

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

In the Matter of St. Benedict's Senior
Community:
Survey Exit Date May 25, 2006

RECOMMENDED DECISION

The above matter was the subject of an independent informal dispute resolution (IIDR) meeting conducted by Administrative Law Judge Kathleen D. Sheehy on July 26, 2006, at 9:30 a.m. at the Office of Administrative Hearings. The OAH record closed at the conclusion of the meeting on July 26, 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.

Susan M. Voigt, Esq., Voigt, Klegon & Rode, LLC, 2550 University Avenue West, Suite 190 South, St. Paul, MN 55114, appeared on behalf of St. Benedict's Senior Community (the facility). The following persons made comments on behalf of the facility: Doug Aretz, Administrator; Tom Wachlarowicc, Director of Nursing; Megan Winkelman, Clinical Nurse Manager; Renee Sorensen, Occupational Therapist; and Mark Becker, MD, Medical Director.

FINDINGS OF FACT

1. St. Benedict's Senior Community is located in St. Cloud, Minnesota. Its campus includes a nursing home with 222 beds, facilities for independent and assisted living, homes for residents with memory loss, and a sub-acute unit for short-term stays.

2. Resident #1, an 87-year-old female, has resided in the facility for 13 years. Her diagnoses include quadriplegia, hypothyroidism, primary lateral sclerosis, and osteoporosis. She also has short-term memory problems and is totally dependent on staff for all activities of daily living. Because of her history of chronic pain, she has standing orders for two pain medications: Ultram (50 mg per J-tube as needed) and morphine sulfate (5-10 mg per J-tube as needed).

Although these medications were ordered on an “as needed” basis, the resident did not request them before she experienced shoulder pain in April 2006.¹

3. Resident #1 began complaining of pain in her right shoulder on the night of April 21, 2006. Facility staff gave the resident Ultram and began monitoring the pain. On April 22, 2006, the resident received two more doses of Ultram for shoulder pain.²

4. On April 23, 2006, nursing notes reflect the resident’s shoulder was red and warm to the touch. In the early morning hours, facility staff gave the resident morphine and an ice pack, and noted good relief of pain. At about 6:00 p.m., family members requested that facility staff contact the on-call physician for an x-ray. The on-call physician ordered a portable x-ray to be taken that evening or the following morning, or in the alternative, advised sending an ambulance to take the resident to the emergency room.³

5. Family members did not want the resident transferred to the emergency room. Because such transfers were stressful to the resident, they preferred that she be treated at the facility. Facility staff then scheduled a portable x-ray to take place that night. At about 8:30 p.m. PPX took the x-ray and at 10:45 p.m. called the results to the facility. The x-ray showed a fracture of the right humeral head. Facility staff called the family and the on-call physician with the results at about 11:00 p.m., and the on-call physician advised updating the resident’s personal physician the next morning.⁴

6. The resident received morphine twice more on the evening of April 23, 2006, and two more doses on the morning of April 24, 2006. Medication administration flow sheets and nursing notes reflect that the morphine was effective in reducing her pain.⁵ At about 2:00 p.m. on April 24, 2006, when the resident was seen by a nurse practitioner employed by the resident’s personal physician, the resident reported that the shoulder had been causing pain but that she was currently comfortable.⁶

7. The nurse practitioner changed the Ultram frequency from “as needed” to every six hours for pain and ordered a shoulder immobilizer. The nurse practitioner’s orders reflect that facility staff advised the nurse practitioner that the occupational therapy department would have to evaluate the resident for the shoulder immobilizer and would review how staff was using the Hoyer lift to transfer the resident to make sure transfers were done appropriately. Immobilizers are not immediately accessible in the facility because they must be sized to fit the resident and cannot be stocked.⁷

¹ Ex. E-2.

² Ex. 2, Attachment B, at 1 and 3 of 24.

³ *Id.* at 3 of 24.

⁴ *Id.* at 1 and 3 of 24.

⁵ *Id.* at 3 of 24; Ex. 3.

⁶ Ex. 2, Attachment B, at 14 of 24.

⁷ *Id.*

8. On the evening of April 24, 2006, facility staff contacted an orthopedic surgeon to update on the resident's fracture and advised that a therapist would be working with the resident for an immobilizer. The family did not wish to remove the resident from the facility for an orthopedic consult, but wanted the resident to be treated at the facility. The family agreed with the plan of care outlined by the nurse practitioner.⁸

9. The resident was given Ultram that evening, and nursing notes indicate the pain medication was effective.⁹

10. The resident slept well and did not complain of pain that night.¹⁰

11. The occupational therapy evaluation was completed by 10:00 a.m. on April 25, 2006. The therapist reviewed the manner in which staff was transferring the resident and advised using a bath blanket or pillow during transfers to protect the shoulder. The therapist also ordered an air mattress for the resident's bed to prevent pressure sores, because the resident could not be repositioned on her right side. Facility staff ordered the shoulder immobilizer that day from a supplier in Illinois and requested delivery within 24 hours.

12. The resident did not complain of pain on April 25, 2006. She received Ultram as ordered but no morphine on that day.

13. At around midnight on April 26, 2006, the resident rated her pain at 4 out of 5 and received morphine. When she was reassessed at about 3:00 a.m., she rated the pain at 2 out of 5.¹¹ The resident denied pain for the remainder of the day.¹²

14. The shoulder immobilizer did not arrive on April 26, 2006, although it had been ordered for delivery that day.

15. At about 5:45 a.m. on April 27, 2006, the resident was given a dose of morphine. The shoulder immobilizer arrived and was fitted by 9:00 a.m. that day. The resident made no further complaints of pain until May 1, 2006, when she was given one additional dose of morphine.

