeed; the RN also believed that R226 had a wanderguard in place at the time of the December 3, 2017 elopement.[77]

57. A cook at the Facility said that R226 had expressed unhappiness at being at the Facility and had attempted elopement several times.[78] The cook reported that once, "way" before the December 3 incident occurred, R226 succeeded in making his way to a gas station across from the police station, evidently wheeling himself down the middle of a road because the sidewalks had not been plowed.[79] The cook reported that R226 was dressed appropriately for winter weather.[80]

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[70] Ex. E at 6-7.
[71] *Id.* at 7-8.
[72] *Id.* at 7.
[73] *Id.*
[74] *Id.*
[75] *Id.*
[76] *Id.* at 8.
[77] *Id.* at 10.
[78] *Id.*
[79] *Id.*
[80] *Id.*

58. A nursing assistant stated that R226 did not like being at the Facility and had attempted to leave, and reported that a wanderguard was not placed on R226 until after the December 3, 2017 incident.[81] The nursing assistant was not aware of other incidents in which R226 had successfully eloped from the facility.[82]

59. The director of nursing and the registered director of clinical services (RDCS) confirmed to the surveyors that R226 successfully eloped on December 3, 2017, but they were unaware of any previous elopement attempts based on R226's clinical records. Both were recently employed at the Facility and had no personal knowledge of events pertaining to R226.[83]

60. Based on this record, the Chief Administrative Law Judge finds that R226 was an elopement risk on the morning of December 3, 2017, when he did, in fact, elope. By that time, R226 had been in the Facility for several weeks, had exhibited confusion and a desire not to be there, and was reported by multiple people to have attempted or threatened to elope before.

61. The Chief Administrative Law Judge does not find that R226 previously eloped. Although the cook reported that R226 previously eloped to a gas station, the cook did not witness R226 during or immediately after the alleged previous elopement, there were no further reports of that incident, and the cook's statement that the previous elopement occurred "way" before the December 3, 2017 incident, despite R226 only coming to the Facility in mid-November, weighs against finding a previous elopement when coupled with the lack of additional documentation or memory of the event. Thus, the Chief Administrative Law Judge finds that it is more likely than not that R226 did not elope successfully before December 3, 2017.

D. General Concerns About Elopement Procedure

62. When asked about the Facility's elopement prevention practices, the RDCS stated that the system needed to be "revamped."[84] The Facility's administrator stated that, when she and the director of nursing started at the facility, they had begun educating the staff on the abuse prevention program, including elopement.[85]

63. A licensed practical nurse reported remembering a resident who had eloped from the facility and had made it to the police station.[86]

64. A nursing assistant reported that, if a resident attempted to leave the facility, nursing assistants could "highly" suggest the need for a wanderguard to a nurse,

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[81] *Id.*
[82] *Id.*
[83] *Id.* at 9.
[84] *Id.*
[85] *Id.*
[86] *Id.* at 11.

but nursing assistants were not able to apply a wanderguard without a nurse's direction.[87]

65. A licensed practical nurse stated that she remembered a previous resident eloping to the police station and the December 3, 2017 elopement of R226.[88]

66. Prior to the survey, the director of nursing, a registered nurse, and the RDCS were informed that other Facility staff had referred to R226 having eloped on another occasion and confirmed they were previously unaware of the alleged incident.[89]

67. A nursing assistant stated that if a resident voiced a desire to leave and had previously attempted to leave the Facility, the staff had to inform the charge nurse as well as all other staff, implement visual checks every five minutes, and apply a wanderguard to the resident if he or she was attempting to leave the Facility.[90]

68. After the Facility conducted an elopement risk assessment on all residents, developed and implemented improved policies and procedures related to elopement, educated staff on the updated policies and procedures, and implemented a quality assurance program to monitor all incidents and accidents to ensure no safety hazards or risks were present, the immediate jeopardy tag was removed at 12:00 p.m. on March 27, 2018.[91]

V. Tag F689: Falls

A. Deficiency Identified

69. Tag F689 includes a deficiency related to Resident 14's fall risk. The citation indicates that immediate jeopardy for R14 began on March 6, 2018, at 11:00 a.m., and was removed on March 27, 2018, at 12:00 p.m., at which time the Department identified continuing deficiency at scope and severity level D.[92]

B. Interpretive Guidelines

70. The interpretive guidelines define a "fall" as unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force, such as being pushed.[93] If a resident would have fallen except for another person or for catching himself or herself, a fall is considered to have occurred.[94] Unless

[87] *Id.*
[88] *Id.*
[89] *Id.*
[90] *Id.*
[91] *Id.* at 11-12.
[92] *Id.* at 2-3.
[93] Ex. F at 2.
[94] *Id.*

evidence suggests otherwise, a resident found on the floor is considered to have fallen.[95]

71. Factors that may result in falls include environmental hazards and cognitive impairment.[96]

72. When a resident falls, proper action following the fall includes: ascertaining if there were injuries and providing treatment as necessary; determining what may have caused or contributed to the fall, including ascertaining what the resident was trying to do before falling; addressing the risk factors for the fall such as the resident's medical condition, facility environment issues, or staffing issues; and revising the resident's plan of care and/or facility practices, as needed to reduce the likelihood of fall.[97]

C. R14's Fall Risk and History

73. On admission to the Facility on January 19, 2018, R14 was an 85-year-old man with a nondisplaced, closed fracture to a cervical vertebra.[98]

74. R14's admission MDS indicated a mild cognitive impairment and stated that R14 had sustained the fracture as a result of a fall at a previous facility.[99] R14 was expected to need long-term care and not to return to the community.[100] R14 wore a brace to support his neck.[101]

75. Despite triggering a falls care area assessment. No comprehensive fall risk assessment was completed.[102]

76. The Department's surveyors observed R14 sitting in his room in his wheelchair for approximately one hour without staff checking on him.[103]

77. During the survey, the Department noted that R14 did not have a call light nearby to summon assistance.[104] The record supports the finding that the Facility knew that R14 either did not or was not able to use his call light to seek assistance.[105]

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[95] *Id.*
[96] *Id.* at 9.
[97] *Id.*
[98] Ex. H.b at 4.
[99] Ex. E at 12.
[100] Ex. H.b at 4.
[101] Ex. E at 12.
[102] *Id.* at 12-13, 15.
[103] *Id.* at 13.
[104] *Id.*
[105] *Id.* at 14; Walker 0554.

