

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

In the Matter of Benedictine Health  
Center of Minneapolis  
Survey Date: July 1, 2005

**RECOMMENDED DECISION**

The above matter was the subject of an informal dispute resolution meeting conducted by Administrative Law Judge Kathleen D. Sheehy on December 14, 2005, at 9:30 a.m. at the Office of Administrative Hearings. The meeting concluded on that date.

Marci Martinson, Unit Supervisor, Division of Facility and Provider Compliance (DFPC), 1645 Energy Park Drive, Suite 300, St. Paul, MN 55108-2970, appeared on behalf of DFPC. Mary Cahill also attended the meeting for the Department of Health.

Susan M. Schaffer, Esq., Orbovich & Gartner, 408 St. Peter Street, Suite 417, St. Paul, MN 55102, appeared on behalf of the Benedictine Health Center (the facility). The following persons made comments on behalf of the facility: Barbara Hylle, Director of Nursing; Dave Brennan, Administrator; John Mielke, MD, Medical Director, and Terry Brooks, Dietician Supervisor with Aviands.

**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.

**FINDINGS OF FACT**

1. Benedictine Health Center is a skilled nursing facility with 120 beds located just outside downtown Minneapolis. It is a nonprofit corporation owned by the Benedictine Sisters of Duluth for the purpose of providing care for the poor and powerless. Its population is different than other nursing homes in that half its residents are male, more than half are under 64 years of age, and 32% have psychiatric diagnoses. The costs of care for 82% of the residents are funded by

Medicaid. Approximately 75% of the residents are placed there by Hennepin County Medical Center. Typically there is a low level of involvement by family in the care of residents, but high involvement by conservators.<sup>1</sup>

### **Tag F 223**

2. Facilities are not permitted to use involuntary seclusion. Involuntary seclusion is defined in the State Operations Manual as separation of a resident from other residents or confinement to his or her room against the resident's will, or the will or the resident's legal representative.<sup>2</sup> DPFC found the facility in violation of this requirement with regard to Resident #19.

3. Resident #19 is a 65-year-old woman with medical diagnoses of paranoid schizophrenia and narcissistic personality disorder, chronic obstructive pulmonary disease, coronary artery disease, asthma, lung cancer, and osteoporosis. She has been committed to the custody of the Hennepin County Medical Center and the Commissioner of Human Services and was admitted to the facility on provisional discharge in December 2000. She has a 30-year history of mental health commitments to state treatment facilities and the Hennepin County Medical Center.<sup>3</sup>

4. Resident #19 has a substantial disorder of thought and mood that grossly impairs her judgment, behavior, and capacity to recognize reality. She is seen every two weeks by a nurse from Hennepin County Medical Center, who administers neuroleptic medication. She also has a county case manager and a professional conservator. She is difficult to manage, even with medications, and remains delusional, paranoid, irritable, and labile. She is loud, vulgar, and uncooperative at the facility. She has threatened staff and residents at the facility.<sup>4</sup> Her mobility is impaired due to multiple fractures and contractures, and she uses a wheelchair to wheel herself throughout the facility.<sup>5</sup>

5. Despite her complex medical and behavioral problems, Resident #19 has done well at the facility since her placement there in December 2000. She has had no psychiatric hospitalizations since then. Her conservator has weekly telephone contact with the resident and regular contact with the facility.<sup>6</sup> The resident is allowed full access to the facility's social environment.

6. The resident's care plan contains many interventions aimed at dealing with her behavior. If she resists care or medications, the plan provides that caretakers will use a calm, firm approach; offer rewards for cooperation; notify a physician if she refuses medications; and send her to the crisis center if she is refusing medications or causing behavior problems or health risks. Staff members are instructed to explain cares ahead of time.<sup>7</sup> To encourage her to

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<sup>1</sup> Comments by Dave Brennan.

<sup>2</sup> 42 C.F.R. § 483.13(b) & (c)(1)(i).

<sup>3</sup> Resident #19, Bates 13.

<sup>4</sup> Resident #19, Bates 1-3.

<sup>5</sup> Resident # 19, Bates 24.

<sup>6</sup> Resident #19, Bates 44-48; social worker notes.

