

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

In the Matter of Ambassador Good  
Samaritan Center  
Survey Exit Date: December 13, 2006

**RECOMMENDED DECISION**

The above matter was the subject of an independent informal dispute resolution (IIDR) conducted by Administrative Law Judge Kathleen D. Sheehy on June 8, 2007. The record of the Office of Administrative Hearings (OAH) closed at the conclusion of the IIDR conference that day.

Marci Martinson, IIDR Coordinator, Licensing and Certification Program, Division of Compliance Monitoring (Division), P.O. Box 64900, St. Paul, MN 55164-0900, appeared for the Division. Mary Cahill, Department of Health, also participated in the conference.

Lynn M. Wieczorek, Voigt, Klegon & Rode, LLC, 2550 University Avenue West, Suite 190 South, St. Paul, MN 55114, appeared for Ambassador Good Samaritan Center (the facility). Marie Barta, Administrator; Kim Stoltzman, Director of Nursing; and Stephanie Solberg-Williams, Assistant Director of Nursing on the Post-Acute Rehabilitation Unit, also participated.

**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. Ambassador Good Samaritan Center is a nursing home located in New Hope, Minnesota. The survey at issue concerns the facility's post-acute care unit. Residents on this unit are typically admitted directly from the hospital for short-term rehabilitation. They tend to progress quickly and sometimes strive for independence before they are physically ready for it.

2. On December 13, 2006, the Division issued a Statement of Deficiencies to the facility, citing violations of Tag F279 (comprehensive care plans), Tag F324 (quality of care, adequate supervision and assistance devices to reduce the risk of falls), and Tag F514 (maintenance of clinical records in accordance with accepted professional standards). In this IIDR proceeding, the facility disputes only Tag F324.

## **Resident #2**

3. Resident #2 was admitted to the facility on September 12, 2006, with short-term memory loss, peripheral vascular disease, and lower extremity weakness and pain. He had open wounds on both legs. He had been living in a long-term care facility before admission to the post-acute unit.

4. On September 18, 2006, at 12:30 a.m., the resident fell while attempting to use the toilet in the tub room. He sustained an abrasion on his left knee. He indicated the toilet in his room was not flushing properly, so he had walked down the hall to use a different one. Staff asked him if he wanted a bedside commode, and he said he preferred that the facility fix the toilet in his room. No other immediate interventions were implemented.<sup>[1]</sup>

5. On September 25, 2006, the facility completed a Resident Assessment Protocol (RAP) summary for falls and concluded the resident was at high risk for falls because of the history of recent falls, leg wounds, lower extremity weakness, impaired balance due to left hemiparesis (from a stroke), and potential gait imbalance due to hypotension or antidepressant medications.<sup>[2]</sup>

6. On September 27, 2006, at 12:00 noon, the resident lost his balance and fell in his room. He had been lying across his bed sideways and stood up quickly, lost his balance, and fell backwards. He was not injured. Staff reminded him to use his walker and to ask for assistance. An incident report noted that the dosage of one of his medications had been increased the day before.<sup>[3]</sup>

7. The resident's plan of care dated October 2, 2006, indicated he was at risk for falls and that he used his walker for ambulation. The care plan called for staff to observe the resident for impaired balance and to assist as needed. The care plan also noted that he would lay across his bed with arms and legs dangling and that staff should assist with repositioning if the resident would permit it.<sup>[4]</sup>

8. On October 6, 2006, at 12:00 noon, the resident was found crawling on the floor in his room. He had spilled a pitcher of water on the bed and the floor, but did not recall how or why he fell. He was not injured. The immediate intervention implemented was to reinforce use of the call light.<sup>[5]</sup> At the time of this fall, the resident was wearing gripper socks,<sup>[6]</sup> but it is unclear when he started wearing them or whether he was to wear them every day, because the resident's care plan was not revised to reflect this intervention.

9. On October 8, 2006, at 4:30 a.m., the resident was found on the floor of his room in a pool of blood from a large laceration on his head. He also had bruising on his left hip and across the center of his torso. He said he had tripped in the dark when returning to bed after using the bathroom. The resident was brought to a hospital emergency room for sutures. In response to this incident, the facility reorganized the furniture in his room, moved the bed so the resident would get in and out on his stronger side, and removed excess furniture.<sup>[7]</sup> Nursing notes indicated the resident's balance was getting worse, that he needed staff assistance at times, and that he would be monitored.<sup>[8]</sup> The resident's care plan was not revised.

