

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

In the Matter of Trevilla of Robbinsdale –
Survey Dates 10/31/03 and 11/12/03

RECOMMENDED DECISION

The above matter was the subject of an independent informal dispute resolution (IIDR) meeting conducted by Administrative Law Judge George A. Beck on Tuesday, October 5, 2004, beginning at 9:30 a.m., at the Office of Administrative Hearings. The meeting concluded on that date. The OAH record closed upon receipt of the final written submission from the Department on October 27, 2004.

Marci Martinson, Unit Supervisor, Division of Facility and Provider Compliance, 1645 Energy Park Drive, Suite 300, St. Paul, MN 55108-2970 represented DFPC. Susan M. Voigt, Esq., April Boxeth, Esq., and Janny Vue, paralegal, Voigt, Jensen & Klegon, LLC, 2550 University Avenue West, Suite 190 South, St. Paul, MN 55114, represented Trevilla of Robbinsdale. Also attending the meeting were Mary Cahill and Carol Moen for the Department of Health; Carol Skare, Michelle Brown, and Charles Kuoto-Messam from Trevilla of Robbinsdale; and Dr. Allan Dummer, the facility's psychologist.

NOTICE

Under Minn. Stat. § 144A.10, subd. 16(d)(6) this recommended decision is not binding on the Commissioner of Health. Under 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.

Based upon the exhibits submitted and the arguments made and for the reasons set out in the Memorandum which follows, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

October 31, 2003 Survey

That the citation with regard to Tag F250 be sustained.

That the citation with regard to Tag F282 be amended through a change in the scope and severity from "G" to "D."

That the citation with regard to Tag F309 be sustained.

That the citation with regard to Tag F318 be sustained.

November 12, 2003 Survey

That the citation with regard to Tag F165 be dismissed.

That the citation with regard to Tag F166 be sustained.

That the citation with regard to Tag F224 be amended through a change in the scope and severity from "H" to "D."

That the citation with regard to Tag F241 be amended through a change in the scope and severity from "H" to "G."

That the citation with regard to Tag F250 be amended through a change in the scope and severity from "J" to "E."

That the citation with regard to Tag F272 be dismissed.

That the citation with regard to Tag F279 be sustained.

That the citation with regard to Tag F353 be sustained.

Dated this 24th day of November 2004.

s/George A. Beck

GEORGE A. BECK
Administrative Law Judge

Reported: Tape-recorded
(Four Tapes, No Transcript Prepared)

MEMORANDUM

Robbinsdale Rehab, formerly Trevilla of Robbinsdale, ("Robbinsdale" or "the facility") cares for approximately 115 residents, a high percentage of whom have special needs resulting from psychiatric diagnoses, depression and other behavioral symptoms. Most of the residents are not elderly, and are therefore dealing with significant physical and mental health problems at a younger age. Many of the residents are angry, frustrated, and difficult to handle.

On October 31, 2003, the Division of Facility and Provider Compliance (DFPC) and its federal counterparts completed a federal oversight survey of Robbinsdale, resulting in violations under four tags. DFPC commenced a follow-up survey shortly thereafter, which concluded on November 12, 2003, and cited the facility for violations under eight more tags. The November 12th survey was compelled by the federal officials through the filing of a complaint with the Minnesota Office of Health Facilities Complaint. DFPC issued a Statement of Deficiency (Form 2567), dated November 25, 2003, to the facility, encompassing all twelve tags.

Survey Exit October 31, 2003

Tag F250 – Social Services

Under 42 C.F.R. 483.15, the facility is responsible for providing “medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.”^[1] Each resident is to receive individual assessment and care planning to meet their needs. Facility surveyors are taught to look for the presence of depression; chronic or acute pain; difficulty with personal interaction and socialization skills; presence of legal or financial problems; abuse of alcohol or other drugs; inability to cope with loss of function; and need for emotional support. “Medically-related social services” means providing or arranging counseling services; making referrals and obtaining services from outside entities; developing care plans to aid the residents’ routines, concerns and choices; and building an effective relationship between residents and facility staff.

DFPC found a violation of 42 C.F.R. 483.15 and assigned a severity and scope level of “G”, meaning that the deficiency is isolated, but that actual harm resulted.^[2] DFPC alleges that Robbinsdale failed to provide medically-related social services to Resident 38. This resident is a 53-year-old diabetic paraplegic who suffers from chronic back pain and depression; he also suffered a stroke in August 2002. Resident 38 takes Paxil for his depression, as well as other medications for his various conditions.^[3] He is a two-time resident of the facility, admitted for the second time on July 24, 2003. His physician described him as quite depressed with decreased coping mechanisms, and recommended a care plan for Resident 38 that “make(s) the best of the situation.”^[4] On July 25, 2003, among other orders, the physician recommended that the resident undergo a psychiatric evaluation in the near future. As of October 30, 2003, the resident had not seen a psychiatrist, and on that day, he inflicted non-fatal knife cuts to his arms and abdomen.^[5]

DFPC alleges that the facility violated 42 C.F.R. 483.15 by not scheduling the psychiatric evaluation ordered by the resident’s physician and by providing him counseling only on an as needed basis when his situation reached crisis proportions. Further, DFPC notes that the resident’s records lacked documentation identifying what individualized approaches were to be implemented in assisting Resident 38 in adjusting to the facility. In addition, DFPC alleges that documentation provided to them by the licensed social worker (“LSW”) was altered to reflect that the facility had discussed a psychiatric evaluation with the resident and that he had declined it in favor of speaking

with the LSW.^[6] DFPC argues that actual harm occurred when the resident inflicted three knife cuts to his forearms and abdomen.

The facility argues that the resident consistently refused treatment and cares from staff and the facility's psychologist, Dr. Dummer,^[7] and that he had a right to refuse treatment under 42 C.F.R. 483.10(b)(4). Resident 38 was highly concerned about payment for his stay at Robbinsdale, for psychological services, and for transportation services. According to the facility, Medicare had covered the resident's initial stay at Robbinsdale, but he had been denied Medicare benefits on his second admission.^[8] Additionally, the resident purportedly received a notice of discharge from the facility on the day he cut himself; facility staff felt that the resident was acting out because of the letter and financial issues, not due to a lack of social services.^[9]

The record demonstrates that the facility failed to provide medically-related social services to maintain the highest possible mental well-being of Resident 38. The facility failed to follow a July 2003 physician recommendation to have Resident 38 undergo a psychiatric examination. The nursing records indicate ongoing incidents in the facility involving the resident (without adjustments of the care plan), although none as serious as his infliction of knife cuts on October 30, 2003. Robbinsdale argues that the resident declined psychiatric services, but there is no documentation to support this claim. The apparent altering of a date on a social worker note to make it appear that the Resident declined services after the July recommendation supports the view that the facility realized there was a problem with its provision of social services. The facility also argues that the knife cuts were not related to a lack of services, but rather to a notice of discharge provided for the resident. It is difficult to conclude that the knife cuts were directly related to a lack of services. But it is significant that the Resident complained that "nobody pays attention to me" after inflicting the wounds rather than complaining about his discharge.

Conclusion

DFPC assigned an appropriate scope level – isolated – since only one resident was involved in this tag. It assigned a severity level of "actual harm that is not immediate jeopardy" resulting in a classification of "G." DFPC points to expressions of dissatisfaction, agitated behaviors and the self-inflicted wounds to support its determination. Even though the self-infliction of cuts may not be clearly related to the lack of services, the severity level is appropriate. The actual harm is the lack of clearly needed services to a resident with Resident 38's disabilities. His ability to reach his highest mental well-being was compromised by the failure to provide the recommended services. A "G" classification is demonstrated to be appropriate.

Tag F282 – Implementation of Care Plan

Under 42 C.F.R. 483.20(k)(3)(ii), the facility must ensure that qualified individuals provide residents services in accordance with their plan of care. Surveyors are to examine whether any problems with quality of care, quality of life, and resident rights

are attributable to the qualifications of the facility staff, or lack of, inadequate or incorrect implementation of the care plan.^[10]

DFPC found five violations of this regulation and assigned an overall severity and scope level of “G”, indicating that the violations were isolated, but that actual harm occurred.

Resident 38

See Tag F250 above for a summary of Resident 38’s diagnoses. The resident’s care plan, dated July 24, 2003, identified altered mood, behavior deficits, mood that was not easily altered, depressed affect, anxiety, repetitive complaints and resistance to cares.^[11] The approaches for dealing with these symptoms were one-on-one (“1:1”) meetings with social services to discuss the resident’s feelings on an as needed basis, encourage the resident to verbalize his feelings as needed, arrange psychiatric consults as ordered, and provide praise for calm interactions with staff.

DFPC acknowledges that the facility had a care plan in place, but asserts that the facility failed to implement his care plan when it did not provide 1:1 meetings and interventions with social services, arrange for psych consultations, educate the resident as to following the plan of care, and administer medications and monitor their effectiveness. DFPC argues that if the resident refused a psychological evaluation, then the facility should have removed that goal from the care plan and replaced it with a goal with which the resident agreed. DFPC assigned Tag F282 to a “G” level because actual harm came to Resident 38 when he self-inflicted knife wounds to his arms and abdomen. This is the only actual harm example under this Tag.

As with Tag F250, Robbinsdale contends that this resident was highly resistant to most of the cares that the facility attempted to provide. According to the facility, the issue is one of “interpretation and degree.” DFPC seems to acknowledge that the facility did provide some assessment and evaluation of the resident, but that the outcome was not desirable or appropriate. Robbinsdale, in turn, argues that a plan of care was in place for this resident, and all of the residents at issue under this tag, and that the success or failure of the plan of care was directly related to the difficulty in serving this type of resident. Facility staff stated that the care was given to the extent possible, as evidenced by the MDS, RAPS, care plan, treatment sheets and behavior logs.^[12]

DFPC repeats the violation for failure to arrange a psych consult under this tag that was also cited under F250. However, it also alleges that the care plan that called for 1:1 visits by Resident 38 with the licensed social worker was not implemented. The facility argues that the resident refused services and has the right to do so. It also argues that there was no reason to believe that the resident would harm himself and that the incident was related to finances. As stated above, the self-inflicted wounds have not been clearly connected to the failure to provide services. However, even setting that issue and the failure to get a psych consult aside, the record still supports a conclusion that a violation occurred when Robbinsdale failed to provide 1:1 services

with the LSW despite documented incidents of acting out by the resident in August, September and October 2003. Rather, it appears that the LSW may have avoided contact with the resident because he was abusive.

Resident 1

Resident 1 was diagnosed with multiple sclerosis and spastic quadriplegia, as well as mild cognitive impairment. This resident requires extensive assistance with daily hygiene activities, and accordingly, the care plan directed facility staff to floss the resident's teeth twice daily as needed and every shower day.^[13] DFPC cited the facility for failing to floss the resident's teeth as per her plan of care based upon statements made by the resident that she did not receive help flossing her teeth and one nursing assistant who said the facility didn't use floss for its residents.^[14]

The standard of oral care, according to Robbinsdale and their expert, is that a resident's teeth must be brushed once every day, and twice if possible.^[15] The facility argued that flossing the residents' teeth is very difficult, but that dental floss was available to residents if they asked for it or if the staff thought it was needed.^[16]

Resident 7

Resident 7 has multiple sclerosis, dementia, and moderate cognitive impairment. This resident also requires extensive assistance with daily hygiene, and the care plan directs facility staff to provide oral care and flossing.^[17] DFPC cited the facility for failing to floss the resident's teeth as per her plan of care based upon statements made by a nursing assistant. In addition, this resident was in hospice care as of April 30, 2003.

The facility's argument regarding the standard of care also applies to this resident.

The care plans for Residents 1 and 7 call for flossing BID or twice a day for Resident 7 and PRN or as needed for Resident 1. The testimony indicated that flossing by untrained staff is not the standard of oral care for nursing home residents. The facility states that floss was available and could be requested. It believes this is a documentation issue rather than a care issue. The statement of Resident 1 and the nursing assistant are sufficient to conclude that flossing was not being done for residents. The facility did not deny that it did not regularly provide such help. However, this must be weighed against the standard of care and the difficulty of flossing the residents' teeth. Given that DFPC did not contest the facility's testimony as to the standard of care, it is recommended that a violation not be found in regard to Residents 1 or 7.

Resident 2

Resident 2 suffers from rheumatoid arthritis and a seizure disorder, and her care plan directs facility staff to perform passive range of motion (PROM)^[18] exercises with the resident's left upper arm five times per week and her left ankle each night.^[19] DFPC cited the facility for failing to provide ROM exercises to the resident's left ankle at

bedtime based upon statements from the resident, facility documentation, and a statement from the nurse manager that she tells her nursing assistants “to do it, but they don’t always do it.”^[20]

First, the facility contends that DFPC took the nursing manager’s statement out of context, and that the nursing manager was repeatedly reminding her assistants to document when a resident received ROM exercises, not to perform the exercises.^[21] The facility argues that the ROM exercises were being performed on Resident 2, but just not being consistently documented.^[22] Furthermore, the resident stated that she did receive her morning PROM exercises regularly.

