

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

In the Matter of Providence Place
Survey Exit Date: October 23, 2007

RECOMMENDED DECISION

The above matter was the subject of an independent informal dispute resolution (IIDR) conducted by Administrative Law Judge Barbara L. Neilson on March 13, 2008. At the end of the conference, the record remained open to allow the Department of Health an opportunity to submit a response to the case law upon which the Facility relied at the conference. The Department did not elect to submit a response, and the record of the Office of Administrative Hearings was deemed closed on March 27, 2008.

Marci Martinson, IIDR Coordinator, Licensing and Certification Program, appeared on behalf of the Department of Health's Division of Compliance Monitoring. Mary Cahill, Planner Principal with the Division of Compliance Monitoring, also participated in the conference.

Susan Voigt, Attorney at Law, Voigt, Klegon & Rode, LLC, appeared on behalf of Providence Place. The following persons made comments on behalf of the Facility: Amanda Johnson, Registered Nurse Consultant; Brad KetterSmith, Occupational Therapist; and Ansu Sasser, Nursing Assistant.

FINDINGS OF FACT

1. On October 8, 2007, the Department of Health's Office of Health Facility Complaints (OHFC) conducted an abbreviated standard survey at Providence Place, a nursing home located in Minneapolis, Minnesota, in connection with a complaint investigation. The complaint involved allegations that a resident who fell at the Facility and later died from a subdural hematoma had not been assessed or monitored adequately by the Facility. As part of the investigative process to determine whether or not the complaint was substantiated, the OHFC investigator concluded that the Facility had failed to ensure that the resident received the necessary supervision and appropriate assistance device to prevent a fall out of the resident's wheelchair.¹

¹ MDH Ex. E-1.

2. On October 23, 2007, the Division issued a Summary Statement of Deficiencies to the Facility, citing one violation of Tag F 323 (accidents and supervision) as a G-level deficiency.²

3. In this IIDR proceeding, the Facility disputes that citation and asserts that it should be removed in its entirety.

Resident #1

4. Resident #1 (“the Resident”) was admitted to the Facility’s Memory Support Unit on February 11, 2002, at the age of 74 years. He remained at the Facility until August 2007. His diagnoses as of February 2007 included hypertension, cardiovascular disease, severe Alzheimer’s disease, senile dementia with delusional features, and depression. He had a history of verbally abusive and physically aggressive and agitated behavior. He was not communicative or responsive to staff. His arms were contracted close to his chest. He was not able to engage in activities of daily living (ADLs) without a great degree of assistance. The Resident used a wheelchair throughout his stay at the Facility.³

5. The Resident was placed on Risperdal during his stay at the Facility. Physician’s orders were written and the Resident’s wife consented to the use of this psychotropic medication. The Facility kept monthly records monitoring the effect of the medication on target behavioral symptoms and conducted quarterly assessments regarding its use.⁴

6. The Facility follows a protocol for the use of restraints to protect residents from injury. Under its protocol, the use of a restraint requires an assessment and a physician’s order. The specific restraint authorized is listed in the Resident’s care plan. Under the Facility’s policies, if psychotropic medications are prescribed to address potentially harmful behaviors of a resident, the use and dosage of the medication is periodically reviewed to determine if the need for that medication continues. Other protocols are followed at the Facility with respect to falls, changes in the condition of residents, reporting of possible abuse or neglect of vulnerable adults, incident reports, and neurological assessments.⁵

7. In October, 2003, the Resident was assessed as needing a restraint to prevent falls. That decision was reached after the Resident sustained his fifth fall since moving to the Facility and the first in which he suffered an injury (abrasions). The Facility decided to use a lap tray that rested on the arms of his wheelchair. The lap tray was secured with a Velcro strap that fastened around the back of the Resident’s wheelchair.⁶ The Resident’s wife consented to the

² *Id.*

³ MDH Exs. G-1 through G-12b, J-7, K-2; Facility Exs. F, N, O, P, S.

⁴ MDH Ex. G-10; Facility Exs. I, J, K, L, P, Q.

⁵ Facility Ex. B.