<sup>7</sup> Resident #19, Bates 17, 21.

attend meals, staff members are to allow her to sit where she chooses and to redirect her if she becomes verbally abusive. The resident is permitted to select her own clothing, and staff members are instructed to provide compliments and to explain in advance what they plan to do.<sup>8</sup>

7. With regard to managing disruptive behaviors, the care plan provides the resident is to have a private room; she is to sleep until she wants to get up; and her conservator is to be updated on all behaviors. It also provides for a “time-out” when her behavior has been disruptive.<sup>9</sup> Time-outs are implemented by nursing staff and involve bringing the resident back to her room from wherever she has been disruptive and transferring her to a regular chair; because of her immobility, she is unable to move from the chair until transferred back to her wheelchair. These time-outs may last up to an hour, or until the resident calms down, and have occurred between five and ten times per year for the duration of her stay at the facility. The resident’s conservator is aware of this plan and the use of time-outs and believes them to be the best and least restrictive way to de-escalate the resident’s behavior.<sup>10</sup> The resident’s personal physician credits the facility’s behavior plan with allowing the resident a great deal of personal freedom and successfully keeping her out of a locked mental institution.<sup>11</sup>

8. Surveyors interviewed the resident on July 1, 2005, at which time the resident expressed her dislike of the timeouts. The surveyor contacted the resident’s conservator on July 6, 2005. In this conversation the conservator told the surveyor that she was aware of the program and had given verbal consent to have time outs in the resident’s room. The conservator also stated that she did not believe other interventions would work for this resident because of her mental illness.<sup>12</sup>

9. Form 2567 describes the care plan and the interview with the resident but fails to include the fact that the surveyor had spoken to the conservator and learned that the conservator had consented to the use of these time-outs as part of the behavior management strategy used by the facility.<sup>13</sup> DFPC staff agreed that there is no legal requirement that the conservator’s consent be in writing.<sup>14</sup>

## **Tag F 250**

10. Facilities are required to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<sup>15</sup> DFPC found the facility had failed to provide social service assistance to seven residents, including Resident #19. In this IIDR, the

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<sup>8</sup> Resident #19, Bates 26, 34.

<sup>9</sup> Resident #19, Bates 20.

<sup>10</sup> Resident #19, Bates 42.

<sup>11</sup> Resident # 19Bates 61.

<sup>12</sup> Resident #19, Bates 103.

<sup>13</sup> Form 2567.

<sup>14</sup> Comment of Marci Martinson.

<sup>15</sup> 42 C.F.R. § 483.15(g).

facility does not seek a change in the citation for any resident other than Resident #19.

11. With regard to that resident, Form 2567 provides that the resident “had a restrictive behavior program of time out in her room that had not been assessed or developed to determined [sic] to meet her psychosocial needs. The social worker had not advocated for the resident to have a less restrictive program to deal with her behavioral outbursts.” For the same reasons found to justify Tag F 224 above, DFPC found the facility in violation of F 250.

### **Tag F 276**

12. A facility must assess a resident using a quarterly review instrument specified by the state and approved by CMS not less frequently than every three months.<sup>16</sup> DPFC found the facility to be in violation of this requirement with respect to Resident #19 and Resident #3.

13. With regard to Resident #19, the facility monitors the resident’s target behaviors on every shift of every day. The number of times she strikes out at staff, the number of times she refuses medications, incidents of verbal abuse, frequency of repeating herself, number of meals refused, and refusal of assistance with activities of daily living are tracked by staff each shift per day.<sup>17</sup>

14. The facility used the behavioral data collected each day to complete quarterly Minimum Data Set (MDS) assessments on the resident on June 1, 2004; August 31, 2004; November 30, 2004; February 22, 2005; and May 24, 2005.<sup>18</sup>

15. Although Form 2567 explicitly refers to the most recent quarterly assessment of the resident, DPFC concluded that the facility was in violation of the assessment requirement because “no behavioral assessments [were] completed to [determine] whether time outs were the most effective and least restrictive method to deal with her outbursts or whether other interventions would be more appropriate.”

