

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

In the Matter of Elim Home Princeton
Survey Date November 25, 2003

RECOMMENDED DECISION

The above-entitled matter was the subject of an informal dispute resolution meeting conducted by Administrative Law Judge Steve M. Mihalchick on Monday, August 9, 2004, beginning at 9:30 a.m., at the Office of Administrative Hearings. The meeting concluded on that date and the record was closed.

Sam Orbovich, Esq., and Susan Schaffer, Esq., Orbovich & Gartner, Chartered, 408 Saint Peter Street, Suite 417, Saint Paul, MN 55102-1187, represented Elim Home (Elim or Facility). Appearing at the meeting for the Department of Health (Health) were Marci Martinson, Health Facility Evaluation Supervisor and Mary Cahill, 85 East 7th Place, Saint Paul, MN 55101. Also appearing at the meeting were Mary Hoffner, Ron Sanford, Bob Dahl, Todd Lundeen, Linda Letich, and Gary Grell from Elim Home. Affidavits were submitted by Dr. Mark Leenay (the physician of a resident), Jenean Erickson, and Connie Senander on behalf of Elim Home.

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

1. That the citation for deficiency number K051 be amended through a change in the scope and severity assigned to the citation, from "L" to "D."
2. That the citation for deficiency number F463 be amended through a change in the scope and severity assigned to the citation, from "K" to "C" for the facility-wide citation and "D" for the citation relating to Resident 26.
3. That the citation for deficiency number F318 is not supported by the record.

4. That the citation for deficiency number F316 be amended through a change in the scope and severity assigned to the citation, from "G" to "E." The portion of the citation that relates to Resident 6 is not supported by the record.

Dated: August 20, 2004

s/Steve M. Mihalchick

STEVE M. MIHALCHICK
Administrative Law Judge

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

MEMORANDUM

Health conducted surveys of Elim on November 18, 2003 and November 25, 2003. Based on these surveys, Health issued four Statements of Deficiency each assigned a severity and scope level. The deficiencies were assigned levels L, K, G, and G, respectively. Each deficiency will be discussed individually.

The survey process operates under the overall authority of the Centers for Medicaid and Medicare Services ("CMS"). CMS is a division of the U.S. Department of Health and Human Services. CMS holds facilities to a standard of substantial compliance. "Substantial compliance" is defined as:

A level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm. 42 C.F.R. § 488.301

When citing deficiencies, surveyors use the CMS "Chart of Enforcement Remedies" (commonly referred to as the "Scope and Severity Grid" or "the Grid"). The level of deficiency and the enforcement action to be taken is set out on each square of the Grid. The scope axis can be isolated, pattern, or widespread. The severity axis has four levels ranging from immediate jeopardy (most severe) to no actual harm with potential for minimal harm (least severe). Each square on the Grid has a letter designation. A is the least serious, and L is the most serious.

Tag K051

Elim's facility was expanded by an addition of a new residential wing in 2003. The new wing was first occupied on November 3, 2003.¹ The facility maintains a fire alarm system that is tested monthly. With the new wing, the fire alarm system was modified so that the activation of the alarm in one wing sounds the alarm in all wings. The facility is also protected by a sprinkler system and, in the new wing, a wireless smoke detection system.

¹ Affidavit of Todd Lundeen at 7.

On September 30, 2003, the fire alarm was tested and functioned properly.² The fire alarm system was tested before the new wing was occupied.³ Due to the frequent access to the system's control panel, the fire alarms were being tested very frequently between November 3, 2003 and November 18, 2003.

On November 18, 2003, the State Fire Marshal was conducting the Life Safety Code inspection of the facility. In the course of that inspection, testing at the pull stations in the old wing was conducted. At a single pull station, the alarm activated in the old wing, but not the new wing.⁴ No other pull stations were affected.⁵ Service technicians were called, but they could not identify the problem within 90 minutes. At that point, the State Fire Marshal declared immediate jeopardy and the facility staff instituted a fire watch condition. An announcement was made, fire doors were closed and staff directed to specifically watch for fire risk.