10. On October 17, 2006, the resident had surgery on both lower legs. He returned to the facility on October 18, 2006.<sup>[9]</sup>

11. On October 19, 2006, at 9:50 a.m., the resident fell asleep while sitting on the edge of his bed and fell forward onto the floor. The resident was not injured. In response to this incident, the facility referred the resident for a physical therapy and occupational therapy evaluation and encouraged him to either sit in a recliner in his room or to lie down in bed.<sup>[10]</sup> The physical therapy and occupational therapy evaluations took place that day; the therapist recommended that physical therapy services continue to improve balance and decrease the number of falls.<sup>[11]</sup> The occupational therapist noted that cognitive testing of the resident indicated moderate impairment that affected the resident's safety awareness and judgment. The occupational therapist recommended therapy to address safety with tasks associated with grooming, hygiene, and dressing.<sup>[12]</sup> The intervention of encouraging the resident to sit in a recliner or to lie down in bed was not included in the resident's care plan.

12. On October 24, 2006, at 3:00 a.m., the resident lost his balance and fell in his room while trying to get out of bed. The resident was not injured. According to an incident report, the corrective action taken to prevent recurrence was to offer to move the resident to a recliner around 2:00 a.m. because he liked to sit for a while after waking up in the night.<sup>[13]</sup> This intervention was not incorporated into the resident's care plan.

13. On October 25, 2006, the resident's risk of falling was reviewed. Over the previous month the resident had gone through multiple changes in his environment and routine and had surgery, which increased his risk of falling. The Interdisciplinary Progress (IDP) Notes provide that the resident had a tendency to wake up early, use the bathroom, and return to sit on the edge of his bed, where he would fall asleep. The notes reflect that his room had been rearranged, he was receiving therapy, and staff would continue to monitor.<sup>[14]</sup>

14. On or about October 27, 2006, the resident was readmitted to the hospital. He returned to the facility on October 30, 2006, with a primary diagnosis of bleeding ulcer on his left leg.<sup>[15]</sup>

15. On October 31, 2006, the resident fell twice. The first fall was at 5:09 a.m., when a nurse was assisting him out of the recliner with the help of a walker and transfer belt, and the recliner slid back behind him. The slipper sock

on his left foot was slightly twisted, so his foot lost traction, and he was unable to stand. The nurse assisted him to the floor, and then obtained help to assist him back to the bed. Staff requested a non-skid mat from physical therapy to place under the lift recliner.<sup>[16]</sup> At about 10:00 a.m., a nurse found him on the floor of his room with his walker tipped over. The resident did not remember what happened. According to an incident report, the facility implemented the corrective action of using a wheel chair and TABs alarm, but these interventions were not added to the resident's care plan.<sup>[17]</sup> The resident refused to use the TABs alarm and threw it at the nurses. After that, the facility made no further effort to use a mobility alarm with him.<sup>[18]</sup>

16. On October 31, 2006, staff completed a Falls Data Collection Tool indicating the resident was at high risk for falls.<sup>[19]</sup>

17. On November 19, 2006, at 12:50 a.m., the resident was found on the floor and said he fell while attempting to move from his recliner to the bed. The resident was not injured. The facility replaced his slipper socks and requested a stickier type of non-stick mat (Dysom) to be placed under the recliner, and the resident was instructed to ask for assistance with transfers.<sup>[20]</sup> These interventions were not incorporated into the care plan.

18. On November 20, 2006, at 8:45 p.m., the resident was found sitting on the floor of his room. He said he slipped out of his recliner chair and slid to the floor. He was not injured.<sup>[21]</sup> No new interventions were implemented.

