OAH 20-0900-36064

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HEALTH

In the Matter of the Independent Informal Dispute Resolution (IIDR) of St. Therese Home	**FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION**

This matter came before Administrative Law Judge Steven M. Bialick for an independent informal dispute resolution proceeding (IIDR) on May 29, 2019, at the Office of Administrative Hearings in St. Paul, Minnesota. The record closed on May 29, 2019.

Becky Wong, HFE-Nursing Evaluator II, appeared on behalf of the Minnesota Department of Health (Department).

Stella French and Rebecca Coffin, Voight, Rode' & Boxeth, LLC, appeared on behalf of St. Therese Home (Facility).

STATEMENT OF THE ISSUE

The following deficiency citation was submitted to the Administrative Law Judge for consideration in this matter:

Tag F689, Immediate Jeopardy (IJ), J, scope and severity level, which the Department reduced to level G after the Facility's IJ removal plan had been verified.

SUMMARY OF RECOMMENDATION

The Administrative Law Judge recommends that tag F689, which was initially assigned scope and severity level IJ, J, but which the Department reduced to level G, be supported in full with no deletion of findings and no further change in the scope or severity assigned to the deficiency citation.

Based on the evidence in the record and the arguments and submissions of the parties, the 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, Form CMS-2567.[4]

4. A deficiency is a failure to meet a participation requirement set forth in 42 C.F.R. Part 483.[5] Deficiencies are cited as alpha-numeric tags, which correspond to a regulatory requirement in 42 C.F.R. Part 483.[6] 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.

5. To assist state agencies in conducting surveys, CMS publishes a State Operations Manual (SOM).[7] The SOM provides guidance to state survey agencies, as well as regulated facilities, as to how CMS interprets the various rules and regulations.[8]

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.[9]

7. Guidance on scope and severity is set forth in the SOM at Appendix P, Deficiency Categorization.[10] 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.[11]

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

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[1] 42 U.S.C. §§ 1302, 1320a-7(j) 1395hh (2018). *See also* 42 C.F.R. § 483 (2018).
[2] *See* 42 C.F.R. §§ 400-498 (2018).
[3] *See, e.g.,* 42 C.F.R. § 488.11 (2018).
[4] *See, e.g.,* Exhibit (Ex.) E.
[5] 42 C.F.R. § 488.301.
[6] *See* Ex. E.
[7] *See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html.*
[8] *See* Ex. A (SOM Chapter 7).
[9] 42 C.F.R. § 488.404.
[10] Ex. D (SOM Appendix P).
[11] *Id.*; 42 C.F.R. § 488.404(b)(1).

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.[12]

9. Scope has three levels: isolated, pattern, and widespread.[13]

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."[14]

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.[15]

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" indicated 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. A copy of the Grid is set forth below:[16]

[12] Exs. C, D.
[13] 42 C.F.R. § 488.404(b)(2).
[14] 42 C.F.R. § 488.404(c).
[15] Ex. C.
[16] *Id.*

	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

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. Case-Specific Findings

13. The Facility is located in New Hope, Minnesota and provides skilled nursing care to residents as well as other services.[17]

14. On June 14, 2017, R1 was 74 years old and was admitted to the Facility with diagnoses that included Alzheimer's Disease, peripheral vascular disease, and chronic kidney disease. R1 was in the memory care unit, and her care plan indicated that she was able to move in bed independently, was at risk of impaired decision-making and communication, was unable to use a call light consistently, and required staff to anticipate her needs and closely monitor her behavior.[18]

15. R1's progress note dated March 30, 2018, indicated that R1 had redness at the left hip. No other skin impairment was noted, at that time.[19]

[17] *See, e.g.,* Ex. 4.
[18] Exs. E at 2, K.a.
[19] Ex. E at 2.

