

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

In the Matter of Pine Haven
Care Center, Inc.
Standard Survey Exit Date
March 6, 2008

RECOMMENDED DECISION

The above matter was the subject of an independent informal dispute resolution (IIDR) conducted by Administrative Law Judge Barbara L. Neilson on February 6, 2009. 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 (the Department). Mary Cahill, Planner Principal with the Division of Compliance Monitoring, also participated in the conference.

Susan M. Schaffer, Attorney at Law, appeared on behalf of Pine Haven Care Center (the Facility). The following persons made comments on behalf of the Facility: Linda Urness, Director of Nursing; Shawn Jensen, Social Services Director; and Steve Ziller, Administrator.

FINDINGS OF FACT

1. On March 6, 2008, the Department of Health's Office of Health Facility Complaints (OHFC) completed a standard survey at Pine Haven Care Center. During the survey, Resident #97 ("the Resident") was interviewed and expressed concerns regarding the failure of the Facility to provide her with oxygen during the early morning hours of February 28, 2008, after she complained of shortness of breath. After investigating these concerns, the OHFC survey team concluded that the Facility did not provide the Resident with the necessary care and services to maintain her highest practicable mental and psychosocial well-being.¹

2. On or about March 19, 2008, the Division issued a Statement of Deficiencies to the Facility. Included among the cited violations was a violation of Tag F 309 (quality of care) with respect to the Resident. The Division determined that the scope and severity of this violation was a G-level, involving actual harm that was isolated but not immediate jeopardy.²

¹ MDH Ex. D.

² MDH Ex. D-7 through D-11.

3. In this IIDR proceeding, the Facility disputes the Tag F 309 citation and asserts that it should be deleted or, in the alternative, the scope and severity score should be reduced to a D-level.

Resident #97

4. The Resident, an 86-year-old woman, was initially admitted on a short-term basis to the Facility on February 22, 2008, for rehabilitation after undergoing triple bypass surgery. Prior to the surgery, the Resident had resided in her own apartment without additional services. The hospital summary issued at the time of her discharge indicated that the Resident's stay in the Facility was anticipated to be less than 30 days, after which it was expected that she would return home. The discharge summary also noted that the Resident was alert, able to understand directions, and "expresses needs clearly and reliably."³

5. At the time the Resident was admitted to the Facility, her diagnoses included chronic ischemic heart disease, hypertension, and diabetes. The Facility's Progress Notes relating to the Resident stated that she was alert and oriented at the time of her admission, with no cognitive impairment. The Resident's Minimum Data Set noted that she did not have any problems with short- or long-term memory, was independent with cognitive skills for daily decision-making, and had not experienced a change in her cognitive status. The Minimum Data Set indicated that the Resident had the ability to make herself understood and to understand others.⁴

6. During the early morning hours of February 28, 2005, a Licensed Practical Nurse (LPN) was on duty at the Facility. Prior to her employment at the Facility, the LPN was an on-call EMT-B (Emergency Medical Technician – Basic) for a local ambulance service.⁵ The Facility's position description for the LPN included the administration of oxygen among her duties.⁶

7. On February 28, 2008, at 12:05 a.m., the Resident summoned the LPN and complained that she was having trouble breathing and needed some oxygen. The LPN placed a pulse oximeter on the Resident's finger and determined that the Resident's arterial blood oxygen saturation level on room air was 97%. The LPN told the Resident that she did not need oxygen, and raised the head of the Resident's bed to see if that would help. At 12:20 a.m., the Resident told the LPN that she had not experienced any relief and continued to have trouble breathing. The Resident sat up in bed so she could catch her breath. She thought she was dying. She asked for a pain pill and some oxygen. The LPN gave the Resident 5 mg. of oxycodone and told the Resident that she did not have a physician's order for the oxygen. The Resident asked the LPN to call the physician and get an order for oxygen. The Resident's vital signs were

³ Facility Ex. 9 at 1, 3, 4, 5.

⁴ Facility Ex. 3 at 1, 11, 12.