19. When the surveyor observed the resident on December 13, 2006, the resident was wearing regular socks without gripper soles. He was sleeping in his recliner, under which there was a non-skid mat, but his call light was not within reach.<sup>[22]</sup>

### **Resident #3**

20. Resident #3 was admitted to the facility on November 18, 2006, with diagnoses that included hemiparesis, dementia, and delirium from a recent stroke.<sup>[23]</sup> A Falls Data Collection Tool administered on November 19, 2006, assessed the resident as a high risk for falls. He required extensive assistance for all transfers and used a wheelchair for mobility. The care plan provided that because he was at high risk for falls, staff would "anticipate [his] needs."<sup>[24]</sup> The resident made some progress in therapy and within a few days was using a platform walker for mobility.<sup>[25]</sup>

21. During the early morning hours of November 24, 2006, staff noted the resident was restless and confused, going from his bed to a recliner to the bathroom and back to bed. He appeared to be most comfortable in his recliner. At 5:04 a.m., the resident was found on the floor in front of his recliner. The resident was not injured. The fall was attributed to possible misuse of the footrest portion of the recliner. The recliner was removed from his room, and a flowsheet was started to monitor his night activities.<sup>[26]</sup>

22. On November 25, 2006, at 8:30 a.m., the resident was found on the floor of his room. He was wearing gripper socks at the time. He said he had

tried to get up and slipped. A TABs alarm was placed, and staff determined that the resident would be kept out of his room except for when he wanted to sleep.<sup>[27]</sup> The resident's care plan was not revised to reflect these interventions.

23. On November 28, 2006, the resident was attempting to reposition himself in a wheelchair. Because he was sitting on a pillow given to him by his wife, he slipped out of the chair and onto the floor. The pillow was taken from the wheelchair. The resident's care plan was not revised.<sup>[28]</sup>

24. On December 1, 2006, the facility completed a RAP summary noting the prior falls and the risk factors of reduced safety judgment, poor balance, and poor endurance. The RAP summary indicated the resident had a mobility alarm on at all times, was kept out of his room except for sleep, and required care planning to reduce his risk of falls.<sup>[29]</sup>

25. On December 7, 2006, at 7:00 p.m., the resident fell forward off the side of his bed while a staff member was helping him get undressed. The resident sustained contusions to his knees. An incident report reflects that staff members were taught to lower the head of the bed when undressing the resident.<sup>[30]</sup> The resident's care plan was not revised.

26. On December 9, 2006, the resident was sitting in a wheelchair next to the nurse's desk when he attempted to stand without help. The chair alarm went off, but before a nurse could get to him, he fell to the floor. The resident was confused about the time and thought he needed to go to therapy. The resident was not injured. The immediate intervention noted on an incident report was that the resident was encouraged not to walk without help. No new interventions were implemented.<sup>[31]</sup>

27. On December 10, 2006, at 12:45 a.m., the resident's TABs alarm went off, and staff found him sitting on the floor next to his bed. He said he was trying to put on his slippers when he fell. The resident was not injured. The intervention noted on an incident report was that staff reoriented the resident to the time and encouraged the resident to stay in bed. The resident's room was rearranged so he could exit the bed on his strong side.<sup>[32]</sup>

28. The resident's bed was against the wall, and he was wearing a mobility alarm when the surveyor observed him on December 13, 2006.<sup>[33]</sup>

#### **Resident #4**

29. Resident #4 was admitted to the facility on October 27, 2006, with diagnoses that included a seizure disorder and right hemiplegia. A Falls Data Collection Tool dated October 28, 2006, found the resident to be at high risk for falls.<sup>[34]</sup>

30. On October 28, 2006, at 9:30 a.m., the resident was found sitting on the on the floor of her room with her back up against the wheelchair. The resident was not injured. An incident report reflects that Dyson (a sticky mat) and a TABs alarm were placed on the wheelchair. In addition, staff requested that occupational therapy modify the wheelchair.<sup>[35]</sup>

31. On October 29, 2006, at 3:10 a.m., the TABs alarm went off, and the resident was found sitting on the floor of her room between her bed and nightstand. The resident could not explain what happened. In an incident report the facility indicated that in response to this incident the bed was rearranged and a blue mat was added to the floor (to cushion a fall) when the resident was in bed. The bed was to be in the low position at all times.<sup>[36]</sup>

32. The resident's initial care plan, dated October 29, 2006, indicates the resident was not ambulating at all and needed the assistance of two persons with all transfers.<sup>[37]</sup>