⁶ MDH Ex. G-12b, G-19; Facility Exs. H, Y.

use of the lap tray for the Resident and a physician's order was issued approving its use.⁷

8. Between October 2003 and December 2005, the Resident sustained three falls at the Facility. On November 20, 2003, the Resident fell in his room at 2:00 a.m. A floor mat was added at his bedside. On June 20, 2004, the Resident was found on the floor in the day room at 11:30 a.m. and suffered facial abrasions. The record does not clearly describe the circumstances surrounding this fall, but the Resident's fall history form indicates that "disciplinary action R/T [related to] lap tray" was imposed. On November 8, 2004, the Resident fell out of his wheelchair after staff neglected to re-attach the lap tray after lunch. He did not have any apparent injuries as a result of that fall.⁸

9. In December, 2005, the Resident was observed lying on the floor of the dining room in front of his wheelchair. According to the incident report, the Resident was agitated when he was taken to the dining room, and another resident observed him pushing on the lap tray until it came loose. He sustained a laceration on his forehead. The Facility conducted an assessment and decided to use a different lap tray for the Resident that would slide over the arms of his wheelchair. The new lap tray continued to be secured with a Velcro strap that fastened around the back of the Resident's wheelchair.⁹

10. On August 27, 2006, the Resident again pushed the lap tray off his wheelchair and fell to the floor of his room in front of his wheelchair, landing on his buttocks. The Facility reviewed and updated the Resident's care plan, made a referral to physical/occupational therapy, and replaced the worn-out Velcro on the lap tray with new Velcro.¹⁰

11. On December 20, 2006, the Resident's Risperdal dose was reduced from 3 mg daily to 2 mg daily.¹¹

12. On January 15, 2007, the Resident once again pushed the lap tray off his wheelchair, attempted to transfer himself, and fell on the floor of his room.¹² The Resident sustained bruises on his forehead, cheek and the bridge of his nose as a result of this fall. The Facility determined that the Velcro straps on the lap tray were worn out and replaced them.¹³ The Facility imposed discipline (a written warning) on the employee who was providing direct care at the time for failing to inform his supervisor of the malfunctioning equipment. The employee disagreed with the discipline and noted that "the Velcro straps were working at the time the resident decided to break them."¹⁴ In addition, the Director of Nursing met with 3 South p.m. staff on January 16, 2007, to discuss the safety of the lap tray Velcro on the wheelchair. The Director of Nursing

⁷ Facility Exs. G, Q.

⁸ MDH Exs. G-19, G-20, G-21.

⁹ MDH Exs. E-1, G-19, G-23.

¹⁰ MDH Ex. G-19, G-24; Facility Ex. D, T.

¹¹ Facility Exs. P, R.

¹² MDH Exs. G-19, G-25; Facility Ex. D.

¹³ MDH Exs. G-19, G-25; Facility Ex. T.

¹⁴ Facility Ex. E.

informed staff during this meeting of the importance of checking and verifying that all appliances and equipment including lap trays and lap buddies were in good working condition. She also directed staff that it was their responsibility to inform maintenance or the appropriate person of all equipment that was not in proper working order.¹⁵

13. Jamison Barber, RN, CNP, examined the Resident on January 22, 2007, one week after the Resident's fall. Mr. Barber stated in his notes relating to the visit that the Resident "has frequent aggressive behavior, usually during the evening and night shift. He also shows signs of internal distress with yelling and striking out. Over this past weekend, he threw himself out of the wheelchair." Mr. Barber assessed the Resident as having severe Alzheimer's-type dementia with aggressive and self-injurious behavior. No further reductions in medication were recommended at that time.¹⁶

14. On February 8, 2007, the Facility completed Resident Assessment Protocol (RAP) Summaries for the Resident relating to falls and physical restraints. The Facility concluded in these RAP Summaries that the Resident was at risk for falls due to impaired mobility and impaired coordination and noted that the lap tray would be used whenever the Resident was in his wheelchair.¹⁷ The RAP Summary indicated that the lap tray was to be released at all meals and every two hours.¹⁸