⁵ Facility Ex. 8.

⁶ MDH Ex. D-10 – D-11.

recorded at 12:31 a.m. as follows: blood pressure 130/80; temperature 98.9; pulse 66, respirations 24; blood sugar 188; oxygen saturation 97.0%.⁷

8. During the IIR, the Director of Nursing, Linda Urness, R.N., testified that the LPN called her about the situation with the Resident at approximately 12:30 a.m. The LPN told Ms. Urness that the Resident's oxygen saturation level was at 97%, and that the Resident was talking normally, was not gasping, was "mildly short of breath," was not confused, and was able to communicate reasonably. An oxygen saturation level of 97% is within normal limits. Ms. Urness told the LPN that, given the Resident's cardiac history, if the Resident continued to complain of shortness of breath, the LPN probably should contact the Emergency Room or the physician on call for further advice.⁸ There is no evidence that Ms. Urness told the LPN to administer oxygen to the Resident at that time.

9. At 1:00 a.m., the Resident still was not feeling any relief. The LPN placed a call at 1:10 a.m. to St. Mary's Hospital Emergency Room for permission to give oxygen. She spoke with Dr. Angela Kurtz, who ordered that the Resident be transported by ambulance to the Emergency Room. The LPN called 911 at 1:15 a.m., and the Resident was transported by ambulance to the hospital at 1:55 a.m. The Progress Notes relating to the Resident indicate that the Resident's son, the Facility Administrator, and the Acting Director of Nursing were notified by telephone.⁹

10. There is no documentation in the Facility's Progress Notes relating to the Resident that the LPN assessed the Resident prior to the time the ambulance arrived for color or warmth of her skin, lung sounds, or edema. In addition, there is no documentation describing whether the Resident's breathing was normal or labored.¹⁰

11. The report prepared by the ambulance attendants indicated that the reason for the dispatch was "chest pain/SOB [shortness of breath]" but identified the Resident's chief complaint as "SOB." The report further noted that the Resident denied any chest pain, dizziness, nausea or lightheadedness when questioned after the crew arrived, and stated that she felt like she was not getting enough oxygen. The ambulance report stated that the Resident's initial pulse oximeter was 94% on room air and her skin appeared pale. She was placed on oxygen at 12 liters per minute. When oxygen was applied, the report indicated that the pulse oximeter went to 100%, her skin became normal, and her shortness of breath went away. The Resident did not complain of shortness of breath during transport to the hospital.¹¹ When the ambulance attendants

⁷ MDH Ex. D-7 – D-8; Facility Exs. 2, 3, and 4.

⁸ Testimony of L. Urness.

⁹ MDH Ex. D-8; Facility Exs. 2, 3, and 4.

¹⁰ MDH Summary at 5-6.

¹¹ MDH Ex. D-9 – D-10; Facility Ex. 4.

administered oxygen to the Resident after they picked her up on February 28, 2008, the Resident felt that she could finally breathe.¹²

12. The hospital emergency room records noted that the Resident's chief complaint was shortness of breath and stated that she denied chest pain or chest pressure. The hospital determined that the Resident had developed some congestive heart failure, and concluded that the Resident required admission for management of her congestive heart failure and to rule out a new acute coronary syndrome.¹³ The hospital's dismissal summary indicated that the Resident was admitted to the cardiac telemetry unit for further monitoring of her heart rate and rhythm, and stated that serial biomarkers and ECG's were positive for myocardial infarction. The summary indicated that the Resident underwent cardiac catheterization and stents were placed to relieve obstruction of coronary blood vessels.¹⁴

13. The Resident remained in the hospital for four days, from February 28, 2008, to March 3, 2008. She returned to the Facility on March 3, 2008, without requiring any major changes in her plan of care.¹⁵