33. On November 4, 2006, at 12:15 a.m., the TABs alarm went off and staff found the resident on the floor in her room. The resident was not injured. The resident fell when she attempted an independent transfer to a bedside commode. The incident report does not reflect that either a blue mat or a lowered bed were in use at the time. Staff placed a bed alarm (a pressure alarm on the mattress that activates when a resident attempts to get out of bed) and reattached the TABs alarm to the resident. Staff requested that maintenance lower the bed to the floor.<sup>[38]</sup>

34. On November 5, 2006, at 1:15 a.m., the TABs alarm went off and staff found the resident lying on the blue mat near her bed. She had been trying to move from the bed to a bedside commode. The bed alarm was in place but had not been turned on. The resident was not injured. Staff re-educated the resident on the need to call for help with transfers, and ensured the TABs and bed alarms were in place and in working order.<sup>[39]</sup> That day the resident's bed was lowered. Progress notes reflect that she was setting off her TABs alarm on a regular basis that day.<sup>[40]</sup>

35. On November 6, 2006, at 12:50 a.m., staff heard the resident crying and found her on the floor, having fallen while trying to use the bedside commode. The TABs alarm was in place and was turned on, but the patient was close enough to the bed that the alarm was not triggered. The bed alarm was in place but was not properly set. The blue mat was not on the floor, and the bed was not in the low position. Staff put the bed in the low position, set the bed and Tabs alarms, and placed a blue mat beside the bed. Staff also moved the commode to the bathroom so the resident would not try to get to it without assistance. After investigating the incident, the facility decided to remove the TABs alarm (and also apparently the bed alarm) and have staff check her every 15 minutes between the hours of 11:15 p.m. and 2:00 a.m. for a few days. The facility also determined that staff should offer to assist the resident with toileting every one and one-half hours.<sup>[41]</sup>

36. On November 8, 2006, at 11:05 p.m., staff went to check on the resident and found her on the floor mat next to her bed. The resident had attempted to use the bathroom without assistance. At the time of the incident the floor mat was in place, the bed was in the low position, and the call light was within the resident's reach. Staff determined to start the 15-minute checks at

10:30 p.m. in response to this incident.<sup>[42]</sup> This intervention was not added to the resident's care plan at the time.

37. On November 9, 2006, the facility completed a falls RAP assessment providing that the resident had suffered a recent stroke and had right-sided hemiparesis, that she was impulsive and had expressive and receptive aphasia and decreased ability to communicate her needs, that she attempted independent transfers and standing without assistance, and that she had had many falls. The resident was then using a mobility alarm for safety and to alert staff. As of that date she would be checked every 15 minutes at night; she had a mat on the floor next to the bed; her bed was in the low position, and she had Dyson in her wheelchair to prevent sliding.<sup>[43]</sup>

38. On November 12, 2006, at 1:10 a.m., staff heard a crash in the resident's room and found her sitting on the floor mat next to her bed. The resident said she had been trying to reach for the light. The resident was not injured. The fall mat was in place, and the bed was in the low position. The incident report describes the corrective action taken as "low bed, blue mat, 15-min. checks from 11:15 p.m. -2 a.m., offer toilet [every one and one-half hours]."<sup>[44]</sup> This intervention was not added to the care plan at the time, and it is unclear when the interventions planned on November 8, 2006, or November 12, 2006, were implemented.

39. On November 20, 2006, the resident's care plan was amended to reflect that the resident needed extensive assistance with bed mobility and transfers, that the wheelchair was her primary mode of locomotion, and that her potential for falls and injury was related to her attempts to stand or transfer without help. The identified interventions were physical therapy as ordered; mat on the floor next to the bed; bed in the low position; and mobility alarm on at all times. In addition, it provides that Dyson would be used in the wheelchair to prevent sliding.<sup>[45]</sup> Another revision made on that date was to assist the resident in using a bedside commode every one and one-half hours.<sup>[46]</sup>

