

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

In the Matter of Providence Place -
Survey Date September 21, 2004

RECOMMENDED DECISION

The above-entitled matter was the subject of an informal independent dispute resolution (IIDR) meeting conducted by Administrative Law Judge Richard C. Luis on Thursday, December 9, 2004, beginning at 9:30 a.m., at the Office of Administrative Hearings. The meeting concluded on that date. The review record was closed at the conclusion of the meeting on December 9, 2004.

Samuel D. Orbovich, Esq., Orbovich & Gartner, Chartered, 408 Saint Peter Street, Suite 417, Saint Paul, MN 55102-1187, represented Providence Place (Providence or Facility). Appearing at the meeting for the Department of Health (Department or Health) were Arnie Rosenthal, Director of the Office of Health Facility Complaints (OHFC), Sue Jackson, Assistant Director of OHFC, and Mary Cahill, Planner Principal for the Department of Health (Department), 85 East 7th Place, Saint Paul, MN 55101. Also appearing at the meeting were Gail Sheridan, Vice President of Tealwood Management Co., Muniat Alaka, Director of Nursing at Providence, Lisa Quiggle, L.P.N., and Holly Horrisberger, occupational therapist at Providence.

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 F225 is not supported by the facts and should be dismissed.
2. That the citation for deficiency number F323 is not supported by the facts and should be dismissed.

Dated: December 20, 2004

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

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

MEMORANDUM

OHFC conducted an abbreviated survey of Providence on September 21, 2004. Based on this survey, OHFC issued a Statement of Deficiencies identifying staff mistreatment of a resident as a violation and a failure to protect a resident from accident hazards as another violation. One deficiency (Tag F225) was assigned a scope level of isolated and severity level of potential for more than minimal harm (Level "D"). The other deficiency (Tag F323) was assigned a scope level of isolated and severity level of actual harm (Level "G").¹ The Facility appealed the deficiencies.

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.

F225

Resident 1 suffers from schizophrenia and Parkinson's Disease and she can be combative in her dealings with other residents and staff.² Resident 1 was at breakfast

¹ OHFC Ex. A.

² OHFC Ex. B.

in the communal dining area in one unit (2 South) of Providence in late April or May.³ While at breakfast, Resident 1 was loud and argumentative with other residents. Employee M was passing medications to 2 South residents as they finished their breakfast meal on that day. Employee M approached Resident 1 and spoke to her in order to calm Resident 1, before the other residents became agitated.⁴ Resident 1 threw milk at Employee M, which landed on Employee M's smock and pants. Employee M was not angered or agitated by this conduct. She returned to the medicine cart and retrieved Resident 1's morning medications and a glass of water. Employee M placed the pills in Resident 1's mouth and was guiding the water cup to Resident 1's mouth. Both Employee M and Resident 1 were holding the water cup. As the cup approached her mouth, Resident 1 began pushing the water cup away, then Resident 1 suddenly let go of the cup.⁵ With the sudden absence of resistance, the cup of water splashed toward Resident 1, landing on her face and bib. Resident 1 was not agitated by this splash of water and took her medications without complaint.⁶

Other staffers were present in the dining area in South 2 that morning. These staffers were working at the food service counter, located behind Employee M when she was passing medications to Resident 1.⁷ None of these staffers witnessed the milk being splashed on Employee M.⁸ No written report of the incident was prepared. Employee M believed that Resident 1 experienced no harm from the incident and that the splashing of water was an unavoidable consequence of Resident 1's actions.

In August 2004, Employee A, one of the staffers on 2 South, was transferred due to personal conflicts with other staff members. Around this time, a Nursing Assistant (Employee C) was reprimanded by Employee M over personal use of the telephone at the nursing station on 2 South. On August 6, 2004, in the course of investigating a complaint against the transferred staffer, Employee A indicated that she would retaliate against those who had complained about her conduct.⁹ On August 11, 2004, an anonymous written complaint over the splashing incident was slid under the door of the Facility's Director of Human Resources. On August 15, 2004, Employee A filed a report as a mandatory reporter indicating that she had heard from an unnamed employee that Employee M had thrown water on a resident. Employee A had not been present in the dining area when the splashing incident occurred, but her report included the names of persons thought to have witnessed the incident.

On August 16, 2004, the Director of Nursing (DON) at Providence began investigating the allegation of Employee M splashing water on Resident 1. As part of the investigation, the DON interviewed staff members who were in the 2 South dining area. Of the four staffers interviewed (other than Employee M), two did not see Resident 1's arms. Two staffers saw Resident 1 moving her arms in relation to the

³ OHFC Ex. A.

⁴ Facility Ex. A, at 2.

⁵ *Id.* at 3.

⁶ *Id.*

⁷ Facility Ex. A, at 3.

⁸ One staffer (Employee E) claimed to have seen Resident 1 and Employee M "struggling over a glass of either milk or juice." OHFC Ex. B. This struggle was identified as occurring prior to picking up the water cup that was involved in the splashing incident. No such struggle occurred.