16. During the course of a survey in May 2006, DFPC investigators contacted the facility's medical director, Dr. Becker. Before he had an opportunity to review the resident's medical record, they asked him how long he would expect it to take to have an immobilizer in place after he ordered it, and he responded by saying "It should be done that day." He also believed the delay in obtaining the immobilizer was significant. He was not aware that the family had refused to send the resident to the emergency room for treatment and fitting of an immobilizer. After review of the medical record, Dr. Becker spoke to the surveyors by telephone and clarified that immobilizers are not immediately available in a nursing home setting and must be ordered. He further stated that

⁸ Ex. 2, Attachment B at 4 of 24; Ex. K-2.

⁹ *Id.*

¹⁰ *Id.*

¹¹ Ex. 3.

¹² *Id.* at 5 of 24.

the delay in obtaining the immobilizer, which he incorrectly believed to be four days in length, was too long.¹³

17. DFPC found the facility's practice was deficient in that "there was a delay in obtaining the prescribed treatment [the shoulder immobilizer] which resulted in actual harm with increased pain and discomfort for the resident." The deficiency was issued at F 309, severity level G, actual harm.

18. The first finding in the 2567 provides as follows: "Resident #1 had a right humeral neck fracture in which there was a delay in obtaining the prescribed treatment which resulted in actual harm with increased pain and discomfort for the resident."

19. There was a delay in obtaining the treatment prescribed on April 24, 2006; however, the statement above that the delay resulted in actual harm "with increased pain and discomfort for the resident" is incorrect. The record reflects that the delay did not cause increased pain and discomfort for the resident. Rather, the record reflects that the resident's pain peaked on April 23, 2006, the day the fracture was diagnosed, and progressively declined after that date in response to medication changes and other recommendations regarding transfer procedures made by the nurse practitioner and occupational therapist and implemented by facility staff.

20. Use of the immobilizer was discontinued on May 24, 2006, when the resident developed a pressure sore beneath it.¹⁴

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 deficiency with regard to F-tag 309 is supported by the facts in that there was a delay in obtaining prescribed treatment; however, the findings with regard to actual harm should be deleted, and the severity level should be reduced to D level, no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

Dated: August 10, 2006.

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

Reported: Taped, one tape

¹³ Exs. G-11b, G-10b.

¹⁴ Ex. K-2.

No transcript prepared

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.

MEMORANDUM

Tag F 309

Federal law requires that “[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.”¹⁵ “Highest practicable” is defined as the highest level of functioning possible, limited only by the individual’s presenting functional status and potential for improvement or reduced rate of functional decline. The facility must ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident’s right to refuse treatment, and within the limits of recognized pathology and the normal aging process.¹⁶

The parties agree that the resident’s fracture was likely pathologic due to her history of osteoporosis and osteopenia and that the facility staff acted properly in obtaining a diagnosis of the fracture on April 23, 2006. The DFPC argues that the deficient practice was the delay in obtaining the shoulder immobilizer after it was ordered on April 24, 2006, and further argues that the delay caused increased pain and discomfort for the resident. The facility contends the family rejected the opportunity to have the immobilizer fitted more quickly when it made the decision not to send the resident to the hospital but to have the resident treated at the facility.

On April 23, 2006, the x-ray was read and the results called to the facility at about 11:00 p.m. A nurse practitioner saw the resident and ordered the shoulder immobilizer at about 2:00 p.m. on April 24, 2006. The facility communicated to the nurse practitioner, and to the family, that if the resident was to be treated at the facility, an occupational therapist would have to evaluate the resident to determine which type of immobilizer should be ordered. There is nothing in the medical record, however, to demonstrate that either the nurse practitioner or the family was aware that once the evaluation was complete the facility intended to order the immobilizer from a distant supplier or that it might

¹⁵ 42 C.F.R. § 483.25.

¹⁶ Ex. D-1.

take several days to obtain it. Under these circumstances, the family's decision to have the resident treated at the facility does not amount to either a "refusal" of faster treatment or advance acceptance of a three-day delay in treatment.

Although there was a delay in implementing the order for an immobilizer, the facility staff acted appropriately to mitigate the resident's pain through use of pain medications and other techniques for protecting the resident's shoulder during transfers. The Administrative Law Judge cannot agree that the delay in fitting the immobilizer caused actual harm to the resident.¹⁷ The medical record reflects that the resident's pain peaked on April 23, 2006, the day the fracture was diagnosed, and progressively declined after that date. On April 23, the resident had three doses of morphine; on April 24, two doses, and on this date the facility implemented the changed orders to provide the resident with Ultram every six hours; on April 25, no morphine at all; on April 26, one dose at midnight; and on April 27, one dose at 5:45 a.m.

In short, the resident went from having morphine every four to six hours on April 23-24 to about once every 30 hours on April 25-27. The resident was clearly more comfortable on April 27 than she was on April 24. In addition, even after the immobilizer was fitted, the resident requested one more dose of morphine on May 1, 2006, so use of the immobilizer did not entirely eliminate her pain. On this record the Administrative Law Judge cannot conclude that the delay in receiving the immobilizer caused increased pain or discomfort for the resident.

K.D.S.

¹⁷ The State Operations Manual defines "actual harm" as a finding of noncompliance that results in a negative outcome that has compromised the resident's ability to maintain and /or reach 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. It does not include a deficient practice that only could or has caused limited consequence to the resident.