14. On March 3, 2008, after the Resident returned to the Facility, Diana Karlstad, a Registered Nurse with the Facility, met with the Resident. According to Ms. Karlstad's notes, the Resident indicated that she was experiencing shortness of breath and chest pain on February 28, 2008, and asked the LPN to give her some oxygen. The LPN told the Resident that she did not need oxygen because her oxygen saturations were 97%. The Resident told the LPN that she did not care what the oximeter said, she needed air. The LPN told the Resident that the Facility did not have a doctor's order for oxygen for her, and the Resident asked her to get an order then. The Resident reported that the LPN then said, "Don't get smart with me, I'm the nurse" and listed off her credentials. The Resident told her that she did not care what credentials the LPN had, she was the patient and was telling her that she needed something. The Resident said that she started to feel better right away when the ambulance crew administered oxygen. According to Ms. Karlstad's notes, the Resident said that "after what happened to her here that night and with how that night nurse treated her, she really didn't want to come back here." Ms. Karlstad then assured the Resident that "how she was treated by that nurse is not our policy," and apologized to the Resident for what she went through that night.¹⁶

15. On March 4, 2008, the OHFC surveyor interviewed the Resident. The Resident relayed information relating to the February 28, 2008, incident. The Director of Nursing, Linda Urness, was subsequently interviewed and reportedly told the surveyor that the LPN who had been working on February 28 did not make the correct decision when she failed to administer oxygen. Ms. Urness told the surveyor that she was available 24 hours a day and could have

¹² MDH Ex. D-10; Facility Ex. 4.

¹³ MDH Ex. D-10; Facility Ex. 5.

¹⁴ Facility Ex. 6 at 2.

¹⁵ Facility Exs. 3, 6; Testimony of L. Urness.

¹⁶ Facility Ex. 7 at 1; see also Facility Ex. 10.

been contacted. The surveyor's interview notes reportedly did not include any mention of the 12:30 a.m. call made by the LPN to Ms. Urness.¹⁷

16. On March 4, 2008, Ms. Urness spoke with the LPN about the incident. The LPN informed Ms. Urness that the Resident complained of shortness of breath at about "13:30 a.m." (sic) but did not show visible signs of this condition. Her oxygen saturations were at 97%. The LPN indicated that the Resident was angry at the time, the LPN consoled her and raised the head of the bed, and the Resident seemed better. However, the LPN indicated that the Resident then stated that she had chest pressure. The LPN said that she did not start oxygen because of the higher oxygen saturation level and the absence of signs of shortness of breath. The LPN said that she thought she needed an order for oxygen to be started. Ms. Urness informed the LPN during the interview that "our standing house orders allow us to start the O2 and for the resident's comfort, she should have started the O2 to calm any apprehension the resident may have had." The LPN told Ms. Urness that she called the ambulance via 911 when the Resident complained of chest pressure.¹⁸

17. Ms. Urness also spoke to the Resident's son on March 4, 2008. He told the Facility that, when the LPN called him to describe the Resident's condition, she explained that the Resident's oxygen saturation was 97% and that was normal, and stated that the Resident did not show signs of being short of breath. The Resident's son told Ms. Urness that perhaps the oxygen should have been administered for his mother's psychological well-being. Ms. Urness told him that the LPN "has been counseled on this issue and that she was asked to review our house standing orders regarding using oxygen for our residents."¹⁹

18. Ms. Urness discussed the incident with the Resident on March 5, 2008. According to Ms. Urness' notes, she "informed [the Resident] that oxygen is available for her and that the nurse should have supplied it under our standing house orders." Ms. Urness also told the Resident that the LPN would be given directions not to have any contact or enter the Resident's room, and informed her that, "following the completion of the investigation there would be significant consideration for termination of this individual."²⁰ During the IIDR, the Facility indicated that the LPN was upset about the February 28 incident and had resigned her employment with the Facility.²¹

19. The Resident was discharged from the Facility to her home on March 11, 2008. At that time, the only home services she received was Meals on Wheels. There is no evidence that the Resident received any further counseling or other services relating to the February 28, 2008, incident.²²

¹⁷ MDH Ex. D-9. The notes were not provided in this proceeding.

¹⁸ Facility Ex. 7 at 2.

