

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

In the Matter of Zumbrota Care Center
- Survey Date August 20, 2004

RECOMMENDED DECISION

The above-entitled matter was the subject of an informal dispute resolution meeting conducted by Administrative Law Judge Richard C. Luis on Wednesday, November 17, 2004, beginning at 9:30 a.m., at the Office of Administrative Hearings. The meeting concluded on that date. The review record was closed with the receipt of supplemental documentation on severity levels, which was filed on November 18, 2004.

Michelle R. Klegon, Esq., Voigt, Jensen & Klegon, LLC, 2550 University Avenue West, Suite 190 South, Saint Paul, MN 55114, represented Zumbrota Care Center (Zumbrota or Facility). Appearing at the meeting for the Department of Health (Department or Health) were Marci Martinson, Health Facility Evaluation Supervisor, Mary Zabel, Mankato Department of Health Unit Supervisor, and Mary Cahill, Planner Principal for the Department, 85 East 7th Place, Saint Paul, MN 55101. Also appearing at the meeting was Maria Freidlund, Director of Nursing at Zumbrota. Dr. Sheila Boss appeared by telephone.

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

RECOMMENDED DECISION

1. That the citation for deficiency number F314 be amended through a change in the scope and severity assigned to the citation, from "G" to "D."

Dated: November 30, 2004

/s/ Richard C. Luis
RICHARD C. LUIS
Administrative Law Judge

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

MEMORANDUM

Health conducted a survey of Zumbrota on August 20, 2004. Based on this survey, Health issued a Statement of Deficiency that was assigned a severity level of harm that does not rise to the level of immediate jeopardy (level 3) and scope level of isolated (level 1).^[1] The Facility appealed the deficiency.

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 ranges from isolated (level 1), pattern (level 2), or widespread (level 3). The severity axis has four levels ranging from immediate jeopardy (most severe or level 4) to no actual harm with potential for minimal harm (least severe or level 1). Each square on the Grid has a letter designation. A is the least serious, and L is the most serious.

Background Facts

Resident 5 was admitted to Zumbrota on September 4, 2002.^[2] Resident 5 had been hospitalized from a fall. Resident 5 is an 89-year-old woman who is obese and suffers from diabetes. Resident 5 suffered from discomfort from the fractures that she suffered to her left wrist and humerus (upper arm) from her fall and discomfort from arthritis on her right side.^[3] At the time of her admission, Resident 5 was suffering from a hematoma over her coccyx that developed rapidly into a decubitus (an open sore).^[4] This sore was assessed as a "Grade IV-V" which is the most serious stage of the condition.^[5] The sore was described as 10 cm by 8 cm in size.^[6] Resident 5 also

suffered from chronic urinary and bowel incontinence. The location of the sore made contamination by feces and urine likely when Resident 5 was incontinent. Resident 5 received a Foley catheter to assist in urine disposal which was consistently used.^[7]

The treating physician for Resident 5 is Dr. Sheila M. Boss, D.O., a member of Zumbrota's staff. Dr. Boss evaluated Resident 5's condition on a regular basis as part of the care assessment process at Zumbrota. Zumbrota arrived at a care plan for Resident 5 that included a minimum of "weekly skin observation per licensed staff" and a goal of no additional stage 2 or greater areas of skin breakdown in that quarter.^[8]

On December 12, 2002, Dr. Santhi Subramanian, M.D. (another Facility staffer), assessed Resident 5's condition and noted his impression that she was suffering from a "Chronic sacral wound."^[9] The wound was described as "an inch deep and 5x5 cm wide" with no evidence of infection and no purulent discharge on the dressing.^[10] The nursing staff had previously noted that wound was "slightly enlarged" and had been "somewhat foul smelling."^[11]

On December 4, 2003, roughly one year later, Dr. Warren Abell examined Resident 5 and noted the sore was approximately 1.5 inches in diameter and no undermining was observed.^[12] The ongoing treatment was to "continue wound care and maintain good nutrition."^[13]