16. With regard to Resident #3, the facility completed quarterly MDS assessments on October 20, 2004, a significant change MDS on October 26, 2004, quarterly assessment on January 25, 2005 and April 25, 2005.<sup>19</sup>

17. Form 2567 alleges that Resident #3’s noncompliance and behaviors related to repositioning and history of skin breakdown “were not reassessed at the time of a 4/25/05 quarterly Minimum Data Set (MDS), even though the MDS identified the resident as having one stage 2 pressure ulcer, as resisting cares on a daily basis and that behaviors were not easily altered.” The

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<sup>16</sup> 42 C.F.R. § 483.20(c).

<sup>17</sup> Resident #19, Bates 95-98.

<sup>18</sup> Resident #19, Bates 63-93.

<sup>19</sup> Resident #3, Bates 5-33.

findings in support of this deficiency include the facility's failure to screen for pressure sore risk using the "Braden Scale" and an alleged lack of assessment in response to the resident's resistive behaviors related to refusing and/or not wanting to get out of bed.

### **Tag F 314**

18. Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters a facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable, and that a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<sup>20</sup> A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Friction is the mechanical force exerted on skin that is dragged across any surface; shearing is the interaction of both gravity and friction against the surface of the skin. Friction and shear are not primary causes of pressure ulcers.<sup>21</sup> The DFPC found the facility in violation with regard to two patients, Resident #3 and Resident #9. The DFPC now agrees that the findings with regard to Resident #9 were moved to Tag F 312, and it has agreed to remove all references to Resident #9 from Tag F 314.

19. Resident #3 is a 43-year-old man who is morbidly obese and severely cognitively and physically impaired as the result of a left hemisphere stroke. When Resident #3 was discharged from Hennepin County Medical Center to a rehabilitation hospital in October 2003, he was comatose and had a stage 3 pressure ulcer on his buttocks. When he left the rehabilitation hospital and was admitted to the facility in December 2003, the pressure ulcer had healed.<sup>22</sup> A Braden Scale assessment at that time produced a score of 16, which put the resident at mild risk of developing a pressure sore.<sup>23</sup> His care plan provided that he was at risk for impaired skin integrity because of his immobility (right side hemiplegia) and weight. The care plan required staff to turn and reposition him every two hours.<sup>24</sup>

20. The resident is able to use a wheelchair to go to meals. Getting him into the wheelchair requires the use of a mechanical lift. Once in the wheelchair, the resident can push the chair using his left foot. He tends to lean to the right because of the weakness on his right side.<sup>25</sup> Beginning in about September 2004, the resident began developing recurrent shearing wounds in the region of the right upper thigh/lower buttock due to sliding out of the

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<sup>20</sup> 42 C.F.R. § 483.25(c).

<sup>21</sup> Interpretive guidelines.

<sup>22</sup> Resident #3, Bates 1, 3.

<sup>23</sup> Ex. M-59.

<sup>24</sup> Resident #3, Bates 88.

<sup>25</sup> Comments of Dr. Mielke.

wheelchair.<sup>26</sup> An occupational therapist recommended a custom gel cushion to relieve pressure, which was ordered and received by October 2004. In November 2004 an occupational therapist noted that the shearing may also stem from moving the resident from bed; because of the resident's size, he could not be moved without shearing occurring.<sup>27</sup> In January 2005 the resident's care plan was revised to require staff to leave his bed rails up to aid in mobility and to lower the head of the bed while doing position changes.<sup>28</sup>

21. In quarterly MDS assessments, these recurring open areas were coded as pressure sores based on the RAP directions to code open areas caused by shear in the section of the form calling for identification of any partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.<sup>29</sup> The consistent entries in the medical record cited above and the comments of the resident's attending physician, however, make clear that these recurring open areas were not lesions resulting from unrelieved pressure, but were rather the result of shearing forces.

22. In early June 2005, prior to the survey, the facility ordered a specialty pressure-reducing mattress suitable for the resident's size and an extra-large wheelchair with a deeper seating surface.<sup>30</sup>

23. During the survey on June 29, 2005, the surveyor documented that the resident was repositioned only briefly, for about one minute per side, between 5:30 p.m. and 8:00 p.m. The following morning, the resident was on his back from 7:20 a.m. to 8:35 a.m. and from 8:41 a.m. to 9:00 a.m.<sup>31</sup>

24. The deficiency was issued at the scope and severity level G, isolated, actual harm that is not immediate jeopardy.

## **Tag F 325**

25. Based on a resident's comprehensive assessment, a facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.<sup>32</sup>

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<sup>26</sup> Resident #3, Bates 83.