40. On November 23, 2006, at 1:20 a.m., the resident was found on the floor of her room. She had attempted to use the bathroom by herself. She hit her head when she fell, but did not injure herself. The low bed and blue mat were in place, and the call light was attached to the bed at the time. According to the incident report, the resident's care plan was amended at this time to require toileting every one and one-half hours during the night. In addition, the facility started an observation flow sheet.<sup>[47]</sup>

41. On November 29, 2006, at midnight, staff found the resident on the floor of her room. She had again attempted to use the bathroom by herself. The resident had a large red spot on her right hip but was not otherwise injured. The call light was in place, and the bed was in the low position, but no blue mat was in place at the time of the incident. The immediate intervention noted was "continue to monitor."<sup>[48]</sup> The resident's care plan was revised to reflect that she had crawled to the bathroom during the night due to unsteady balance and poor gait. Approaches identified were to offer assistance with the toilet every one and

on-half hours during the night, encourage use of the call light, assist, use a low bed and blue mat on the floor, and physical/occupational therapy.<sup>[49]</sup>

42. On December 5, 2006, at 5:30 a.m., the resident was found on the floor of her room. She had attempted to transfer herself from bed to a wheelchair. She was not injured. The incident report describes the corrective action taken as discontinuance of the low bed.<sup>[50]</sup> This intervention was not, however, removed from the resident's care plan.

43. On December 8, 2006, at 6:55 a.m., staff found the resident kneeling on the floor with her walker in front of her. The resident said she couldn't wait any longer, presumably to use the bathroom, and was using a walker to attempt to reach the bathroom when her knees gave out. The resident was not injured. At the time of this incident, the bed was in the low position and the blue mat was on the floor. The facility decided to remove the blue mat to prevent tripping now that the resident was more mobile, and put a commode at her bedside.<sup>[51]</sup> The care plan was not revised to reflect these changes.

44. On December 12, 2006, at 4:20 a.m., a staff member had assisted the resident to the commode and went to the station to get supplies. When staff returned, the resident was on the floor. She had attempted to transfer herself back to bed. The resident had hit her head but had no apparent injuries. The fall mat was still in place beside the resident's bed. The incident report provides that corrective action taken in response to this incident was to place a non-skid floor mat next to the resident's bed.<sup>[52]</sup> This change was not added to the resident's care plan.

45. When the surveyor observed the resident on December 13, 2006, the bed was at normal height and there was a non-skid mat on the floor beside the bed.<sup>[53]</sup>

## **Resident #5**

46. Resident #5 was admitted to the facility on November 23, 2006, with diagnoses that included Alzheimer's dementia and a recent stroke.<sup>[54]</sup> A Falls Data Collection Tool completed November 24, 2006, indicates the facility assessed the resident as being at high risk for falling.<sup>[55]</sup> The resident's care plan does not reflect any interventions to prevent falls until December 13, 2006, although interventions were used before then.

47. On November 30, 2006, at 10:15 a.m., the resident's TABs alarm sounded and staff found the resident lying on the floor. The resident said she was trying to pick up a comb that had fallen on the floor. She was not injured. The resident was encouraged to ask for assistance.<sup>[56]</sup>

48. On December 2, 2006, at 3:10 a.m., staff found the resident sitting on the floor in her room. She had tried to get to the bathroom by herself. The resident was not injured. At the time of this incident the bed was in the low position, a blue mat was on the floor, and the call light was in reach. The bed alarm, however, was not working because it was set in "remote" mode. The

immediate intervention was to set the bed alarm in the correct mode so that it worked.<sup>[57]</sup>

49. On December 6, 2006, a Falls RAP assessment was completed. The assessment noted the resident had fallen on November 30, 2006, and December 2, 2006. It further noted that the resident started taking trazedone for sleep on November 28, 2006, and that she was wearing a TABs alarm because she attempts independent transfers and has decreased ability to follow directions.<sup>[58]</sup>

50. On December 13, 2006, after arrival of the surveyor, the resident's care plan was revised to note the use of a TABs alarm at all times. There is no reference in the care plan to use of a low bed or a blue mat. When the surveyor observed the resident on December 13, 2006, the resident was sitting on a low bed, which was positioned against the wall. There was a mat on the floor, and a mobility alarm was sounding.<sup>[59]</sup>