16. On March 31, 2018, the Facility's staff found R1 with both legs hanging over the left side of her bed. R1's right shin was resting against the edge of the baseboard heater cover.[20]

17. The staff assessed R1 and found a reddened area on R1's leg that was thought to be a burn from the heater next to R1's bed. The staff repositioned R1's bed away from the wall heater and notified R1's physician and family representative.[21]

18. It was determined that R1 had a burn to her right leg that occurred when she put her legs out of the side of the bed and onto the baseboard heater cover.[22]

19. R1's hospice progress note dated April 6, 2018, indicated that R1's right shin burn measured six centimeters by five centimeters on the wound perimeter. The wound had a small amount of yellow drainage.[23]

20. The burn to R1's right leg was initially treated with Bacitracin. That treatment was not effective, so a nurse practitioner discontinued that treatment and ordered Silvadene 1% cream, which is used to prevent and treat wound sepsis in patients with second and third-degree burns. The nurse practitioner directed that R1's burn be treated twice daily until healed. The nurse practitioner also requested that the Facility refer R1 to the Facility's wound physician for further assessment and treatment.[24] R1's wound healed without further complications.[25]

21. On April 9, 2018, the beds of four other residents in the Facility's memory care unit (R2, R3, R4, and R5) were against the wall with the heater. At that time, R2 was in bed next to the wall with the heater.[26]

22. On April 10, 2018, the beds of R2, R3, R4, and R5 were still against the wall with the heater. At that time R2 was in bed.[27]

23. On April 9, 2018, and April 10, 2018, R2 and R3 were 75 years old, R4 was 87 years old, and R5 was 91 years old. Each of those residents had multiple medical conditions which included Alzheimer's Disease or dementia.[28]

24. No evidence was presented which indicated that R2, R3, R4, or R5 sustained burns from the heater.

25. On April 9, 2018, the Facility's mechanical specialist (MS) stated that he became aware of R1's burn incident a week after it happened. He had not checked the

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[20] *Id.*
[21] Ex. E at 3.
[22] *Id.*
[23] *Id.*
[24] Ex. E at 3, 4.
[25] Testimony (Test.) of Wendy Koempel.
[26] Ex. E at 4.
[27] *Id.*
[28] Exs. K. b, c, d, e.

surface temperature of the heaters in the past, but he checked the surface temperatures in three rooms on April 9, 2018, and the temperatures were from 95 to 100 degrees Fahrenheit at that time.[29]

26. On April 9, 2018, MS stated that he had not been involved in a safety assessment of the heaters in regard to residents with cognitive impairments and did not do one after R1's burn incident.[30]

27. On April 9, 2018, MS stated that he had not previously checked the temperature of heaters and heater covers and was not aware of such process being in place at the Facility.[31]

28. On April 9, 2018, MS stated that he anticipated that bed positions would be changed to prevent this type of burn injury from happening in the future, but that those changes had not been done except for the bed in R1's room.[32]

29. On April 9, 2018, MS stated that the Facility had no system in place to check and record surface temperature or determine the appropriate baseboard temperature.[33]

30. On April 9, 2018, a registered nurse at the Facility (RN) stated that, since R1's burn incident, staff had repositioned all beds next to the wall with the heater. RN said she was not aware of a process for monitoring residents' safety in rooms with regard to the baseboard heater. RN was not aware of additional beds that had not been moved to reduce the hazard of burns from baseboard heaters in the memory care unit.[34]

31. On April 9, 2018, the Facility's plant operations director (OD) stated that his staff used a heat gun to check resident room temperatures weekly, but temperatures were not documented. OD said the staff responsible for the memory care unit had moved all beds away from walls with heaters. OD stated that he double and triple checked with the nursing department to ensure that all beds were moved away from walls with heaters.[35]

32. On April 9, 2018, the Facility's director of nursing stated that staff had been educated to ensure that beds were away from walls with heaters throughout the campus. The director stated that no safety assessment was completed for residents with beds against the wall with the baseboard heater in the memory care unit. The

[29] Ex. E at 4.
[30] *Id.*
[31] *Id.*
[32] Ex. E at 4, 5.
[33] Ex. E at 5.
[34] *Id.*
[35] *Id.*

director was not aware of additional residents' beds that had not been moved to reduce the hazard of burns from baseboard heaters in the memory care unit.[36]

33. On April 10, 2018, multiple staff stated that they were educated on ensuring that residents' beds were away from the walls with heaters, but the positions of the beds for R2, R3, R4, and R5 had not been repositioned or changed since R1's burn incident.[37]

34. On April 16, 2018, the Facility's administrator stated that, after R1's burn incident, the Facility moved all beds away from heaters, but some of the beds were moved back to positions near heaters. The administrator stated that the Facility educated staff, updated care plans to address bed position changes with families during care conferences and would continue to monitor staff to ensure that residents were safe at the Facility. The administrator was not aware of additional resident beds that had not been moved to reduce the hazard of burns from baseboard heaters in the memory care unit.[38]