Health cited Elim for failure to maintain the fire alarm system in good working order and concluded that immediate jeopardy and a pattern of deficiencies existed to support an L-level deficiency, which is widespread, immediate jeopardy to resident health or safety. The violation was not widespread. The fire alarm functioned in the wing where the pull station was located. The cause of the failure to sound the alarm in the new wing was the act of a maintenance person. This is an isolated violation on the scope scale. There was no jeopardy to persons in the old wing of the facility since the alarm functioned fully in that wing. Elim maintained a fire safety plan that required an intercom announcement of a hazard situation, even before activating the fire alarm.⁶ For any risk of harm to exist for persons residing in the new wing, the staff would have to fail to communicate a fire risk to the new wing and a failure of the functioning smoke detection system in the new wing would have to occur. Such a combination of failures is unlikely and appropriately falls under the Level 2 on the severity scale (no actual harm with potential for more than minimal harm that is not immediate jeopardy). Using the Scope and Severity Grid, a D-level deficiency is supported by the facts.⁷

Tag F463

On November 3, 2003, Elim installed a wireless call system to enable residents to contact nursing assistants. The system used call buttons in the resident rooms and bathrooms to send pages to the particular staff member assigned to that area. As designed, if the page is not answered within five minutes, a supervisor is paged. If that page is not answered, the facility director on duty is paged. Staff and residents were instructed in how to use the system.

² Ex. A-2, A-3.

³ Affidavit of Todd Lundeen at 7.

⁴ Ex. A-2, A-3.

⁵ Affidavit of Todd Lundeen at 8.

⁶ Affidavit of Todd Lundeen, Ex. H.

⁷ This reduced level of severity is also supported by the outcomes in other similar circumstances involving other facilities. A civil money penalty of \$50.00 per day was found appropriate where a fire alarm system failed to activate the door closure system for over a month. ***Alden Estates of Evanston v. Centers for Medicare & Medicaid***, Docket No.C-00-433 Decision No. CR1009 (DHHS Appeals Board, March 4, 2003).

The wireless system was the only installed system in the new wing. The wireless system was added to the old wing of the facility. Elim intended to use the wireless system as a replacement for the existing system in the old wing of the facility. The existing system used call buttons and lights that would activate outside the resident's room and at the central nursing station. The replacement of the existing system was necessitated by the difficulties experienced in repair and replacement of parts.⁸ The existing system was not removed. Elim also maintained a back-up system that involved distributing bells to residents that they would ring to summon staff. This bell system had been in use as a back-up system since at least 1988.⁹

During the November 18, 2003 visit, Health surveyors were informed that the wireless paging system was not working properly. Ghost pages were occurring that morning, showing calls for assistance that were not made. The surveyors began testing the system at 11:30 a.m. by triggering pages in resident rooms and awaiting responses. Staff responses to the pages were sporadic, due in part to the renumbering of rooms (pagers showed new room numbers) and in part with unfamiliarity with the pager system. Staff began distributing bells to the residents at 11:58 a.m.¹⁰ The Director of Nursing discussed the situation with surveyors at 12:30 p.m. and began investigating the system malfunctions.

The surveyors concluded that the training on the wireless call system had been inadequate. At least one nursing assistant had not turned her pager on to be able to receive messages. Some of the programming in the wireless system for routing messages was not functioning properly. These problems were promptly addressed.¹¹

On November 19, 2003, the facility advised the surveyors that the wireless system had been returned to use. On November 20, 2003, the surveyors examined the operation of the call system for Resident 26. Due to Resident 26's infirmities, a pull cord was run to the bed from the wireless transmitter.¹² That particular transmitter had been tested on November 19 and found to be functioning. The unit was malfunctioning on November 20. The transmitter was replaced on November 20, 2003.