Dr. Boss observed Resident 5 on December 16, 2003. Nursing staff had raised concerns that the ulcer has worsened. Resident 5 was described as "completely non-ambulatory" and with "very little motivation."^[14] Efforts to get Resident 5 to engage in physical therapy to improve her strength and perhaps the ability to stand were abandoned due to repeated refusals. The ulcer was observed to be 3 by 2 cm. Two small ulcerations were present from the tape used to hold the bandage in place over the chronic ulcer.^[15] Dr. Boss directed that DuoDerm be used to secure the bandage and continue the current wound care, which is applications of Dakin's solution.^[16]

Dr. Subramanian examined Resident 5 on February 17, 2004, noting that she was suffering from a "Chronic non-healing ulcer of the sacrum."^[17] The ulcer was described as remaining "infected for some time now."^[18] Dr. Subramanian discussed with Resident 5 the need for lying on her side for "airing out her back."^[19] Resident 5 told Dr. Subramanian that she could not do that, due to her hip pain.^[20] Dr. Subramanian urged Resident 5 to work with the nursing staff to find a comfortable position to allow the wound to improve.^[21] The report also indicates that the nursing staff had observed that the ulcer had shown "some signs of healing and starting to close but it is a slow process at this point."^[22]

On March 16, 2004, Dr. Subramanian examined Resident 5. Most of the examination related to Resident 5's overall condition and control of her diabetes. The ulcer was not examined, since Resident 5 was lying in bed. She made no complaints about the ulcer at that visit.^[23] Nursing staff indicated that no change for better or worse had been noted in the ulcer.^[24]

On April 19, 2004, Facility staff contacted Dr. Abell to inquire if 0.25% Dakin's solution would be appropriate for Resident 5 (the order called for a 0.5% solution). In the alternative, safe gel hydrating dermal wound dressing was proposed. Dr. Abell approved using whichever was available.^[25]

On May 11, 2004, Dr. Subramanian examined Resident 5. He noted that Resident 5 suffered from "chronic non-healing decubiti."^[26] Resident 5 described her condition as "much better now" and nursing staff had reported signs of healing by the ulcer.^[27] The ulcer was described by nursing staff as being "just the size of a dime."^[28] Resident 5 had been spending time in a chair which seemed to aid in healing.^[29]

On June 29, 2004, Dr. Boss evaluated Resident 5. The past medical history noted "chronic sacral decubitus." On examination, the ulcer was described as "2x2 cm, clean, non-erythematous." No drainage was observed and Dr. Boss characterized the ulcer as "grade 2-3, closer to a grade 2."^[30] The current assessment included a reference to the sore, noting that it was a "Sacral decubitus, stable and healing slowly."^[31] The current wound care for the ulcer was indicated at "SAF-Gel with ABD pad with CombiDERM to hold it in place."^[32]

On July 6, 2004, Dr. Boss evaluated Resident 5 due to a change observed by the nursing staff in the condition of the ulcer. The ulcer was approximately 3 cm in size, at grade 2-3, with a dark base and no surrounding erythema (skin rash). Dr. Boss' record of that evaluation states:

Resident is 89 years old evaluated today because of a change in her sacral coccyx decubitus. She has had this for nearly 2 years now. It has gradually decreased in size. The last time I checked, it was actually doing very well down to just about a grade 2, 3 cm ulceration. Nurses had noticed more drainage and that the base of the wound was looking darker. The resident is not having any pain there. She has not been febrile. The drainage has been serosanguineous. The resident lays on her back almost continuously despite encouragement from the nurses to lie on her side periodically to take pressure off of this decubitus. Over the years, she has done very poorly with physical therapy. Has not been motivated to increase her strength and currently needs assistance even with just turning in bed.

* * *

Will add to the present treatment SAF-Gel to the wound daily. Daily cleansing with normal saline and then application of a wet-to-dry dressing and continue to observe. If drainage increases, we can go back to Aquacel dressing right to the wound bed which is what we used in the very beginning.^[33]

On July 8, 2004, the nursing notes for Resident 5 included an observation that her sore was "foul smelling" and that the open area was approximately 1 cm, with the

surrounding area red.^[34] Similar notes regarding treatment indicated that the condition was being addressed on July 12, 13, 15, and 19, 2004.^[35] Resident 5's eating habits changed during this period, reflected in her protein levels dropping.^[36] Dr. Boss inquired about the change and Facility staff told her that Resident 5 was not taking all of her protein supplements.^[37]