¹⁹ Facility Ex. 7 at 3.

²⁰ Facility Ex. 7 at 4.

²¹ Testimony of L. Urness.

²² Facility Exs. 3, 6; Testimony of L. Urness.

20. In the view of the Facility's Director of Nursing, standing orders must be followed until Facility staff members make direct contact with the Mayo Clinic physician on-call or the hospital emergency room.²³ The Facility's Standing Orders, which were signed by a physician on January 10, 2007, contained the following information relating to emergency oxygen:

May use supplemental oxygen for acute dyspnea **or** sats [saturation rate] less than 87% via nasal cannula 1 – 2 liters or mask at 4 liter flow rate. Wean supplemental oxygen as tolerated to keep saturation rate above 87% and alert the doctor or nurse practitioner if condition not relieved in one hour or condition declining.²⁴

The Standing Order did not define acute dyspnea.

21. The Facility's Oxygen Administration policy and procedure dated October 24, 2005, stated:

Standing oxygen order May use oxygen up to 2 liters via nasal cannula PRN [as needed]. If the nurse observes symptoms of respiratory distress such as acute: congestion, shortness of breath, abnormal lung sounds or change in level of consciousness.

The policy did not indicate what should be done if the symptoms of which the resident complained were not observed.²⁵

22. On March 5, 2008, Shawn Jensen, the Facility's Social Services Director, talked with the Resident. The Resident told Ms. Jensen that the only concern she had regarding with her stay at the Facility was what happened before she went to the hospital on February 28, 2008. Ms. Jensen did not see any indication that the Resident was experiencing increased fear or anxiety as a result of that incident.²⁶

23. On March 5, 2008, the Facility reported the incident to the Common Entry Point. The Facility stated in its report that the LPN did not need an order to give oxygen to the Resident because "it is listed on the standing orders sheet." The Facility indicated that the LPN "may have made an inappropriate decision to withhold oxygen from resident despite not observing respiratory distress." The Facility further noted that the Director of Nursing "will be reprimanding [the LPN] and there is serious consideration for termination."²⁷

24. The report was reviewed and screened out on the grounds that the incident did not constitute an allegation of maltreatment under the Vulnerable Adults Act, Minn. Stat. § 626.557. The report thus was not forwarded to the OHFC or the Department of Human Services. The County Intake Worker told the Facility's social worker that the nurse probably could have given the Resident

²³ Testimony of L. Urness.

²⁴ MDH Ex. D-10 (emphasis added).

²⁵ MDH Ex. D-10.

²⁶ Testimony of S. Jensen.

²⁷ Facility Ex. 10 at 3.

oxygen for comfort and may have exercised bad judgment. However, the Intake Worker indicated that the situation seemed to involve an error in therapeutic conduct that did not result in physical harm.²⁸

25. On March 6, 2008, the Department issued Tag F 309 (quality of care) relating to the treatment of the Resident on February 28, 2008. Tag F 309 alleges a violation of 42 C.F.R. § 483.25, which provides in relevant part:

Quality of Care. 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.

The Statement of Deficiencies concluded that the Resident “experienced harm due to her inability to receive oxygen during a period of dyspnea which caused the resident to become anxious and feel like she was dying.” The Statement of Deficiencies mistakenly indicated that the Facility “failed to ensure that [the Resident] *who was receiving oxygen* received the appropriate services.”²⁹ The Resident was not in fact receiving oxygen on February 28, 2008, and did not have a specific order for oxygen administration at that time.³⁰

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 309 is supported by the facts as to Resident #97, but the phrase “who was receiving oxygen” on page 7 of the Statement of Deficiencies is inaccurate and should be deleted, and the scope and severity level should be reduced to level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy).

Dated: February 23, 2009

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

Reported: Digitally recorded (no transcript prepared).

²⁸ Facility Ex. 10 at 3; Testimony of L. Urness and S. Jensen.

²⁹ MDH Ex. D-7.