78. R14 was hearing impaired and used hearing aids.[106] Surveyors observed a nursing assistant dressing R14 without putting in his hearing aids, and, on another occasion, observed R14 being wheeled to watch television in his room while his hearing aids were on a bedside table.[107]

79. Patient records indicated that R14 had suffered two falls at the Facility in March 2018.[108]

80. The first fall occurred on March 6, 2018, when R14 fell forward from his wheelchair while reaching for something on his nightstand.[109] R14 suffered skin tears on his knuckles and arm from the fall, which were treated.[110] An incident report about the fall did not indicate what R14 was reaching toward and indicated an intervention of not leaving R14 alone in his room unless laying down.[111] The intervention was not added to R14's care plan, and R14 continued to be left alone in his room in his wheelchair.[112]

81. The second fall occurred on March 11, 2018.[113] The fall was not witnessed, but R14 was discovered to be on his knees over the footrests of the legs of his wheelchair facing toward the bedside table.[114] R14 reopened a previous skin tear in the fall, which was treated.[115] The Facility did not generate an incident report for this fall, and did not assess the fall or propose further interventions to minimize future risk.[116]

82. On March 22, 2018, during the survey, a registered nurse stated that R14 was not to be left in his room unattended unless in bed.[117] The registered nurse stated that the falls policy indicated that a falls form should be completed to report a fall, and was not able to locate the Facility's falls policy.[118] On the same date, two nursing assistants reported that they were unaware of fall interventions for R14 and said he was allowed to be in his room unattended and without special monitoring.[119]

83. On March 22, 2018, the RDCS reported she could not find a falls policy for the Facility when she began working there on March 20, 2018, and had obtained a corporate policy and procedure for staff to begin using on March 21, 2018.[120] The

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[106] Ex. E at 14.
[107] *Id.*
[108] *Id.* at 16.
[109] *Id.*
[110] *Id.*
[111] *Id.* at 16-17.
[112] *Id.* at 17.
[113] *Id.*
[114] *Id.*
[115] *Id.*
[116] *Id.*
[117] *Id.*
[118] *Id.*
[119] *Id.* at 17-18.
[120] *Id.* at 18.

RDCS confirmed that the falls policy was ineffective in preventing R14 from falling, that the intervention of not leaving R14 alone in his room if not in bed was not implemented, and that R14 had not been comprehensively assessed for the March 11, 2018 fall.[121]

84. On March 22, 2018, while the administrator and RDCS were developing a removal plan that would address R14's fall risk, R14 fell in his room while unattended.[122] R14 did not suffer major injuries.[123] The RDCS stated that R14 would be given one-to-one staff supervision until appropriate interventions and safety plans were in place.[124]

85. The Facility implemented a plan to remove the immediate jeopardy that included: (1) comprehensive fall assessment; (2) updated care plan; (3) physical therapy assessment; (4) development and implementation of a policy and procedure for falls and immediate interventions after a fall; (5) education for staff on R14's plan of care and revisions to fall prevention policy.[125]

VI. Tag F689: Lifts

A. Deficiencies Identified

86. The deficiencies concerning lifts in Tag F689 pertained to Resident 2 and Resident 8.[126]

87. According to the Statement of Deficiencies, immediate jeopardy for R2 began on September 15, 2017, and was removed on March 27, 2018, at 12:00 p.m., at which time the Department identified continuing deficiency at scope and severity level D.[127]

88. Similarly, the Statement of Deficiencies found that immediate jeopardy for R8 began on March 9, 2018 and was removed on March 27, 2018, at 12:00 p.m., at which time the Department identified continuing deficiency at scope and severity level D.[128]

B. Interpretive Guidelines

89. Mechanical assistive devices for transfer include, but are not limited to, portable and stationary total body lifts and sit-to-stand devices.[129]

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[121] *Id.*
[122] *Id.*
[123] *Id.*
[124] *Id.* at 18-19.
[125] *Id.* at 19.
[126] *Id.* at 3-4
[127] *Id.* at 3.
[128] *Id.* at 4.
[129] Ex. F at 14.

90. When using assistive devices, three primary factors are associated with an increased risk of accident: (1) resident condition, including lower extremity weakness, decreased range of motion, and poor balance, which can be exacerbated by cognitive impairment; (2) personal fit and device condition, including proper maintenance of a device and how well a device meets the individual needs of the resident; and (3) staff practices.[130]

91. Factors that may influence a resident's risk of accident during transfer include staff availability, resident ability, and staff training and competency.[131]

92. A facility has a responsibility to respect a resident's choices, which must be balanced by considering the resident's right to direct the care they receive with the potential impact of these choices on their well-being and on the facility's obligation to protect residents from harm. Verbal consent does not eliminate a facility's responsibility to protect a resident from an avoidable accident. Residents do not have the right to demand that a facility use specific medical interventions or treatments that the facility deems inappropriate.[132]

C. R2's Lift Risk and History

93. R2 was a resident with severe cognitive impairment, including diagnoses of Parkinson's disease and dementia, who required extensive staff assistance for daily function.[133]

94. A lift mobility status form dated December 31, 2017 indicated that R2 did not have the ability to bear weight on her legs.[134] R2's care plan, dated December 28, 2017, indicated that R2 was to be moved with a full-body mechanical lift operated by two staff members.[135] The plan directed staff to use caution while using the lift to transfer R2 so that she did not strike her arms, legs, or hands against surfaces.[136]

95. A nursing assistant indicated during the survey that the lift could be operated by either one or two staffers depending on how comfortable the staffers were using the lift.[137]

96. On March 22, 2018, a surveyor reported seeing a nursing assistant use the lift to place R2 in bed without assistance, and reported that R2's feet rubbed against the lift during the transfer.[138]

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[130] *Id.*
[131] *Id.*
[132] *Id.* at 7-8.
[133] Ex. E at 19.
[134] *Id.*
[135] *Id.* at 20.
[136] *Id.*
[137] *Id.*
[138] *Id.* at 21.