Resident 11

This resident has multiple sclerosis with weakness, neurological deficits, and a high risk of falling. The resident requires total assistance with all daily activities. Due to this condition, Resident 11’s plan of care directed that she have PROM to her upper and lower extremities.^[23] The October 2003 care plan directed PROM to be performed on the lower extremities three times per week, and the treatment plan directed the nursing rehabilitation staff to perform the required PROM. Resident 11’s treatment record showed only seven instances of PROM exercises in the month of October 2003.^[24] A nursing assistant interviewed by surveyors indicated that PROM would be performed on a patient only if it appeared on the assignment sheet, and that no such assignment appeared on Resident 11’s sheet.^[25] Again, DFPC relies on the statements of the Nurse Manager that “I tell them to do it, but they don’t always do it (ROM).” During the survey, DFPC surveyors affirmed that nursing assistants were trained in PROM exercises and that it was the responsibility of the Nurse Manager to insure completion of ROM exercises.^[26]

The facility concedes that nursing assistants perform only those activities appearing on the assignment sheet, and that PROM exercises were not included on Resident 11’s assignment sheet. The facility maintains that Resident 11 refused cares, including PROM exercises, but that these refusals were not appropriately documented. Ultimately, the facility argues that Resident 11’s condition did not decline due to the lack of PROM exercises.

The record supports the conclusion that Residents 2 and 11 were not receiving all of the PROM exercises called for in their care plan. One resident and a nursing assistant attested to this and the exercises were not always documented. However, the nursing managers comment about “they don’t always do it” appears to refer to documentation rather than assisting with the exercises.

Conclusion

DFPC set a scope and severity rating of G for the violations cited in F282. This means that the scope was isolated and the severity was “actual harm that is not immediate jeopardy.” The guidelines for surveyors indicates that this severity level is for a negative outcome that has compromised the resident’s ability to reach the highest

practicable physical, mental or psychosocial well-being. It does not include a deficient practice that has caused a limited consequence to the resident. The record does not contain evidence of a negative outcome for this tag. The lapse in flossing and PROM exercises have not been shown to have led to a negative outcome. Neither does the lack of LSW contact appear to be directly linked to the self-inflicted injury as alleged. Rather the violations are more properly classified as “no actual harm with potential for more than minimal harm” which includes minimal physical, mental or psychosocial discomfort to the resident. It is recommended that this tag be classified as SS=D.

F309 – Quality of Care

This tag involves two residents and concerns the use of pain medication to alleviate pain symptoms associated with cares performed on the residents. The regulation requires that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

In the Guidance to Surveyors, “Highest practicable’ is defined as the highest level of functioning and well-being possible, limited only by the individual’s presenting functional status and potential for improvement or reduced rate of functional decline. Highest practicable is determined through the comprehensive resident assessment by competently and thoroughly assessing the physical, mental or psychosocial needs of the individual.” For the purposes of this tag, the DFPC has highlighted the portion of the Guidance that reads: “If services and care are being provided, determine if the facility is evaluating the outcome to the resident and changing the interventions if needed. This should be done in accordance with the resident’s customary daily routine.”

Resident 17

Resident 17 is diagnosed with Rheumatoid Arthritis, stasis ulcers due to venous insufficiency with skin lesions, and urinary incontinence. The survey alleges “Resident #17 suffered actual harm when he was not provided with adequate pain management during dressing changes.” Because of the finding of actual harm observed on one occasion, the scope and severity level was set at G.

The surveyor observed the resident receiving cares and having dressings changed. During the dressing changes on 10/31/03, the surveyor observed the resident moaning, screaming, vocalizing “ow”, “oh” and “ah” and at one point, jumping.^[27] The resident had not received pain medication prior to the procedure, nor was he given any during the procedure after he indicated he was in pain. The resident’s medication administration record (MAR) indicated that the last time he had received pain medication was at 1 a.m. on 10/31/03.^[28]

The facility is aware that the resident suffers from daily pain. The surveyor’s record review revealed a progress note dated 9/10/03, written by the LSW, that stated

“the resident was having much pain and would yell out during dressing changes.”^[29]
The resident may receive Oxycodone for pain every 4 hours as needed.^[30]

The facility responds that Resident 17 has pain whenever his limbs are moved.^[31] The resident’s care plan does not call for Oxycodone before each dressing change, but rather as needed. The resident’s care plan also states that the resident “is able to make needs known.” The facility argues that the resident could have asked for pain medication if he wanted to receive it. The Surveyor Notes Worksheet states that Resident 17 stated “Pain = they give me pills if I ask for them.”^[32]

The facility maintains that the pain experienced by the resident is due to his clinical condition, not to some action or inaction on the part of facility staff. The record indicates otherwise. If a resident is showing the verbal and non-verbal signs of pain as observed by the surveyor, and no pain medication is offered to meet that need, the Oxycodone is not being provided “as needed.” Providing the pain medication after the treatment has concluded, or only upon request, may, as it did on at least one observed occasion, result in the resident experiencing pain due to staff inaction.

Resident 6

Resident 6 is a 63-year-old female at the end stage of Multiple Sclerosis who is on hospice and has renal failure.^[33] The surveyor observed the resident to moan, and heard her say “that hurts” during cares, on two different days.^[34] Many people with MS suffer from pain according to DFPC.

The Facility responds that Resident #6’s Pain Data Collection and Assessment dated October 2, 2002 states “Res denies Pain @ this time.”^[35] The same exhibit also indicates that no complaints of pain were noted in several subsequent reviews. The facility states that the resident “never complained about pain nor did she ask for any medication for pain during the course of her treatments.”^[36] An assessment completed 08-05-2003 notes under “Pain Symptoms,” that the resident does not complain or show evidence of pain.^[37] The RN Visit records for 10/2/03, 10/8/03, 10/9/03, 10/16/03, 10/20/03, 10/28/03, and 10/30/03, all state that the resident denied having pain and no non-verbal signs of pain were observed.^[38] A bi-weekly interdisciplinary plan of care summary dated 10/21/03 also states that the Patient “denies pain” and “is able to make needs known to staff.”^[39]

The resident’s Minimum Data Set (MDS) dated 8/5/03 indicates the resident suffered from both short- and long-term memory loss.^[40] DFPC argues that “[t]here is no indication the assessments were performed at a time when the resident was receiving cares or when her extremities were being moved.” DFPC speculates that the resident may deny having pain if she is asked about it after the cares have been provided or when her limbs are not being moved. There is no support in the record for the assumption that the resident was asked if she had pain only after her cares were completed or when her limbs were not being moved.

Nevertheless, if a resident says “that hurts” or displays non-verbal signs of pain, a reasonable response is to offer pain medication at that time. The fact that the resident has denied pain in the past, or not been observed to exhibit non-verbal signs of pain in the past, does not excuse the failure to offer pain medication when the resident clearly expresses that something is painful. Failure to offer pain medication when a resident complains of pain is not consistent with the facility’s responsibility to provide care that will maintain a resident’s “highest practicable physical, mental, and psychosocial well-being.” The facility did not evaluate the outcome to the resident and change the intervention as needed.

Conclusion

DFPC assigned a scope and severity rating of “G” for the violations noted in tag F309. This means it determined that the scope was isolated and the severity was “actual harm that is not immediate jeopardy.” Robbinsdale urges that this deficiency be lowered to a “D” which would mean that the severity would be no actual harm but with potential for more than minimal harm. That severity level does not square with the observations of the residents by the surveyors, since they observed the residents in pain. The harm was directly related to the violation. The scope and severity level of “G” is sustained.

Tag F318 – Quality of Care; Range of Motion Treatment

Under 42 C.F.R. 483.25(e)(2), residents with limited range of motion must receive appropriate treatment and services to increase their range of motion and/or to prevent further decrease in range of motion. Adequate preventive care may include active ROM or passive ROM performed by the facility staff, and application of splints and braces.^[41] Clinical conditions such as bed rest, stroke, multiple sclerosis, cerebral palsy, arthritis, and late stage Alzheimer’s are primary risk factors for decreased range of motion. A reduction in ROM is considered unavoidable only if adequate assessment, appropriate care planning, and preventive care was provided and resulted in limitation in ROM.^[42]

DFPC found three violations of the regulation and assigned an overall severity and scope level of “E” to the tag, meaning that the facility engaged in a pattern of events where no actual harm occurred, but where a potential for more than minimal harm that is not immediate jeopardy existed.

Resident 2

See the factual summary above regarding Resident 2 under Tag F282. The resident’s care plan, dated September 26, 2003 directs the nursing staff to provide the resident with left upper arm PROM five times per week and PROM to the left ankle at night.^[43] According to Resident 2, she regularly receives PROM on her left upper arm, but since her move to another floor in the facility in July, there is only one nursing assistant that will routinely perform PROM on the resident’s ankle.^[44] During the month of October, 2003, the resident’s treatment plan documentation noted PROM having been provided 14 out of the last 29 days.^[45] DFPC objects to the alleged haphazard

method of providing PROM, and the facility's failure to include this resident's PROM on daily staff assignment sheets. DFPC acknowledges that Resident 2's ROM limitations may not have been avoidable, but is instead concerned with whether the facility was following its own care plan.

As with Tag F282 above, the facility contends that DFPC took the nursing manager's statement out of context, and that the nursing manager was repeatedly reminding her assistants to document when a resident received ROM exercises, not to perform the exercises. The facility argues that the ROM exercises were being performed on Resident 2, but just not being consistently documented.

Resident 11

See the factual summary and arguments of the parties above regarding Resident 11 under Tag F282.

As indicated above, the record establishes that Residents 2 and 11 had limitations in ROM and that the exercises were not always implemented. The facility's argument that the exercises were done but not documented cannot be credited in light of the comments of Resident 2 and the nursing assistant. Allowing staff to fail to document services means that whether the services were provided is in doubt. The DFPC established that violations more likely than not occurred.

Resident 7

Resident 7 has MS with a severe limitation of all extremities. Accordingly, in addition to the facts summarized above under Tag F282, this resident's care plan also included PROM exercises once a day to prevent further loss of range of motion in the upper and lower extremities.^[46] DFPC relies on treatment plan documentation to demonstrate that the facility only provided PROM exercises to Resident 7 twice in September 2003, and four times in October 2003.^[47] DFPC acknowledges that Resident 7 had a history of refusing cares, but that the facility never documented those refusals.

Robbinsdale argues that Resident 7 often refused cares and medication and that he signed a Refusal of Care or Treatment form on August 6, 2002.^[48] The facility also produced a Multi-Disciplinary Therapy Screening Tool, dated August 27, 2003, indicating that skilled therapy intervention was not appropriate for Resident 7 at that time.^[49]

The record shows that it is more likely than not that Resident 7 did not receive the PROM exercises called for in the care plan. The Refusal of Care cited by Robbinsdale does not specifically include ROM exercises. The screening tool dated August 27, 2003 notes that skilled therapy may not be appropriate but indicates it may be provided by hospice if appropriate. The record indicates that it was provided on occasion after August 27, 2003. A violation was established.

Conclusion

- Tag F318 was issued at an E level because DFPC concluded three residents were affected on a regular basis, thereby establishing a pattern. DFPC labeled the severity level as “not actual harm with potential for more than minimal harm.” The facility suggests that this deficiency should be eliminated. However, the record establishes the violations and DFPC has shown a pattern. The severity cannot reasonably be characterized as having only the potential for minimal harm since the failure to perform ordered ROM exercises for residents with arthritis, MS, and with a severe limitation of all extremities could have a potential for more than minimal harm. The “E” scope and severity rating is appropriate.

Survey Exit November 12, 2003

F165 – Grievances - Reprisal

This tag involved five residents and concerned alleged retaliation against residents who make complaints. The regulation states that the resident has the right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment that has been furnished as well as that which has not been furnished. The Guidance to Surveyors clarifies that the right to voice grievances is not limited to a formal, written grievance process, but also includes a resident’s verbal complaint to facility staff.

Resident A

Resident A is paralyzed and unable to use her arms and legs. She is totally dependent on staff for all bodily needs. In an interview, Resident A stated that if she and her roommate speak up and complain, the nursing assistants (NAs) ignore them.^[50] Resident A reported that the NAs would come in, turn off her call light, and leave without even asking what she wanted.^[51] She stated that this made her “feel terrible” and that she was “fearful” that no one would answer her call light at all.^[52]

DFPC alleges that this “resident was harmed due to the mental anguish of being ignored and as evidenced by her statement “It makes me feel terrible.” There is no question that being ignored is unacceptable in the case of someone totally dependent upon staff for her needs. However, the cited violation here concerns the retaliation against residents for voicing a grievance. The resident does not indicate that she is retaliated against for speaking up; instead she reports that she does speak up and is ignored. DFPC does not allege that the resident was ignored, and therefore discriminated against, because she made complaints; to the contrary, it alleges under other tags that residents’ needs were often ignored.^[53] This resident’s reported experience does not support a finding that residents suffered discrimination or reprisal after making complaints.