<sup>27</sup> Resident #3, Bates 72. By this time, the resident had experienced a significant weight gain and weighed approximately 300 lb.

<sup>28</sup> Resident #3, Bates 96. Although Form 2567 provides that the revised care plan does not state how frequently the resident was to be turned and repositioned, the document clearly provides that the resident was to be turned and repositioned every two hours. The resident was using a special mattress designed to heal and prevent pressure ulcers, but it had a 250-lb capacity. See Bates 110.

<sup>29</sup> Resident #3, Bates 5-33.

<sup>30</sup> Resident #3, Bates 104, 118-20.

<sup>31</sup> Ex. M-9a.

<sup>32</sup> 42 C.F.R. § 483.25(i)(1).

26. Resident #10 was a 65-year-old man with recurrent head and neck cancer that had required radical jaw dissection, a patent tracheotomy, chronic obstructive pulmonary disease, and a 30-year history of chronic alcohol abuse and smoking. He also had a history of refusing tube feedings. He was admitted to Fairview University Medical Center on April 27, 2005, with a fracture of the left humerus from a fall. He was severely underweight, although his actual weight is not clear. A registered dietician who assessed him in the hospital contacted the home healthcare provider that had been bringing him tube-feeding supplies; according to their records, the resident weighed 85 lb on April 25, 2005. Hospital records reflected that his admission weight was 70 lb, but the dietician questioned whether this was accurate.<sup>33</sup>

27. After an orthopedist recommended treating the fracture conservatively, the resident was admitted to the facility on May 2, 2005, at which time he weighed 90.4 lb.<sup>34</sup> Although the hospital discharge orders called for five cans per day of Ensure Plus, the dietician who assessed the resident at the facility recommended switching to Probalance five times per day.<sup>35</sup>

28. On May 7, 2005, the resident was weighed when given a bath. He weighed 90 lb.<sup>36</sup>

29. On May 9, 2005, the resident was re-admitted to Fairview University Medical Center when he pulled out his J-tube. After this was replaced, the decision was made to surgically repair his left humeral fracture because it had become unstable. He remained hospitalized until May 20, 2005, when he was readmitted to the facility.<sup>37</sup> At the time of readmission his weight was 86 lb. The dietician recommended continuing with a continuous tube-feeding regimen,<sup>38</sup> but based on his lab results recommended a slight decrease in the amount recommended by the hospital (to 35 cc per hour).<sup>39</sup>

30. On May 26, 2005, the resident was taken to the hospital and diagnosed with a right proximal humerus fracture. He was returned to the facility with a shoulder immobilizer.<sup>40</sup>

31. On June 16, 2005, the dietician recommended increasing the amount to 40 cc per hour, and facility staff called the physician for approval on June 21, 2005. The physician's nurse indicated she would call back with any

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<sup>33</sup> Resident #10, Bates 10.

<sup>34</sup> Resident #10, Bates 63.

<sup>35</sup> Resident #10, Bates 64.

<sup>36</sup> Resident #10, Bates 157.

<sup>37</sup> Resident #10, Bates 18.

<sup>38</sup> Resident #10, Bates 65, 262.

<sup>39</sup> Resident #10, Bates 68, 252.

<sup>40</sup> Resident #10, Bates 48-49.

changes to the tube feeding order.<sup>41</sup> Facility staff contacted the physician again on June 23, 2005, at which time the recommendation was approved.<sup>42</sup>

32. No weight is recorded for the resident after May 24, 2005 until June 26, 2005, when the resident weighed 82.2 lb.<sup>43</sup> On July 1, 2005, the resident weighed 80.6 lb.<sup>44</sup> The medical records reflect that the resident declined being weighed several times.<sup>45</sup>

33. On July 1, 2005, the dietician recommended increasing the resident's tube feeding rate by 5 cc to encourage weight gain. Because of the holiday weekend, this recommendation was not faxed to the physician's office for approval until July 6, 2005.<sup>46</sup>

34. On July 8, 2005, the dietician recommended an additional increase in tube feeding in bolus form. The physician approved the increase that day.<sup>47</sup> On that day, the resident weighed 83.6 lb.<sup>48</sup>

35. On July 12, 2005, the resident's physician recommended continuous feeding instead of bolus feedings to avoid weight loss due to "clumping."<sup>49</sup>

36. On July 14, 2005, the resident's weight had declined to 79 lb, likely as a result of "clumping" from the bolus feedings. On July 20, 2005, he weighed 87.7 lb. On that date, he was admitted to the hospital for coffee ground emesis. He was readmitted to the facility on July 23, 2005, and he died 13 hours later.<sup>50</sup>

37. Form 2567 inaccurately describes the series of events above and incorrectly provides that the facility failed to implement an ordered increase on June 7, 2005.

