

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

In the Matter of Texas Terrace Care Center; **RECOMMENDED DECISION**
Survey Exit Date June 13, 2008

The above matter was the subject of an independent informal dispute resolution (IIDR) conducted by Administrative Law Judge Kathleen D. Sheehy on October 29, 2008. The OAH record closed at the conclusion of the conference that day.

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

Matt Bedard, Administrator; Dawn Wozniak, RN; and Kristie Johnsrud, Administrator-Trainee, appeared without counsel on behalf of Texas Terrace Care Center, 7900 West 28th Street, St. Louis Park, MN 55426. Amy Wiffler, Regional Director of Operations, Extendicare Health Services, Inc., also participated on behalf of Texas Terrace Care Center.

FINDINGS OF FACT

1. In June 2008, the Department of Health's Office of Health Facility Complaints (OHFC) conducted an abbreviated standard survey at Texas Terrace Care Center in connection with a complaint investigation concerning the suicide of Resident #1 at the Facility.

2. On December 10, 2007, the Division issued a Summary Statement of Deficiencies to the Facility, citing violations of Tag F 309 (quality of care) as a D-level deficiency, concluding the deficiency was isolated with potential for more than minimal harm that was not immediate jeopardy.¹

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

Resident #1

4. Resident #1 was admitted to the Facility in February 2008 with diagnoses including congestive heart failure and depression. He was taking medication for depression, but he had no signs or symptoms of suicidal ideation.

¹ MDH Ex. D.

He had signed advance directives providing that he did not wish to be intubated or resuscitated (DNI/DNR).²

5. At about 2:55 p.m. on May 24, 2008, a nursing assistant noticed that the call light was on for the resident's room. He knocked on the door and got no response. He attempted to open the door and was only able to open it about two inches. He thought he could see the resident's arm through the opening of the door. He touched the arm and got no response. The nursing assistant then called three nurses from the nursing station for help. He tried again to open the door, but did not push too hard because he was afraid the resident was standing next to the door and might fall. When the door opened a few more inches, he was able to see that there was something around the resident's neck, and he thought the resident may have hung himself. One of the nurses then paged a supervisor and called 911.³

6. The police received the 911 call at 3:06 p.m.⁴

7. When the nurse who had called for a supervisor and emergency assistance returned to the resident's room, she asked the nursing assistant to help her push the door open. The supervisor arrived at about the same time and instructed all the employees not to touch the door but to wait for the police to arrive. The employees then stopped attempting to enter the room.⁵

8. The firefighter who was the first responder arrived at 3:11 p.m. He found the door to the room open about four to five inches. He moved the resident's arm out of the way and was able to open the door by pushing on it with his other hand. It required relatively little force to open the door.⁶ The firefighter and a police officer found that the resident had hung himself using the cord for the call light, which he had pulled out of the wall and knotted around the doorstop at the top of the door. The resident's skin was warm, but he did not have a pulse and was not breathing. A suicide note was taped to the resident's chest under his shirt. Emergency responders started cardiopulmonary resuscitation, but stopped when the facility produced documentation of the resident's DNR status.⁷

9. Based on interviews and record review, the Division concluded that the Facility failed to 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. Based on these findings, the Department issued Tag F 309 (quality of care), which alleges a violation of 42 C.F.R. § 483.25.

² MDH Ex. G-1a; Ex. F-1.

³ Ex. D-4.

⁴ Ex. F-2.

⁵ Ex. D-3; Progress Notes 5/24/08.

⁶ Ex. F-2.

⁷ Ex. D-6.

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

Tag F 309 is supported by the facts and should be affirmed.

Dated: November 13, 2008.

s/Kathleen D. Sheehy

KATHLEEN D. SHEEHY
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

Tag F 309 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.”⁸

As reflected in the State Operations Manual (SOM), the intent of 42 C.F.R. § 483.25 is to ensure the resident 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. “Highest practicable” is defined as the highest level of functioning and well-being possible, limited only by the individual’s presenting functional status and potential for improvement or reduced rate of functional decline. Highest practicable is determined through the comprehensive resident assessment. In any instance in which there has been a lack of improvement or a decline, the survey team must determine if the occurrence was unavoidable or avoidable. A determination of unavoidable decline or failure to

⁸ 42 C.F.R. § 483.25.

reach highest practicable well-being may be made only if all of the following are present: an accurate and complete assessment; a care plan which is implemented consistently and based on information from the assessment; and evaluation of the results of the interventions and revising the interventions as necessary.⁹

The Facility maintains that it provided all possible care to the Resident, that its staff could not open the resident's door, and that its staff was not trained in techniques to break down the door under these circumstances. This argument overstates the facts and the nature of the citation. The citation was not issued because the staff members failed to break down the door; the record is clear that breaking down the door was not required to obtain entry into the room. Entering the room was awkward, because the resident's body was between the door and the open bathroom door on the inside of his room, but a firefighter was able to push the door open with one hand. The citation was issued because the supervisor directed the other employees not to touch the door and to stop trying to enter the room to provide assistance. The supervisor apparently assumed, without conducting any medical assessment, that the resident was dead. The supervisor knew only that the resident was hanging from the door and that he was not responsive. Approximately five minutes passed between the supervisor's direction to stop trying to enter the room and the arrival of emergency responders, who openly questioned why staff had not entered the room and attempted to administer medical intervention.

The issue here is whether the Facility failed to provide all the necessary nursing care and services to maintain the Resident's highest practicable well-being. The Department has established that the supervisor's direction that other employees should stop attempting to enter the room until emergency services arrived amounted to a departure from compliance that precludes a finding that the Resident's decline was unavoidable.

After careful consideration of the record, the Administrative Law Judge concludes that the Division has demonstrated that the citation is supported by the facts and should be affirmed.

K.D.S.

⁹ MDH Ex. F.