³⁰ See, e.g., Facility Ex. 3 at 9, 10, 11 (use of supplemental O2 was “N/A” or “None” on Feb. 22-27, 2008); Facility Ex. 10 at 3. After the Resident returned to the Facility from the hospital in early March, the Progress Notes indicated that the Resident did “have an order for 2L/NC PRN as needed,” but there is no evidence that supplemental oxygen was ever administered to the Resident during the remainder of her stay. Facility Ex. 3 at 1-7.

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 Facility asserts that the deficiency alleged in this case under Tag F 309 should be rescinded completely or, in the alternative, that the scope and severity level should be reduced from a level G to a level D. 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.”³¹

As reflected in the State Operations Manual (SOM) issued by the Centers for Medicare and Medicaid Services (CMS), the intent of 42 C.F.R. § 483.25 is to ensure that a resident does not deteriorate within the limits of the resident’s right to refuse treatment and within the limits of recognized pathology and the normal aging process. “Highest practicable” is defined in the SOM 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,” and is determined “through the comprehensive resident assessment by competently and thoroughly addressing physical, mental or psychosocial needs of the individual.”³² Where there has been a lack of improvement or a decline, surveyors must determine whether the occurrence was unavoidable or avoidable. Under the SOM, a determination of unavoidable decline or failure to reach highest practicable well-being may be made only if all of the following are present: (1) an accurate and complete assessment; (2) a care plan which is implemented consistently and based on information from that assessment, and (3) evaluation of the results of the interventions and revising the interventions as necessary.³³ Surveyors are directed to determine if the resident is being provided services and care and whether the facility is evaluating the outcome to the resident and changing the interventions if needed.³⁴

The Department asserts that the Facility did not provide the Resident with care and services to maintain her highest practicable mental and psychosocial

³¹ 42 C.F.R. § 483.25.

³² MDH Ex. E (excerpt from SOM App. PP) at E-1.

³³ MDH Ex. E-3 - E-4.

³⁴ MDH Ex. E-4.

well-being when the Resident complained of symptoms of oxygen deprivation. It points out that the Resident was found to be cognitively aware and able to communicate her needs when she was admitted to the Facility shortly before the incident, and clearly stated to the LPN on duty on February 28, 2008, that she felt she needed oxygen. The Department emphasizes that there is no evidence in the Facility records that the LPN or other Facility staff thoroughly assessed the Resident to determine her cardiac and respiratory status when she complained of an inability to obtain sufficient oxygen, even though she had diagnoses of heart conditions and had recently undergone bypass surgery. Because the Resident continued to feel anxiety related to her condition for over an hour and a half prior to getting relief through the administration of oxygen, stated that she thought she was dying during this time period, and was sufficiently upset that she made sure the surveyor was aware of the situation and her concerns several days later, the Department argues that the Resident experienced psychosocial harm.

In contrast, the Facility maintains that there is objective evidence that it provided all necessary care and services to the Resident and that the Resident did not suffer any actual harm as a result of the Facility's failure to administer oxygen to her during the early morning hours of February 28. It asserts that the LPN responded promptly to the Resident's call for assistance, immediately assessed the Resident's condition (including use of a pulse oximeter to take oxygen saturation reading), raised the head of the bed, and provided requested pain medication. The Facility further contends that the LPN contacted the Director of Nursing at approximately 12:30 a.m., called the hospital emergency room at 1:10 a.m. when the Resident's condition did not improve, and summoned an ambulance at 1:15 a.m. The Facility argues that the actions of the LPN resulted in the Resident receiving timely services she needed in the emergency room.³⁵

Based upon the records provided in connection with this IIDR, the Administrative Law Judge has determined that the Facility did not provide the necessary care and services for the Resident to attain the highest practicable mental and psychosocial well-being on February 28, and that the citation with regard to Tag F 309 is supported by the facts.³⁶ There is no dispute that the Resident was alert, oriented, cognitively competent, and able to describe her symptoms and express her needs. It appears that the LPN took some steps to evaluate the breathing difficulty reported by the Resident on February 28 by checking the Resident's oxygen saturation and vital signs, and considered the effect of a few interventions (raising the head of the bed, providing pain medication). However, there is no evidence the Resident was thoroughly

³⁵ The Facility speculates that, had oxygen been administered in the Facility, the Resident's immediate symptoms of shortness of breath may have been relieved and her admission to the hospital may have been delayed.