35. The Facility's Safety and Supervision of Residents policy and procedure dated December 2007, indicated that the Facility strives to make the environment as free from accident hazards as possible. The policy indicated that the Facility's accident-prevention priorities for resident's safety, supervision, and assistance include a Facility-oriented approach to safety by addressing risks for groups of residents and identifying environmental hazards, developing strategies to mitigate or remove hazards to the extent possible, and training employees to try to prevent avoidable accidents. The policy indicated that the Facility's staff will use various sources to identify resident risk factors, implement interventions to reduce accident risks and hazards, and monitor the effectiveness of the interventions. The policy indicated that resident-specific risks and environment hazards, such as bed safety, falls, electrical safety, and water temperatures, are addressed based upon the complexity of the resident's condition.[39]

36. The Facility's Abuse Investigation and Reporting policy and procedure dated August 2017, indicated that the Facility is committed to providing an environment that is as safe as possible for each resident. The policy indicated that the Facility will have an overall proactive approach for the detection and prevention of abuse and neglect.[40]

37. The Department determined that the Immediate Jeopardy (IJ) that began on March 31, 2018, was removed on April 11, 2018, when the Facility reviewed and/or completed fall assessments, updated care plans, moved beds away from the baseboard heater, confirmed that all room radiator temperatures were checked and documented, educated nursing staff on risks related to safe bed positioning for residents, and educated maintenance staff on documenting resident room checklists, including the

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[36] *Id.*
[37] Ex. E at 6.
[38] *Id.*
[39] Ex. E at 6, 7.
[40] Ex. E at 7.

temperature of the heater and baseboards. The directors of nursing and maintenance were assigned responsibility for monitoring the nursing and maintenance tasks respectively.[41]

38. No evidence has been presented that indicates the Facility was aware of the hazard that caused R1's burn prior to R1's burn incident.

III. The Department's Investigation

39. As a result of R1's burn incident, the Department conducted a site survey of the Facility in April 2018. The Facility's mechanical specialist, plant operations director, director of nursing, a registered nurse, and multiple staff members were interviewed. The survey was completed on May 1, 2018.[42]

40. As a result of the survey, an F689 deficiency citation tag was issued, at a scope and severity level of IJ, J, related to the Facility's failure to reduce the risk of accident hazards. The hazards resulted in harm to one resident (R1) and the potential to harm other residents (R2, R3, R4, R5). R1 was found to have a second degree burn; and R2, R3, R4, and R5, were determined to be at risk for Immediate Jeopardy; due to a baseboard heater being next to their beds. The IJ was determined to have begun on March 31, 2018 and was removed on April 11, 2018.[43]

41. After the IJ was removed, the Department determined that noncompliance remained at the lower scope and severity level of G, which represented an isolated pattern for potential of harm, which was not Immediate Jeopardy.[44]

IV. The Facility's Response

42. The Facility disputes the Department's determination that the Facility had failed to comply with F689, or that an IJ, J, level scope and severity deficiency, which was later lowered to a G level, occurred.[45]

43. The Facility claims that R1's March 31, 2018 burn incident was an unavoidable accident, and that the second degree burn R1 sustained was not a "serious injury" as required under the protocol for issuing an IJ. The Facility also claims that the "non-serious" harm was isolated to R1 and did not meet the definition of potential for harm to R2, R3, R4, or R5, failing the second criteria required for issuing an IJ.[46]

44. The Facility timely filed a request for an IIDR proceeding pursuant to Minn. Stat. § 144A.10 subd. 16 (2018).

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[41] *Id.*
[42] Ex. E.
[43] *Id.*
[44] *Id.*
[45] Letter from Stella French, (May 23, 2019).
[46] *Id.*

V. Incorporation

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

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

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. The citation is supported in full, with no deletion of 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.[47]

[47] Minn. Stat. § 144A.10 subd. 16(d).