Health issued a deficiency tag on the communications system, maintaining that Elim created an immediate jeopardy situation by the pattern of failures in the communications system. The deficiency was cited at the K-level on the Grid. The rule governing this area is 42 C.F.R. § 483.70, which states in pertinent part:

Sec. 483.70 Physical environment. The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.

* * *

⁸ Affidavit of Todd Lundeen at 2.

⁹ *Id.* at 5.

¹⁰ Exhibit S-15b.

¹¹ Affidavit of Todd Lundeen at 5.

¹² Ex. S-20a.

(f) Resident call system. The nurse's station must be equipped to receive resident calls through a communication system from -- (1) Resident rooms; and (2) Toilet and bathing facilities.

Health cited Appendix Q of the *HCFA Guidelines for Determining Immediate Jeopardy* as supporting the tag. That Appendix indicates that the call system requirement "is met only if all portions of the system are functioning"¹³ Health relied upon *Guidelines for Determining Immediate Jeopardy* to assess the severity level of the deficiency found.¹⁴ The language relating to communications systems states:

B. Failure to prevent neglect ... 7. Non-functioning call system without compensatory measures;¹⁵

Elim asserts that the facility had and used compensatory measures. In support of this contention, Elim cites the holding in ***Heritage Park Nursing Center v. Centers for Medicare & Medicaid***, Docket No.C-00-079, Decision No. CR1051 (DHHS Appeals Board, May 27, 2003)(***Heritage Park***), as support for its argument.

In ***Heritage Park***, the facility's call light system was known to be broken for six days before a service technician was called. The facility initiated two-hour staff checks on residents seven days after the system broke down. The facility distributed bells on the twelfth day after the system broke down and adopted a policy at that time on the use of an alternative call system.¹⁶ The K-level assessment for these deficiencies was upheld on appeal.¹⁷

There is no specific level of technology for a communication system required by the regulation. Any technological system can fail. The guidelines applying the communication system requirement recognize this limitation by providing facilities the safe harbor of a back-up system to meet the requirement. In this matter, when the wireless paging system malfunctioned, Elim began distribution of the low-tech back-up system (bells) within thirty minutes of the malfunction being recognized. While the scope of the problem was widespread, the severity of the problem is appropriately categorized as no actual harm with potential for minimal harm (C-level on the Grid) due to the prompt utilization of compensatory measures.

Regarding Resident 26, the wireless call system transmitter malfunctioned and was replaced. The problem lasted, at most, for one day. Under these circumstances, the deficiency was isolated, affecting only one resident, and resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy (D-level on the Grid).

¹³ Ex. R.

¹⁴ Ex. E-1.

¹⁵ Ex. E-3.

¹⁶ ***Heritage Park***, Findings D-H.

¹⁷ ***Heritage Park***, Conclusions 1-3.

Tag F318

Resident 7 was admitted to Elim on November 2, 2000. At that time, Resident 7 was ambulatory with a walker. Resident 7 suffered from contractures in his legs. The contractures were noted on one side initially and then noted as bilateral (on both legs) by January 2003. Resident 7 was nonambulatory by January 11, 2003, due to hip problems.¹⁸ To address the contractures condition, abductor braces were prescribed. These braces are designed to passively prevent contractures. Resident 7 also received range of motion (ROM) exercises that were intended to prevent further reductions in his mobility and flexibility in his legs. Resident 7's plan of treatment notes indicated that he was in significant pain, and that therapists should "progress ROM carefully, as [Resident 7] has a history of dislocation."¹⁹ Resident 7's daily activity restrictions note that his hip must be kept immobilized when he is getting up.²⁰

The therapy exercises were continued until April 2003, when they were discontinued.²¹ Resident 7's treatment notes indicated that his physical therapy goals were met at that time. His notes from June 24, 2003 indicated that Resident 7's hip pain had increased and extended to pain in his legs caused by movement. His progress notes from late July indicated that Resident 7 was taking pain medication merely to tolerate repositioning in bed.²² He was taking Vicodin for pain on a three times daily basis, all through August 2003.²³ Similar pain was noted on October 20, 2003.²⁴