### **Resident #1**

51. Resident #1 was admitted on December 2, 2006, with diagnoses that included lower extremity weakness, dementia, confusion, and Parkinson's disease. The resident did not speak or understand English. Upon admission, a nurse advised the family that the resident was at risk for falls because of her unsteady, rigid gait, impaired communication, language barrier, and dementia. Staff advised setting her bed in the lowest position, and a TABs alarm was put in place.<sup>[60]</sup> Although the resident's family requested a fall mat, the facility believed such a mat would pose a tripping hazard because the resident was mobile.<sup>[61]</sup> That afternoon the resident was resistive to cares, transferred unsafely, and refused her medications.<sup>[62]</sup>

52. At about midnight on December 3, 2006, the resident was sleeping restlessly.<sup>[63]</sup>

53. On December 3, 2006, at 1:20 a.m., staff heard the "faint sound" of an alarm in the resident's room and found the resident on the floor, lying on her right side, halfway between the bed and the bathroom. The resident was agitated and did not understand staff efforts to determine whether she was hurt. The alarm was replaced. At 4:30 a.m., staff called the resident's daughter to seek her help in communicating with the resident. After speaking to the resident, the daughter advised that the resident denied pain and was confused about where her husband was. At the time of the incident, the low bed was not yet in place.<sup>[64]</sup> Later that afternoon, the resident was transferred to the hospital for treatment of a right hip fracture.<sup>[65]</sup>

54. At some point on the night shift of December 3, 2006, a nurse completed a Falls Data Collection Tool indicating the resident was at high risk of falling.<sup>[66]</sup>

### **Survey**

55. The Division conducted a partial extended survey on December 13, 2006, in response to a complaint. The Division then became aware that the

facility had a policy of requiring completion of five-page incident reports concerning falls, but the facility maintained the narrative descriptions, investigation, and corrective action sections (pages three through five) in a locked cabinet that was not accessible to staff providing resident care. At that time the Division issued a Statement of Deficiencies to the facility, citing violations of Tag F279 (comprehensive care plans), Tag F324 (quality of care, supervision and assistance devices to reduce the risk of falls), and Tag F514 (maintenance of clinical records in accordance with accepted professional standards).<sup>[67]</sup> With regard to Tag F324, the Division found deficient practices with regard to Resident # 2, 3, 4, 5, and 1 in that the facility had failed to provide adequate supervision and assistance devices to prevent falls.

56. The Division also determined with regard to Tag F324 that there was an immediate and serious threat to resident health and safety beginning on September 18, 2006, with the facility's failure to assess causal factors and the efficacy of interventions with regard to Resident #2, and it continued with regard to Resident #3 and Resident #4 due to the facility's failure to comprehensively assess the circumstances of falls, ensure that interventions were implemented, and monitor interventions for efficacy. The Division determined the immediate jeopardy continued through December 13, 2006, at 5:30 p.m., when a corrective plan was approved. At that time, the scope and severity of the deficiency was lowered to level E, a pattern of deficiency with the potential for more than minimal harm. The plan of correction required, among other things, that assessments and plans of action would be documented in the resident's interdisciplinary progress notes, that interventions would be incorporated into the resident's care plan, and that a falls committee would review incident reports and charts to ensure that assessments and interventions were appropriate.<sup>[68]</sup>

57. In this IIDR, the facility disputes only Tag F324 and the determination of immediate jeopardy.

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 Tag F324 is supported by the facts and should be AFFIRMED as to scope and severity.

Dated: June 19, 2007.

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

Reported: Digital recording (no transcript)

## MEMORANDUM

The DFPC abbreviated standard survey completed December 13, 2006, resulted in three tags. The facility does not dispute that its documentation practices failed to conform to federal requirements concerning care planning and maintenance of clinical records. As noted above, the facility challenges only Tag F324 and the determination of immediate jeopardy.