Resident B-1

Resident B-1 reported that staff yelled at her, but that she hasn't reported it because she is afraid of retaliation.^[54] This resident wanted to remain anonymous.^[55] The facility responded that "[b]ecause of the resident's own diagnosis, and according to MDH's own Resident Review Worksheet, page 1 (see MDH Exhibit J6a), this resident is not interviewable."^[56]

Even if resident B-1 were "interviewable," DFPC has not shown that the resident does not have "the right to voice grievances without discrimination or reprisal." The regulation does not speak of the "fear" of retaliation, but rather the right to be free from discrimination or reprisal. Nothing that B-1 said supports the DFPC's allegation that she was unable to voice grievances without retaliation; only that she had not voiced grievances for fear of retaliation. Fear of retaliation does not meet DFPC's burden to show that residents are deprived of the right to voice grievances without discrimination or reprisal.

Resident 19

Resident 19's "most prominent problem" is anxiety.^[57] He has repetitive anxious concerns and persistently seeks attention or reassurance regarding schedules and relationship issues.^[58] Resident 19 told the surveyor that he had complained during the 10-31-03 survey that an NA had been late putting him to bed and getting him up from bed.^[59] The resident stated that the NA about whom he had complained came back within a half hour after the complaint had been made and "verbally accosted" him.^[60]

The incident reported by Resident 19 provides some evidence of reprisal for having exercised the right to voice a grievance. The facility responded that the surveyor had not complied with the Principles of Documentation (POD) in this instance.^[61] DFPC quotes the POD as follows: "To the greatest extent possible, the surveyor verifies the information obtained from interview through observation or record review. In the absence of other objective validation of information, information may also be confirmed/verified through multiple interview sources."^[62]

Resident 19's statements were made during a group interview.^[63] Therefore, the surveyor was in a position to confirm this information through multiple interview sources at that time. The surveyor did ask whether staff would retaliate and at least 3 residents agreed.^[64] In response to the question, the surveyor reports that the group laughed, and one resident said "Well, of course we fear retaliation."^[65] As stated above, "fear" of retaliation is not a violation. This regulation is intended to ensure that residents are able to voice grievances without retaliation, not that they be free of the fear that it might happen.

Resident 7

Resident 7 is a 54-year-old who suffers from severe depression, psychosis, and a history of ideations. The facility understood DFPC to characterize a no harm contract and an agreement that the resident made with the Director of Nursing as reprisal.^[66] In fact, DFPC makes no allegation that Resident 7 experienced discrimination or reprisal

for voicing grievances, only that she felt “in the middle” between the surveyor and the Director of Nursing.^[67] Even if feeling “pressure” could be interpreted to be discrimination or reprisal, there is no evidence that Resident 7 had voiced any grievance prior to signing the agreement. There is inadequate support in the record for including Resident 7 in this tag.

Resident B-2

DFPC does not allege that this resident was unable to voice grievances because of discrimination or reprisal, or even that he was retaliated against. On the contrary, this resident, who is the president of the Resident Council, stated that the administrator listens to grievances brought up by the council, “but nothing is done.”^[68]

Conclusion

This regulation is designed to ensure that residents have the right to voice grievances without discrimination or reprisal. This regulation does not say anything concerning the adequacy of the facility’s response to grievances, but concentrates on the consequences, if any, faced by residents who voice grievances. Whether the facility takes any action to resolve voiced grievances is the subject of the next tag. Looking solely at the issue of discrimination or reprisal for grievances, DFPC has not met its burden of proof. The incident reported by Resident 19 was not verified and the staff’s action was not clearly linked to the complaint. It is recommended that this be dismissed.

F166 – Grievances - Resolution

This tag concerned the response of facility administration to resident grievances. The regulation requires prompt efforts by the facility to resolve complaints brought by residents. The Guidance to Surveyors states that prompt efforts to resolve grievances include the facility’s acknowledgement of grievances and active work toward their resolution.

The facility described its process for following up on complaints raised in the Resident Council meetings as follows: Grievances brought up in Resident Council Meetings result in recommendations to various facility departments.^[69] The department receives a copy of the complaint and is supposed to respond before the next Council meeting concerning how it intends to resolve the issue. The facility also presented testimony that individual’s complaints were handled in a timely fashion.^[70]

The President of the Resident Council presented a different picture concerning the administration’s response to concerns raised by residents. He reported that many residents have stated that it is not worth attending Resident Council meetings because nothing is done in response to resident complaints.^[71] He stated that the facility administrator listens to the complaints, but no action is taken to resolve them.^[72] There was no evidence that the facility had any kind of tracking system for complaints. DFPC

alleges that the facility did not have a system that documented and monitored complaints, and thus there was no means to evaluate whether concerns were adequately addressed.^[73]

Specifically, DFPC alleges that facility administration did not acknowledge and/or work to resolve specific resident complaints about:^[74]

1. Staffing

Resident Council Meeting minutes from the months of January,^[75] February,^[76] April,^[77] May,^[78] August,^[79] and October,^[80] 2003 contained resident concerns regarding insufficient staff to meet their needs. Two of the most frequent complaints concerning inadequate staffing were the slow or inadequate response to call lights, and the treatment residents received from the weekend staff. These concerns were also commonly raised in the interviews conducted with residents during the survey.

a. Call lights

The slow or inadequate response to call lights was a grievance raised at the January,^[81] February,^[82] April^[83] and May,^[84] 2003 Resident Council Meetings. It was also the subject of an individual resident's complaints,^[85] as well as several residents at the group interview.^[86] Residents stated that they had to wait up to two hours for a staff person to respond to a call light.^[87] Several residents also complained that staff would come in to their room, shut off the call light, and leave without asking what the resident needed.^[88]

The facility responded by presenting the results of its call audit^[89] and with testimony from Michelle Brown^[90] that there are some residents who use their call lights excessively, some that even ring them several times a minute.^[91] There is no indication from the call light audit that residents are using their call lights several times a minute,^[92] or even several times a day. The call light audit indicates a quick response time overall.^[93]

However, one of the complaints is not the length of time it takes for a staff member to answer the call light, but rather that the response is inadequate, or even nonexistent. The call light audit provides no indication of the quality of the response to the residents using their call lights. This additional complaint could explain why response times appear very good on the audit, and yet resident complaints about staff responses when they used their call light continually. The problem was likely the quality of the staff response more than simply the timeliness of it. There is ample evidence of resident complaints about this issue over time. In summary, the number of complaints about staff response to call lights, and the consistency of the issues raised, demonstrate by a preponderance of the evidence that this grievance was not resolved.

b. Staffing levels

There were complaints concerning staffing levels in the January^[94] and October^[95] 2003 Resident Council minutes, as well as in the group interview conducted by a surveyor.^[96] Residents complained about staffing levels on the weekends in particular in the August,^[97] September,^[98] and October,^[99] 2003 Resident Council Meetings.

In response to complaints concerning staffing levels in general, the facility responded that it staffed at the levels allowed by the budget.^[100] The residents' complaints regarding inadequate care on the weekends were forwarded to the facility administration and the nursing department on a Resident Council Action Form.^[101] There was no response from facility administration.^[102] The nursing department responded by speaking to all of the staff involved and gave each of them a verbal warning. It also posted the list of concerns where staff could see it.^[103]

In response to complaints about inadequate staffing, the facility administrator stated that the facility staffs at a level of 3.6 hours per resident, better than the level at most facilities.^[104] DFPC responded that the issue is not whether the facility maintains the minimum staffing level required by the State, or even whether it is better-staffed than other comparable facilities, but rather whether it has adequate staffing to meet the needs of the residents. The sheer number of complaints over time about staffing levels and the resulting inadequate care, suggests that the staffing level is not adequate or, even if adequate in terms of numbers of staff people, is not responsive to resident needs.

The facility has not altered its staffing levels in response to these complaints.^[105] Instead, the surveyor was told by several different people (staff and residents) that certain staff is regularly sent home an hour to an hour and a half early.^[106] One staff person reported having to complete 8 hours of work in 7 hours, and stated "we need more help."^[107]

The statements of both residents and staff, and the lack of responsiveness on the part of the facility administration, are sufficient to meet DFPC's burden of proof for its allegation that staffing levels are not adequate.

2. Incontinence products

Resident Council Meeting minutes from April,^[108] May,^[109] June^[110] and July^[111] of 2003 contain resident complaints regarding a change in the incontinence products provided by the facility and worn by certain residents.^[112] The residents did not like the new products because they leaked, were uncomfortable and caused skin irritation.^[113] Staff also complained that the new products leaked and therefore required more whole bed changes than the former products.^[114]

There is conflicting information in the exhibits provided by the DFPC concerning whether the facility acknowledged and took action to resolve these grievances. There is no documented response to a memo sent to the Nursing Department in April of 2003.^[115] The Quarterly Resident Council Report for 7/03 – 9/03, however, states

“Residents discussed the issues regarding the new incontinent products that the facility had begun to use. After discussing with their nurses and administration, different products were chosen for some of the residents that had concerns.”^[116]

Nevertheless, at the time of group interviews during the October^[117] and November^[118] 2003 surveys, there were still complaints about the new incontinence products. In fact, those residents who could afford the \$60 a month required to purchase the “chux” brand were buying them themselves. The facility provided no evidence that it acknowledged or responded to this resident concern.^[119] DFPC met its burden in showing that the facility did not fulfill its obligations under this regulation with respect to resident grievances about incontinence products.

3. Showers

Resident Council Meeting Minutes for May,^[120] June^[121] and September,^[122] 2003 contain issues concerning the showers. Although DFPC characterizes all of these issues as complaints regarding the cleanliness of the showers, only the May and June minutes contain such complaints; the September minutes contain a complaint concerning the drainage of one of the showers since a new floor was installed.^[123] One resident interview also contained grievances concerning the cleanliness or neatness of the shower area,^[124] and the surveyor observed some areas of one shower that were not clean.^[125] In summary, there were resident complaints brought to the Resident Council in May and June, as well as one resident complaint during the survey, concerning the cleanliness of the showers. No other complaints appear in the record.

The facility responded that the showers are cleaned daily.^[126] There is nothing in the record to indicate that they are not.^[127] DFPC has not produced any evidence to suggest that daily cleaning of the showers is an insufficient response to complaints about the cleanliness of the showers. The fact that there were no complaints brought to the Council after June, and that only one resident raised the issue, suggests that the response to the grievances resolved the shower cleanliness problem for the great majority of the residents. The fact that the surveyor observed some hair and scuff marks, and some easily removed dirt, does not demonstrate, by a preponderance of the evidence, the lack of facility acknowledgement and response to resident concerns regarding shower cleanliness.

4. Linens

Resident Council Meeting minutes for April,^[128] May^[129] and June^[130] of 2003 contain complaints from residents concerning the texture of the linens. Specifically, residents complain that the sheets and towels are rougher than they were before. There are no recorded complaints concerning the linens after June of 2003.^[131]

The facility’s response to the residents’ concerns consists of a memo entitled “RESIDENT COUNCIL CONCERN” from Denise L. Morin, Housekeeping/Laundry Manager.^[132] The memo states in part that Ms. Morin called and faxed a letter of

concern to the central laundry concerning the resident complaints. She was informed that the laundry had not changed its soaps or softeners and that they regularly received new linens.^[133]

The one interview in the November survey that raises this issue contains the following comment concerning the texture of the linens: “personally I don’t see as a problem [indecipherable word] who will complain – rest of residents happy – some will co[mplain] about anything.”^[134] Resident interviews do not support DFPC’s contention that the texture of the linens is an issue that was complained of by residents and not addressed by the facility.

DFPC faults the facility for not “conduct[ing] further investigation to determine if the type of linens had been changed or [] pursu[ing] a different linen company.”^[135] Given that there were no complaints raised in the Resident Council or in individual resident interviews after June of 2003, and the Resident Council received a response concerning this issue from the Housekeeping/Laundry Manager, the record does not support the DFPC’s assessment that “the administrator did not respond to complaints about the rough texture of the linens.”^[136]

5. Mail delivery on weekends

The Resident Council Meeting minutes for September^[137] of 2003 contain a concern about the delivery of mail on weekends.^[138] The concern was that “there have been a couple of times when the mail has been delivered after 2:00 p.m. on Saturdays and then it is not being distributed to the residents until Monday.”^[139] At the next Resident Council meeting, the Director of Nursing stated that it was the responsibility of the weekend receptionist to sort the mail and deliver it to the floors. If the mail had not been delivered by 2:00 p.m., the receptionist was to inform the Nursing Supervisor who would sort and deliver the mail to the floors.^[140]

A group interview of the residents on 11/10/03 indicated that the mail had not been delivered over the preceding weekend. This suggests that the facility response to the complaint about mail delivery was not adequate to address the problem. The requirement of this tag is that the facility acknowledge a complaint and actively work to address the grievance. The facility presents no evidence that it effectively did so in this instance.^[141]

Conclusion

In summary, the facility demonstrated that resident complaints about the cleanliness of shower areas and the texture of the linens were resolved. The facility’s acknowledgement and response to resident grievances concerning staffing, incontinence products, and mail delivery on weekends were shown to be inadequate by a preponderance of the evidence.