15. On April 25, 2007, the Facility's nursing staff sought to have the Resident referred for evaluation by an Occupational Therapist (OT) because his elbows were becoming red from pressing on his lap tray. Nursing staff called the Nurse Practitioner to request that OT evaluate whether the Resident needed a new wheelchair, and the Nurse Practitioner issued an order the next day authorizing OT to evaluate and treat the Resident for wheelchair management up to six visits over 4 weeks. Brad Ketttersmith, an OT employed by the Facility, conducted the evaluation. The Resident did not lean forward in his wheelchair during the time that Mr. Ketttersmith evaluated him. Mr. Ketttersmith reviewed the Resident's chart, spoke with nursing staff, added padding to the Resident's lap tray to reduce the irritation to his elbows, and ordered thick elbow pads for future use. Mr. Ketttersmith adjusted the foot rest and determined that the Resident was positioned properly in his 18" x 18" wheelchair.¹⁹

16. A physician's progress note dated May 2, 2007, indicated that the Resident was on Risperdal for a target behavior of becoming distressed and throwing himself out of his wheelchair.²⁰

17. The Facility completed a Minimum Data Set quarterly assessment of the Resident on July 12, 2007, and updated his care plan on July 17, 2007.

¹⁵ MDH Ex. G-25; Facility Ex. E.

¹⁶ MDH Ex. G-12b.

¹⁷ MDH Exs. G-10, G-11.

¹⁸ MDH Ex. G-11; see also MDH Ex. G-16.

¹⁹ MDH Ex. G-27b; Facility Exs. R, W; Comments of Ketttersmith.

²⁰ MDH Ex. G-12a; Facility Exs. P, Q.

The Facility conducted a quarterly assessment of the Resident's use of the lap tray restraint on July 26, 2007. The latter assessment noted that use of the wheelchair lap tray should be continued because the Resident continued to lean forward 80% of the time. The assessment further indicated that the Resident's cognitive and physical impairments rendered him at "high risk" for falls and noted that the lap tray was the least restrictive restraint. The record includes documentation that the Facility also conducted assessments of the lap tray on prior occasions (November 9, 2006, December 29, 2006, January 31, 2007, and April 27, 2007).²¹

18. On August 15, 2007, the Resident was examined by Roberta Meyers, M.D. Dr. Meyers concluded that the reduction in the Resident's dose of Risperdal in December 2006 from 3 mg daily to 2 mg daily had been accomplished "with good success." She further noted that, on July 29, 2007, the Resident received 1 mg of Lorazepam for yelling and swearing at other residents and staff and, on August 4, 2007, he again received Lorazepam when he became agitated and pushed a wheelchair into others at his table. Dr. Meyers recommended continued monitoring and no further reduction in the Resident's Risperdal at that time. She found that the Resident "is tolerating this relatively low dose of Risperdal well and continues to have some breakthrough exacerbations in behavior."²²

19. On August 22, 2007, the Resident was assisted with his morning cares and helped into his wheelchair by Employee H, a Nursing Assistant who had worked at the Facility for approximately 2 ½ years. Employee H fastened the lap tray to the Resident's wheelchair using the Velcro straps and found the Velcro straps to be in proper condition. Employee H then moved the Resident out into the corridor near the dining room and the nurses' desk to wait until it was time to go in for breakfast. Employee H went to assist other residents. Other staff members were also present in the vicinity of the Resident. While assisting another resident with shaving, Employee H heard a loud noise, and saw that the Resident had fallen face first on the floor. His lap tray had landed some distance in front of him. Employee H and others immediately went to assist the Resident.²³

20. Employee H had never seen the Resident manage to remove the lap tray from his wheelchair before the August 22, 2007, fall, but had heard from other staff that it had happened.²⁴ Employee H had observed occasions where the Resident had moved the tray slightly forward, but the strap was still in place. On those occasions, the nursing assistants had pushed the tray back and re-secured the strap.²⁵

²¹ Facility Ex. H; MDH Exs. G-13, G-14, G-15, G-16, G-17.

²² Facility Ex. P.

²³ MDH Exs. G-26, G-28a, L and P; Facility Ex. B.

²⁴ MDH Ex. L-4.

²⁵ MDH Ex. P.