### Tag F 324

Each 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.<sup>[69]</sup> The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.<sup>[70]</sup> 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.<sup>[71]</sup>

The State Operations Manual (SOM) defines “accident” as an unexpected, unintended event that can cause a resident bodily injury.<sup>[72]</sup> 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:

- 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?<sup>[73]</sup>

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.<sup>[74]</sup>

Section 483.25 does not make a facility strictly liable for accidents that occur, but it does require the facility to take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents.<sup>[75]</sup> A facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods must constitute an adequate level of supervision under all the circumstances. Whether the supervision is adequate depends on the resident's ability to protect him or herself from harm. Thus, the issue is whether the quality of the supervision or the use, or lack thereof, of assistive devices at the facility was such that residents with known or foreseeable risks were subject to the risk of injury from accidental causes in their daily activities.<sup>[76]</sup>

The Division argues that with regard to all five residents, the facility was aware of the risk of falls but failed to take adequate steps to prevent them, either because the facility failed to perform the necessary assessments, failed to document interventions in the care plan, failed to implement the interventions, failed to review the efficacy of the interventions as needed, or failed to revise the care plan to reflect new interventions.

The facility argues that it assessed all five residents as being at risk for falling, it did implement interventions, and although it did not always incorporate the interventions into the care plans, staff members did communicate the need for them orally in morning meetings. The facility argues that there is no requirement that its assessment of causal factors, interventions, or information relating to assistive devices be in writing.

Contrary to the facility's argument, 42 C.F.R. § 483.20 requires that a facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. In addition, facilities must develop a comprehensive care plan for each resident to address the needs identified in the assessment.<sup>[77]</sup> Specifically, the care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being as required under § 483.25.<sup>[78]</sup> There is no basis for the facility's argument that services and interventions intended to prevent accidents under § 483.25(h) are not required to be written in the care plan.

The sheer number of falls by these residents is compelling evidence of problems with the facility's systems relating to fall prevention. Although Resident #2 was clearly at risk for falling when he was admitted, he was not assessed for this risk until a week after his first fall. No interventions were implemented other than observation, repositioning, and reinforcement of the need to seek assistance until after the resident had lacerated his head. None of the interventions implemented afterward were incorporated into the resident's care plan. Resident #3 was assessed quickly, but his care plan was not revised to reflect interventions implemented after he fell several times. Resident #4 was

assessed quickly, but the facility did not incorporate the interventions into the care plan and did not consistently implement them. The facility implemented a number of interventions for Resident #5, but it did so without documenting them in the care plan, and some of the interventions were not used properly. Resident #1 was assessed promptly, but the interventions for her were not fully or effectively implemented before she fell and broke her hip (the low bed was not in place, the TABs alarm was not working properly). The Administrative Law Judge concludes the facility clearly failed to ensure that these residents received adequate supervision and assistance devices to prevent accidents.

Immediate jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause, serious injury, harm, impairment, or death to a resident.<sup>[79]</sup> Serious harm, injury, impairment, or death does not have to occur before a determination of immediate jeopardy is appropriate; the high potential for these outcomes to occur in the very near future also constitutes immediate jeopardy.<sup>[80]</sup> The SOM contains a non-exclusive list of "triggers" that may assist surveyors in making a determination of immediate jeopardy; included on the list are lack of supervision for individuals with known special needs and repeated occurrences such as falls, which place the individual at risk of harm without intervention.

In this case, Resident #2 did suffer actual harm in the form of a large scalp laceration that required a trip to the emergency room, and Resident #3 sustained contusions to both knees. There was a high potential for additional harmful outcomes for the other residents as well. Most if not all of these residents had cognitive impairments, whether temporary or long-term, that affected their judgment, awareness, and ability to stay safe. It was the facility's responsibility to supervise these residents adequately to mitigate the foreseeable risk that they would fall and injure themselves, and the facility failed to meet this standard.

Finally, the facility argues that all it did in agreeing to the corrective plan on December 13, 2006, was to reduce to writing the policies that were already in place. This is not accurate. The plan of correction required, among other things, that assessments and plans of action would be documented in the resident's interdisciplinary progress notes, not just in incident reports that were not available to staff providing resident care; that all interventions would be incorporated into the resident's written care plan; and that a falls committee would review incident reports and charts to ensure that assessments and interventions were appropriate. This corrective plan was required to address the systemic issues that created the potential for serious harm, injury, impairment, or death to individuals residing in the facility. The immediate jeopardy determination should be affirmed.

K.D.S.