97. On March 24, 2018, after a registered nurse verified that R2's care plan called for two staffers to assist in lifts and transfers, a nursing assistant was observed operating the lift to transfer R2 without an additional staffer, and R2's feet/shoes were observed to rub the lift.[139]

98. During a transfer of R2 from bed to wheelchair on March 21, 2017, which involved both a nursing assistant and a registered nurse, a surveyor reported that the nursing assistant's operation of the lift caused R2's feet to bump into the lift repeatedly, and that the nursing assistant did not ask the registered nurse for assistance in controlling R2's feet.[140] The registered nurse noticed the feet bumping against the lift and held R2's feet away from the lift as the transfer was completed.[141]

99. An incident report dated September 15, 2017, said that R2 suffered a "[s]uperficial" skin tear from grabbing the lift while being lifted. The size of the skin tear was not reported, and the report did not address the number of staffers present or the interventions implemented to lower the risk of skin tears.[142]

100. An incident report dated October 29, 2017, reported that R2 suffered a minor skin tear, reported as "just a little pink," because she grabbed the lift while it was in motion.[143] The report noted that R2 had been reminded not to grab the lift but that she continued to do so.[144] The report did not address the number of staffers present or the interventions implemented to lower the risk of skin tears.[145]

101. An incident report dated November 15, 2017, stated that R2 suffered a small skin tear and bruise from being pinched by the moving parts of the lift, which she grabbed while being lifted.[146] The report notes that R2 has a "tendency" to grab the lift, but did not address the number of staffers present or the interventions implemented to lower the risk of skin tears.[147]

102. The immediate jeopardy was removed on March 27, 2018, after the Facility implemented a removal plan to complete a comprehensive transfer/lift assessment for R2, updated her care plan to direct staff on safe transfer/lift procedures, developed and implemented a policy and procedure for safe handling of residents while being lifted, and education as to the new policies and procedures.[148]

D. R8's Lift Risk and History

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[139] *Id.* at 23.
[140] *Id.* at 20.
[141] *Id.* at 20-21.
[142] *Id.* at 21.
[143] *Id.*
[144] *Id.*
[145] *Id.* at 22.
[146] *Id.*
[147] *Id.*
[148] *Id.* at 24.

103. R8 was a resident at the Facility diagnosed with adult failure to thrive, diabetes, essential hypertension, muscle weakness, and non-compliance with medical treatment or regimen.[149] R8's care required extensive assistance from one staff member for transfers, dressing, personal hygiene, and impaired balance.[150]

104. On February 9, 2018, a physical therapist at the Facility recommended that R8 use a sit-to-stand lift when transferring.[151]

105. R8's records lacked a mechanical lift evaluation to identify an appropriate sling size and determine how many staff would be appropriate when using a sit-to-stand lift to transfer R8.[152]

106. On March 9, 2018, records indicated that R8 passed out while in the sit-to-stand lift.[153] Testing revealed that R8 had low blood pressure and was at risk of losing consciousness when using the lift.[154] Passing out due to low blood pressure is referred to as experiencing a syncopal event.[155]

107. A new physical therapy evaluation and plan of treatment prepared on March 12, 2018, recommended the use of a more intensive full-body lift for transferring R8.[156] On March 24, 2018, staff used the full-body lift to transfer R8.[157] R8 reported that she did not like the full-body lift because it was "scary" and "feels like a roller coaster."[158] R8 stated that she was going to "try [her] hardest not to end up in that thing," referring to the full-body lift.[159]

108. A record generated on March 14, 2018, indicated that nursing staff discussed using the full-body lift with R8, but R8 requested to use the sit-to-stand lift because she wanted to be independent.[160] The record lacked documentation that staff informed R8 of the potential risks of continuing to use the sit-to-stand lift.[161]

109. The survey determined that the March 9, 2018 event was the only syncopal event that R8 suffered in the sit-to-stand lift.[162]

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[149] *Id.*
[150] *Id.*
[151] *Id.*
[152] *Id.* at 25.
[153] *Id.*
[154] *Id.* at 25-26.
[155] *Id.* at 26.
[156] *Id.* at 26-27.
[157] Walker 0197.
[158] *Id.*
[159] *Id.*
[160] Ex. E at 28.
[161] *Id.*
[162] *Id.* at 29.

110. On March 21, 2018, R8 requested assistance to use the restroom.[163] A registered nurse who had not received training on the sit-to-stand lift assisted R8 in using the lift to use the restroom.[164]

111. On March 21, 2018, the RDCS stated that the use of two assistants to help R8 would be warranted if R8 had suffered more than one syncopal event.[165] The RDCS said that nursing did not believe the full mechanical lift was appropriate for R8 despite the physical therapy recommendation.[166] The RDCS stated that no further interventions were necessary because a change in R8's blood pressure medication was effective to stabilize her blood pressure.[167]

112. On March 21, 2018, a physical therapist stated that he evaluated R8 for safe transfers and determined that R8 could use the sit-to-stand lift.[168] The physical therapist stated that he did not evaluate R8 for fit in the lift because he expected nursing would be able to determine that based on R8's behavior, full medical history, participation level, and weight.[169]

113. Immediate jeopardy was removed on March 27, 2018, at 12:00 p.m., after the Facility implemented a removal plan including: (1) completing a comprehensive transfer/lift assessment for R8; (2) updating R8's care plan to direct care staff on R8's safe transfer using either the sit-to-stand or mechanical lift as warranted; (3) discussing risks and benefits with R8 and R8's power of attorney of continued use of sit-to-stand lift; (4) developing and implementing a policy and procedure regarding safe handling of residents while in full-body lifts; and (5) educating staff on changes to the standing lift policy and changes to R8's care plan.[170]

VII. Bias

114. At the IIDR hearing, Walker argued that Lyla Burkman was biased against the owners of the Facility because they are Jewish, and that Ms. Burkman's bias was the motivating cause of the survey findings.