⁹ OHFC Ex. B, Anecdotal Notes.

water glass. Employee C described the incident as Employee M having “picked up a glass and ‘dashed water’ on [Resident 1].”¹⁰

In assessing the allegation, the DON considered Employee M’s history of no prior abuse complaints, the documented work conflicts between staffers, and the staff descriptions of the incident. The DON concluded that the splashing of water was unintentional. To ensure compliance with future reporting obligations, the DON required all involved employees to review the Facility Vulnerable Adult Policy. All 2 South employees were required to take a refresher course on vulnerable adult policies and procedures. Also, Resident 1’s behavioral plan of care was reviewed with 2 South staff.¹¹

Surveyors investigated the incident as part of their September 21, 2004 survey. They were told by a staffer (Employee D) that she informed a Dietary Supervisor (Employee N) of the incident. The surveyors were told that Employee N had informed the Dietary Manager (Employee J) of the incident. Employees D and N said that Employee J had interviewed them and that Employee J told them that the incident would be reported to the Director of Human Resources (Employee K). No dates were provided for any of these claims of having reported the incident. The substance of that claimed reporting was not provided to the surveyors.¹² Employee K denied that anyone had formally or informally reported the splashing incident. Employee K told the surveyors that the first report of the incident was the anonymous complaint slid under the door on August 11, 2004.

In addition to the employee interviews, the surveyors considered a reprimand that Employee M had received in January 2003 for speaking in an unprofessional manner to a fellow employee as supporting the conclusion that Employee M intentionally splashed water on Resident 1.¹³ OHFC concluded that a deficiency occurred, citing 42 CFR § 483.13(c)(1)(ii).¹⁴ The deficiency was determined to be isolated with no actual harm resulting, but with the potential for more than minimal harm. That determination resulted in the assignment of level D to the deficiency.

Nursing homes are required to comply with the standards of resident behavior and facility practices set out in 42 CFR § 483.13, which states:

Sec. 483.13 Resident behavior and facility practices.

- (a) Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

¹⁰ Facility Ex. B, at 7.

¹¹ Facility Ex. B, at 7.

¹² The substance of the reporting would include, for example, whether any written report was made, when the report was made, and how the incident was described (potential abuse or mere accident).

¹³ OHFC Ex. C. This reliance is unwarranted. An emotional exchange with a coworker is completely different from a caregiver’s interactions with an impaired resident. In addition, the reprimand was for conduct occurring over a year prior to the splashing incident. There is no nexus in conduct or time to connect the reprimand to the splashing incident.

¹⁴ OHFC Ex. A.

(b) Abuse. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

(c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (1) The facility must—

(i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

(ii) Not employ individuals who have been-- (A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or (B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and

(iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

(2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

There is no assertion that an accidental spill of water on a resident under the circumstances described by Employee M constitutes a reportable incidence of abuse. OHFC relies entirely on the perceptions of other staffers that Employee M intentionally threw water onto Resident 1 in asserting that abuse occurred and that such abuse was not reported or investigated in a timely fashion. Where an incident is minor and is not abuse (such as the water splash incident), there is nothing to report, and therefore nothing to investigate. The absence of an immediate investigation where the incident is not apparently abuse (and not reported) is not a violation of 42 CFR 483.13.

OHFC asserts that there was evidence of a faulty reporting system at the Facility, citing interviews with Employees D, N, and J in support of that contention. The ALJ does not find the information passed to the surveyors by these employees to be credible.¹⁵ There was no documentation generated of any complaint being reported to the Dietary Manager (Employee J) and no documentation of a report being passed up to the Director of Human Resources (Employee K). The reporting policy of the Facility requires that the Administrator and Director of Nursing be immediately informed of any complaint of abuse.¹⁶ The policy also requires a written report be prepared within five days.¹⁷ Had the incident occurred as the allegation of abuse contends, there would likely have been ample reports from staffers and residents alike.

The timing of the complaint and the filing of the complaint directly with the Director of Human Resources are consistent with a motivation of retaliation rather than a good faith concern about resident care. The prompt investigation by the Facility when a complaint was filed suggests that Facility employees knew that allegations of abuse were not ignored. Since the incident was not reported at the time, one can infer that staff believed the incident to be accidental when it occurred. The incident was reported, months later, as an instance of abuse in retaliation for a dispute with a coworker.

When the Director of Human Resources at Providence received a report alleging misconduct, an investigation was initiated. This occurred even though the date of the alleged misconduct was long past and the alleged misconduct was not substantial. The Facility used appropriate investigation and decision-making to conclude that: 1) Resident 1 had water splashed on her; 2) the incident was an accident, and; 3) that Resident 1 had not been harmed by the accident. The Facility addressed any lingering concerns regarding appropriate care for residents and the importance of timely reporting of incidents by requiring staff to take a vulnerable adult course and review Facility vulnerable adult policies.