DFPC issued this tag at a scope and severity of “E” meaning that there was no actual harm with a potential of harm and a pattern present. The record shows that three

of the matters raised by residents were not resolved, while two concerns were resolved. The facility argues that this tag should be dismissed because it maintained minimum staffing levels. However, the regulation requires prompt resolution of complaints rather than specific staffing levels. The unresolved complaints that were supported represent a pattern. And the unresolved staffing complaints relating to call lights and staff response justify a conclusion that there was a potential for more than minimal harm. The staff cannot determine the seriousness of a request for assistance without a prompt response to a call light. The record therefore supports an imposition of an “E” rating.

F224 – Staff treatment of residents

The regulation requires the facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. The Guidance to Surveyors states that the intent of this regulation is to ensure that residents are not mistreated or neglected. Neither the DFPC nor the facility addressed the development and implementation of policies and procedures to address treatment of residents. All of the evidence and arguments addressed the issue of whether residents had been mistreated or neglected.

DFPC uses many of the same examples as evidence under this tag as it does for F241, *infra*, concerning affronts to resident dignity. Several of the allegations under that tag were not proven by a preponderance of the evidence. It is reasonable to conclude that if the evidence did not establish an affront to a resident’s dignity, then it is not sufficient to establish mistreatment, neglect or abuse. For that reason, two of the 11 residents that were identified as having been mistreated, neglected or abused because of the same incidents contained in F241 are not discussed here.

In addition, four of the 11 residents referred to in this tag were allegedly mistreated, neglected or abused on the basis of the following evidence: “Harm was evident when 4 out of 5 residents in the group who needed help with toileting stated that they had to wet themselves because nobody came when they put their call lights on for help.”^[142] DFPC has not met its burden of proof that there was mistreatment, neglect or abuse of residents by simply repeating a general statement made by unidentified residents. Finally, two other residents are included in this tag because they feared retaliation. They are not identified and no evidence is provided to support the allegation that their fear of retaliation somehow resulted in mistreatment, neglect or abuse. For these reasons, these six residents are not discussed here.

Resident 19

The allegations concerning treatment of Resident 19 were not sufficient to establish an affront to the resident’s dignity, and are also insufficient to establish mistreatment, abuse or neglect.

Resident A

Resident A is paralyzed and unable to use her arms and legs. She is totally dependent on staff for all bodily needs. Resident A reported that the nursing assistants would come in, turn off her call light, and leave without even asking what she wanted.^[143]

The facility produced a call light audit^[144] that indicates that, during the time period of the audit, call lights were generally turned off promptly, within several minutes of the time that the call light was turned on. The audit does not provide any information concerning the action taken by the staff answering the call.^[145]

The facility argues that the surveyor has not complied with the Principles of Documentation in this instance, by confirming the information from observation or multiple resident interviews.^[146] However, in this case, that is not a fair characterization of the evidence in the record. Several other residents voiced the same complaint concerning staff coming into their rooms to turn off the call light and leaving without asking what the resident wanted or needed.^[147] The frequency with which different residents voiced the same complaint in survey interviews, and the number of times that this concern appears in the Resident Council Meeting minutes,^[148] support the validity of the complaints voiced by Resident A concerning lack of responsiveness.

For the reasons listed above, the ALJ determined under F241 that such treatment was an affront to the resident's dignity. Failure to respond to call lights and resident requests for assistance are also evidence of resident neglect. In the case of resident A, DFPC has shown neglect by a preponderance of the evidence.

Resident 9

Resident 9 is a 40-year-old male who suffers from traumatic brain injury, short- and long-term memory problems, severely impaired cognitive skills, and depression. This resident has multiple behavioral concerns, such as repetitive verbalizations, calling out for help, and verbal abuse of others.^[149]

DFPC alleges that facility staff did not get the resident out of his bed upon his request. On November 9, 2003, during an interview with a surveyor, the resident wanted to get out of bed. The resident's call light was on the floor, and therefore inaccessible to him. After assistance from the surveyor, the resident was able to turn on the call light. A staff member responded, then went to find another staff person to assist her in getting the resident out of bed.^[150]

When the surveyor returned to the resident's room one-half hour later, the resident was still in bed.^[151] The surveyor asked a staff person why the resident was still in bed, and was told that this was a "behavior" the resident engaged in. Upon review of the resident's records, the surveyor could find no reference to a behavior of repeatedly wanting to get out of bed.

The facility objects to the surveyor's assumption of what occurred in Resident 9's room since the surveyor's notes clearly show that the surveyor was not with Resident 9 in his room the entire period of time in question.^[152] The facility asserts that the resident's MDS,^[153] Mood and Behavior Monitoring Log,^[154] Data Collection & Assessment,^[155] and progress notes for March 2002 through October 2003^[156] all note the resident's behavior problems and interventions. The Facility's evidence shows that on November 5, 2003, the resident continually put on his call light to request to get out of bed when he had just lay down. This one recorded incident does not establish a behavior on the part of the resident.

A resident's request in the early afternoon to get out of bed is reasonable, and failure to respond to that request is an affront to the resident's dignity, as found in F241. However, one example of a resident waiting in bed for a half hour to get out of bed does not establish by a preponderance of the evidence that the resident was mistreated, neglected or abused.

-

Resident B

Resident B reported that staff yelled at her, but that she hadn't reported it because she is afraid of retaliation.^[157] This resident wanted to remain anonymous.^[158] The facility responded that "[b]ecause of the resident's own diagnosis, and according to MDH's own Resident Review Worksheet, page 1 (see MDH Exhibit J6a), this resident is not interviewable."^[159]

Even if resident B were "interviewable," DFPC has not shown that the resident was mistreated, neglected or abused. The statement of one resident, particularly when that resident suffers from depression and anxiety,^[160] is not sufficient to meet the DFPC's burden of demonstrating that this regulation has been violated.

Resident 24

The allegations and evidence concerning treatment of Resident 24 were not sufficient to establish an affront to the resident's dignity, and are also insufficient to establish mistreatment, abuse or neglect.

Conclusion

The DFPC has established that residents were neglected in the case of Resident A, but not in the case of the other residents cited. The DFPC cited this tag as a scope and severity rating of "H" which means that actual harm was found and a pattern existed. The record does not support a finding of a pattern since only one instance of neglect was supported. Nor does the record demonstrate actual harm to Resident A by the failure to respond to call lights. Rather a finding of "no actual harm with potential for more than minimal harm" better fits the evidence. It is therefore recommended that the scope and severity be determined to be at a "D" level.

F241 – Quality of Life - Dignity

DFPC alleges that the facility failed to promote dignity (self-worth and self-esteem) in caring for residents who were physically handicapped and dependent on staff for meeting their physical needs. According to the DFPC, four residents from the Resident Group meeting^[161] and Residents A, 9, 19 and 24 were harmed by the lack of respect and lack of staff interventions to promote each resident's dignity. DFPC found multiple violations of 42 C.F.R. § 483.15(a) and assigned a scope and severity level of "H," meaning that there is a pattern of the deficiency, resulting in actual harm that is not immediate jeopardy.

This regulation requires the facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The Guidance to Surveyors further defines dignity to mean that in their interactions with residents, staff carries out activities that assist the resident to maintain and enhance his/her self-esteem and self-worth. DFPC has starred the example of "Assisting residents to attend activities of their own choosing."

This tag centers on the facility staff's alleged failure to answer call lights; and an alleged pattern of appearing in the residents' room after the call light was used, and turning off the call light without inquiring why the call light was lit, or responding to requests for assistance. DFPC acknowledges that "much of this deficiency is represented by resident interview," thus the resident's mental state, and the corroboration of the interview information with information obtained by observations and from records, are relevant to the validity of the information recorded by the surveyor.

Resident 19

Resident 19's "most prominent problem" is anxiety.^[162] He has repetitive health complaints, such as an obsessive concern with bodily functions.^[163] The resident also has a short-term memory problem.^[164] Resident 19 told the surveyor that facility staff threw his soiled diapers on the floor. On another occasion, instead of throwing the diaper away, the staff person allegedly placed it on his desk next to his head.

The incidents reported by Resident 19 provide evidence of lack of respect and insults to resident dignity. The facility responded that the surveyor had not complied with the Principles of Documentation (POD) in this instance.^[165] DFPC quotes the POD as follows: "To the greatest extent possible, the surveyor verifies the information obtained from interview through observation or record review. In the absence of other objective validation of information, information may also be confirmed/verified through multiple interview sources."^[166]

One staff person testified that Resident 19 frequently makes up stories as a result of his memory problems and significant anxiety.^[167] He also stated that what the

resident alleged could not be accurate. He testified that staff would place a soiled diaper in the wastebasket, which is located next to the resident's bed.^[168] The desk was across the room.^[169] The uncorroborated statement of one resident, particularly when that resident suffers from anxiety and memory problems, is not sufficient to meet the DFPC's burden of demonstrating that this regulation has been violated.

Resident A

Resident A is paralyzed and unable to use her arms and legs. She is totally dependent on staff for all bodily needs. Resident A reported that the nursing assistants would come in, turn off her call light, and leave without even asking what she wanted.^[170]

The facility produced a call light audit^[171] that indicates that, during the time period of the audit, call lights were generally turned off promptly, within several minutes of the time that the call light was turned on. The audit does not provide any information concerning the action taken by the staff answering the call.^[172]

The facility again argues that the surveyor has not complied with the Principles of Documentation in this instance, by confirming the information from observation or multiple resident interviews.^[173] However, in this case, that is not a fair characterization of the evidence in the record. Several other residents^[174] voiced the same complaint concerning staff coming into their rooms to turn off the call light and leaving without asking what the resident wanted/needed. The frequency with which different residents voiced the same complaint in survey interviews, and the number of times that this concern appears in the Resident Council Meeting minutes,^[175] support the validity of the complaints voiced by Resident A concerning lack of responsiveness.

The failure to respond to resident requests for assistance is an affront to resident dignity. The DFPC has shown a violation of this regulation by a preponderance of the evidence.

Resident 9

Resident 9 suffers from traumatic brain injury, short- and long-term memory problems, severely impaired cognitive skills, and depression. This resident has multiple behavioral concerns, such as repetitive verbalizations, calling out for help, and verbal abuse of others.^[176]

DFPC alleges that facility staff did not get the resident out of his bed upon his request. On November 9, 2003, during an interview with a surveyor, the resident wanted to get out of bed. The resident's call light was on the floor, and therefore inaccessible to him. After assistance from the surveyor, the resident was able to turn on the call light. A staff member responded, then went to find another staff person to assist her in getting the resident out of bed.^[177]

When the surveyor returned to the resident's room one-half hour later, the resident was still in bed.^[178] The surveyor asked a staff person why the resident was still in bed, and was told that this was a "behavior" the resident engaged in. Upon review of the resident's records, the surveyor could find no reference to a behavior of repeatedly wanting to get out of bed.

The facility objects to the surveyor's assumption of what occurred in Resident 9's room since the surveyor's notes clearly show that the surveyor was not with Resident 9 in his room the entire period of time in question.^[179] The facility asserts that the resident's MDS,^[180] Mood and Behavior Monitoring Log,^[181] Data Collection & Assessment,^[182] and progress notes for March 2002 through October 2003^[183] all note the resident's behavior problems and interventions. The Facility's evidence shows that on November 5, 2003, the resident continually put on his call light to request to get out of bed when he had just lay down. One recorded incident does not establish a behavior on the part of the resident. A resident's request in the early afternoon to get out of bed is reasonable, and failure to respond to that request is an affront to the resident's dignity.

Resident 24

DFPC alleges that this resident "experienced psychological harm when staff came in the room and she found it necessary to yell, "hey its me" to get assistance. Staff allegedly just walked away. She explained that she could only get their attention by getting, "out of control by screaming to get attention." There is no cite to any interview or other evidence in the record concerning the statements of this resident. The facility argues that, according to the principles of documentation, surveyors must corroborate statements with direct observation or documentation.^[184] DFPC does not respond to this argument in its Response, and has not proven by a preponderance of the evidence that this regulation was violated as to this resident.

Conclusion

DFPC has demonstrated a failure to promote dignity in the case of Resident A and Resident 9. It cited this violation at a scope and severity level of "H" meaning that actual harm and a pattern was found. The record supports a determination that actual harm occurred given the condition of these two residents and the seriousness of the incidents. However, the scope is isolated since only two residents were shown to be involved in the violation. A scope and severity rating of "G" is appropriate based upon the record.