115. Walker's bias argument was based on wholly circumstantial evidence, including (1) certain publicly viewable images shared by Ms. Burkman as Facebook posts in 2011 and 2012, (2) the presence of what Walker characterized as "Jewish tropes" in the Statement of Deficiencies, (3) the statement that a different Department representative (not Ms. Burkman) had specifically inquired in 2015 as to whether the Facility's new owners were Jewish; and (4) certain actions of Department representatives in another proceeding involving the same ownership company.

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[163] *Id.* at 28.
[164] *Id.*
[165] *Id.* at 30.
[166] *Id.*
[167] *Id.*
[168] *Id.* at 31.
[169] *Id.*
[170] *Id.* at 32-33.

116. While the six images shared via Facebook that were discussed at the IIDR hearing included references to various "others," including through the use of the term "retard" and by referencing those who do not speak English natively, none included any specific reference to Jews or expressed an explicitly antisemitic or anti-Jewish viewpoint.[171]

117. According to Walker, the alleged "Jewish tropes" in the Statement of Deficiencies concern (1) Ms. Burkman's use of the word "property" in quotation marks to describe the Facility and (2) statements — found in a deficiency that is not at issue in this IIDR — that referenced the Facility's insufficient spending on staff. The relevant pages were not offered into the record by the Department or the Facility. Ms. Burkman testified that she probably used the quotation marks because she was quoting the executive with whom she was speaking, although she did not recall the executive's name.[172]

118. In another proceeding involving a nursing facility owned by the same company as Walker, a Department surveyor asked the director of nursing at that facility whether its owners were Jewish.[173] The bias and/or appearance of impropriety in that statement were supposed to be reported up to management.[174] Although the Chief Administrative Law Judge agreed to extend the record close date so that the Department representatives could inquire as to whether that had been done or otherwise present the Department's response to the bias allegation, the Department's supplemental filings made no reference to the events underlying Walker's bias argument.[175]

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

CONCLUSIONS OF LAW

1. The Commissioner of the Department of Health (Commissioner) and the Chief Administrative Law Judge have jurisdiction in this matter, pursuant to Minn. Stat. §§ 14.57, 44A.10 (2018).

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

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

[171] Received copies of Facebook posts; Testimony (Test.) of Lyla Burkman.
[172] Test. of L. Burkman.
[173] Informational Statement of Shawn Dorr-Jones.
[174] Representation of Walker counsel.
[175] Test. of L. Burkman.

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.[176]

3. 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 with all regulatory requirements.[177]

4. Walker provides long-term care and skilled nursing and is subject to the federal Social Security Act and 42 C.F.R. Parts 483 and 488 (2018).

5. All regulated long-term care and skilled nursing home facilities must provide 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.[178]

6. "Immediate jeopardy" means a situation in which a facility's noncompliance with one or more requirements has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.[179]

I. Tag F880

7. 42 C.F.R. § 483.80 imposes upon skilled nursing facilities the obligation to implement an infection prevention and control program (IPCP) to prevent and control the outbreak of infectious diseases.

8. Interpretive guidelines state that a facility must establish and maintain an IPCP designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

[176] Minn. Stat. § 144A.10, subd. 16(d) (2018).
[177] 42 C.F.R. § 488.303 (2018).
[178] 42 C.F.R. § 483.15(a).
[179] Ex. D.a at 3.

An IPCP must include, at minimum, a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, and visitors.[180]

9. Pursuant to developing an IPCP, a facility must develop and implement written policies and procedures for the provision of infection prevention and control. At minimum, these policies need to include: (1) at least annually, and as necessary, a review and revision of the IPCP based on facility assessment; (2) an ongoing system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (3) when and whom possible incidents of communicable disease or infection should be reported within the facility; (4) which communicable diseases are reported to local/state public health authorities; (5) how to use standard precautions and when to use transmission-based precautions such as contact, droplet, or airborne isolation precautions, and consideration of specific precautions such as hand hygiene, PPE, facemasks, and isolation precaution by room assignment or restriction of movement.[181]

10. The Chief Administrative Law Judge finds that Walker was deficient with regard to its IPCP obligations. Specifically, the evidence establishes that Walker did not implement proper droplet and isolation protocols in the event of an outbreak of influenza.

11. Although the observed failures to locate PPE and abide by handwashing procedures while dispensing medication during the March 2018 survey is not sufficient evidence to establish a causal link between staff procedure and the outbreak of influenza A in January 2018, it is evidence supporting the inference that the scope and implementation of Walker's PPE and handwashing policies were deficient to address the risk and potential harm of an influenza outbreak in the Facility.

12. Because the three residents who were diagnosed with influenza A at the facility[182] all refused flu shots, the link between the deficiencies found by the Chief Administrative Law Judge and the fact that three residents contracted influenza A at the Facility is insufficient to establish immediate jeopardy or actual harm. It is more likely that these residents' infection with influenza A was caused by their refusal to receive a flu shot than the deficient practices and procedures of the Facility and its staff.