Based upon 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 with regard to F-tag 223 is not supported by the facts and should be rescinded because there was no deficient practice.

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<sup>41</sup> Resident #10, Bates 68, 255.

<sup>42</sup> Resident #10, Bates 258.

<sup>43</sup> Resident #10, Bates 205.

<sup>44</sup> Resident #10, Bates 66, 240.

<sup>45</sup> Resident #10, Bates 240, 279.

<sup>46</sup> Resident #10, Bates 69, 266.

<sup>47</sup> Resident #10, Bates 260.

<sup>48</sup> Resident #10, Bates 66, 69.

<sup>49</sup> Resident #10, Bates 70.

<sup>50</sup> Resident #10, Bates 66-67.

2. That the findings with regard to Resident #19 should be removed from F-tag 250 because there was no deficient practice with regard to this resident. The scope and severity of the citation should remain as originally issued with regard to other residents.

3. That the citation with regard to F-tag 276 is not supported by the facts and should be rescinded because there was no deficient practice. The facility completed the required quarterly MDS assessments.

4. That the citation with regard to F-tag 314 is valid because a deficient practice was accurately documented (failure to reposition the resident every two hours). The severity level, however, should be reduced from G to D because the deficient practice did not cause actual harm to the resident.

5. That the citation with regard to F-tag 325 is supported in full; however, the findings should be revised to reflect the correct sequence of events. The facility failed to adequately monitor the resident's weight between May 24, 2005 and June 26, 2005. After discovering the resident's significant weight loss, it took an excessively long time to obtain the physician's orders to increase tube feedings.

Dated this 29th day of December, 2005.

s/Kathleen D. Sheehy

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KATHLEEN D. SHEEHY

Administrative Law Judge

Reported: Tape-recorded (two tapes, no transcript)

### **MEMORANDUM**

F 223—The issue with regard to this alleged deficiency is a purely legal one. Involuntary seclusion is a form of resident abuse. The interpretive guidelines define involuntary exclusion as separation of a resident against the resident's will, or the will of the resident's legal representative. The guidelines then provide that emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs. If a resident is receiving emergency short-term separation, it is not considered involuntary seclusion as long as this is the least restrictive approach for the minimum amount of time, and is being done according to resident needs and not for staff convenience. The guidelines suggest a number of questions to be asked to determine if an emergency short-term intervention is the least restrictive

approach, and these questions provide the basis for the findings with regard to this alleged deficiency.

The practice of using time-outs was identified in the resident's care plan at the time of her admission and was agreed to by her conservator. It was not an involuntary exclusion as defined by the regulation. The analysis used to determine whether an "emergency or short-term separation" amounts to an involuntary seclusion in violation of the regulation is not applicable when seclusion is a technique that is already in the care plan and has been agreed to by the resident or the resident's legal representative. All of the alleged deficiencies in the care plan identified by DFPC—the lack of specificity as to time, the lack of analysis of behavioral triggers, the alleged lack of documentation to demonstrate that this is the least restrictive approach—would be relevant if the conservator had failed to provide consent to this technique, and if the facility were defending the practice as an emergency or short-term monitored separation used until an appropriate care plan could be developed. The DFPC's position—that consent is irrelevant unless the facility has performed a complete functional behavioral assessment documenting that seclusion is the least restrictive approach—is inconsistent with the language of the regulation and the guidelines. Even if DFPC were interpreting the guideline correctly as a legal matter, the record here would support a finding that these infrequently used time-outs are the least restrictive approach to managing this resident's behaviors given her history of much more restrictive placements and her severe mental illness.