By November 2003, Resident 7 was nonambulatory and confined to a wheelchair.²⁵ He suffered a fall that caused a hip fracture on November 11, 2003. Resident 7 received a hip replacement at that time. Resident 7 was wore abductor braces while in his wheelchair. Resident 7's care plan included palliative care only.²⁶

Resident 7 suffered from a decline in his ambulatory abilities and had contractures prior to his hip fracture. After his fracture and hip replacement, Resident 7 was confined to wheelchair and suffered repeated hip dislocations. The medical staff of Elim described Resident 7 as being continually in pain.²⁷

Health issued a deficiency tag on the lack of ROM therapy provided to Resident 7. Health maintained that Elim did not meet its obligation to provide services to residents to increase ROM or prevent further decrease of ROM. The deficiency was cited at the G-level (isolated actual harm that is less than immediate jeopardy) on the Grid.

¹⁸ Affidavit of Jenean Erickson, Ex. 11a.

¹⁹ Affidavit of Jenean Erickson, Ex. 11b.

²⁰ *Id.* Ex. 12.

²¹ Ex. N-2.

²² Affidavit of Jenean Erickson, Ex. 14b.

²³ *Id.* Ex. 15b.

²⁴ *Id.* Ex. 15a.

²⁵ Affidavit of Mark Leenay, M.D., at 2.

²⁶ *Id.* at 3.

²⁷ Testimony of Linda Lettich, R.N.

The regulation regarding the ROM services to be provided is 42 C.F.R. § 483.25, which stated in pertinent part:

(e) Range of motion. Based on the comprehensive assessment of a resident, the facility must ensure that-- (1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and (2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

Resident 7 experienced hip dislocations on January 19, February 4, and June 22, 2003.²⁸ The hospital discharge instructions from June 24, 2003 indicated that Resident 7 “should be nonambulatory with range of motion as tolerated.”²⁹ Health relies upon the general standard that ROM exercises are to be provided and Elim’s charting that made no reference to pain to conclude that Resident 7 should have received ROM exercises. The evidence shows that Resident 7 suffered from conditions that made ROM exercises difficult, painful, and probably futile.

Health asserts that Resident 7 could have been medicated to allow him to tolerate the additional pain arising from the ROM exercises. The record shows that Resident 7 was receiving significant amounts of pain medication to address ongoing pain. There is no evidence in the record that Resident 7 could have tolerated the pain likely to accompany ROM exercises due to his hip condition simply by increasing the amount of pain medication that Resident 7 was receiving.

The medical professionals responsible for Resident 7’s care did not indicate that these ROM exercises were necessary or likely to maintain Resident 7’s existing range of motion. Resident 7’s clinical condition supports a conclusion that a reduction in his ROM was unavoidable. The frequency of Resident 7’s hip injuries, his reporting of pain, and consistent medication to address ongoing pain indicate that the absence of ROM exercises does not constitute a deficiency.

Tag F316

Resident 6 had a condition known as a “neurogenic bladder” caused by a stroke. This condition was noted on Resident 6’s Bladder Control Problems sheet.³⁰ Her medical record (completed April 9, 2003) indicated that she used a foley catheter and that Resident 6 was not candidate for bladder retraining due to her condition.³¹

Resident 6 was hospitalized on May 9, 2003 with a principal diagnosis of eight conditions, one of which was “acute urinary tract infection with probable urosepsis.”³² Resident 6 was discharged from the hospital on May 16, 2003. Her discharge

²⁸ Ex. N-1, N-2.

²⁹ Ex. N-2.

³⁰ Facility Ex. 6.

³¹ *Id.*

³² Ex. M-6.

summary, completed by Dr. Gregory Schoen, stated “Will also leave her Foley catheter indwelling.”³³ Resident 6’s diagnosis listing on May 16, 2003 noted “with probable urosepsis” and “retention, urine, NOS [not otherwise specified].”³⁴ A handwritten note was added to the latter diagnosis stating “neurogenic bladder.”³⁵ Resident 6 was discharged to Elim at that time.