13. The Chief Administrative Law Judge finds that the scope and severity level L is not warranted as to scope or severity. The Chief Administrative Law Judge recommends that the scope and severity level of Tag F880 be reduced to E, reflecting a pattern of behavior that did not cause actual harm but had the potential to cause actual harm less severe than immediate jeopardy.

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[180] Ex. G at 4.
[181] *Id.* at 5-6.
[182] As discussed in the Findings of Fact above, the Chief Administrative Law Judge does not find that R125 contracted influenza at the Facility.

II. Tag F689

14. The three disputed deficiencies under Tag R689 fall within 42 C.F.R. § 483.25(d), which requires that facilities remain as free of accident hazards as possible, and that each resident receive adequate supervision and assistance devices to prevent accidents.

15. The CMS interpretive guidelines regarding accident prevention state that facilities can take a systemic approach to address and mitigate the risk of accident.[183] Systems to address the risk of accident include the identification of hazards; the evaluation of hazards; the implementation of individualized, resident-centered interventions; and monitoring for the effectiveness and modification of interventions when necessary.[184]

A. Elopement

16. CMS interpretive guidelines state that elopement is when a resident leaves the premises or a safe area without authorization and/or the necessary supervision to do so. Residents who elope may be at risk of heat or cold exposure, dehydration or other medical complications, drowning, or being struck by a motor vehicle. Policies that clearly define the mechanisms and procedures for assessing or identifying, monitoring, and managing residents at risk for elopement can help facilities to minimize the risk of a resident eloping. Residents at risk for elopement should have interventions in their comprehensive plan of care to address the potential for elopement.[185]

17. R226 was not an identified risk for elopement at the time of his admission to the Facility, and so the Facility's failure to identify a risk of elopement, or to address elopement in R226's plan of care at the time of his admission, were not deficient.

18. Shortly into R226's stay at the Facility, he began to exhibit confused behavior and express his displeasure at being in the Facility, and multiple staffers saw him trying to leave the Facility without authorization. At some point between his admission to the Facility and his December 3, 2017 elopement, the Facility should have identified him as an elopement risk based on these behaviors, and their failure to do so was deficient.

19. The Facility's deficiency in identifying R226 as an elopement risk is mitigated by the fact that R226 was not an elopement risk upon his admission and was only at the Facility for a few weeks before his December 3, 2017 elopement. Further, when R226 did elope, Facility staffers noticed his absence quickly and were able to facilitate his quick and safe return and promptly address the elopement risk by applying a wanderguard.

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[183] Ex. F at 3.
[184] *Id.*
[185] *Id.*

20. Reports from Facility staffers support the finding of deficiencies in the Facility's general elopement policy and training. Specifically, the record demonstrates that the Facility should have had better training and procedures in place to identify elopement risk more quickly and to place wanderguards on residents at higher risk of elopement. But there is not enough evidence to support a finding that this was a pattern of behavior, because the only documented instance of an improperly addressed elopement risk involved R226 during his short stay in the Facility.

21. As to the elopement deficiency under Tag R689, the Chief Administrative Law Judge finds that the scope and severity level K is not supported by the record. The Chief Administrative Law Judge recommends that the scope and severity level of Tag R689, as it pertains to elopement, be reduced to D, reflecting isolated behavior that did not cause actual harm but had the potential to cause actual harm less severe than immediate jeopardy.

B. Falls

22. The interpretive guidelines define a "fall" as referring to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force, such as being pushed.[186] If a resident would have fallen except for another person or for catching himself or herself, a fall is considered to have occurred.[187] Unless evidence suggests otherwise, a resident found on the floor is considered to have fallen.[188]

23. Factors that may result in falls include environmental hazards and cognitive impairment.[189]

24. When a resident falls, proper action following the fall includes: ascertaining if there were injuries and providing treatment as necessary; determining what may have caused or contributed to the fall, including ascertaining what the resident was trying to do before falling; addressing the risk factors for the fall such as the resident's medical condition, facility environment issues, or staffing issues; and revising the resident's plan of care and/or facility practices, as needed to reduce the likelihood of fall.[190]

25. The evidence supports the finding that the Facility was deficient by failing to address the repeated and predictable falls suffered by R14. There is no evidence that the Facility attempted to ascertain what R14 was trying to reach for on his bedside table so that it could reduce the risk that he would continue this behavior. Furthermore,

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[186] *Id.* at 2.
[187] *Id.*
[188] *Id.*
[189] *Id.* at 9.
[190] *Id.*

Facility staffers were not provided sufficient instruction as to R14's care plan to ensure that he was not left alone in his room seated in his wheelchair where falls occurred.

26. The Facility's deficiency was mitigated by the fact that R14 did not have a history suggesting a risk for falls leading to serious injury. Instead, all of R14's documented falls involved attempting to reach for something on a bedside table and falling slightly forward in his wheelchair, leading to minor injuries to his hands and face. Although the repeated nature of these falls and injuries is concerning, they do not support a finding of serious injury, harm, impairment, or death, as required for immediate jeopardy; and they do not lead to the inference that such serious consequences were likely to result from the Facility's deficient conduct.

27. The Facility's deficiencies as to R14's fall risk, which involved an individual who was left in the same circumstances leading to his original fall on two later occasions, including once during the survey, support the finding of a pattern of deficient behavior.

28. As to the fall deficiency under Tag R689, the Chief Administrative Law Judge finds that the scope and severity level K is not supported by the record. The Chief Administrative Law Judge recommends that the scope and severity level of Tag R689, as it pertains to falls, be reduced to H, reflecting a pattern of behavior that actually caused injury less severe than immediate jeopardy.