21. The Resident sustained two skin tears to the right side of his face and an abrasion to his forehead from the fall. Employee H assisted the Resident back into his wheelchair and inspected the lap tray and its fastening mechanism. The lap tray and Velcro straps were determined to be in good working order.²⁶ The Facility nursing staff informed the nurse practitioner and the Resident's family of the fall and monitored the Resident's condition.²⁷ The nurse practitioner called the Facility later on August 22, 2007, with new orders that included having the OT evaluate the Resident's wheelchair positioning and possibly a new wheelchair.²⁸

22. Employee F, an LPN and nurse coordinator for the Resident's unit of the Facility, completed an Incident Report with respect to the fall on August 23, 2007. In the Incident Report, Employee F indicated that all straps were checked and tightened and the lap tray was assessed after the incident occurred. She also noted that the Resident "always sat forward and leaned" while in his wheelchair, and follow-up measures would include having OT evaluate the Resident for wheelchair positioning and a possible new wheelchair.²⁹

23. On August 23, 2007, the Resident's condition worsened and he was sent to the hospital. Hospital staff determined that the Resident had a subdural hematoma. The Resident died on August 27, 2007. The Medical Examiner's report indicates that the cause of death was "blunt-force craniocerebral injury" due to an accidental fall.³⁰

Survey

24. The OHFC conducted an abbreviated standard survey of the Facility on October 8, 2007. The surveyor reviewed the Resident's medical records, conducted interviews, and examined Facility documentation relating to the Resident.³¹

25. Based upon the documentation provided by the Facility, the surveyor determined that the Resident was assessed for injury after the August 22, 2007, fall, neurological assessments were initiated in accordance with the Facility's protocol, the nurse practitioner was informed, and the Resident was monitored.³²

26. Interviews with Facility staff were conducted as part of the Division's survey. Employee B, an RN who had been the Director of Nursing at the Facility since October 2006, told the surveyor that she had imposed disciplinary action on staff after the Resident's January 2007 fall to stress the importance of checking the strength of the Velcro strap on the lap tray. She

²⁶ MDH Exs. G-26, M-7, and M-8; Comments of Johnson.

²⁷ MDH Exs. G-28a, G-28b, and G-30; Facility Ex. Z.

²⁸ MDH Ex. G-28a; Facility Ex. R.

²⁹ Facility Ex. D.

³⁰ MDH Exs. H-2, I.

³¹ MDH Ex. E.

³² MDH Ex. E-2.

noted that a new tray had been in place for the Resident since the January 2007 fall and that monitoring was being done on a weekly basis. She examined the Resident's lap tray after the August 23, 2007, fall and found it to be in good shape. She speculated that perhaps a seizure or stroke triggered the strength for the Resident to push the tray off the wheelchair. She stated that, "In general, the Velcro was not strong enough – just by looking at it."³³

27. Employee C, a Nursing Assistant who had worked for the Facility for nine years, told the surveyor during interviews on October 8 and 18, 2007, that the Resident used a lap tray when he was in his wheelchair, but no alarm was used. She stated that, since she had been there, she had seen the Velcro on the Resident's lap tray come part on two different occasions. She believed that, rather than using his hands, the Resident removed the tray by leaning forward with all of his weight. She said that the lap tray was re-attached and the Resident did not fall on those two occasions. On October 18, 2007, Employee C said that she had observed the Velcro strap on the Resident's lap tray coming apart "a couple of months" before his last fall in August 2007. She further stated that the Resident was by the nurses' station at the time, the Velcro was not in disrepair, and other staff including Employee F observed the Velcro coming loose.³⁴

28. Employee D, another Nursing Assistant who had been employed at the Facility for eight months, was also interviewed on October 8 and 18, 2007. Employee D told the surveyor that the Resident leaned forward into the lap tray when he was in his wheelchair, and she was concerned that the Resident could fall out because the lap tray was secured with Velcro. Employee D stated that she saw the Resident's Velcro come loose on one occasion approximately eight months earlier. Employee D could not recall the condition of the Velcro on the strap at that time. She further stated that she had reported her concerns about the Resident's safety to a Facility nurse, Employee F, multiple times during her eight months of employment.³⁵

29. Employee F, an LPN and Nurse Coordinator, was interviewed on October 8 and 18, 2007. Employee F did not begin working at the Facility until February 2007. The August 22, 2007, incident was the first time she was aware that the lap tray had come off the Resident's wheelchair. The only concern she previously had about the lap tray was the Resident's placing his arm and elbows on the tray. She looked at the lap tray after the August 22, 2007, incident and the tray and Velcro straps looked fine. Employee F also indicated that the Velcro was checked weekly to ensure that there were no cracks and it was in working order. Although Employee F had access to the Resident's fall logs, she was not aware of the Resident's previous falls from the wheelchair in January 2007 and August 2006. After reviewing the earlier falls, she told the surveyor that it was

³³ MDH Ex. O.