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- [1] Ex. M-16, M-17.
- [2] Exs. M-1, M-2, M-7.
- [3] Ex. M-20.
- [4] Ex. M-10.
- [5] Ex. M-22.
- [6] Ex. 5 (Incident report 10/6/06).
- [7] Exs. M-25, M-47.
- [8] Ex. M-47.
- [9] Ex. 2 (Interdisciplinary Progress Notes 10/18/06).
- [10] Exs. M-27 to M-29b.
- [11] Ex. 4.
- [12] Ex. 3.
- [13] Ex. M-32b.
- [14] Ex. 2 (IDP notes 10/25/06).
- [15] Ex. 2 (IDP notes 10/30/06).
- [16] Ex. M-35.
- [17] A TABs alarm is a box that can be attached to the resident's wheelchair or bed, with a string that is attached to the resident by a magnet. If the resident moves far enough to make the magnet fall off, an alarm should sound, alerting staff to the resident's attempt to move.
- [18] M-38b.
- [19] Ex. M-9.
- [20] Ex. M-39 to M-41.
- [21] Exs. M-42 to M-43.
- [22] Ex. V-4.
- [23] Exs. N-5, N-11.
- [24] Ex. N-17.
- [25] Ex. 9 (IDP Notes 11/24/06).
- [26] Ex. 11 (IDP Notes 11/24/06); Ex. N-20 to N-22; Ex. 15.
- [27] Ex. N-23 to N-25.
- [28] Ex. N-26 to N-28.
- [29] Ex. N-11.
- [30] Ex. N-29 to N-31.
- [31] Ex. N-32 to N-34.
- [32] Ex. N-35 to N-37.
- [33] Ex. V-3.
- [34] Ex. O-24 to O-25.
- [35] Ex. 24 (Incident Report 10/28/06).
- [36] *Id.* (Incident Report 10/29/06).
- [37] Ex. O-27.
- [38] Ex. 24 (Incident Report 11/4/06).
- [39] Ex. 24 (Incident Report 11/5/06).
- [40] Ex. 20 (IDP Notes 11/5/06).
- [41] Ex. 24 (Incident Report 11/6/06).
- [42] Ex. 24 (Incident Report 11/8/06).
- [43] Ex. 19.
- [44] Ex. 24 (Incident Report 11/12/06).
- [45] Ex. O-27.
- [46] Ex. O-28.
- [47] Ex. 24 (Incident Report 11/23/06).
- [48] Ex. 24 (Incident Report 11/23/06).
- [49] Ex. O-30.

- [50] Ex. 24 (Incident Report 12/5/06).
- [51] *Id.* (Incident Report 12/8/06).
- [52] *Id.* (Incident Report 12/12/06).
- [53] Ex. V-2.
- [54] Ex. P-1.
- [55] Ex. P-4.
- [56] Ex. 26 (Incident Report 11/30/06).
- [57] *Id.* (Incident Report 12/2/06).
- [58] Ex. 25.
- [59] Ex. V-3.
- [60] Ex. Q-16.
- [61] Exs. T-1, T-2.
- [62] Ex. Q-15.
- [63] Ex. Q-15.
- [64] Ex. 31.
- [65] Ex. Q-19.
- [66] Ex. 29.
- [67] Ex. O.
- [68] Ex. G-1, G-2.
- [69] 42 C.F.R. § 483.25.
- [70] 42 C.F.R. § 483.25 (h)(2).
- [71] Ex. H-1.
- [72] *Id.*
- [73] Ex. H-1, H-2.
- [74] Ex. F.
- [75] *Odebolt Nursing & Rehabilitation Center v. Centers for Medicare a& Medicaid*, Docket No. C-04-262 (Dep't App. Bd. Mar. 13, 2007) (<http://www.hhs.gov/dab/decisions/CR1574.html>); *Woodstock Care Center v. Thompson*, 363 F.3d 583 (6<sup>th</sup> Cir. 2003).
- [76] *Id.*
- [77] 42 C.F.R. § 483.20(k)(1).
- [78] 42 C.F.R. § 483.20(k)(1)(i).
- [79] 42 C.F.R. § 489.3.
- [80] SOM, Ex. D-3.