C. Lifts

29. Mechanical assistive devices for transfer include, but are not limited to, portable and stationary total body lifts and sit-to-stand devices.[191]

30. When using assistive devices, three primary factors are associated with an increased risk of accident: (1) resident condition, including lower extremity weakness, decreased range of motion, and poor balance, which can be exacerbated by cognitive impairment; (2) personal fit and device condition, including proper maintenance of a device and how well a device meets the individual needs of the resident; and (3) staff practices.[192]

31. Factors that may influence a resident's risk of accident during transfer include staff availability, resident ability, and staff training and competency.[193]

32. The responsibility to respect a resident's choices is balanced by considering the resident's right to direct the care they receive with the potential impact of these choices on their well-being and on the facility's obligation to protect residents from harm. Verbal consent does not eliminate a facility's responsibility to protect a resident from an avoidable accident. Residents do not have the right to demand that a

[191] *Id.* at 14.
[192] *Id.*
[193] *Id.*

facility use specific medical interventions or treatments that the facility deems inappropriate.[194]

i. Resident R2

33. The record supports the finding that, by having a single staffer operate the mechanical lift for R2 on two documented occasions (March 22 and March 24, 2019), the Facility was deficient in implementing R2's patient care plan, which called for two staffers to operate the lift. It is a significantly mitigating factor that R2's feet rubbing on the lift, which did not cause documented injury, was the only reported consequence of the deficiency.

34. Facilities must prevent avoidable accidents.[195] An accident is avoidable if it occurs because the facility failed to identify and evaluate hazards and implement and monitor the effectiveness of appropriate interventions.[196]

35. The record does not support the finding that R2's tendency to grab onto moving parts of the lift and suffer skin tears put R2 in immediate jeopardy beginning in September 2017. The record supports the finding that staff took appropriate steps to warn R2 to grab the correct part of the lift. Further, the evidence in the record does not support the conclusion that the skin tears suffered by R2 were a result of a failure to have two staffers. On this record, the skin tears suffered by R2 were the result of an unavoidable accident.

36. As to R2's lift deficiency under Tag R689, the Chief Administrative Law Judge finds that the scope and severity level K is not supported as to scope, severity, or timeframe. The Chief Administrative Law Judge recommends that the scope and severity level of Tag R689, as it pertains to R2's lift, be reduced to A, reflecting isolated behavior that did not cause harm, and that the start of the deficiency be placed at March 22, 2018, the date that a surveyor witnessed a single staffer transferring R2 using the lift.

ii. Resident R8

37. The record supports the finding that the Facility's failure to train a registered nurse who was called to assist R8 to use a sit-to-stand lift was deficient.

38. The record does not support the finding that the Facility's failure to switch R8's transfers immediately to a mechanical lift was deficient. The evidence shows R8's strong preference to use the sit-to-stand lift instead of the mechanical lift to preserve her independence and dignity. Although the Facility should have documented that it informed R8 of the possible health consequences to her decision, the record reflects that R8 had a single syncopal event, that she was expected to normalize her blood

[194] *Id.* at 7-8.
[195] *Id.* at 1.
[196] *Id.*

pressure following a change in medication, and that physical therapy and nursing both agreed that a sit-to-stand lift would remain appropriate.

39. As to R8's lift deficiency under Tag R689, the Chief Administrative Law Judge finds that the scope and severity level K is not supported as to scope, severity, or timeframe. The Chief Administrative Law Judge recommends that the scope and severity level of Tag R689, as it pertains to R2's lift, be reduced to A, reflecting isolated behavior that did not cause harm, and that the start and end of the deficiency be placed at March 21, 2018, the date that an untrained registered nurse assisted R8 in using the lift.

III. Bias

40. The Chief Administrative Law Judge finds that Ms. Burkman's Facebook posts from 2011 - 2012 are not sufficient to support the conclusion that she holds anti-Jewish bias or sentiment.

41. The Chief Administrative Law Judge finds that the specific language at issue in the Statement of Deficiencies does not evidence bias or appearance of bias. The language was reviewed by several levels of Department personnel and pertains to matters that would be expected to arise in a survey report.

42. On this record, the Chief Administrative Law Judge concludes that there is insufficient evidence to find that Ms. Burkman was biased against Walker or that any of her personal views negatively influenced the survey findings.[197]

Based upon these Conclusions of Law, the Chief Administrative Law Judge makes the following:

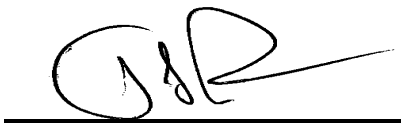
RECOMMENDED DECISION

The Chief Administrative Law Judge recommends that the Commissioner **REDUCE** Deficiency Tag F880 to Level E because the Department's survey findings do not support scope and severity level L, and **REDUCE** Deficiency Tag F689 to Levels D,

[197] The Chief Administrative Law Judge is concerned at the Department's lack of direct response to these serious allegations given that they were apparently raised in an earlier proceeding for the Department's inquiry and review.

H, A, and A, with the two A-Level deficiencies reduced in timeframe, as set forth in the Conclusions of Law above, because the Department's survey findings do not support scope and severity level K.

Dated: June 7, 2019



TAMMY L. PUST
Chief Administrative Law Judge

Reported: Digitally Recorded
No transcript prepared

NOTICE

Under Minn. Stat. § 144A.10, subd. 16(d)(6) (2018), this recommended decision is not binding upon the Commissioner of Health. Pursuant to Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility, indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative law Judge within ten calendar days of receipt of this recommended decision.

MEMORANDUM

This IIDR centered on a dispute over four deficiencies cited across two tags. The first deficiency, which falls under Tag F880, concerns the Facility's procedures regarding influenza; the rest of the deficiencies fall under Tag F689. At the IIDR, Walker raised the issue of bias or the appearance of bias with regard to Lyla Burkman, the unit supervisor overseeing the survey of the Facility. The Chief Administrative Law Judge discusses each issue below.

I. Tag F880

At the IIDR, the Department argued that the Facility placed residents in immediate jeopardy by failing to develop and implement a sufficient infection prevention and control program relating to influenza. There was an outbreak of influenza A at the Facility in January 2018.