³⁴ MDH Exs. E-3, J.

³⁵ MDH Exs. E-3 - E-4, K-4, K-5, K-7.

possible that the fall on August 22, 2007, could have been prevented. Employee F denied that any staff had reported any concerns to her about the Resident's safety regarding his use of the lap tray. She also denied observing the Resident's Velcro come loose prior to his fall on August 22, 2007.³⁶

30. The surveyor interviewed Employee H on October 9, 2007. Employee H had worked as a Nursing Assistant at the Facility for 2-1/2 years and often worked with the Resident. He told the surveyor that he fastened the Resident's lap tray prior to his fall on August 22, 2007, and found the Velcro to be in normal condition. He also told her that he had never before seen the Resident remove the lap tray.³⁷

31. The surveyor interviewed Employee I, an Occupational Therapist, on October 11, 2007. Employee I stated that a lap tray is the ideal intervention for residents who lean forward in their wheelchairs but indicated that an additional intervention could have been a Tilt-in-Space wheelchair. Employee I was not the Occupational Therapist at the Facility who had actually worked with the Resident.³⁸

32. Since the lap tray formerly used by the Resident had been circulated among other residents, the Facility could not identify the specific lap tray that the Resident had used on August 22, 2007, at the time of the survey in October 2007. The Facility's Director of Nursing did, however, show the surveyor all of the lap trays used in the Facility that attached with Velcro. None of these lap trays was in a condition which caused concern.³⁹ In her report, the surveyor did not acknowledge that all the lap trays were observed, but merely indicated that "the Resident's lap tray was not observed by the investigator while on-site, because the facility did not know which lap tray [he] utilized"⁴⁰

33. Based on interviews and record review, the Division concluded that the Facility failed to ensure that one of its residents received the necessary supervision and appropriate assistance device to prevent a fall out of that resident's wheelchair. On October 23, 2007, the Division issued one tag, Tag F 323 (accidents and supervision), as a G-level deficiency. The deficiency is based on an alleged violation of 42 C.F.R. § 483.25(h), which states as follows:

Accidents. The facility must ensure that—

- (1) The resident environment remains as free of accident hazards as is possible; and
- (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

³⁶ MDH Exs. E-4, M.

³⁷ MDH Ex. L.

³⁸ MDH Ex. N. Facility Ex. AA describes "Tilt-in-Space" wheelchairs.

³⁹ Comments of Johnson.

⁴⁰ MDH Ex. E-3.

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 F 323 is supported by the facts and should be affirmed as to scope and severity.

Dated: April 10, 2008.

s/Barbara L. Neilson
BARBARA L. NEILSON
Administrative Law Judge

Reported: Digitally recorded (no transcript prepared).

NOTICE

In accordance with Minn. Stat. § 144A.10, subd.16(d)(6), this recommended decision is not binding on the Commissioner of Health. As set forth in 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

The Division's abbreviated survey conducted in October 2007 resulted in one deficiency. The Facility asserts that the Tag should be rescinded in its entirety.

Tag F 323

Tag F 323 is based upon an alleged violation of 42 C.F.R. § 483.25(h). Section 483.25 encompasses quality of care requirements that apply to long term care facilities. It generally 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."⁴¹ Subpart (h) of the regulation, which relates more specifically to accidents, requires facilities to ensure that "[t]he resident environment remains as free of accident hazards as possible" and "[e]ach resident receives adequate supervision and assistance devices to prevent accidents." Decisions issued by the federal Department of Health and Human Services' Departmental Appeals Board make it clear that,

⁴¹ 42 C.F.R. § 483.25.

while section 483.25 does not render a facility strictly liable for accidents that occur, it does require that facilities 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.”⁴² In addition, even though facilities are given the flexibility to choose the methods they wish to use to prevent accidents, the chosen methods must constitute an adequate level of supervision under the circumstances. Therefore, “the issue is whether the quality of the supervision or the use, or lack thereof, of assistive devices at the long-term care facility was such that residents with known or foreseeable risks were subject to the risk of injury from accidental causes in their daily activities.”⁴³

