

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

In the Matter of Rose of Sharon Manor,
Survey Exit Date: April 12, 2006

RECOMMENDED DECISION

The above matter was the subject of an independent informal dispute resolution (IIDR) meeting conducted by Administrative Law Judge Steve M. Mihalchick on July 24, 2006, at 9:30 a.m. at the Office of Administrative Hearings. The OAH record closed at the conclusion of the meeting on July 24, 2006.

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, Planner Principal of the Division of Compliance Monitoring, also attended the meeting.

Michelle R. Klegon, Voigt, Klegon & Rode, LLC, 2550 University Avenue West, Suite 190 South, St. Paul, MN 55114, appeared on behalf of Rose of Sharon Manor (the facility). The following persons made comments on behalf of the facility: Jennifer Francis, Assistant Director of Nursing Services; Keith Lovaas, physical therapy assistant; and Christina Francis, facility cook.

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. Rose of Sharon Manor is an 85-bed nursing home facility located in Roseville, Minnesota.
2. Resident #1 is an 82-year-old male who was admitted to the facility on or about September 7, 2005. The Resident suffered from cognitive

impairment, depression, and suicidal ideation.¹ The Resident came to the facility from the hospital where he had been after falling at home and sustaining a head injury on August 30, 2005.

3. Daily activity notes from September 11-13 show that the Resident needed little or no assistance with bed mobility and transfers to and from bed, wheelchair, and standing position.² The notes also indicated that the Resident was agitated, confused, and prone to wandering.

4. The Resident was discharged from the facility to the hospital on or about September 14, 2005, to have his psychotropic medications re-evaluated.

5. On September 15, 2005, the Resident's physician conducted an examination and medical history on the Resident. The physician noted that the Resident's gait and balance were unsteady and that he was at a high risk of falling.³ His assessment and treatment plan stated that his symptoms would have to be managed in reverse order, with delirium first and depression second. One of the last items on the Resident's treatment plan stated that there should be a physical therapy consultation and treatment requested for his gait and balance problems.⁴

6. On September 20, 2005, the facility staff completed a minimum data set for the Resident, in which they noted that the Resident was largely independent in bed mobility, transfers, walking in his room and the hallways, and general movement on the unit floor.⁵ The minimum data set also indicated that the Resident had been observed wandering around the unit floor and that it was difficult to alter his behavior. As for balancing, the Resident was steady while sitting and unsteady while standing.

7. Upon the Resident's discharge from the hospital back to the facility on October 4, 2005, the Resident's patient care admitting orders indicated that the facility should use fall precautions with him. The orders further indicated that the Resident required the assistance of one person to ambulate and stand.⁶ Physical therapy notes from the hospital indicated that the Resident needed contact guard assistance and was receiving stand by assistance and the use of a rolling walker. He was also on multiple psychotropic medications for agitation, which increased his risk of falling. On that same day, the facility's physician encountered the Resident in the hallway of the facility walking unassisted with an unsteady gait.⁷

¹ Exhibit H-4.

² Ex. N.

³ Exs. H-4 through H-7.

⁴ Exs. H-6 and H-7.

⁵ Ex. L.

⁶ Exs. H-2 and H-3.

⁷ Ex. H-39.

8. Upon readmission on October 4, 2005, the facility conducted a Berg Balance Test⁸ on the Resident and concluded that the Resident was able to stand without using his hands and stabilize himself independently, sit for two minutes under supervision, sit safely with minimal use of his hands, and transfer himself safely with the definite use of his hands.⁹ The Resident scored 33 out of a possible 56 points, placing him at a high risk for falls. The testing did not assess how far the Resident could reach or lean forward without losing his balance while sitting in a chair.

9. The following day, the facility completed a fall prevention and management plan of care, which included keeping the call light in reach of the Resident while he was in bed.¹⁰ The care plan did not address whether the Resident needed supervision while sitting or standing.

10. Nursing notes from October 4-6 indicated that the Resident was independent with walking and toileting, did not identify him as a fall risk, and did not include any interventions to reduce his risk of falling.¹¹

11. On the evening of October 5, 2005, a facility staff person found the Resident on the floor of his room. He was not able to say what had happened. The Resident did not sustain any injuries.¹² Based upon that fall, on October 7, the facility instituted the use of a bed alarm and placed a mat on the floor by his bed.¹³ None of the interventions addressed the Resident's risk of fall while sitting or walking.

12. On the evening of October 7, 2005, the Resident fell forward out of his chair in the dining room and sustained cuts to his forehead and nose.¹⁴ The Resident was sent to the hospital emergency room and admitted to the hospital with a non-displaced neck fracture and a closed head injury. The cut to his forehead was sutured in the emergency room.¹⁵

13. The Resident developed pneumonia while hospitalized and died in the early-morning of October 9, 2005. The cause of death was listed as pneumonia with contributing conditions of a subdural hematoma¹⁶ and dementia.

14. Shortly thereafter, the facility came under investigation by the DFPC based upon a complaint by the Resident's family. The facility site visit occurred on April 12, 2006. On April 27, 2006, the DFPC issued a Statement of Deficiencies to the facility, finding that the facility failed to supervise or assist the Resident to prevent accidents, resulting in a violation that was isolated and

⁸ The Berg Balance Test is an objective assessment tool used to assist in evaluating a resident's functional mobility, balance, and ability to perform common daily living tasks safely.