4. A regulated facility is subject to remedial action if it is not in "substantial compliance" with one or more regulatory standards.[48] 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.[49] 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.[50]

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.[51]

6. An "accident" is an "unexpected or unintentional incident, which results or may result in injury or illness to a resident."[52] "Hazards" are elements of the resident environment "that have the potential to cause injury or illness."[53] "Free of accident hazards as is possible" means "free of accident hazards over which the facility has control."[54]

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.[55]

8. An "unavoidable accident" means that an accident occurred despite sufficient and comprehensive facility systems designed and implemented to:

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[48] 42 C.F.R. § 488.400.
[49] 42 C.F.R. § 488.301.
[50] *Id.*
[51] Ex. F at 1.
[52] *Id.*
[53] Ex. F at 2.
[54] *Id.*
[55] Ex. F at 1.

- Identify environmental hazards and individual resident risk of an accident, including the need for supervision; and

- Evaluate/analyze the hazards and risks and eliminate them, if possible and, if not possible, reduce them as much as possible;

- Implement interventions, including adequate supervision, consistent with the resident's needs, goals, care plan, and current professional standards of practice in order to eliminate or reduce the risk of an accident; and

- Monitor the effectiveness of the interventions and modify the interventions as necessary, in accordance with current professional standards of practice.[56]

9. "Supervision/Adequate Supervision" refers to an intervention and means of mitigating the risk of an accident. Facilities are obligated to provide adequate supervision to prevent accidents. Adequate supervision is determined by assessing the appropriate level and number of staff required, the competency and training of staff, and the frequency of supervision needed. This determination is based on the individual resident's assessed needs and identified hazards within the resident environment.[57]

10. The level of supervision that is "adequate" may vary from resident to resident and from time to time for the same resident.[58]

11. "Immediate Jeopardy" is defined as a situation in which the provider's or supplier's noncompliance with one or more requirements, conditions of participation, conditions for coverage, or conditions for certification has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident or patient.[59]

12. Serious harm, injury, impairment, or death does not have to occur before considering Immediate Jeopardy. The high potential for these outcomes to occur in the very near future also constitutes Immediate Jeopardy.[60]

13. Determining whether a facility is in compliance with a particular requirement, condition of participation, or condition for coverage depends upon the manner and degree to which the provider or supplier satisfies the various standards within each condition.[61]

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[56] *Id.*
[57] Ex. F at 2, 5.
[58] Ex. F at 5.
[59] 42 C.F.R. § 489.3.
[60] *See* Ex. D.a at 3.
[61] 42 C.F.R. § 488.26 (b).

14. 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.[62]

15. Deficiencies are assigned to the Grid according to a determination of scope and severity.[63] Relevant here are level IJ, J, which may be assigned when there is Immediate Jeopardy to a resident's health or safety which is isolated; and level G, which may be assigned when a deficiency is isolated and there is actual harm that is not Immediate Jeopardy.[64]

16. Deficiency tag F689, which the Department initially assigned scope and severity level IJ, J, but then reduced it to level G after the Facility's IJ removal plan had been verified, is supported in full with no deletion of findings and no further change in the scope or severity assigned to the deficiency citation.

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

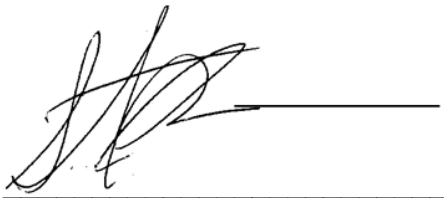
18. Any portion of the Memorandum below more properly considered a conclusion of law is incorporated herein.

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

RECOMMENDATION

Citation tag F689, which the Department initially assigned scope and severity level IJ, J, but then reduced it to level G after the Facility's IJ removal plan had been verified, should be supported in full with no deletion of findings and no further change in the scope or severity assigned to the deficiency citation.

Dated: June 7, 2019



STEVEN M. BIALICK
Administrative Law Judge

Reported: Digitally recorded
No transcript prepared

[62] 42 C.F.R. § 488.301.
[63] Ex. C.
[64] *Id.*

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 10 calendar days of receipt of this recommended decision.

MEMORANDUM

On June 14, 2017, R1 was 74 years old and was admitted as a resident to the Facility, with diagnoses that included Alzheimer's Disease, peripheral vascular disease, and chronic kidney disease. Her care plan indicated that she was able to move in bed independently, was at risk of impaired decision-making and communication, was unable to use a call light consistently, and required staff to anticipate her needs and closely monitor her behavior.