On July 20, 2004, Dr. Subramanian, performed rounds and observed Resident 5. Dr. Subramanian took a wound culture for analysis. The laboratory results were available on July 23, 2004. The laboratory results showed that the wound was infected and that an antibiotic was indicated for addressing the infection.^[38]

On July 24, 2004, the nursing notes for Resident 5 indicated that her wound measured approximately 2.5 cm by 1.5 cm, with some signs of infection ("green-brown areas inside wound").^[39] The notations do not reflect a condition extraordinarily different from the condition of Resident 5's wound from other points in her time in the Facility. The nursing notes from this period reflect that Resident 5 was consistently noncompliant with nursing staff regarding lying on her side to allow the wound to heal. The dressings were changed twice a day, with the wound being cleaned and Dakin's solution applied before placing a dressing.^[40]

Included in the Department's survey notes is a reference to a notation on July 28, 2004, of Resident 5's wound being measured as 10 cm by 7.5 cm and 8 cm deep.^[41] The nursing notes from this period do not reflect such a significant change in Resident 5's condition.^[42] On August 1, 2004, the observed condition of the wound reflected improvement.^[43]

On August 2, 2004, the nursing staff inquired as to whether antibiotics were to be started for Resident 5's sore. Dr. Boss responded that the antibiotic Augmentin was to be started and issued an order to that effect on August 3, 2004.^[44] Resident 5's condition was regularly checked throughout this period.^[45] By August 24, 2004, Dr. Subramanian assessed the wound as improved over the past few months, but Resident 5 still had signs of infection in the wound. The wound measured 5 cm by 3 cm, with undermining on both sides.^[46]

A wound therapy consultant examined Resident 5 on August 25, 2004, and discussed the possibility of cauterizing the wound. Dr. Boss agreed with the approach and the wound was cauterized on August 31, 2004. The sore measured 4 cm in diameter at that time. Dr. Boss anticipated that the procedure would need to be repeated every two weeks and that dressings would continue to be applied as previously directed.^[47]

Analysis and Argument

Long-term diabetes results in peripheral neuropathies (loss of sensation). Healing is often impaired by this condition.^[48] The Department maintains that Resident 5's diabetes was under control and therefore this condition should not have affected

Resident 5's healing. The Department did not introduce expert testimony to support this contention.

Health cited Zumbrota for failure to document Resident 5's wound size on at least a weekly basis. The Department relies upon the documentation from Resident 5's medical file to assert that the sore was demonstrating "slow gradual improvement, particularly from last December until June of this year [2004], at which time the ulcer began to show signs of signs of deterioration as evidenced by a fax to the physician dated 6-3-04 indicating greenish blue drainage coming from the ulcer and a foul smelling drainage." The Department maintains that the eleven-day period from the availability of the lab results (July 23) to the initiation of antibiotic therapy (August 3) caused harm to Resident 5.

The citation was assessed as a Level 1 on the scope scale since the deficiency affected only one resident. The deficiency was assessed as a Level 3 on the severity scale (actual harm that is not immediate jeopardy). Based on the Scope and Severity Grid, a G-level deficiency was assigned by the Department. Zumbrota appealed the F-tag, asserting that any deficiency was isolated (level 1) and should not score higher than 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, the Facility asserts that no more than a D-level deficiency is supported by the facts.

Quality of Care

Under 42 CFR 483.25(c), a facility has the obligation ensure that residents do not develop avoidable pressure sores. The federal rule requires that:

- (c) Pressure sores. Based on the comprehensive assessment of a resident, the facility must ensure that—
 - (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and
 - (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.^[49]

Resident 5 received appropriate care from the time she entered the Facility. The sore that developed was the result of her fall and was unavoidable. Resident 5 received necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. The Facility has demonstrated that the sore did not heal due to Resident 5's diabetes and her lack of compliance with the directions of her physicians and Zumbrota's nursing staff.

In spite of the Facility's efforts, Resident 5's sore became infected. This condition was not caused by any failure of treatment by Facility staff. Under the

circumstances, the infrequency of problems with Resident 5's sore over the two-year period that she has been in care is evidence of quality care.