As of June 20, 2003, Resident 6 was mostly noncommunicative due to another stroke and her failure to thrive. Resident 6’s progress note on that date referenced the catheter and the made mention of her urine output.³⁶ Her failure to produce urine had been of clinical concern during her previous hospitalization.³⁷

On November 25, 2003, the survey team visited Elim. The surveyors opined that there was no diagnosis to support use of an indwelling catheter for Resident 6 and she was suffering from a urinary tract infection.³⁸ The survey team interviewed a nurse practitioner who was not aware of Resident 6’s diagnosis of neurogenic bladder.³⁹ At the behest of the surveyors, nursing staff removed the catheter.⁴⁰

The survey team also observed that five residents (Resident 4, Resident 8, Resident 13, Resident 17 and Resident 18) did not receive toileting or incontinence checks every two hours. The time that each resident went over the two hour period ranged from 29 minutes to one hour and ten minutes. Based on these observations, Health issued a deficiency tag on appropriate treatment for bladder function. The deficiency was cited at the G-level on the Grid, which is isolated actual harm that is less than immediate jeopardy.

Dr. Leenay opined that Resident 6’s neurogenic bladder condition was appropriately addressed with an indwelling catheter.⁴¹ Health pointed out that Resident 6’s December 5, 2002 discharge summary from a hospital stay indicated that Resident 6 had an indwelling catheter that could be removed at the nursing home.⁴² No time period was specified as to when the catheter should be removed. Elim points out that this instruction applied to a prior placement of Resident 6, not to Elim.⁴³

Health relied upon the existence of an infection and the presence of fecal bacteria in Resident 6’s urine to support the severity assessment of the cited deficiency. Resident 6 was under the care of two doctors who directed the use of an indwelling catheter. The laboratory results and medical notes relied on by Health to show that Resident 6 suffered an infection due to the indwelling catheter are from physicians who were administering Resident 6’s care.⁴⁴ Elim is not free to disregard the directions of

³³ Ex. M-8.

³⁴ Facility Ex. 6.

³⁵ *Id.*

³⁶ *Id.*

³⁷ Facility Ex. 6.

³⁸ Ex. F-1, F-2.

³⁹ Ex. F-2, F-3.

⁴⁰ Testimony of Linda Letich.

⁴¹ Affidavit of Mark Leenay, M.D., at 2.

⁴² Ex. M-2.

⁴³ Affidavit of Jenean Erickson, at 3.

⁴⁴ Exs. M9-12.

treating physicians regarding patient care. Elim has shown that Resident 6's infection was an unavoidable outcome of following the physicians' directions. The cited deficiency regarding catheter use is not supported by the record in this matter.

In addition to the catheter use, Health maintains that the toileting or checking for incontinent episodes of the five residents was not timely "as per their plans of care and/or assessments" ⁴⁵ Health's allegation was that the facility was not in substantial compliance with regulation 42 C.F.R. § 483.25(d)(2) and its corresponding F-Tag, F316. Health found this to be a G-level deficiency (isolated, actual harm that is less than immediate jeopardy). The regulation states:

(d) Urinary Incontinence. Based on the resident's comprehensive assessment, the facility must ensure that-- ... (2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

Elim asserted that the Health is basing its action on a two-hour toileting standard that was part of a repealed rule. Health points out that the care plans of the residents call for toileting (or offering the opportunity for toileting) every two hours. Health has demonstrated that Elim was not in substantial compliance with the toileting standard. The noncompliance ranged from twenty-nine minutes to one hour and ten minutes for the cited residents. There is no evidence that this noncompliance caused harm to the affected residents, but it does have the potential for more than minimal harm. The scope of the noncompliance fits the category of pattern. Therefore, the deficiency is appropriately classified as E-level on the Grid.

S.M.M.

⁴⁵ Tag F316, Summary.