Tag F250 – Social Services

This tag relates to 42 C.F.R. 483.15 and the provision of medically-related social services. The regulation was described under the 10/31/03 survey and the same general information applies in this instance. Under this tag, DFPC found a violation of 42 C.F.R. 483.15(g) and assigned a severity and scope level of "J", meaning that the

deficiency is isolated, but that immediate corrective action is necessary because the facility's noncompliance with one or more rules has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility. Serious injury, harm, impairment or death does not have to actually occur before considering immediate jeopardy.^[185] Facility surveyors are taught to look for "triggers" when assessing immediate jeopardy, such as lack of facility supervision for an individual with known special needs; failure to adequately monitor individuals with known severe self-injurious behavior; and failure to carry out a doctor's order.^[186] Resident 7 is the only immediate jeopardy example under this Tag.

Resident 7

This resident is a 54-year-old woman suffering from severe depression, psychosis, and a history of suicidal ideations. She admits to sometimes hearing voices during bouts of severe depression. This resident was admitted to Robbinsdale on October 28, 2003, during the course of the first survey. Just prior to her admission, she had been voluntarily hospitalized for depression.^[187]

DFPC first relies on the November 9, 2003, interview between the surveyor and Resident 7, at which time the resident appeared severely depressed and suicidal.^[188] She indicated that her will had been prepared, that she was having a hard time, that she was hearing voices, and that she was feeling anxious and putting herself down. She had recently spoken with her son and was upset and tearful. The resident told the surveyor that she had informed the Fairview-University hospital staff that she had a plan for killing herself, and she acknowledged that she felt suicidal on that day. That same day, the surveyor reviewed the resident's hospital records, which revealed her suicide plan and worsening depression as well as her history of suicidal ideations.^[189] DFPC alleges that Resident 7's facility admission records show no evidence of her severe depression and suicidal ideations and that the care plan lacked an approach to monitor the resident's feelings and status.^[190] DFPC also points to an interview with a Robbinsdale nurse on November 9, 2003, during which the nurse indicated that she was not aware of any special monitoring needs for Resident 7.^[191] Based upon these arguments, the surveyors concluded that the facility failed to provide the resident with social service interventions to meet her needs and protect her from a possible act of self-injurious behavior, or suicide attempt, or hallucinations. DFPC labeled the resident an immediate jeopardy ("IJ") situation.

The facility asserts that the very reason Resident 7 came to Robbinsdale was to be in a safe environment so that she could focus on her well-being. Consequently, the facility argues that the staff was aware of the resident's mental health issues, and points to an evaluation the resident had with a facility staff person the day after she was admitted to Robbinsdale during which they discussed methods for the resident to calm herself and confirmed her already-scheduled outside counseling appointment.^[192] The facility acknowledges that it is possible that some of the night staff might not have known of the resident's special monitoring needs because the resident was so new to

the facility. Here, as under some of the previous tags, the facility seeks to demonstrate that the surveyors wrote up the violations in such a way as to take resident statements out of context or leave out information critical to the intended meaning of the statement. For instance, regarding the November 9, 2003 interview between Resident 7 and the surveyor, the surveyor did not indicate on Form 2567 that the resident, after saying “I’m feeling a little anxious putting myself down,” then went on to say “If I don’t get better . . . I could go to her . . . Susan is the social worker.”

The facility also objected to DFPC’s failure to note on the Form 2567 that the resident, in response to the question of whether she was suicidal now, responded “um, no.” Ultimately, Robbinsdale claims that this information never appeared on the Form 2567, which DFPC intended to use to support the “IJ” finding. This resident received extensive counseling services in her day treatment program, which continued to some degree after her admission to the facility.^[193] And the facility reported the resident’s concerns regarding hearing voices to her psychiatrist on at least two occasions.^[194] A facility staff person stated that the resident’s psychiatrist expressed frustration at Robbinsdale staff for contacting him or her every time the resident heard voices.^[195] Further, the facility also relies on a “no harm” contract signed by Resident 7 on November 10, 2003, to show that she would talk to facility staff if she started thinking suicidal thoughts.^[196]

The record indicates that DFPC was selective in the statements it attributed to Resident 7. The surveyor’s notes, when read in their entirety, show that the resident did know that there were individuals at the facility that could help her if she became increasingly suicidal.^[197] But it was apparent that she had put thought into the implications of suicide and a possible plan. The resident went on to state that she could never get away with a suicide attempt because of all the people at the facility, and she acknowledged that she felt particularly sad at the time of the interview because of conversations with her son.

The records from her hospital stay just prior to admission at Robbinsdale show that she entered the hospital voluntarily, and that while she has had numerous suicidal ideations, she has made no suicide attempts.^[198] She expressed that the day treatment program had been helpful to her, and that she needed to be encouraged to go more often. The physician noted that Resident 7 was able to contract for safety and that she was at low to moderate risk for self-harm. Further hospital documentation from that stay indicates “no present active self-harm” and plans for her to remain under clinical observation.^[199] The “no harm” contract presented by the facility is dated after the surveyor interview with the resident and after the surveyor declared an “IJ” situation. Accordingly, it cannot be considered as evidence of what the facility did to help Resident 7 in the time prior to the surveys.

Resident 7’s care plan does list depression, self-injury, and a history of suicidal ideations as problems. The resident’s stated goal is to “be safe in her environment” and the approach to reach that goal is to administer medications and treatments per doctors’ orders, monitor for side effects and effectiveness of medication, update the doctor as needed, and take resident to safety in an emergency.^[200] On October 30, 2003 the

resident was scheduled for an appointment with a psychologist on November 14, 2004.^[201] Progress notes from November 3 and 4, 2003, indicate that facility staff was responding to the resident's statement that she was hearing voices by contacting her physician and monitoring her.^[202]

The surveyor spoke to Resident 7 shortly after a tearful phone call with her son. The Form 2567 did not include comments of the resident indicating that she was not immediately suicidal. The record indicates that the IPOC included appropriate information on Resident 7's condition and she did receive 1:1 services shortly after admission. However, some staff were unaware of the resident's suicide issues 10 days after admission and did not appear to be prepared to monitor this, nor did the care plan have a monitoring component.

The record demonstrates a violation in that the resident's needs were not met – her suicidal tendencies were not monitored and staff was not prepared to intervene. The DFPC found this violation to be an immediate jeopardy severity rating based primarily on the resident interview. However, based upon the record as a whole, the severity is more accurately classified as “no actual harm with potential for more than minimal harm.” It does not appear that serious harm occurred or was likely. Neither was there a negative outcome compromising the resident's ability to reach her highest practicable mental well-being. The resident knew who to talk to at the facility to seek help. That she was having a difficult day when interviewed does not establish that it was caused by a lack of services.

Resident 16

This resident, a 33-year-old male, was committed to Robbinsdale by a court order^[203] on May 8, 2003, from the hospital where he was recovering from a fractured jaw, a fractured hip, and a broken elbow sustained during a suicide attempt. The resident has diagnoses of major recurrent depression and schizophrenia. Prior to his admission, a Level II pre-admission screening was done to determine if the placement at Robbinsdale was appropriate. The screening indicated that the resident was to have mental health case management and weekly psychotherapy as arranged by the facility.^[204]

DFPC alleged that this therapy and case management was not provided to the resident, citing the facility's failure to implement the psychologist's recommendations as part of the care plan, assist with the resident's mood through one-on-one interactions with staff,^[205] and monitor the resident when he was found sitting on a bridge in the facility.^[206] Specifically, DFPC observed that two of the resident's social service assessments, completed on May 9 and 12, 2003, did not reference his suicidal history or his need for follow-up care, and in fact, represented the resident's suicide attempt as a “fall” with trauma.^[207] In a care note dated May 13, 2003, Dr. Dummer recommended that facility staff have individual contact with Resident 16 and attempt to expose him to sensory stimulating activities.^[208] DFPC saw no evidence of such care documented by the facility.

On July 28, 2003, the resident attended a follow-up hearing in court regarding his commitment to Robbinsdale, at which time the court determined that he would remain at the facility for “observation, evaluation, diagnosis, care, treatment and, if necessary, confinement.”^[209] In the time following that hearing, DFPC alleges that the facility arranged therapy for the resident only every three weeks, as opposed to every week as required by the pre-screening admission. DFPC further asserts that the nursing notes do not indicate that the resident was getting help with his mood issues and focuses instead on the resident’s physical issues.^[210] DFPC also relies on the August 2, 2003 incident where facility staff found the resident sitting on the railing of the fourth floor bridge. In the course of attempting to help the resident, a facility nurse left him alone long enough for him to climb back over the railing. The resident did jump or fall from the bridge and sustained lacerations to his chin and lips.^[211]

Dr. Dummer testified, on Robbinsdale’s behalf, that the facility generally followed his recommendations with respect to the resident’s care and treatment. The facility documented that Resident 16 was taking his medication as ordered and focusing on healing.^[212] The resident and his psychiatrist had even begun to work on a discharge plan to get the resident back into independent living. Dr. Dummer met with the resident on a regular basis after the diagnostic assessment, and at no time did the resident express suicidal ideations.^[213] The facility documented that between May 9, 2003 and July 31, 2003, a facility staff person had one-on-one time with the resident on eleven occasions.^[214] The facility argued that the resident was never left alone on the bridge railing, that the staff observed him carefully and talked with him, and that the resident moved back onto the railing when a staff member left to get the assistance of another staff person.^[215]

The resident’s care plan lists his problems with suicide attempts, schizophrenia, ineffectual coping, danger to self, depression, withdrawn behavior, and depressed affect with goals of remaining safe and injury free as well as complying with physicians’ orders and allowing facility staff to assist him with cares.^[216] The stated approach to reaching his goals is one-on-one sessions as needed and visits with Dr. Dummer. The record indicates that the resident saw Dr. Dummer once in May, twice in June, and once in July.^[217] The facility documented therapeutic recreation one-on-one visits almost weekly between May 9 and July 31, 2003. But neither the progress notes nor the Activities of Daily Living, Mood, and Behavior Tracking Record demonstrate that facility staff closely monitored the resident’s mood or mental care; the bulk of that evidence relates to the resident’s physical condition, as suggested by DFPC. The facility and DFPC accounts of the August 2, 2003 incident on the bridge railing are supported by the record.

The issue is whether the facility provided medically-related social services to Resident 16. The record justifies a conclusion that the facility fell short by failing to clearly monitor the resident’s clearly serious mental health problems. The psychotherapy appointments fall short of the initial assessment and the psychologist’s recommendation for individual contact does not appear to have been fully implemented. The facility’s treatment focuses on the resident’s physical problems rather than his psychological issues. The progress notes do not reflect “mental health

case management.” The resident’s “fall,” while not determinative as to this alleged violation, is some indication of a lack of services. A violation has been shown.

Resident 1

Resident 1 is a 33-year-old female diagnosed with anxiety, depression and agitation. She has cognitive impairment and is paralyzed on her left side. The surveyors found that Resident 1 displayed emotional and behavioral issues in August, September, and October 2003.^[218] She was experiencing the loss of a friend and also having inappropriate sexual fantasies and boundary issues with facility staff and residents. The resident’s physician noted her boundary issues and recommended that the resident have female caregivers whenever possible; the physician also suggested further consultation with the resident’s psychiatrist about medications related to the resident’s increased sexual impulsivity.^[219]

DFPC acknowledges that the resident discussed some of these issues with Dr. Dummer in September but suggests the facility failed to provide regular counseling or one-on-one visits with Resident 1 to help her deal with the loss of her friend.^[220] DFPC alleges that the facility did not implement the physician’s recommendations or other interventions with the resident through adequate assessment and revision of the care plan. Therefore, it believes the resident was not provided with social services based on her needs.

The facility responds to this allegation by pointing to the resident’s plan of care, which addresses issues of mood, feelings, lost roles, crying and sadness.^[221] The plan of care was updated on October 31, 2003 with goals and interventions regarding the resident’s recent behavior. In addition, Robbinsdale argues that the resident’s three meetings with Dr. Dummer,^[222] four 1:1 meetings with her LSW,^[223] and numerous contacts and conversations with facility staff^[224] were all methods of providing the resident with social services based on her needs.

The record shows that on September 9, 2003, the resident’s physician recommended a consult with psychiatry regarding the resident’s medications relative to her sexual impulsivity.^[225] There is no indication that this was ever done. Her medications were changed on November 3, 2003. Approaches to her care plan goals included monitoring behavior and her care plan, encouraging the resident to express her feelings, administering medications and monitoring side effects, checking on the resident’s needs, having the resident visit with Dr. Dummer, and calming her down.^[226] The record documents the resident’s appointments with Dr. Dummer on May 20, July 22, and September 2, 2003. The one-on-one meetings between the resident and facility staff occurred on January 1, 2003, April 30, 2003,^[227] July 25, 2003, and October 23, 2003. Five of the seven documented interventions took place prior to the behavioral issues and sexual fantasy/boundary problems.

The facility documented seven one-on-one meetings in the first ten months of 2003, however only two occurred after the sexual fantasy behavioral problems arose. The record supports a conclusion that the resident was experiencing ongoing behavior

problems without a response from the facility in terms of planning or interventions. Although the resident was demanding with staff, the attention she received as a result was not therapeutic. It appears that a recommendation for a consult with psychiatry in regard to medication was not followed up by the facility. The DFPC has demonstrated a violation.