If there was a deficiency here, it was that the care plan was not sufficiently specific in describing the circumstances in which time outs would be used, the length of a time out, how the use of this procedure was to be tracked, or how the resident was to be monitored during a time out. This may be a violation of 42 U.S.C. § 483.20(k) (concerning care plan requirements), but there was no abuse of this resident through use of involuntary seclusion.

F250—The resident was undisputedly doing well based on the care plan in place. Based upon the agreement of the conservator and the infrequency with which this practice was used, the record does not demonstrate that additional social services were required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of this resident.

F276—The regulation requires that a facility perform a *comprehensive* assessment within 14 calendar days of admission; within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's condition; or not less than once every 12 months. A *quarterly review* assessment must be performed once every three months. The purpose of the quarterly review assessment is to track the resident's status between comprehensive assessments, and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status.<sup>51</sup> Guidelines

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<sup>51</sup> Ex. J-6.

developed by CMS provide that an assessment is “[t]aking stock of all observations, information and knowledge about a resident; understanding the resident’s limitations and strengths; finding out who the resident is.”<sup>52</sup> CMS has always accepted the MDS as a primary data source and has not required duplicative documentation; completion of the MDS, however, does not remove the facility’s responsibility to document a more detailed assessment of particular issues of relevance for the resident.<sup>53</sup>

Although the facility was cited for failure to assess using the quarterly review instrument specified by the state, the record is clear the facility performed the required quarterly assessments in a timely manner. What the DPFC has found to be deficient is the failure to do some type of clinical assessment at the time the MDS was completed; for Resident 19, some kind of functional behavioral assessment to determine whether time outs were the least restrictive approach to managing behavioral outbursts, and for Resident #3, a Braden Scale assessment of risk for pressure sores. The guidelines submitted by the DPFC confirm that the regulation does not mandate any specific assessment tool.<sup>54</sup> In addition, the guidelines make clear, for example, that it is a matter of clinical judgment how frequently to use a standardized pressure ulcer risk assessment tool to assess a resident’s risk.<sup>55</sup>

Here, the facility completed the quarterly assessments as required by the regulation. There is no claim that the quarterly assessment did not accurately reflect the residents’ clinical condition, and the facility was not cited for failing to perform a comprehensive assessment, failing to determine that a significant change had occurred in the resident’s condition, failing to revise or update the care plan as necessary, or failing to provide any necessary care or services.<sup>56</sup> If the failure to perform a particular type of assessment fails to meet a professional standard of care, then it should be cited as such; however, the facility should not be cited for failing to provide quarterly documentation that it did in fact provide.

F 314—Because of the consistency with which this was documented in the resident’s medical record from September 2004 through June 2005, the Administrative Law Judge has accepted the facility’s position that the recurring open spots on the resident’s right upper thigh were due to shearing and were not pressure ulcers. Although a deficient practice was observed (the failure to effectively reposition the resident every two hours), this practice did not cause actual harm to the resident. The severity level should be reduced to D, no actual harm with potential for more than minimal harm that is not immediate jeopardy.

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<sup>52</sup> Ex. J-1.

<sup>53</sup> Ex. J-5.

<sup>54</sup> Ex. K-8.

<sup>55</sup> Ex. K-8 (many clinicians recommend use of a standardized pressure ulcer risk assessment tool to assess a resident’s risk upon admission, weekly for the first four weeks, “then quarterly, or whenever there is a change in cognition or functional ability.”).

<sup>56</sup> A Braden Scale assessment of Resident #3 performed just after the survey had results similar to the first one, indicating there was no need to revise the care plan at that time.

F 325—Although the findings in Form 2567 are inaccurate, the corrected record would support the citation. The resident was receiving nutrition adequate to meet his estimated needs, but he was still losing weight, and the facility was not aware of the weight loss for more than one month. Although the record is clear that the resident's significant weight loss was due in large part to his complicated medical condition, surgeries, intestinal infection, and other factors, and that the weight loss cannot be entirely attributed to a lack of nutrition, the Administrative Law Judge is convinced after a careful review of the record that some portion of it was due to the facility's failure to more carefully monitor his weight and to determine in a timely fashion why it was happening. This is sufficient to support the scope and severity at which the deficiency was issued—G, isolated, actual harm that is not immediate jeopardy.

K.D.S.