

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

In the Matter of Episcopal Church Home  
of Minnesota

**RECOMMENDED DECISION**

The above matter was the subject of an independent informal dispute resolution (IIDR) meeting convened by Administrative Law Judge Kathleen D. Sheehy on November 16, 2004 beginning at 9:30 a.m. at the Office of Administrative Hearings. The meeting concluded on that date and the OAH record closed.

Marci Martinson, Unit Supervisor, Licensing and Certification Program, Division of Health Policy, Information, and Compliance Monitoring, Department of Health, 1645 Energy Park Drive, Suite 300, St. Paul, Minnesota 55108-2970, appeared for the Department of Health. Susan M. Voigt, Esq., and Peter Hendricks, Esq., Voigt, Jensen & Klegon, LLC, 2550 University Avenue West, Suite 190 South, St. Paul, Minnesota 55114, represented Episcopal Church Home of Minnesota. Also attending the meeting were Mary Cahill for the Department of Health and Mike Karel, Peggy Mueller, Colleen Fabricius from Episcopal Church 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 this 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 following Memorandum, the Administrative Law Judge makes the following:

**RECOMMENDED DECISION**

1. The record supports the severity assigned to tag F310 ("G," isolated with actual harm). This tag should be affirmed.
2. The record does not support tag F311, which should be removed from the Statement of Deficiencies. This tag should be dismissed.

Dated this 30<sup>th</sup> day of November 2004.

/s/ Kathleen D. Sheehy  
KATHLEEN D. SHEEHY  
Administrative Law Judge

Reported: Tape-recorded.  
(Two tapes, no transcript prepared)

### MEMORANDUM

The Department completed a survey at Episcopal Home of Minnesota on August 13, 2004. Two tags issued in the Statement of Deficiency (Form 2567) are in dispute.

#### Tag F310

The first tag (F310) alleged that the facility failed to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the resident's clinical condition demonstrate that diminution was unavoidable. Specifically, the Department alleged that the resident's ability to transfer herself between surfaces (to or from bed, chair, wheelchair, or standing position) and to ambulate in her room and in the corridor of her floor declined, and that the decline was the result of a lack of services in violation of 42 C.F.R. § 483.25(a)(1), as opposed to being an unavoidable consequence of the resident's physical or mental condition.

This resident was a 91-year-old woman who had lived on the board and care floor of the Episcopal Home for three years with a diagnosis of senile dementia. In April 2004 the facility assessed her as being independent in bed mobility, ability to transfer between surfaces, and walking in her room; she required supervision while walking in the corridor.<sup>[1]</sup> In May 2004 she entered a physical therapy program because of a series of recent falls. The physical therapy was discontinued on June 1, 2004 when the therapist discharged her to nursing "for walking program for endurance." At the time she could use a rolling walker for approximately 75 ft. with stand-by assistance (close monitoring/verbal cues).<sup>[2]</sup>

On July 1, 2004, a physical therapist evaluated the resident and found she could use a wheeled walker on a level surface for approximately 80 feet, with stand-by assistance.<sup>[3]</sup> The therapist completed a Gait Recommendations Worksheet, however, indicating that the resident was independent and required only distant supervision and occasional cueing for safety. She recommended that the resident walk daily and indicated the resident's potential for rehabilitation was good.<sup>[4]</sup>

By July 12, 2004, the facility documented a decline in the resident's ability to attend to activities of daily living (ADLs) due to increased dementia. The documentation reflects that she was still independent, however, in her ability to transfer between surfaces. In her room and in the corridor, she required supervision and set-up help. Her care plan, revised on July 13, 2004, indicates that she was fearful, had an unsteady

gait, and was using a wheelchair at the time. It further indicated she was at risk for falling due to refusal to use a walker and refusal to wear shoes. Her long-range goal was to ambulate with a rolling walker and “assist of one,” which means physical assistance of one person.<sup>[5]</sup>

On July 20, 2004, the resident was transferred to a floor providing skilled care because of incontinence and increased need of care in personal hygiene. Facility records provide that she was independently mobile; that she had a history of falls; that she refused to use her walker; and that she needed to be reminded to use her walker.<sup>[6]</sup> The nursing progress notes indicate that, at least through August 5, 2004, the resident was ambulating with her walker and with stand-by assistance.<sup>[7]</sup>

When the survey was conducted between August 10 and 13, 2004, the surveyor did not observe the resident walking at all; she was being pushed in a wheelchair to meals and around the floor. The surveyor observed the resident to have difficulty attempting to stand, and could not find the wheeled walker in her room. When questioned by the surveyor on August 12, 2004, a nursing assistant stated that the resident “doesn’t walk,” or words to that effect. A nurse manager located the resident’s wheeled walker down the hall, outside the room of another resident. When a nurse manager attempted to help the resident out of the wheelchair, the resident required physical assistance to stand and was shaky. The resident walked for approximately 30 feet with stand-by assistance, then required physical help to sit in a recliner.