As reflected in Appendix PP of the State Operations Manual (SOM), the intent of 42 C.F.R. § 483.25(h) is to “ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents.” This includes “[i]dentifying hazard(s) and risk(s); [e]valuating and analyzing hazard(s) and risk(s); [i]mplementing interventions to reduce hazard(s) and risk(s); and [m]onitoring for effectiveness and modifying interventions when necessary.”⁴⁴

The SOM defines “accident” as “any unexpected or unintentional incident, which may result in injury or illness to a resident.”⁴⁵ 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. The SOM further characterizes accidents as either “avoidable” or “unavoidable” in nature and describes each category as follows:

- “Avoidable Accident” means that an accident occurred because the facility failed to:
 - Identify environmental hazards and individual resident risk of an accident, including the need for supervision; and/or
 - Evaluate/analyze the hazards and risks; and/or
 - Implement interventions, including adequate supervision, consistent with a resident’s needs, goals, plan of care,

⁴² *Odebolt Nursing & Rehabilitation Center v. Centers for Medicare & Medicaid*, Docket No. C-04-262, Decision No. CR1574 (March 13, 2007), available at *citing Woodstock Care Center v. Thompson*, 363 F.3d 583, 590 (6th Cir. 2003). The *Odebolt* decision is available at www.hhs.gov/dab/decisions/CR1574.htm.

⁴³ *Odebolt* slip op. at 6.

⁴⁴ MDH Ex. F-1.

⁴⁵ *Id.*

and current standards of practice in order to reduce the risk of an accident; and/or

- Monitor the effectiveness of the interventions and modify the interventions as necessary, in accordance with current standards of practice.
- o “Unavoidable Accident” means that an accident occurred despite facility efforts to:
 - Identify environmental hazards and individual resident risk of an accident, including the need for supervision; and
 - Evaluate/analyze the hazards and risks; and
 - Implement interventions, including adequate supervision, consistent with the resident’s needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident; and
 - Monitor the effectiveness of the interventions and modify the interventions as necessary, in accordance with current standards of practice.⁴⁶

The SOM acknowledges that “[n]ot all accidents are avoidable” and stresses that “[a] fall by a resident does not necessarily indicate a deficient practice because not every fall can be avoided.”⁴⁷ The SOM points out that assistive devices can help to prevent accidents, but advises facilities that they should weigh the benefits and risks associated with their use.⁴⁸ It notes that assistive devices “can pose a hazard if not fitted and/or maintained properly. Personal fit, or how well the assistive device meets the individual needs of the resident, may influence the likelihood of an avoidable accident”⁴⁹ The SOM further cautions that assistive devices “may be hazardous when they are defective, disabled, or improperly used (i.e., used in a manner that is not per manufacturer’s recommendations or current standards of practice).”⁵⁰ The Investigative Protocol instructs surveyors to consider whether assistive devices such as physical restraints “do not meet the resident’s needs (poor fit or not adapted); and/or used without adequate supervision, in relation to the facility’s assessment of the resident”⁵¹

⁴⁶ MDH Ex. F-2.

⁴⁷ MDH Ex. F-3, F-10; *see also* F-24.

⁴⁸ MDH Ex. F-14, F-15.

⁴⁹ MDH Ex. F-15.

⁵⁰ MDH Ex. F-10.

⁵¹ MDH Ex. F-20.

The SOM describes the proper actions to be taken by the facility after a fall by a resident as follows:

Evaluation of the causal factors leading to a resident fall helps support relevant and consistent interventions to try to prevent future occurrences. Proper actions following a fall include:

- Ascertaining if there were injuries, and providing treatment as necessary;
- Determining what may have caused or contributed to the fall;
- Addressing the factors for the fall; and
- Revising the resident's plan of care and/or facility practices, as needed, to reduce the likelihood of another fall.⁵²

The SOM also indicates that investigators should determine if there are facility practices in place to "implement interventions to reduce or eliminate" identified hazards or risks "to the extent possible" and "monitor the effectiveness of the interventions."⁵³ Similarly, MDH Information Bulletin 02-14 relating to assessment, planning, intervention and evaluation for individuals who have a recent history of falls and/or who are at risk of falls notes that facility staff should consider whether the interventions set forth in the care plan are effective and accurate.⁵⁴

The Division maintained that the Resident's fall on August 22, 2007, could have been avoided. While it acknowledged that the Facility did implement interventions to reduce the Resident's fall risk, it argued that the Facility did not analyze all of the data involving the Resident's needs and risk factors to ensure that his individual needs were met and his assistive devices were appropriate for him. In particular, the Division contended that the Facility staff knew that the interventions it had implemented were not always working, but did not make necessary revisions. It asserted that the Facility was aware of the fall risk posed by the Resident's agitated behaviors and his tendency to lean forward in his wheelchair, and contended that the Facility should have sought different equipment other than the lap tray with a Velcro strap to restrain the Resident from falls.