The record supports the finding that three residents, all of whom previously refused flu shots, contracted influenza A at the Facility. A fourth resident, who died in January 2018, also had influenza, but more likely than not contracted it outside the Facility. Eight other residents had flu-like symptoms but were not diagnosed with influenza.

The record also supports the finding that the Facility's IPCP was deficient. Although the survey reported that some staffers had worn gloves and masks during the outbreak, there was no record that isolation gowns were worn, and staffers had difficulty

locating personal protective equipment or a PPE policy when asked. There was no evidence that the Facility established or followed a protocol to limit possible exposure to influenza via droplets. Although documentation showed that some of the residents who had been diagnosed with influenza had been told to remain in their rooms, there was no evidence that isolation gowns had been used or that a uniform isolation policy was in place.

Causation is a key factor in determining the severity and scope levels of a deficiency. Here, the Department found a Level L deficiency, corresponding to severity of 4 and scope of "widespread." For severity to be 4, which means immediate jeopardy, the facility's noncompliance must cause, or be likely to cause, serious injury, harm, impairment, or death to a resident receiving care.[198] For scope to be widespread, the problems causing the deficiencies must be pervasive in the facility and/or represent systemic failure that affected or has the potential to affect a large portion or all of the facility's residents.[199]

The fact pattern in this IIDR does not match the causality required for top-of-the-box scope or severity levels. As to scope, there were patterns of deficiency among several staffers and only three Walker residents were diagnosed with influenza A at the Facility. This is more in line with a "pattern" scope, in which more than a very limited number of residents are affected and/or more than a very limited number of staffers are involved.[200]

As to severity, a key missing factor from the Department's analysis is the causal role of flu shots. All three residents who were diagnosed with influenza refused a flu shot, as was their right to do. Although there was a pattern of deficiency in the Facility's IPCP, the Chief Administrative Law Judge concludes that, on this record, the lack of flu shot is the strongest causal factor toward explaining why particular residents contracted the flu. Thus, the Chief Administrative Law Judge does not conclude that the Facility's noncompliance caused serious injury, harm, or impairment. These facts accord better with severity level 2, which covers, among other scenarios, noncompliance that has the potential to lead to injury less severe than immediate jeopardy.[201]

The Chief Administrative Law Judge concludes that the survey findings support a "pattern" scope and severity Level 2, which corresponds to a Level E deficiency, and thus recommends that the Department revise Tag F880 to Level E.

II. Tag F689: Elopement

At the IIDR, the Department argued that the Facility had placed R226 in immediate jeopardy by failing to properly assess his risk of elopement and allowing him to elope.

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[198] Ex. D at 2.
[199] *Id.*
[200] *See id.* at 2.
[201] *See id.* at 1-2; Ex. C at 1.

R226 was correctly not identified as a risk for elopement at the time of his admission to the Facility. As R226's stay in the Facility progressed, his behavior began to demonstrate that he was developing an elopement risk. Most notably, multiple staffers reported that R226 stated a desire to leave the Facility and tried to leave unauthorized on more than one occasion.

R226 was only at the Facility for a few weeks before he eloped for about an hour on December 3, 2017. When R226 eloped, Facility staffers noticed his absence quickly and were able to facilitate his quick and safe return and promptly address the elopement risk by applying a wanderguard. One staffer at the Facility reported that R226 had previously eloped, but the Chief Administrative Law Judge finds it more likely than not that this reported elopement did not occur with respect to R226.

Immediate jeopardy requires that a Facility's noncompliance causes, or is likely to cause, serious injury, harm, impairment, or death. In R226's case, he did not suffer any actual injury. Further, the record indicates that, despite occasional confusion, R226 was recuperating from an injury, was physically capable and generally mentally sound, and was expected to return to the community in the near future. R226 was in fact transferred to an assisted-living facility five days after his elopement. This record does not support the conclusion that R226 was the kind of resident for whom eloping would necessary create a likelihood of serious injury, harm, impairment, or death. That said, R226's elopement did place him at risk of suffering some injury below the level of immediate jeopardy, and so severity level 2 is warranted.[202]

As to scope, the Department found a "pattern," meaning, in this instance, that the same resident had been affected by repeated occurrences of the same deficient practice.[203] The Chief Administrative Law Judge concludes that an "isolated" scope is warranted because R226 eloped only once, and had only been at the Facility for a few weeks before his elopement, which gave staff very little time to assess his elopement risk considering that R226 was correctly not identified as an elopement risk upon intake.

The Chief Administrative Law Judge concludes that the survey findings support an "isolated" scope and severity level 2, which corresponds to a Level D deficiency, and thus recommends that the Department revise Tag F689, as it pertains to R226's elopement, to Level D.

III. Tag F689: Falls

At the IIDR, the Department argued that the Facility had placed R14 in immediate jeopardy by failing to properly assess his risk of him falling from his wheelchair in light of repeated falls suffered by R14.

When a resident falls, proper action following the fall includes: ascertaining if there were injuries and providing treatment as necessary; determining what may have

[202] *See* Ex. C at 1, Ex. D at 1-2.
[203] *See* Ex. D at 2.

caused or contributed to the fall, including ascertaining what the resident was trying to do before falling; addressing the risk factors for the fall such as the resident's medical condition, facility environment issues, or staffing issues; and revising the resident's plan of care and/or facility practices, as needed to reduce the likelihood of fall.[204]

The evidence supports the finding that the Facility was deficient by failing to address the repeated and predictable falls suffered by R14. There is no evidence that the Facility attempted to ascertain what R14 was trying to reach for on his bedside table so that it could reduce the risk that he would continue this behavior. Furthermore, Facility staffers were not provided sufficient instruction as to R14's care plan to ensure that he was not left alone in his room seated in his wheelchair where falls occurred.

