

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

In the Matter of LaCrescent Health Care
Center – Survey Date: August 17, 2006

RECOMMENDED DECISION

The above matter was the subject of an informal dispute resolution meeting conducted by Administrative Law Judge Raymond R. Krause on Monday, October 30, 2006, beginning at 9:30 a.m., at the Office of Administrative Hearings. The meeting concluded on that date.

Marci Martinson, Unit Supervisor, Division of Compliance Monitoring, 1645 Energy Park Drive, Suite 300, St. Paul, MN 55108-2970 represented the Minnesota Department of Health (the Department). Larry J. Pupp, Executive Director, Golden Living Center of LaCrescent (formerly LaCrescent Healthcare Center), 101 Hill St., LaCrescent, MN 55943, represented LaCrescent Health Care Center. Also attending the meeting was Mary Cahill for the Department.

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

That the citation with regard to F-Tags 323, 324, and 327 be sustained.

Dated this 2nd day of November, 2006.

s/Raymond R. Krause

RAYMOND R. KRAUSE
Administrative Law Judge

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

On August 17, 2006, the Department completed a standard survey of LaCrescent Health Care Center (LaCrescent). MDH issued a Statement of Deficiencies, known as CMS Form 2567, describing deficiencies identified by "F-tags" related to violation of the requirements of participation.

In this request for Informal Dispute Resolution, LaCrescent challenges the August 17, 2006 survey findings under Minn. Stat. § 144A.10, subd.16 and submits three F-tags for determination.

Tag F323 – Accidents

Under 42 C.F.R. 483.25(h)(1), the facility must ensure that the resident environment remains as free of accident hazards as is possible.

The surveyors found a violation of 42 C.F.R. 483.25(h) and assigned a severity and scope level of "D", meaning that the deficiency is isolated, and that no actual harm occurred but that the potential exists for more than minimal harm that is not immediate jeopardy. The deficiency alleges that LaCrescent failed to provide documentation of proper safety assessment for the use of bed side rails, and that the side rails were utilized in a manner that could lead to accidents.

With regard to two residents, the surveyors found that bed side rails were being used. In neither case was a comprehensive safety assessment done to determine if bed side rails were needed or were the best and safest alternative. The survey also noted gaps between the mattress and the side rails and indicated that these gaps were violations which could cause accidental entanglement and injury. No actual entanglements or injuries were reported with regard to either resident.

LaCrescent argues that the bed side rails are described by the manufacturer as "assist rails", not side rails, and are therefore not subject to the guidelines, that the gaps between the rails and the mattresses in question fell within the FDA recommended guidelines and were therefore compliant, and finally that the clinical benefit of the narrower pressure relieving mattress and the higher level of independence afforded by the rail to Resident #2, outweigh the risk of entrapment.

LaCrescent's arguments with regard to the possible therapeutic value of the narrow mattress, the measurement of the gaps, and the need to balance a resident's personal choice and dignity with the risks to safety are very compelling. However, when no assessment has been done to determine the actual risks to these individual residents, a determination cannot be made on safety versus therapeutic value. The key point of the deficiency is that an individual assessment of the risks of side rail usage is necessary in order to make a judgment about whether the benefits outweigh the risks. Further, without the assessment, it is not possible to determine whether the side rails are the safest alternative or whether they are needed at all.

The alleged gaps between rail and mattress may or may not comply with federal guidelines but the ALJ cannot make a determination as to whether the side rails were

“an accident hazard”¹ because no safety assessment was completed for either resident cited. Use of bed side rails without a safety assessment for the individual resident is a deficiency in and of itself. It is, therefore, recommended that Tag 323 be sustained and remain at the present scope and severity determination.

Tag F324 – Accidents

The surveyors found one violation of 42 C.F.R. 483.25(h)(2), which requires that the facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. An overall severity and scope level of “D” was attached to this F-Tag.

Resident #7 was found out of position and in a potentially precarious position on her bed three times during the period from July 8, 2006 to July 31, 2006. No actual falls or injuries occurred. After the first incident, staff assessed Resident #7 as being at risk for falls and had the bed placed in the low position, placed a blue safety mat on the floor next to the bed, discussed safety with the resident, and encouraged her to leave the door open to permit better supervision.

No further assessments were made regarding safety or the need for additional supervision after either the second or third incident. The nursing notes do indicate, however, that the resident was being monitored.

LaCrescent argues that the initial safety measures were adequate and no further assessments in that regard were needed. The focus of their assessment was on finding the cause of the vertigo-like symptoms which were causing the resident to pull herself to unsafe positions in bed.

The requirement of 483.25(h)(2) is that each resident receive adequate supervision and assistance devices to prevent accidents. In this case, the initial assessment resulted in some interventions that arguably reduced the risk of an accident. However, the subsequent two instances of the resident pulling herself into unsafe positions and her refusal to leave the bed in the low position should have been a warning that further assessment was warranted. Searching for the cause of her disorientation and feelings of movement was commendable and was the proper way to get at the root cause of the accident danger. It was, however, necessary to complement that type of assessment with one that dealt with additional devices or supervisory solutions to the reoccurring dangers in which the resident placed herself. Again, it is the lack of adequate assessment of risks and the safety of possible solutions that supports this deficiency.

¹ 483.25(h)(1).

Tag F327 Hydration

The surveyors found one violation of 42 C.F.R. 483.25(j) which requires that the facility provide each resident with sufficient fluid intake to maintain proper hydration and health. An overall severity and scope level of “D” was attached to this F-Tag.

Resident #2 had left LaCrescent and had been admitted to hospital for five days for a urinary tract infection, urosepsis, and dehydration. Upon discharge from hospital on June 21, 2006, Resident #2 returned to LaCrescent. Her physician ordered the staff to “push clear liquids” and “Please have pitcher of water at arm’s reach for patient”.² A dietary note dated June 27, 2006, noted that the resident should be encouraged to drink the beverages provided.³ The resident’s care plan indicated that the resident should be encouraged to take fluids between meals and fluid intake should be monitored.⁴

On August 14, 2006, the surveyors observed the resident seated in a recliner with a water pitcher that was not within reach and a glass, which was empty, also not in reach.⁵ The surveyors observed the resident during three meals and saw her consume minimal or no liquids and observed no staff encouraging her to drink more fluids.⁶ An interview with LaCrescent’s Director of Nursing established that Resident #2’s fluid intake was not being monitored.⁷ The Department does acknowledge that the resident was not, at the time of the survey, exhibiting signs of dehydration.

LaCrescent argues that the resident was not, in fact, dehydrated, that the doctor did not order monitoring of fluids, and that the Department’s definition of “monitor” is more expansive than LaCrescent’s. The ALJ does not find these points to be persuasive.

The resident had recently been hospitalized for dehydration, among other things. The facility’s dietary consultant assessed the resident to be at risk for dehydration. The resident’s physician ordered the “encouragement” of fluids. The facility’s care plan indicated that fluids should be monitored. Nevertheless, the Director of Nursing admitted that no monitoring of fluids was taking place. Furthermore, during the survey, there was no observed “encouragement” of fluids going on at meal time or at any other time. The water pitcher and glass that the surveyors did observe were not within reach of the resident. There is insufficient evidence of any kind of monitoring or encouragement of fluid intake to recommend a dismissal of this tag.

R.R.K.

² Exhibit H-39 a and b.

³ Ex. H-40.

⁴ Exs. H-30, H-24, and H-27.

⁵ Ex. N-3.

⁶ Ex. N-3, N-4.

⁷ Ex. N-4.