The Facility argued in response that it took the actions required under the SOM and contended that the Division is attempting to hold it responsible for an unavoidable accident. The Facility emphasized that it assessed the Resident for all risks, including falling, on a quarterly basis. It contended that it decided to use

⁵² *Id.* (footnotes omitted).

⁵³ MDH Ex. F-19.

⁵⁴ MDH Ex. D-3. The Centers for Medicare and Medicaid Services (CMS) revised its Interpretive Guidelines for these regulatory requirements effective August 17, 2007. The Minnesota Department of Health provided training on the new guidance on September 17, 2007, and began surveying using this guidance on October 1, 2007. See MDH Ex. F-1.

the Velcro lap tray restraint through the assessment process and incorporated the use of that restraint into the Resident's care plan. The Facility further maintained that it reacted appropriately to each of the Resident's falls by investigating, assessing, and correcting the situation that permitted the falls. It argued that the interview statements of Employees C and D are contrary to information provided by other nursing assistants and contended that Employees C and D were untruthful and were upset with the Facility because they had both received discipline in the past for failing to notify superiors when they were leaving the floor.⁵⁵

After careful consideration of the record as a whole, the Administrative Law Judge concludes that the Division has demonstrated that the citation is supported by the facts and should be affirmed as to scope and severity. The record shows that, while the Facility did identify the Resident's risks of falling, evaluate those risks, and implement interventions, it failed to adequately monitor the effectiveness of those interventions and modify them as necessary. For that reason, it is recommended that the deficiency be affirmed.

It is clear from the record that the Resident engaged in agitated behaviors that included "throwing himself" out of his wheelchair (see medical notes issued on January 22, 2007, and May 2, 2007). It is also undisputed that he leaned forward in his wheelchair most of the time with sufficient force to produce redness on his elbows by April of 2007. Moreover, it is evident that, prior to his fatal fall in August 2007, the Resident managed to push the lap tray off and fall out of his wheelchair in December 2005, August 2006, and January 2007. The Facility responded to the December 2005 fall by beginning to use a new lap tray for the Resident that slid more securely over the arms of his wheelchair, but continued to use a Velcro strap to attach the lap tray to the back of the wheelchair. The Facility responded to the August 2006 fall by replacing the "worn out" Velcro strap, and responded to the January 2007 fall by again replacing the Velcro, disciplining staff for failing to report its deteriorating condition, and clarifying to staff their responsibility to check the Velcro.

Two Facility employees who worked with the Resident provided information to the surveyor that supported the view that the Facility failed to adequately monitor the effectiveness of the interventions it was using for the Resident and make necessary modifications. Employee C told the surveyor that, a "couple of months" before the Resident's August 2007 fall, she had observed the Resident push off the lap tray on two occasions when he did *not* fall and when the Velcro was *not* in disrepair.⁵⁶ This information undermines the Facility's assertion that Employee C was referring to the Resident's August 2006 or January 2007 falls as well as its contention that the Resident was only able to remove the tray when the Velcro was worn. As reflected in the surveyor's notes and the Statement of Deficiencies, Employee C further stated that she informed

⁵⁵ Comments of Johnson.

⁵⁶ MDH Exs. E-3, J-4, J-8J-10, J-11.