The facility maintains that there was no decline in the resident’s ability to transfer or ambulate after transfer to the skilled care unit because the care plan indicates she was refusing to walk and had to be reminded to do so before she was transferred. The record clearly demonstrates that, at minimum, the resident’s ability to transfer between surfaces declined after she moved to the skilled care unit, and there is no documentation to support that this was a consequence of her physical or mental condition. The facility also contends that the physical therapist incorrectly noted that the resident was independent, when her other notations indicate stand-by assistance was required. Even if this was an error, it does not explain the decline in the resident’s ability to transfer and the decline in the distance she was capable of walking, even with stand-by assistance.

The facility also maintains that nursing assistant ambulation records document that the resident was walked once or twice on most days between July 21 and August 12. References to walking in the progress notes stop on August 5, 2004. The undersigned believes the facility’s contention that as the resident’s dementia increased, she had less and less interest in walking. Based on the record as a whole, however, it appears more likely than not that the resident’s decline occurred over a relatively short period of time because staff on the skilled care floor were not as attentive to her ambulation program. The timing of the decline appears to coincide with the vacation schedules of the nurse managers on the unit, who were covering for each other between July 19 and August 10, 2004.<sup>[8]</sup>

The issue then becomes whether this deficient practice caused actual harm to the resident. Actual harm is noncompliance that results in a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental, and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. This does not include a deficient practice that only could or has caused limited consequence to the resident.<sup>[9]</sup> A severity rating of "G" is appropriate for actual harm that is not immediate jeopardy; a severity rating of "D" is appropriate when there is no actual harm, but there is potential for more than minimal harm that is not immediate jeopardy. The undersigned concludes there was some compromise of the resident's ability to maintain her "highest practicable" physical well-being. On this record, the Administrative Law Judge cannot say the consequences for this resident were limited. Therefore there was actual harm and the "G" rating is appropriate.

### **Tag F311**

The second tag (F311), issued with regard to two different patients, alleged that the facility failed to ensure that the residents were given the appropriate treatment and services to maintain or improve their abilities in violation of 42 C.F.R. § 483.25(a)(2). Resident No. 10 is a 90-year-old resident who had dementia caused by organic brain syndrome. On June 23, 2004, a physical therapist recommended walking three times daily to all meals or during the day, with stand-by help and supervision.<sup>[10]</sup> Her physician noted on July 6, 2004 that she was seen for progressive dementia with a decline in her functional status. He noted she was refusing to get out of bed and refusing ambulation. She was confused, disoriented, and not able to walk.<sup>[11]</sup> An assessment on July 9, 2004, indicated that she needed limited assistance in transferring and walking in her room, and the type of support required was one-person physical assistance. According to the assessment, the resident had not walked in the corridor during the seven prior days.<sup>[12]</sup> Her care plan provided that she was debilitated due to malaise and fatigue and was being treated for a persistent urinary tract infection.<sup>[13]</sup> She was also recovering from a compression fracture of her lumbar spine.<sup>[14]</sup>

On July 9, 2004, the nursing progress notes indicate that the resident remained very needy and passive; that she was encouraged to ambulate; and that she was not interested in doing so.<sup>[15]</sup> Nursing assistant ambulation records document that the resident frequently refused to walk, but the records are not complete.<sup>[16]</sup> At some point during this month, the resident contracted pneumonia.<sup>[17]</sup>

On July 27, 2004, the resident was transferred to the skilled care unit due to increased needs for help with activities of daily living. Nursing notes the next day indicate the resident can walk when she chooses.<sup>[18]</sup> The ambulation records are blank for July 28-August 1 and August 3-4 and 6.<sup>[19]</sup> On August 4, 2004, the nursing notes provide that the resident does not ambulate, she is transported by wheelchair to all destinations pushed by staff. The resident did walk during two shifts on August 5, and after that time the records indicate she was not able to walk. On August 10, 2004, her physician noted the resident had had a difficult month with pneumonia and a UTI. He noted the further decline in her transfers and functional status and indicated he would

ask physical therapy for transfer training and strengthening, although her goals are limited and prognosis guarded.<sup>[20]</sup>

On August 11, 2004, the surveyor observed the resident being pushed in a wheelchair by staff. When the surveyor asked the nurse manager whether the resident could walk, the nurse manager indicated she did not know. A physical therapy evaluation performed that day indicated the resident could walk up to 200 ft.