At the review, the Department contended that failing to begin treatment with antibiotics for a period of eleven days demonstrates the severity of the deficiency. Facility nursing staff observed Resident 5 very frequently during the critical period of July-August 2004. There is no indication that antibiotics were critical to Resident 5's progress in treating her wound. The Facility's history with Resident 5's wound indicated that consistent medical treatment resulted in varying clinical results. Resident 5 had been treated with antibiotics before and not shown significant improvement related to the treatment. The condition of Resident 5's wound appeared to deteriorate after the antibiotics were started in August 2004.

The Department also maintains that there was no record of measurements of the wound ranging from June 1 to July 21, 2004.^[50] This absence of measurements is acknowledged to be a deficiency from the Facility's protocol for recording resident status. The Department asserts that failure to maintain a consistent and available record of the wound size is a deficiency that supports the imposition of a G Level deficiency.

The record in this matter shows that Resident 5 was receiving consistent, frequent observation and appropriate care by doctors and nurses who were very familiar with her condition and diligent in noting changes in the status of her chronic sore. These changes included notations of wound size, but these notations were not logged in a single location as required under the Facility's protocol. Failing to log the wound size in a single location did not affect any clinical decision to treat Resident 5's wound. Under these conditions, failure to follow the protocol for recording the size of her sore at least weekly is not a Level 3 in severity. The appropriate deficiency score is isolated (affecting only one resident) and resulting in no actual harm with the potential for more than minimal harm (Level 2).^[51] This scoring results in a D-level deficiency on the Grid and that deficiency level is supported by the record.

R.C.L.

^[1] Dept. Ex. 19A.

^[2] Dept. Ex. 3D, page 13.

^[3] Testimony of Dr. Boss, Tape 1.

^[4] *Id.* Dr. Boss attributed the speed of the sore's development to Resident 5's taking Coumadin, a blood thinner.

^[5] Dept. Ex. 4; Testimony of Martinson, Tape 1.

^[6] Facility Ex. D, at 1. The note was written on October 8, 2003, describing the condition of the wound in October 2002.

^[7] Facility Ex. G.

^[8] Facility Ex. G.

^[9] Dept. Ex. 15.

^[10] *Id.*

- [11] *Id.*
- [12] Facility Ex. A, at 6.
- [13] *Id.*
- [14] Facility Ex. A, at 7.
- [15] *Id.*
- [16] *Id.*, at 8.
- [17] Dept. Ex. 16A; Facility Ex. A, at 10.
- [18] *Id.*
- [19] *Id.*
- [20] *Id.*
- [21] Dept. Ex. 16B; Facility Ex. A, at 10.
- [22] *Id.*
- [23] Dept. Ex. 17.
- [24] Facility Ex. A, at 11.
- [25] Facility Ex. A, at 13.
- [26] Dept. Ex. 18A.
- [27] *Id.*
- [28] Facility Ex. A, at 15. A dime is slightly less than 2 cm in diameter.
- [29] *Id.*
- [30] Facility Ex. A, at 17.
- [31] Dept. Ex. 7.
- [32] Facility Ex. A, at 17.
- [33] Facility Ex. A, at 18.
- [34] Dept. Ex. 8B.
- [35] Dept. Ex. 8.
- [36] Testimony of Dr. Boss, Tape 1.
- [37] *Id.*
- [38] Dept. Ex. 9.
- [39] Facility Ex. C, at 23.
- [40] *Id.*
- [41] Facility Ex. F, at 11. The source of this information is not listed and no witness testified as to the accuracy of the document. Zumbrot's Director of Nursing testified that the notation was not an accurate measurement.
- [42] Facility Ex. C, at 24. Without a more complete description of the information as a record maintained by the Facility indicating the "10 cm by 7.5 cm" and "8 cm deep" notation, the document suffers from foundation and hearsay defects and should be given little, if any, weight.
- [43] Facility Ex. 3, at 25.
- [44] Dept. Exs. 10 and 12.
- [45] Facility Ex. C, at 25-30.
- [46] Facility Ex. D, at 11.
- [47] *Id.*, at 12.
- [48] Testimony of Dr. Boss, Tape 1.
- [49] 42 CFR 483.25(c).
- [50] Testimony of Mary Zabel, Tape 2.
- [51] See Department Ex. 19C.