R14 did not have a history suggesting a risk for falls leading to serious injury. All of R14's documented falls involved attempting to reach for something on a bedside table and falling slightly forward in his wheelchair, leading to minor injuries to his hands and face. Although the repeated nature of these falls and injuries is concerning, they do not support a finding of serious injury, harm, impairment, or death, as required for immediate jeopardy. Because R14's history did not suggest a risk for more serious falls, this record does not support the inference that serious injury, harm, impairment, or death were likely to result from the Facility's deficient conduct.

The Chief Administrative Law Judge agrees with the Department that the Facility's deficiencies as to R14's fall risk, in which an individual who was left in the same circumstances leading to his original fall on two later occasions, including once during the survey, support the finding of a pattern of deficient behavior.

The Chief Administrative Law Judge concludes that the survey findings support a "pattern" scope and severity level 3, which corresponds to a Level H deficiency, and thus recommends that the Department revise Tag F689, as it pertains to R14's falls, to Level H.

IV. Tag F689: Lifts

At the IIDR, the Department argued that the Facility had placed R2 and R8 in immediate jeopardy due to improper use of mechanical transfer lifts.

R2 was a cognitively impaired resident who required the use of a full mechanical lift to transfer between bed and a wheelchair. The survey findings cited to three reports from 2017 in which R2 was pinched, resulting in a skin tear, because she grabbed onto a moving part of the lift instead of the handle. Each report noted that R2 had a tendency to grab the moving part of the lift and discussed addressing the issue with R2 or by staffer protocol.

The Chief Administrative Law Judge finds that this was not a deficiency. Under 42 C.F.R. § 483.25(d)(2), facilities are charged with preventing avoidable accidents. Unavoidable accidents are defined as accidents that occur despite sufficient and

[204] Ex. F at 9.

comprehensive facility systems designed and implemented to identify and evaluate hazards, implement interventions, and monitor the effectiveness of those interventions.[205] The record supplied by the Department supports the finding that the skin tears suffered by R2 were a result of unavoidable accidents. After each accident, Facility staff intervened in an attempt to avoid repeats of the same accident, and the last report documents that staff discussed how staffing changes could help avoid R2's grabbing.

A surveyor twice witnessed a single staffer using the mechanical lift to transfer R2 despite her care plan calling for two staffers to transfer R2. The surveyor reported that R2's feet/shoes rubbed against the lift. The Chief Administrative Law Judge finds that this was a deficiency because it was contrary to R2's care plan. The scope of this deficiency was isolated to two reported incidents on March 22 and March 24, 2018, and the severity was minimal because rubbing feet is not likely to cause injury.

The Chief Administrative Law Judge concludes that the survey findings support an "isolated" scope and severity level 1, which corresponds to a Level A deficiency, and thus recommends that the Department revise Tag F689, as it pertains to R2's lift, to Level A. Because the first deficiency was reported on March 22, 2018, the Administrative Law Judge recommends that the start of the deficiency be placed at that date.

R8 was a mobility-limited resident who used a sit-to-stand lift for activities like using the restroom. The record shows that R8 temporarily suffered low blood pressure that was improved when her course of medication was altered. During the period of low blood pressure, R8 passed out while in the sit-and-stand lift. Physical therapy recommended that R8 use a full mechanical lift, but both R8 and her nurses disagreed with the recommendation because R8 wanted to have more dignity and independence and did not enjoy the experience of using a full lift. When it became clear that R8's low blood pressure would resolve and physical therapy, a new physical therapy recommendation stated that she could continue to use the sit-to-stand lift.

The record does not support the finding that the Facility's failure to switch R8's transfers immediately to a mechanical lift was deficient. The evidence shows R8's strong preference to use the sit-to-stand lift instead of the mechanical lift to preserve her independence and dignity. Although the Facility should have documented that it informed R8 of the possible health consequences to her decision, the record reflects that R8 had a single syncopal event, that she was expected to normalize her blood pressure following a change in medication, and that physical therapy and nursing both agreed that a sit-to-stand lift would remain appropriate.

The record supports the finding that the Facility's failure to train a registered nurse who was called to assist R8 to use a sit-to-stand lift on March 21, 2018 was a deficiency. The deficiency was isolated to a single occurrence and did not result in injury.

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[205] *Id.* at 1.

The Chief Administrative Law Judge concludes that the survey findings support an "isolated" scope and severity level 1, which corresponds to a Level A deficiency, and thus recommends that the Department revise Tag F689, as it pertains to R8's lift, to Level A. Because the first deficiency was reported on March 22, 2018, the Administrative Law Judge recommends that the start of the deficiency be placed at that date.

V. Bias

The Facility cites to Justice Chutich's dissent in *Kind Heart Daycare, Inc. v. Comm'r. of Human Servs.*,[206] for the proposition that regulatory agencies should not create the appearance of "unseemly bias" in disciplinary proceedings. The Facility alleges that certain Facebook posts shared by Lyla Burkman, the unit supervisor for the survey, coupled with certain comments in the Statement of Deficiencies, create the appearance of bias against the Facility's Jewish owners.

The Chief Administrative Law Judge finds insufficient evidence to establish bias or the appearance of bias directed at Jewish people. Ms. Burkman's Facebook posts, while likely offensive to some people, are from 2011-2012 and do not directly express anti-Jewish bias or sentiment. The Chief Administrative Law Judge cautions the Department, however, because although every person has a right to free and public speech, government officials also have a duty to make their decisions in accordance with law and a responsibility to respond to allegations that expressed bias has clouded their judgment.

The Chief Administrative Law Judge finds that this did not occur in the present case because the specific language at issue in the Statement of Deficiencies is not evidence of bias or the appearance of bias. The language was reviewed by several levels of Department personnel and pertains to matters that would be expected to arise in a survey report.

T. L. P.

[206] 905 N.W.2d 1 (Minn. 2017).