The Department alleges that although the resident still had the ability to ambulate, she was not offered the opportunity on a regular basis. The facility contends that the resident was offered the opportunity to walk and declined it, as is her right under 42 C.F.R. § 483.10(b)(4). This resident was ill and increasingly confused in the month preceding the survey. As with resident No. 2 above, the Department has focused on the nurse manager's lack of knowledge about the resident's ability at the time the surveyor questioned her. This may not have been a reassuring response to the surveyor, but it does not necessarily follow that the facility's practice with regard to this patient was deficient, especially when the documentation suggests otherwise. The facility has documented staff efforts to encourage this patient to ambulate and the resident's refusal to participate while she was ill. The physician's notes confirm that the resident's functional status declined because of her illness with pneumonia and recurrent UTIs prior to August 10, 2004. The Administrative Law Judge concludes the Department has failed to meet its burden of showing that the facility failed to provide ambulation services to maintain or improve the abilities of resident No. 10. It appears more likely than not that the decline in this resident's functional status was an unavoidable consequence of her recent illnesses.

Resident No. 16 is an 81-year-old woman with senile dementia. She was admitted to the facility in the end of May 2004. The facility assessed her as able to walk with supervision and setup help in her room and with limited physical assistance by one person in the corridor. A physical therapist recommended walking two to three times daily to meals or shower, 150 to 200 ft, for four to five minutes with the assistance of one person. Her care plan, dated June 2, 2004, indicated she would ambulate to and from the dining room for every meal.<sup>[21]</sup> Her physician ordered ambulation in the hall twice a day with assistance of one person.<sup>[22]</sup> When her physician saw her on July 7, 2004, he noted she was ambulating twice daily with assistance and was able to walk about 300 feet behind a wheelchair.<sup>[23]</sup> Ambulation records reflect that she generally walked twice each day from July 1 through August 11, although a few days she walked once and two days are blank. The surveyor observed the resident on August 10-11 being wheeled to the evening meal on August 10 and to breakfast and lunch on August 11.

The Department contends the facility failed to provide ambulation according to the resident's care plan, which called for ambulation to all meals. The facility contends that it simply failed to amend the care plan to conform with the physician orders for ambulation in the hall two times per day. The Department does not appear to dispute that this resident was walking twice a day in the halls; it maintains the deficient practice was the failure to ensure the resident walked to all three meals. This deficiency was

issued at a scope and severity of D, isolated, no actual harm with potential for more than minimal harm.

The facility provided ambulation opportunities in compliance with the physician's orders. The Administrative Law Judge concludes the facility was in compliance with regard to resident No. 16. The citation to F311 should be removed from the Statement of Deficiencies.

K.D.S.

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[1] Ex. D-4.

[2] Ex. D-14.

[3] Ex. D-15.

[4] Ex. D-16.

[5] Ex. D-18-22.

[6] D-23.

[7] E.33-41.

[8] Ex. O.

[9] Ex. A-2.

[10] Ex. G-15. The resident was discharged from physical therapy on July 12, 2004. The therapist noted at that time that she could walk 250 ft. with stand-by assistance but that she was at high risk for falling because of decreased balance, cognition, and safety awareness.

[11] Ex. 311-B.

[12] Ex. G-4b.

[13] Ex. G-7a-7b.

[14] Ex. G-13.

[15] Ex. G-21.

[16] See *also* Ex. G-22 (nursing progress notes July 20, 2004: resident refuses ambulation, resistant to getting up; needs encouragement to let staff groom and dress her; resident not conversing).

[17] Ex. 311-B.

[18] Ex. G-18.

[19] Ex. G-16.

[20] Ex. 311-B.

[21] Ex. H-86.

[22] Ex. 311-K.

[23] Ex. 311-L.