Resident 18

Resident 18 is a male diagnosed with flat affect, end stage congestive heart failure, and chronic renal failure. He was admitted to Robbinsdale on July 10, 2003.

DFPC contends that the facility did not provide the resident with social service interventions to assist him in coping with his debilitating health condition and poor prognosis for recovery by failing to update his care plan with appropriate interventions for his flat affect and mood swings. The care plan identifies negative comments, flat affect, mood swings, and a potential for isolation as problems for Resident 18.^[228] The goal is for the resident to socialize with staff and other residents, and social services is to help in the intervention. On November 10, 2003, surveyors observed Resident 18 sitting on his bed in the dark looking unkempt.^[229] He had a flat affect and answered questions vaguely. During an interview with surveyors on November 11, the resident's social worker explained that new "admits" are seen by social services on an as-needed basis when facility staff make a note for a resident to be seen, and at least quarterly.^[230] DFPC asserts that even though Resident 18's physical health was rapidly deteriorating, that was all the more reason to focus on his mental and emotional health in his final days.

Robbinsdale counters with the resident's physician's statements that, given his condition, the resident was not a candidate for any intervention, only palliation and hospice.^[231] The facility argued that the resident regularly participated in facility activities,^[232] had one-on-one visits with social services, and generally improved while at Robbinsdale.^[233]

Social service progress notes from July 14, 2003, state that the resident resisted cares almost daily and that his mood was not easily altered.^[234] Four days later, facility staff noted on the resident's MDS that he had not exhibited any mood and behavior patterns since his arrival at Robbinsdale.^[235] On July 21, 2003, the resident refused to complete a mini-mental state assessment because he was irritable. The record does not demonstrate what activities the resident was involved in, only that he was involved.

DFPC asserts that Resident 18 should have received more social service interventions to meet his deteriorating health and poor prognosis. However, the record shows that the resident resisted cares daily. He was involved in activities 1/3 to 2/3 of the time, had 1:1 services and improved while at Robbinsdale. DFPC has not met its burden to show that this resident, whose physician stated he had end stage congestive heart failure and renal failure, was denied needed social services.

Resident 22

This resident is diagnosed with chronic health concerns, a brain tumor, seizure disorder, and depression. DFPC noted that the resident's minimum data set (MDS)^[236] and resident assessment protocol (RAP)^[237] indicated that the resident displayed anger, unpleasant mood in the morning, and anxiousness at least five days per week. The RAP indicated that the facility would address the triggered mood items in the care plan. Upon review of the care plan, DFPC observed that it did not address precursors to the resident's anger or specific steps to take in response to it.^[238] DFPC also noted few social service visits with the resident.^[239] And when surveyors interviewed the social worker during the survey, the social worker affirmed that the care plan lacked the problem, goal, and approaches for the resident's mood patterns.^[240]

The facility seeks to have the alleged violation regarding this resident stricken from the Form 2567, due to the DFPC's alleged failure to previously identify the resident. DFPC claims that the Roster/Sample Matrix and the Resident Review Worksheet both identified Resident 22, and that both of these documents were submitted to the facility prior to the hearing as part of the information exchange. It appears that the facility should have been able to identify this resident based upon the information exchange. Nonetheless, given the post-hearing briefing schedule, the facility had a fair opportunity to address the DFPC's arguments relating to this resident. The facility made no request to continue the meeting or to submit further evidence.

The facility has presented nothing to refute DFPC's substantive allegations, and the record presented does support those allegations. The resident's annual MDS, dated August 7, 2003, indicates that the resident has daily or almost daily anger, repetitive anxious complaints, unpleasant mood in the morning, and repetitive physical movements.^[241] Three pages later in the document it suggests that the facility would provide no intervention programs for this resident for mood, behavior, and cognitive loss.^[242] The care plan directed the facility to monitor and document inappropriate behavior episodes, interventions and the resident's response; provide cues and redirection when inappropriate behaviors are exhibited; praise the resident for appropriate responses to stress; remove the resident from stressful situations; engage in one-on-one meetings with the resident as needed; and allow the resident to vent her emotions.^[243] A lack of needed social services has been demonstrated.

Resident 3

Resident 3, a 29-year-old female, was admitted to the facility on October 10, 2003, with mild mental retardation, acute respiratory distress syndrome, bi-polar disease, manic depressive disorder, dependent personality disorder with passive aggressive features, and sleep apnea.^[244]

DFPC argues that the resident's MDS and RAPs, as well as a social service note dated October 13, 2003, all indicate that the resident was depressed, anxious, and sad three to five times per week as shown through unpleasant mood in the morning, sad and pained facial expressions, anxious complaints, repetitive health complaints, and

refusal to take her medications four to five times per week.^[245] Progress notes also showed that the resident was functioning at the level of an 11 or 12-year-old and that she had refused meals on at least two occasions.^[246] On October 17, 2003, the resident's physician noted that the resident could see the facility house psychologist on an as-needed basis.^[247] The resident's care plan indicated that the interventions for her mood symptoms would be to meet with social services and Dr. Dummer.^[248] The surveyor review of the record found no documentation of visits with social services or with Dr. Dummer prior to November 10, 2003.^[249] During the interview with the surveyor on November 10, 2003, the resident stated that she did not like it at the facility and that she was sleeping a lot because she was depressed.^[250] DFPC cited this deficiency because it alleges that the facility did not implement the planned interventions for this resident, and when her mood failed to improve, the facility did not add or change interventions.

The facility indicated that the resident refused her medication, sometimes refused to eat, and when a staff person observed the resident crying on the telephone on October 16, 2003, the facility called Dr. Dummer to set up an appointment with the resident. The facility argues that the reason for the late involvement of Dr. Dummer had to do with the resident being transferred/admitted to the hospital for several days. The resident was transferred to the hospital with chest pains on October 24 and did not return to the facility until October 27, 2003.^[251] The following day she left the facility for a follow-up medical appointment.^[252] On the day of her appointment with Dr. Dummer, the resident refused to see him due to fatigue and discomfort.^[253] And by the surveyor's notes, they found this resident uninterviewable.^[254] The facility considers all documents that contain interventions and care issues to constitute the resident's care plan and reiterated a resident's right to refuse treatment.

The progress notes also demonstrate that the resident was transported to the clinic on October 21, 2003 to have her J-Tube removed.^[255] For the next few days, she was in great pain, and shortly thereafter, she entered the hospital with chest pains, as discussed above. The record as a whole shows that the resident's physical health was the significant and primary issue of concern during the first month of her stay at Robbinsdale. The facility arranged the appointment between Dr. Dummer and the resident as promptly as it could, given the resident's significant physical health issues. The record does not show that the facility failed to provide needed social services in the month that Resident 3 was at Robbinsdale in light of the resident's more pressing physical health issues. An appointment with the psychologist was made six days after the resident's admission and the resident then refused to see him. Although the resident told the surveyor she did not like it at the facility, DFPC has not shown that needed social services were not provided.

Resident 14

Resident 14 is 66-year-old woman diagnosed with multiple sclerosis, spastic quadriplegia, depression, and dysphasia. She was admitted to Robbinsdale on January 8, 1992. The resident saw Dr. Dummer on March 4, 2003, at which time he recommended that the resident see him for further psychotherapy to address her

disability and the placement at Robbinsdale.^[256] He noted that the resident expressed discouragement, low self-esteem, sadness, loss of interest in life, and feelings that life is not worth living.^[257] Dr. Dummer also recommended that the staff and social services interactions with the resident should be planned to take place in an environment conducive to her expressing herself.^[258]

DFPC argues that the plan of care did not adequately address each of Dr. Dummer's recommendations, and that the record does not demonstrate that staff gave consistent emotional support to the resident in times of sadness or that social services were provided. As an example, DFPC refers to the resident's mood and behavior symptom monitoring log, which indicates that the resident had two episodes of crying in October 2003.^[259] DFPC argues that the notation of the two episodes, without interventions, on the mood log and the failure to note the episodes on the resident's weekly charting show that the facility staff failed to provide emotional support to the resident. DFPC searched the record for evidence that follow-up visits were arranged between the resident and Dr. Dummer and found none. This was verified by a social worker at the facility on November 9, 2003, who then stated she would call and set up therapy sessions for the resident.^[260]

The facility argues that the resident's communication difficulties and preferences are indicated on her Psychosocial Well-Being module and her Cognitive Loss/Dementia module.^[261] The latter module shows that the resident has withdrawn from activities, but that she was offered independent activities.^[262] The Psychosocial module indicates that the resident does not enjoy large group situations and directs the staff person to her care plan.^[263] Robbinsdale argues that the care plan refers staff to the Caregiver Instruction Sheet located in the resident's room, which provides tips on facilitating expressive and receptive communication.^[264] The facility asserts that the resident was receiving one-on-one contact each time a staff person assisted the resident with her cares. The facility also cites to a series of complex medical situations, for instance small strokes, pain, and fever that may have interfered with the resident's receipt of medically-related social services. As to the Caregiver Instruction Sheet noted above, DFPC claims that surveyors never saw this document during either survey, and that the facility did not present the document in its pre-hearing submissions.

The record supports that the facility acknowledged the resident's aversion to large group situations and her withdrawal from activities. The RAP module consistently directs the reader to the resident's care plan. Examined in more detail, the care plan indicates that the resident has, among other things, ineffective coping mechanisms, verbal aggression, difficulty in new situations, crying episodes, and becomes easily annoyed when people cannot understand her speech.^[265] Besides monitoring her medications, the care plan directs facility staff to allow the resident to vent upset feelings, to remind her to relax and take time to form her thoughts and sentences when she is frustrated, and have 1:1 sessions with social services as needed.^[266] But the care plan says nothing about arranging follow-up visits between the resident and Dr. Dummer. The care plan does refer facility staff to a Caregiver Instruction Sheet in the resident's room for facilitating communication with the resident.^[267] However, the document does not appear in the record. Finally, during the interview between the

social worker and the surveyor on November 9, 2003, not only did the social worker acknowledge that follow-up therapy sessions had not been scheduled, she also agreed that the sessions had been overlooked.^[268]

DFPC has sustained its burden of proof to show that medically-related social services were not provided to Resident 14. The facility acknowledged its failure to follow up on Dr. Dummer's March recommendation for follow-up psychotherapy, until November of 2003. Dr. Dummer also recommended planned interactions for the resident. Although the resident was adverse to large group situations, the only documented interaction with the resident appears to be the provision of daily cares for her. Given the resident's difficulties as noted in the mood log, it must be concluded that the resident was not receiving needed services.

Resident 6

Resident 6 has a diagnosis of organic brain syndrome, cerebral palsy, hydrocephalus, quadriplegia, personality disorder, depression, and chronic convulsive disorder. The resident's MDS and RAP show that he experienced depression, anxiety, and sad mood, as shown through repetitive health complaints, repetitive anxious complaints not health related, expressions of unrealistic fear, crying and tearfulness.^[269] Dr. Dummer, after a therapy session with the resident on February 18, 2003, directed the facility care team to open up the resident's mood by reminiscing about his family, urged the staff to approach the resident intermittently about any problems he was having at the facility and urged social services to see the resident periodically for consultation.^[270]

DFPC argues that the care plan specifically targeted the resident's anxiety and behavior concerns but did not address his depression and sad mood. Specifically, DFPC points to the care plan intervention that the resident would meet with Dr. Dummer and that the facility staff would "remove resident from others and talk to resident until anxiousness subsides."^[271] Furthermore, DFPC claims that Dr. Dummer's recommendations to the care team regarding the resident's anxiety^[272] were not discussed in the resident's social services notes, and therefore, DFPC could not conclude that staff and social services had implemented those recommendations. DFPC also relies on the surveyor interview with social services, in which the social worker admitted that she did not perform one-on-one services with the resident until Robbinsdale nursing staff reported a problem or a need.^[273] Ultimately, DFPC alleges that a deficient practice exists because Robbinsdale did not implement the planned interventions to improve the resident's mood.

The facility argues that the resident's progress notes do show one-on-one time with a social worker.^[274] Furthermore, the facility argues that its staff monitored the resident's mood and behavior via the Mood and Behavior Symptom Monitoring Log during October 2003.^[275] The facility places emphasis on Dr. Dummer's use of the words "intermittently" and "periodically" when indicating how often to approach the resident for discussion or consultation with staff and social services.^[276]

The care plan does place greater emphasis on the resident's anxious behaviors than his depressed mood,^[277] and it does not address any of Dr. Dummer's recommendations made on February 18, 2003. According to the record, the facility's monitoring of the resident's mood and behavior occurred only during October 2003, eight months after Dr. Dummer made his recommendations. A progress note from September 24, 2003, indicates that one-on-one time between the resident and facility staff is often consoling to him,^[278] but the record shows one-on-one visits with the resident in April 2002, well before Dr. Dummer's treatment plan, and in November 2003, well after his recommendations. The facility's social service contacts with this resident do not meet even the guideline of "periodically." The DFPC has shown a failure to provide needed medically-related social services for Resident 6.