Tag F225 cited 42 CFR 483.13(c)(1)(ii) as the deficient practice regarding the splashing incident. That provision prohibits the Facility from employing as a staff member someone who has been found guilty of abuse or who is listed on the registry as having committed abuse. Employee M has not been found guilty of abuse and is not listed on the registry as someone prohibited from working in the nursing home setting. No deficiency has been demonstrated by OHFC with regard to Tag F225.

F323

Resident 2 lacks the physical ability to travel without assistance. Transferring Resident 2 from her wheelchair to her bed requires the assistance of two staffers and

¹⁵ The information reported to the surveyors from Employees D, N, and J, if true, would necessarily mean that four Facility employees, including one supervisor, one manager, and the Director of Human Resources failed to follow the Facility's abuse reporting policy. The ALJ considers the "reporting" referred to by those employees to have been mentioning that an accident had occurred regarding water being spilled. In such a context, there would not have been an abuse report or subsequent investigation. In such a context, the Director of Human Resources could not be expected to remember that a report of an accidental spill of water had been previously mentioned by staff.

¹⁶ Facility Ex. D, at 000268.

¹⁷ *Id.* at 000269.

use of a mechanical lift (Hoyer lift). Resident 2 did not have any medical order that would authorize the use of restraints when in her wheelchair. Resident 2 had no history of falls from her wheelchair.

The Facility's physical therapist directed that a laptray be attached to Resident 2's wheelchair. The reason for the laptray was to assist with Resident 2's posture. The normal attachment of a laptray is to slide it on and fasten it using the mechanism in front. That mechanism allows the occupant of the wheelchair to remove the laptray. The laptray release mechanism does not require significant strength to use. Where the laptray is used as a restraint, straps are threaded through attachments to the wheelchair and clasped together behind the seat of the wheelchair. In that arrangement, a resident occupying the wheelchair cannot reach the clasps to unfasten the straps or remove the tray. In May 2004, Resident 2's physical therapist directed that the laptray straps be removed from the device, since there was no basis for using restraints on Resident 2 and the attaching screws posed a risk of skin injury.¹⁸

On August 4, 2004, Resident 2 had returned to her room after dinner. As part of her evening routine Resident 2 was wheeled into a position in her room facing the window. Staff began preparing for additional evening cares and awaiting the Hoyer lift to transfer Resident 2 from her wheelchair to her bed. Resident 2 fell forward, dislodging her laptray. She suffered a laceration to her forehead and a knee injury. Staff responded immediately to obtain medical care for Resident 2.

OHFC conducted interviews with staff regarding the August 4, 2004 incident. Several staff members indicated that the equipment was incapable of being secured due to a missing clasp on the laptray straps.¹⁹ OHFC indicated at the hearing that the missing clasp was the only basis for finding a deficiency.²⁰ The deficiency was scored as having a scope of isolated and a scale of actual harm to a resident that is not immediate jeopardy. With that scoring, the F323 deficiency was assigned a level of G.

The standard of treatment of residents regarding the use of restraints is set out in 42 CFR § 483.13(a), which states in pertinent part:

The resident has the right to be free from any physical ... restraints ... not required to treat the resident's medical symptoms.

There were no medical symptoms displayed by Resident 2 that required the use of restraints. No orders had been issued by any doctor or therapist that indicated restraints were to be used. Under 42 CFR § 483.13(a), Providence was prohibited from using devices that would act as restraints on Resident 2.

The Department has issued a brochure, *Safety Without Restraint*, to describe appropriate uses of and restrictions on the use of restraints for residents of nursing homes.²¹ Using a laptray that could not be removed by Resident 2 would constitute the

¹⁸ Facility Ex. G.

¹⁹ OHFC Ex. A.

²⁰ Rosenthal Testimony, Tape 1.

²¹ Facility Ex. H.

use of a restraint. Use of a restraint that was not ordered for medical reasons would be a deficiency. The Department brochure indicates that the appropriate avoidance of restraints entails risk to residents of injuries from fall and that such risk cannot entirely be avoided.²²

OHFC interviewed Resident 2's physical therapist as part of their survey. The physical therapist indicated that the lap tray was used solely to improve Resident 2's posture. The lap tray was not intended for use as a restraint.²³ OHFC did not consider that fastening the straps on the laptray would have had transformed the laptray into a restraint.²⁴ OHFC did not consider whether the use of a restraint was prohibited regarding Resident 2 before issuing a statement of deficiency.

OHFC's finding of a deficiency for not using a restraint that lacks a medical justification places the Facility in a "Catch-22." One standard would be violated if the restraint is used and another standard would be violated if the restraint is not used. Since no medical order existed to justify use of a restraint, there is only one governing standard and that standard **requires** that no restraint be used. The Facility met that standard by not threading the laptray straps behind Resident 2's seat. The condition of the clasp was irrelevant to Resident 2's fall and does not support the finding of a deficiency.

R.C.L.

²² *Id.* at 7.

²³ Horrisberger Testimony, Tape 1.

²⁴ Rosenthal Testimony, Tape 2.