On March 31, 2018, R1 resided in the Facility's memory care unit, and her bed was located next to the baseboard heater. She sustained a second-degree burn to her right leg when she put her legs off the side of her bed and onto the baseboard heater cover.

On April 6, 2018, R1's burn wound measured six centimeters by five centimeters on the perimeter and had a small amount of yellow drainage. The wound was initially treated with Bacitracin. That treatment was not effective, so a nurse practitioner changed the treatment to Silvadene 1% cream, which is used to prevent and treat wound sepsis in patients with second and third-degree burns. The nurse practitioner also requested that the Facility refer R1 to the Facility's wound physician for further assessment and treatment. The burn wound healed without further complications.

R1's March 31, 2018 injury alerted the Facility to the hazard posed by having beds next to the baseboard heater. However, on April 10, 2018, the beds of four other residents in the memory care unit (R2, R3, R4, and R5) were still against the wall with the heater.

On April 16, 2018, the Facility's administrator stated that, after R1's burn incident, the Facility moved all beds away from heaters but some of the beds were moved back to positions near the heaters.[65] The Facility is unable to say why the beds were moved back to positions near the heaters or who moved them back.[66]

In April 2018, as a result of R1's burn incident, the Department conducted a site survey of the Facility. Based on that survey, the Department issued an F689 deficiency citation tag to the Facility. The Department determined that the scope and severity level for the citation was IJ (Immediate Jeopardy), J, from March 31, 2018 until April 11,

[65] Ex. E at 6.
[66] *See, e.g.,* Test. of Renae Shore.

2018, when the IJ was removed. After the IJ was removed, the Department determined that noncompliance remained at the lower scope and severity level of G.

The Facility requests that the Department rescind the F689 deficiency citation in its entirety or, at a minimum, reduce the scope and severity of the citation to a D level. It argues that the injury to R1 was an unavoidable accident, that it was in compliance with all safety requirements, that it provided adequate supervision, and that R1's burn was not a serious injury.

The Facility also claims that it was not aware of the hazard caused by the heater until R1 was injured, and that it acted to alleviate that hazard after R1's burn incident.

However, the Facility could have easily discovered the hazard caused by the heater if it had measured the temperature of the heater and the heater cover before R1 was injured. In addition, the Facility did not provide adequate supervision of the memory care unit when it failed to ensure that the beds of R2, R3, R4, and R5 remained away from the heater, after it discovered the hazard. The injury to R1 was an avoidable accident, and the Facility could have avoided potential injuries to R2, R3, R4, and R5 by ensuring that their beds remained a safe distance away from the heater.

The Administrative Law Judge also disagrees with the Facility's claim that R1's injury was not a serious injury. R1's wound was a second degree burn that measured six centimeters by five centimeters and developed yellow drainage. It could not be adequately treated with Bacitracin and was at risk for developing sepsis.

The Department determined that the Immediate Jeopardy that began on March 31, 2018, was removed on April 11, 2018, because the Facility had reviewed and/or completed fall assessments; updated care plans; moved beds away from the baseboard heater; confirmed that all room radiator temperatures were checked and documented; educated nursing staff on risks related to safe bed positioning for residents; educated maintenance staff on documenting resident room checklists, including the temperature of the heater and baseboards; and assigned responsibility for monitoring the nursing and maintenance tasks to the directors of nursing and maintenance respectively. However, removing the Immediate Jeopardy did not change the fact that R1 had sustained actual harm, or that the Facility failed to ensure that beds were kept away from the baseboard heater after it was aware of the hazard.

A facility may be issued a F689 deficiency citation tag if it fails to ensure that the resident environment remains as fee of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. A scope and severity level of IJ, J, for an F689 tag is appropriate if there is an Immediate Jeopardy to resident health or safety. A scope and severity level of G is appropriate if there is actual harm that is not Immediate Jeopardy. A scope and severity level of D is only appropriate if there is no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.[67]

[67] Ex. C.

The Department has demonstrated that the F689 deficiency citation, with an initial scope and severity level of IJ, J, was appropriate. The Department has also demonstrated that it appropriately reduced the scope and severity level of the citation to G after the Facility's IJ removal plan had been verified.

Therefore, the Administrative Law Judge recommends that the F689 tag, at the initial IJ, J, level and the subsequent G level, be supported in full with no deletion of findings and no further change in the scope or severity assigned to the deficiency citation.

S. M. B.