-

Resident 9

See Tags F224 and F241 above for a summary of Resident 9's diagnoses and the facts and allegations at issue.

DFPC alleges that the facility failed to provide adequate interventions to the resident when facility staff did not get the resident out of his bed upon his request. DFPC suggests that the Mood and Behavior Symptom Monitoring Log shows that the resident's verbally abusive behaviors only occur when the resident requested to get up out of bed. In addition, DFPC objects to an undated hand-written care plan,^[279] submitted to DFPC after the time of the survey. Specifically, this document indicates that the resident frequently asked to get up after being laid down in his bed.

As to the resident's care plan, the facility asserts that resident's short-term and long-term memory impairment, behavior issues, and life stressors are all identified as problems and have suggested approaches such as administering medications, encouraging the resident to express his feelings, and monitoring the resident for episodes of inappropriate behavior.^[280] Included under life stressors are decreased condition, loss of independence, and "inappropriate use of call light."^[281] In addition, the resident's MDS,^[282] Mood and Behavior Monitoring Log,^[283] Data Collection & Assessment,^[284] and progress notes for March 2002 through October 2003^[285] all note the resident's behavior problems and interventions. In total, the facility argues, these documents create a plan of care for this resident.

The hand-written one-page care plan document was not available to surveyors at the time of the survey, and it is not clear from the record whether the document was drafted before or after the survey. Regardless, the care plan addresses the resident's inappropriate use of his call light; the behavior log notes that on one particular day the resident repeatedly wanted to get out of bed immediately after being put into bed; and the progress notes show that time with social services was available as needed. The resident's progress notes indicate that from the time of the resident's admission to the facility until the time of the survey, there was no marked change, positive or negative, in his behavior.^[286] Contrary to DFPC's assertion, the behavior log indicates that the

resident was verbally abusive in situations other than when he wanted to get out of bed. The resident did receive individual assessment and care planning, even though it wasn't always effective.

DFPC uses the same set of facts to support its allegations under Tags F224, F241, and F250. The evidence presented under each tag was sufficient to establish a "dignity" violation but is not enough to show that the facility failed to provide Resident 9 with medically-related social services.

Conclusion

The scope and severity rating for Tag F250 was set by DFPC at "J" because it concluded that Resident 7 was in immediate jeopardy. If the Commissioner agrees that that conclusion was not justified, then the S/S rating should be adjusted. The DFPC has demonstrated a pattern in regard to this violation. In regard to severity, it is reasonable to conclude that this is a deficient practice that only caused a limited consequence for the residents. There was no obvious directly linked negative outcome that compromised the residents' ability to reach their highest practicable mental well-being. The record shows several failures on the part of the facility to provide needed services that had the potential to compromise the residents' ability to attain their highest mental and psychosocial well-being. Accordingly the scope and severity rating should be set at "E" – reflecting a pattern and "no actual harm with potential for more than minimal harm that is not immediate jeopardy."

Tag F272 – Comprehensive Assessments

Under 42 C.F.R. 483.20(b)(1), the facility must make a comprehensive assessment of a resident's needs, using the Resident Assessment Instrument (RAI) specified by the State. The RAI includes the MDS and utilization guidelines, which include the RAPs. The assessment must include eighteen specified factors, two of which are mood and behavior patterns, and psychosocial well-being.^[287] The facility is responsible for performing this assessment on newly admitted residents and then again on an annual basis and after significant changes in status. The facility must address all needs and strengths of a resident regardless of whether the issue appears in the MDS and RAP. In other words, the scope of the RAI does not limit the facility's responsibility to assess and address all care needed by the resident. "The facility is responsible for addressing the resident's needs from the moment of admission."^[288]

DFPC found a violation of 42 C.F.R. 483.20(b) and assigned a severity and scope level of "D", meaning that the deficiency is isolated and no actual harm occurred, but where a potential for more than minimal harm that is not immediate jeopardy existed. Resident 7 is the sole violation under this tag. See the factual summary and the arguments of the parties regarding Resident 7 under Tag F250 of the November 12, 2003 survey.

DFPC argues that despite the facility's knowledge of the resident's mental illness, drug abuse, low to moderate risk of self-harm, worsening depression, and suicidal

ideations, the facility failed to conduct a comprehensive assessment of Resident 7's needs and develop an individualized care plan at the moment of admission. DFPC refers to a lack of documentation in several places on the social services assessment evaluation.^[289] In addition, the surveyors found that the care plan lacked specificity as to the resident's suicidal ideations and the history, method, and actual approaches to deal with them. Finally, DFPC relies on the guidance to surveyors that the facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or RAPs.^[290]

The facility cites to its previous arguments at Tags F165 and F250 of the November 12, 2003 survey and reiterates that the Fairview Admission Assessment was in the resident's medical records upon her arrival at Robbinsdale, and that the facility was aware of her history and suicidal ideations from the moment of admission.

The record indicates that the IPOC included appropriate information on Resident 7's condition, and she did have 1:1 contact with a social worker the day of her admission to the facility. While the IPOC is not dated, DFPC makes no argument about its timeliness and instead suggests it lacks individualized interventions. The federal regulation at issue makes the facility "responsible for addressing the resident's needs from the moment of admission." The regulation does not state that the RAI must be completed at the moment of admission.

Conclusion

The DFPC has not met its burden of proof to show that a violation of the regulation occurred. The record indicates that the facility met its responsibility to address the resident's needs from the point of admission based upon the IPOC, the Fairview assessment, and the social worker contact. Robbinsdale was aware of the resident's needs. It is recommended that this tag be dismissed.

Tag F279 – Resident Assessment

Pursuant to 42 C.F.R. 483.20(k)(1), the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the physical, mental, and psychosocial services that are to be furnished, as well as any services that would otherwise be required under 42 C.F.R. 483.25 but are not provided because the resident has exercised his rights under 42 C.F.R. 483.10, including the right to refuse treatment.^[291] An interdisciplinary team, working with the resident, resident's family, surrogate, or representative, should develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, based upon the comprehensive assessment.^[292]

DFPC found a violation of 42 C.F.R. 483.20(k) and assigned a severity and scope level of "D", meaning that the deficiency is isolated and no actual harm occurred, but where a potential for more than minimal harm that is not immediate jeopardy

existed. Resident 16 is the sole violation under this tag. See the factual summary and the arguments of the parties regarding Resident 16 under Tag F250 of the November 12, 2003 survey.

Resident 16 had mood and behavior concerns as shown through negative statements; persistent anger with others; self-depreciation; sad, pained and worried facial expressions; withdrawal from activities of interest; and reduced social interactions.^[293] DFPC acknowledges that the facility provided documentation of tracking the resident's mood between May 2003 and August 2003. However, DFPC objects to the alleged failure of the facility to include precursors to the resident's behaviors or strengths of the resident that might have helped him to deal with his issues. Specifically, the facility did not address questions such as: Was the staff to create a safe environment? How was the staff to prevent the resident from acting on self-destructive impulses? Was the staff to remove potentially harmful objects? Was the staff to provide close supervision? Was the staff to keep the resident involved in activities or programs? Consequently, DFPC argues that specific individualized care plan interventions were not developed for this resident.

The facility's argument under this tag is largely the same as the one put forth under Tag F250 above. The facility asserts that the interventions in the care plan were being followed.

But the issue is whether the facility developed a comprehensive care plan that includes measurable objectives and timetables to meet the resident's needs. Prior to his admission to Robbinsdale, a pre-admission screening indicated that the resident was to have mental health case management and weekly psychotherapy as arranged by the facility. The care plan directs psych consults as ordered with possible interventions of seeing Dr. Dummer and/or 1:1 visits as needed. Those interventions fall short of what was required by the pre-admission screening. As a whole, the record does not demonstrate measurable objectives and timetables.

Conclusion

Accordingly, a violation of the regulation has been shown. The severity level of no actual harm within potential for more than minimal harm is appropriate given the resident's suicide attempt and diagnoses of major recurrent depression and schizophrenia. The pattern is isolated and therefore the rating of "D" is sustained by the record.

Tag F353 – Nursing Services

Pursuant to 42 C.F.R. 483.30, the facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.^[294] Sufficient staff means that the facility must provide services by sufficient numbers of licensed nurses and other nursing personnel on a 24-hour basis. A review of a facility's nursing services must take place

during a standard survey if quality of care problems have been discovered and during any extended survey. The ability to meet the requirements of §§ 483.13 (resident behavior and facility practices), 483.15(a) (quality of life – dignity), 483.20 (resident assessment), 483.25 (quality of care) and 483.65 (infection control) determines sufficiency of nursing staff.^[295] The surveyor guidance manual indicates that the determining factor in sufficiency of staff is the ability of the facility to provide needed care for residents. Both quantity and quality of staff should be considered.

DFPC found a violation of 42 C.F.R. 483.30(a) and assigned a severity and scope level of “E”, meaning that there was a pattern of the deficiency and no actual harm occurred, but where a potential for more than minimal harm that is not immediate jeopardy existed. The determination was based on the examples and problems noted in Tags F250, F224, and F241 of the November 12, 2003 survey. See the facts and arguments set forth in each of those tags.

In summary, DFPC supports this allegation with Resident Council Minutes from January, April, August, September, and October 2003, in which residents voiced concerns about insufficient staff, call lights not being answered, not being brought to meals on time, and not receiving evening snacks. Residents felt that there were not enough nurses and nursing assistants to meet the needs of the residents on an every shift basis and that not all staff working at the facility was “quality.”

The facility refers to its responses under Tags F250, F224, and F241, and reiterates that their staffing ratios indicate that they are staffing at a higher level than required.

Conclusion

According to the regulation, the sufficiency of nursing staff is determined by the facility’s ability to meet residents’ needs in areas such as quality of care, quality of life, and resident assessment. The violations established under Tags F250, F224, and F241 involved staff treatment of residents, quality of care provided to residents, and the dignity of residents. The violations range in scope from isolated to a pattern, and in severity from actual harm to no actual harm with a potential for minimal harm that is not immediate jeopardy. The ALJ recommends that the scope and severity finding of “E” be sustained, even though actual harm was found to occur under Tag F241 and could theoretically justify an increase in scope and severity under this tag. Because the threshold for finding actual harm in a dignity violation is so easily met and the facts under Tag F241 did not overwhelmingly support a finding of actual harm, that determination is consistent with DFPC’s finding of a “no actual harm” severity level under this tag. DFPC has shown by a preponderance of the evidence that the facility violated Tag F353 at a scope and severity level of “E.”

G.A.B.

-
- [1] Ex. A-1.
- [2] Ex. C-1.
- [3] Ex. D-1.
- [4] Ex. D-4.
- [5] Exs. D-52 through D-55.
- [6] Ex. D-34.
- [7] Exs. K.J.-5-1 - 5-5.
- [8] Ex. K.J.-4.
- [9] Exs. K.J.-6-1 - 6-22.
- [10] Ex. J.
- [11] Ex. L-7.
- [12] Exs. D-5, D-13, and L-4.
- [13] Ex. M-8.
- [14] Exs. M-22a, M-23a.
- [15] Testimony of Kathy Geurink, registered dental and public health hygienist.
- [16] Ex. M-23b.
- [17] Ex. N-9.
- [18] Range of motion is defined as the extent of movement of a joint. Ex. Q-1.
- [19] Exs. O-4 and O-5.
- [20] Exs. O-13, O-16a, and L.T.-2.
- [21] Testimony of Michelle Brown.
- [22] Ex. L.T.-3.
- [23] Ex. P-7.
- [24] Ex. P-19.
- [25] Ex. P-22b.
- [26] Ex. U-38b.
- [27] Ex. F-1 – F-2.
- [28] Ex. F-2.
- [29] Ex. F-3.
- [30] Ex. JV-2. The comments/nursing observations recorded indicate that the administration of Oxycodone was effective in relieving pain. These observations suggest that the patient was given the Oxycodone when experiencing pain and the medication relieved or helped with the pain. There is no indication in that document that the resident was not receiving pain medication as needed.
- [31] Facility Response, dated October 11, 2004, at 8.
- [32] Ex. JV-4.
- [33] Facility Response at 8.
- [34] Ex. H.
- [35] Exs. SS-1-1 – 1-2.
- [36] Facility Response at 8-9.
- [37] Ex. H-12.
- [38] Exs. SS-2-1 – 2-8.
- [39] Ex. SS-2-9.
- [40] Ex. H-9.
- [41] Ex. Q-1.
- [42] Ex. Q-1. Limb or digit immobilization due to injury or surgery in a clinical condition that can lead to unavoidable reduction in ROM. See *id.*
- [43] Exs. T-11, T-12.
- [44] Exs. T-4, T-29, and T-30b.
- [45] Ex. T-21.
- [46] Ex. V-15.
- [47] Exs. V-27, V-28.
- [48] Exs. J.K.-1-1, 2-1, and 4.