⁹ Ex. A.

¹⁰ Ex. B.

¹¹ Exs. H-32 through H-34.

¹² Exs. H-36 and H-42.

¹³ Ex. B.

¹⁴ Exs. H-38, H-44, and H-45.

¹⁵ Exs. I-1, I-7, I-8, and I-11.

¹⁶ The hematoma was the result of the Resident's fall at home on August 30, 2005.

caused actual harm but was not immediate jeopardy (scope and severity level G).

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

The citation with regard to F-tag 324 is supported by the facts and should be affirmed as to scope and severity.

Dated: August 8th, 2006.

/s/ Steve M. Mihalchick
STEVE M. MIHALCHICK
Administrative Law Judge

Reported: Taped, one tape
No transcript prepared

MEMORANDUM

The DFPC abbreviated standard survey completed April 12, 2006, resulted in one deficiency.

Tag F 324

The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.¹⁷ The intent of this provision is that the facility identifies each resident at risk for accidents and/or falls, and adequately plans care and implements procedures to prevent accidents.

The State Operations Manual ("SOM") defines "accident" as an unexpected, unintended event that can cause a resident bodily injury.¹⁸ If a resident has had an accident, the SOM directs surveyors to review the facility's investigation of that accident and their response to prevent the accident from recurring.

DFPC investigators consider the following questions in this type of investigation:

¹⁷ 42 C.F.R. § 483.25 (h)(2).

¹⁸ Ex. D-1.

- Is the resident assessed for being at risk for falls?
- What care-planning and implementation is the facility doing to prevent accidents and falls for those residents identified at risk?
- How did the facility fit, and monitor, the use of that resident's assistive devices?
- How were drugs that may cause postural hypotension, dizziness, or visual changes monitored?¹⁹

This deficiency is a Quality of Care deficiency. As with all Quality of Care issues, the facility is required to assess care plan interventions, implement the care plan, and then evaluate and revise the care plan as necessary. With Quality of Care concerns that occur prior to the completion of the resident's initial Minimum Data Set and initial Resident Assessment Protocols (within the first 14 days after admission), surveyors are directed to determine if the facility is conducting ongoing assessment and care planning and if appropriate care and services are being provided.²⁰

Because falls are among the most common and serious problems facing elderly persons, the Minnesota Department of Health has provided information to health care providers regarding available resources to help health care providers assess and implement interventions for individuals who have a recent history of falls or who are at risk of falls. Falling is associated with considerable mortality, morbidity, reduced functioning and premature nursing home admissions from the community. Incidence rates of falls in nursing homes and hospitals are almost three times the rates for community-dwelling persons over the age of 65.

A number of controlled studies have revealed that detecting a history of falls and performing a fall-related assessment are likely to reduce the future probability of falls when coupled with interventions.²¹ The assessment for falls needs to be individualized for each person. When providers or surveyors evaluate an assessment process, they need to consider if the process includes gathering all data, reviewing the data and then analyzing the data to develop individualized interventions. The data should be analyzed timely to prevent similar incidents from reoccurring. A history of falls is a strong predictor of future falls.²²

After the assessment process, a plan needs to be developed with interventions based on the causes derived from the individualized assessment. After an individualized plan is developed, then it must be communicated to all staff and implemented.²³

¹⁹ Ex. D-2.

²⁰ Ex. E-3.

²¹ Ex. G-1.

²² Ex. G-2.

²³ Ex. G-3.

The DFPC argues that the facility knew that the Resident was at a high risk for falls based upon his history of falls, information provided on the hospital transfer form identifying his risk of falls and needed interventions, assessments, examinations, and observations made by facility staff. Knowing what they did, the DFPC argues that the facility failed to take adequate measures to eliminate or reduce the possibility of the Resident's falling. As a result, the Resident fell again and sustained a head injury three days after he was re-admitted to the facility.

The facility argues that it did evaluate the Resident's risk of falls by administering the Berg Balance Test, which showed that the Resident could safely and independently transfer from a sitting to a standing position and back again, as well as transfer to different sitting positions independently. The facility also points to the fall prevention and management plan of care that identified goals to minimize the Resident's risk of falls and implemented interventions to meet those goals. The facility's record also demonstrates that it knew of the Resident's tendency to wander and implemented interventions to prevent that behavior.

The Administrative Law Judge concludes that the facility has not presented sufficient evidence to demonstrate that the results of the survey were incorrect. Based upon the facility's investigation record, the surveyors reasonably determined that the facility failed to supervise and assist the Resident to prevent further falling accidents.

Resident #1 returned to the facility after a two-week hospital stay. During his stay in the hospital, his medications were evaluated and changed and he was identified as having an unsteady gait. The facility was aware of this and should have immediately reassessed his fall potential and developed and implemented a plan to reduce the potential of more falls with injuries. The facility did not analyze the data related to the resident's medications and physical therapy assessments and did not plan and implement interventions to minimize the risk of falls when the resident was walking, sitting, reaching or transferring from a sitting to standing position. Accordingly, Tag F 324 should be affirmed as to scope and severity.

S. M. M.