³⁶ However, as noted above, the Administrative Law Judge has recommended that the phrase "who was receiving oxygen" on page 7 of the Statement of Deficiencies be deleted because that statement is not supported by the medical records.

assessed to determine her cardiac and respiratory status when she complained that she was unable to get enough oxygen, even though she had recently undergone bypass surgery and had a history of heart conditions. For example, there is no documentation that the LPN evaluated the color or warmth of the Resident's skin, her lung sounds, or the existence of edema, and no indication whether her breathing was normal or labored.

Due to the lack of assessment, it appears that appropriate interventions were not instituted to assist the Resident to maintain her highest level of functioning. The Resident continued to feel anxiety related to her condition for over 1½ hours before obtaining relief through the administration of oxygen. The ambulance report and the hospital emergency room report provide some corroboration of the Resident's assertions about her need for oxygen, since her feelings of shortness of breath were relieved by the administration of oxygen, and it was determined that the Resident had developed some congestive heart failure.

The particular intervention sought by the Resident—the administration of supplemental oxygen—was denied because the LPN believed there was no order in effect that permitted her to provide the Resident with oxygen. In fact, the Facility's standing orders permitted the use of supplemental oxygen **either** for acute dyspnea (shortness of breath) **or** where the oxygen saturation rate was less than 87%. The standing orders did not define "acute," but that term is generally used to connote the abrupt onset of symptoms.³⁷ Because there is no indication in the medical records that the Resident was experiencing shortness of breath on a chronic or frequent basis prior to February 28, the sudden onset of that complaint on February 28 would appear to be acute in nature, and fall within the standing orders. Indeed, the Facility's Director of Nursing acknowledged in her discussions with the LPN and the Resident on March 4 and 5, 2008, that the Facility's standing orders would have allowed the administration of oxygen to the Resident and that the LPN should have administered the oxygen for the Resident's comfort and to calm her apprehension. It is also significant that the Director of Nursing viewed the LPN's conduct as sufficiently serious in nature to warrant her removal from contact with the Resident and the potential termination of her employment.

The Department contends that the deficiency was properly issued at a scope and severity level of G (an isolated deficiency that resulted in actual harm that is not immediate jeopardy).³⁸ The Facility argues that the Resident did not show actual harm within the meaning of level 3, and urged that, at a minimum, the scope and severity level be reduced to a level D.³⁹

³⁷ See www.medterms.com.

³⁸ MDH Ex. D-7.

³⁹ Minn. Stat. § 144A.10, subd. 16(d)(5), specifically authorizes determinations issued in connection with IIDR proceedings to include a finding that a citation's "[s]everity [is] not supported," and permits a recommendation to be made that a citation be "amended through a

Where a deficiency is found, the SOM indicates that four possible scope levels are possible: isolated, pattern, and widespread. Because there is no evidence that any other resident was affected, it is appropriate to consider the scope of the current deficiency to be isolated. Four possible severity levels also are available under the SOM: level 1 (no actual harm with potential for minimal harm); level 2 (no actual harm with potential for more than minimal harm that is not immediate jeopardy); level 3 (actual harm that is not immediate jeopardy); and level 4 (immediate jeopardy to resident health or safety). In this instance, the Department selected Level 3, which is defined as “noncompliance that results in a negative outcome that has compromised the resident’s ability to maintain and/or reach his/her highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. This does not include a deficient practice that only could or has caused limited consequence to the resident.”⁴⁰ The Facility urges that it would be more appropriate to select severity level 2, which involves “noncompliance that results in no more than minimal physical, mental and/or psychosocial discomfort to the resident and/or has the potential (not yet realized) to compromise the resident’s ability to maintain and/or reach his/her highest practicable physical, mental and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.”