[49] Ex. J.K.-5.

[50] Exs. B-1 – B-2.

[51] Ex. B-1.

[52] Ex. B-2.

[53] The appropriateness of the facility's response to grievances is the subject of the next tag (F166) and is discussed in the context of that regulation.

[54] Ex. C.

[55] Department's written argument for F165.

[56] Facility Response at 10.

[57] Ex. DS-1.

[58] Ex. DS3-2.

[59] Department's written argument for F165.

[60] Ex. D.

[61] Facility Response at 10.

[62] Department Response, dated October 27, 2004, at 7.

[63] Ex. D.

[64] Ex. D.

[65] Department's written argument for F165.

[66] Facility Response at 11.

[67] This is what DFPC says concerning resident 7 and this tag: "During the survey, resident #7 was asked by the facility to sign a statement contradicting what she had told the surveyor. The resident experienced pressure as evidenced by her statement of feeling in the middle. . . . Resident #7 reported during an interview on the initial tour of the facility on 11/9/04 at 2:10 p.m. that she had suicidal thoughts and had heard voices since coming to the facility. The surveyor informed the Director of Nursing at 8:30 p.m. on 11/9/04 of concerns about lack of suicidal preventions and interventions for the resident. At 10:09 p.m. the Director of Nurses produced a "No Harm Contract" that he had the resident sign. The contract stated the resident wasn't suicidal at any time since she had been in the facility. The resident on re-interview on 11/10/03 reported that she felt she was 'in the middle.' The resident stated that she hadn't fully read the contract but that it was not accurate because she had been suicidal and reported feeling that way on 11/09/04."

[68] Department's written argument for F165.

[69] Facility Response at 9.

[70] Facility Response at 9.

[71] Ex. D-2.

[72] Ex. D-2.

[73] See Department's written argument for F166. The Department cites to the notes of an interview with the facility's administrator and director of nursing, but the notes were not sufficiently legible to verify that this is what the notes said. See Ex. F-2.

[74] The facility does not argue that these complaints were not made, and/or not brought to the attention of the facility staff and administration. Both parties agree that they were, and there is testimonial and documentary evidence of the same. Thus, the only issue for determination is whether the facility acknowledged these complaints and actively worked toward their resolution.

[75] Ex. C-19.

[76] Ex. C-18.

[77] Ex. C-13.

[78] Ex. C-12.

[79] Ex. C-7.

[80] Ex. C-1.

[81] Ex. C-19.

[82] Ex. C-18.

[83] Ex. C-13.

[84] Ex. C-12.

[85] Ex. D-3.

[86] Exs. G-1a – G-2b.

[87] Exs. G-2a, G-2b.

[88] Exs. G-1a – G-2b.

[89] Ex. 1-1. This audit was conducted from March – November, 2003. The response times were apparently recorded by a staff person other than the person answering the call light.

[90] Facility's Second Floor Nurse Manager.

[91] Facility Response at 13.

[92] If residents were using their call buttons as frequently as several times a minute, one would expect to see such usage showing up on the call light audit. There is no evidence of such use on the facility's call audit documentation. See Ex. 1-1. In fact, for all of October and November of 2003, there are only ten recorded uses of the call light.

[93] While the response time is a few minutes in most instances, there are some entries that raise a question about the accuracy of the recording. For example, on 4/1/2003, there is a call light "time on" of 6:30 AM and "time off" of 4:31 AM, and on 4/22/03 there is a "time on" of 2:30 -m (sic) and a "time off" of 2:23 p.m. It is possible that these are simple typographical errors. However, the fact that these errors are contained in the exhibit submitted in this proceeding raises a question about how closely the audit was examined by staff and administrators. Attempting to assess staff responsiveness, and to learn from the audit, would be part of a facility's active work to resolve complaints.

[94] Ex. C-19.

[95] Ex. C-1.

[96] Ex. G-2b. See also Ex. H.

[97] Ex. C-7.

[98] Ex. C-4.

[99] Ex. C-1.

[100] Ex. C-19.

[101] Exs. J-1 and J-2.

[102] See Ex. J-2. See also Exs. G-1a – G-4a. The Resident Council President also confirmed the lack of a response from the administration concerning the problem of insufficient staff. Ex. D-2.

[103] Ex. J-1.

[104] Ex. F-1a.

[105] Ex. F-2.

[106] See, e.g., Ex. H; Exs. G-1a – G-4a.

[107] Ex. H.

[108] Ex. C-13.

[109] Ex. C-11.

[110] Ex. C-10.

[111] Ex. C-5.

[112] The old products were known as "chux" or "chuks." Both spellings appear in the record, and are described as a cloth-like material that served as a diaper. The new products were described as more like plastic than cloth. Exs. C-11 and C-13.

[113] Exs. G-1a – G-4a.

[114] Exs. K and G-4a.

[115] Ex. J-5. A second copy of this same memo is exhibit J-7, and contains handwritten notes indicating that a "new product will be coming." However, there is no indication of who may have made those notes, and no evidence that this issue was satisfactorily resolved.

[116] Ex. C-9.

[117] Ex. G-4a.

[118] Ex. G-3a.

[119] See, e.g., Facility response.

[120] Ex. C-11.

[121] Ex. C-10.

[122] Ex. C-4.

[123] Ex. C-4.

[124] Ex. D-1.

[125] Ex. L.

[126] Ex. F-3.

[127] The surveyor's observations in one of the shower areas are not inconsistent with daily cleaning of heavily-used showers.

[128] Ex. C-13.

[129] Ex. C-11.
[130] Ex. C-10.
[131] The Department alleges in its written argument for this tag that complaints about linens also appeared in the July and August Resident Council Minutes. The Minutes provided by DFPC for those months do not contain linen complaints. See Exs. C-7, C-8, and C-9.
[132] Ex. C-14. The memo is not dated.
[133] Ex. C-14.
[134] Ex. D-1.
[135] Department's written argument for F166.
[136] Department's written argument for F166.
[137] Ex. C-4.
[138] The Department alleges that this concern was also raised at the October meeting. The minutes indicate that the "issue regarding mail being passed out on the weekend was reviewed," presumably because the Director of Nursing was in attendance and could respond.
[139] Ex. C-4.
[140] Ex. C-1.
[141] See Facility Response dated October 11, 2004.
[142] The Department cites to Exhibit G-1 as support for this statement. The reference should be to Ex. F-1, which simply records the statement, without any more information provided.
[143] Ex. B-1.
[144] Ex. 1-1.
[145] Testimony of Michelle Brown (stating that many residents ring the call lights often, sometimes as often as several times per minute). See Facility Response at 13.
[146] Facility Response at 13.
[147] See discussion of F166 *supra*.
[148] See discussion of F166 *supra*.
[149] Exs. M-4 and M-8.
[150] Ex. C-16.
[151] Exs. M-2a and M-23.
[152] Exs. PG-7-1, 7-2, and page 13 of the Form 2567.
[153] Ex. PG-2-1.
[154] Ex. PG-4.
[155] Ex. PG-5.
[156] Exs. PG-6-1 through 6-4.
[157] Ex. C.
[158] Department's written argument for F165.
[159] Facility Response at 10.
[160] Ex. SD-4.
[161] The statement made by these residents and DFPC's failure to meet its burden of proof is discussed in F224, *supra*.
[162] Ex. DS-1.
[163] Ex. DS 3-2.
[164] Ex. DS 3-2, § B2.
[165] Facility Response at 13.
[166] Department Response at 7.
[167] Facility Response at 10.
[168] Facility Response at 13.
[169] Facility Response at 13.
[170] Ex. B-1.
[171] Ex. 1-1.
[172] See discussion of F166 *supra*.
[173] Facility Response at 13.
[174] See discussion of F166 *supra*.
[175] See discussion of F166 *supra*.
[176] Exs. M-4 and M-8.
[177] Ex. C-16.

[178] Exs. M-2a and M-23.
[179] Exs. PG-7-1, 7-2, and page 13 of the Form 2567.
[180] Ex. PG-2-1.
[181] Ex. PG-4.
[182] Ex. PG-5.
[183] Exs. PG-6-1 - 6-4.
[184] Facility Response at 15.
[185] Ex. A-4.
[186] Ex. A-6.
[187] Ex. E-6.
[188] Ex. E-3a.
[189] Exs. E-4a, 6, 8, 10, 12.
[190] Exs. E-15, 16, 17, 18, 20, 21, 27a.
[191] Ex. E-29.
[192] Ex. A.B.-7-1.
[193] Ex. A.B.-7-1.
[194] Ex. A.B.-10-2 and 10-3.
[195] Testimony of Robbinsdale staff person.
[196] Ex. A.B.-11-1.
[197] Exs. E-3a, 3b.
[198] Ex. E-6.
[199] Exs. E-8, 10.
[200] Exs. E-26a, 27a.
[201] Ex. A 1310.
[202] Exs. E-22a, 22b.
[203] Ex. F-31.
[204] Ex. F-10.
[205] Exs. F-41 - 42b, and F-43a - 46b.
[206] Ex. F-45b - 46b.
[207] Ex. F-13 - 16.
[208] Ex. F-36.
[209] Ex. F-31.
[210] Exs. F-41a - 42b and F-43b - 46b.
[211] Exs. F-46a-46b.
[212] Ex. O.O.-1.
[213] Exs. O.O.-2-3 - 2-5.
[214] Ex. O.O.-3-1.
[215] Exs. F-45b-46b.
[216] Exs. F-25a - 25b.
[217] Exs. F-35 - 39.
[218] Exs. G-23b-34b.
[219] Ex. G-3.
[220] Ex. G-13.
[221] Ex. J.F.-1.
[222] Exs. J.F.-2-1 - 2-3.
[223] Exs. J.F.-4-1 - 4-4.
[224] Testimony of Carol Skare and Michelle Brown.
[225] Ex. G-3.
[226] Ex. G-13.
[227] Ex. J.F.-4-2. A date of April 30, 2002, is noted in the exhibit. This appears to be a typo, and should likely read April 30, 2003.
[228] Ex. H-13.
[229] Ex. H-3a and 3b.
[230] Ex. C-11.
[231] Ex. J.G.-1-1, 1-2.
[232] Ex. J.G.-2.

[233] Testimony of Carol Skare and Michelle Brown.

[234] Ex. H-23.

[235] Ex. H-9.

[236] Ex. I-6.

[237] Ex. I-12.

[238] Exs. I-15 and I-21.

[239] Exs. I-27a - 28.

[240] Ex. C-12.

[241] Ex. I-6.

[242] Ex. I-9.

[243] Ex. I-21.

[244] Ex. C-12 and Facility Response.

[245] Exs. J-2d, 2x, 2y, and J-3.

[246] Exs. J-4c and 5g.

[247] Ex. J-7.

[248] Ex. J-8j.

[249] Ex. C-13.

[250] Ex. J-6c.

[251] Ex. J-5e.

[252] Ex. J-5e.

[253] Ex. J-5h.

[254] Ex. J-6a.

[255] Ex. J-5b.

[256] Ex. K-3, 4.

[257] Ex. K-3.

[258] Ex. K-4.

[259] Ex. K-51.

[260] Ex. K-2a.

[261] Exs. C.S.-1, -2.

[262] Ex. K-16b.

[263] Ex. K-15b.

[264] Ex. C.S.-3.

[265] Ex. K-30.

[266] The facility appears to interpret one-on-one visits broadly, so that such a visit is provided each time the resident received cares, whether physical or mental.

[267] Ex. K-28.

[268] Ex. K-2a.

[269] Exs. L-6 and L-13.

[270] Ex. L-27.

[271] Ex. L-20.

[272] Ex. L-27.

[273] Ex. L-2.

[274] Ex. D.M.-0-8.

[275] Ex. D.M.-3.

[276] Exs. D.M.-1-1 - 1-3. Facility testimony at the hearing indicated that Dr. Dummer only saw Resident 6 once, because the resident did not have the cognitive capabilities necessary for therapy.

[277] Exs. L-20 and 21.

[278] Ex. L-31.

[279] Ex. M-26.

[280] Exs. P.G.-3-1 - 3-2.

[281] Ex. P.G.-3-3.

[282] Ex. P.G.-2-1.

[283] Ex. P.G.-4.

[284] Ex. P.G.-5.

[285] Exs. P.G.-6-1 - 6-4.

[286] Exs. P.G.-6-1 - 6-4.

[\[287\]](#) Exs. A-1 A -2. "Mood and behavior patterns" refers to the resident's patterns of mood and behavioral symptoms. "Psychosocial well-being" is the resident's positive or negative feelings about him or herself or his/her social relationships.

[\[288\]](#) Ex. A-1.

[\[289\]](#) Exs. F-1 - F-3.

[\[290\]](#) Ex. A-1.

[\[291\]](#) Exs. A-1 - A-3.

[\[292\]](#) Ex. A-1.

[\[293\]](#) Exs. L-4 and L-25 - 26.

[\[294\]](#) Ex. A-1.

[\[295\]](#) Ex. A-2.