“the nurse” (including Employee F) of those incidents. Moreover, as reflected in the interview notes and Statement of Deficiencies, Employee D told the surveyor that she had observed the Velcro on the Resident’s lap tray come loose on one occasion approximately eight months before her interview in October 2007. She further indicated that the Resident tended to lean forward on the tray and push the tray forward and the nursing assistants would “have to hold him back.” Employee D asserted that she had reported safety concerns about the Resident to Employee F “multiple times” during the past year.⁵⁷ The citation is also supported by the interview statement of the Director of Nursing that, “In general, the Velcro was not strong enough - just by looking at it”⁵⁸ and by the interview statement of the nurse coordinator for the Resident’s unit that the August 2007 fall may have been avoidable had she known of prior problems with the Resident’s lap tray or the Resident’s previous falls out of his wheelchair.⁵⁹

Both parties received copies of the surveyor’s interview tapes, and there was no showing that the surveyor inaccurately recorded the facts related by Employees C and D in the Statement of Deficiencies or in her interview notes. Neither Employee C nor Employee D attended the IIDR or otherwise recanted their earlier statements. The mere fact that other employees did not observe the Resident remove the lap tray does not mean that Employees C and D were not being truthful, particularly since Employee H also acknowledged that he had observed the Resident push the tray slightly forward on occasion.⁶⁰ Moreover, the mere fact that Employees C and D had received discipline from the Facility in the past (for circumstances unrelated to this Resident) does not in itself render their interview statements unbelievable.

The Division discussed several alternative means that the Facility might have used to more adequately prevent the Resident from falling, such as a lap tray with a strap that buckled, a lap tray that clamped onto the wheelchair, or a reclining “Tilt-in-Space” type of wheelchair. Mr. Kettersmith, the OT who evaluated the Resident in April 2007 for elbow redness, did not observe the Resident leaning forward in his wheelchair and apparently was not made aware that he frequently did so. Mr. Kettersmith commented during the IIDR that he did not try to come up with another intervention for the Resident because no one told him that there was a problem with the Velcro strap holding tight.

Mr. Kettersmith was not familiar with lap trays that used clamps. He noted in his comments during the IIDR that the use of a buckling strap rather than a Velcro strap would be more restrictive in the sense that it would be harder for a resident to get free, but would otherwise afford a resident the same ability to

⁵⁷ MDH Exs. E-3 through E-4, K-4 through K-5, K-7, K-9.

⁵⁸ MDH Ex. O-7.

⁵⁹ MDH Ex. E-4, M-1, M-7, M-8, M-9, M-10.

⁶⁰ The employee who was disciplined after the Resident’s January 2007 fall also stated in his response to the Notice of Discipline that “the Velcro straps were working at the time the resident decided to break them.” Facility Ex. E.

move around as the Velcro strap.⁶¹ The Facility noted that it had used lap belts with plastic buckles prior to 2005, but phased out the use of such straps due to the Facility's experience with the buckles breaking. It believes that the Velcro straps are safer and easier to maintain, pointing out that the condition of Velcro can be readily observed and it can be replaced as it becomes worn. In his comments at the IIDR, Mr. Kettersmith indicated that he believed that the use of a lap tray with a traditional wheelchair was a better intervention than a reclining wheelchair because it supported retention of trunk strength. He believed that use of a reclining wheelchair would have likely resulted in deterioration of the Resident's physical condition. He also noted that a reclining wheelchair may still be tipped over with agitated movement from side to side.

The Facility's approach seemed to presuppose that only Velcro straps could be used on lap trays for all residents in the Facility. Under the present circumstances, such a supposition did not allow the Facility to ensure that the Resident had an assistive device that was adequate to prevent accidents under 42 C.F.R. § 483.25(h), and did not provide for adequate consideration of the individual Resident's need for a modification of the intervention, as required by the SOM. The facts support the Division's position that the Facility failed to adequately monitor the effectiveness of the intervention for the Resident and make necessary modifications. For the reasons discussed by Mr. Kettersmith, it may not have been appropriate for the Facility to require the Resident to use a reclining wheelchair. However, the Resident's agitation, tendency to lean forward, and continuing attempts to move the tray should have prompted the Facility to modify the intervention, taking into consideration the individual needs of this particular Resident and the devices available, by using a different fastening device for the lap tray (such as a metal buckle), using a tray that attached more securely, or implementing some other approach.

Based upon the record as a whole, the Administrative Law Judge concludes the Division has demonstrated that the citation is supported by the facts and that the accident suffered by the Resident was avoidable within the meaning of the rule and the SOM. Accordingly, it is recommended that Tag F 323 be AFFIRMED.

B. L. N.

⁶¹ Although the surveyor's written interview notes were at times sketchy and hard to decipher, there is no dispute that the tape recordings of the interviews were provided to counsel for the Facility in advance of the IIDR.