CMS has developed a scope and severity grid for use by surveyors,⁴¹ as well as a Psychosocial Outcome Severity Guide to be used in conjunction with the grid to assist in the determination of the severity of a psychosocial outcome to a particular resident.⁴² The guide indicates that surveyors should consider both psychosocial outcomes and physical outcomes in determining the severity level, and emphasizes that they are equally important. The guide specifies that negative psychosocial outcomes under Severity Level 3 include:

Chronic or recurrent fear/anxiety that has compromised the resident’s well-being and that may be manifested as avoidance of the fear inducing situation(s) or person(s); preoccupation with fear; resistance to care and/or social interaction; moderate aggressive or agitated behavior(s) related to fear; sleeplessness due to fear;

change in the severity assigned to the citation.” There is no language in the statute limiting such situations only to immediate jeopardy or substandard quality of care severity levels. In addition, the federal regulations set forth in 42 C.F.R. § 488.331(a) require states to offer facilities an informal opportunity “to dispute survey findings.” Thus, notwithstanding CMS’s informal policy statements to the contrary in the State Operations Manual and Program Letter instructions, it appears that the Department’s determination that the Resident suffered actual harm is a “survey finding” that may be disputed by the Facility in this IIDR.

⁴⁰ MDH Ex. C (excerpt from SOM App. P) at C-1 – C-2.

⁴¹ MDH Ex. C-11.

⁴² MDH Ex. C-3 – C-4.

and/or verbal expressions of fear. Expressions of fear/anxiety are not to the level of panic and immobilization.⁴³

The guide further notes that examples of negative psychosocial outcomes under the lesser Severity Level 2 include:

Fear/anxiety that may be manifested as expressions or signs of minimal discomfort (e.g., verbal expressions of fear/anxiety; pulling away from a feared object or situation) or has the potential, not yet realized, to compromise the resident's well-being.⁴⁴

It is evident that the Resident was distressed and anxious about her breathing difficulty on February 28 and the failure of the Facility staff to provide her with supplemental oxygen at that time. She stated that she felt like she was dying. Once the ambulance arrived and she received supplemental oxygen, the Resident indicated her symptoms were relieved, and the higher oximeter reading obtained by the ambulance crew and the improved skin color they noted provided objective evidence of this fact. The Resident remained sufficiently unhappy about the manner in which she was treated by the LPN on February 28 to voice complaints about the situation when she was approached by Facility staff and by the OHFC surveyor.

Under the circumstances presented here, however, there is no proper basis for the Department's conclusion that the Resident experienced "chronic or recurrent" fear or anxiety that has compromised the Resident's well-being. There is no evidence that she became preoccupied with fear, repeatedly expressed fearfulness, experienced sleeplessness, resisted cares or social interaction, avoided the fear-inducing situation, or engaged in aggressive or agitated behaviors. Although the Resident expressed some reluctance to return to the Facility after the events of February 28, it is significant that she did, in fact, do so. The mere fact that the Resident mentioned her complaint regarding her treatment on February 28 to the surveyor and Facility staff and described to them the anxiety she felt at the time is not sufficient, in itself, to support a finding that the incident has caused chronic or recurrent fear or anxiety. In fact, the Resident's courage in making her objections known to the surveyor and Facility staff suggests that her well-being and her convictions have not been compromised. Despite her additional hospitalization on February 28, the Resident was able to return to her own home within less than thirty days, the timeframe originally anticipated at the time of her initial admission to the Facility, and there is no indication that she is receiving any psychological counseling or other services for any type of chronic anxiety stemming from the February 28 incident. The psychosocial outcome experienced by the Resident in this case more appropriately falls under lesser severity level 2, resulting in a D-level deficiency.

⁴³ MDH Ex. C-8 (emphasis added).

⁴⁴ MDH Ex. C-9.

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. The citation should be amended by reducing the scope and severity from G to D.

B. L. N.