

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

In the Matter of Good Samaritan  
Society—  
University Specialty Care Center  
Standard Survey Exit Date: December  
5, 2008

**RECOMMENDED DECISION**

The above matter was the subject of an independent informal dispute resolution (IIDR) meeting conducted by Administrative Law Judge Kathleen D. Sheehy at 1:00 p.m. on October 14, 2009, at Good Samaritan University Specialty Care Center, 22 – 27<sup>th</sup> Avenue SE, Minneapolis, MN 55414. The OAH record closed at the conclusion of the meeting on October 14, 2009.

Marci Martinson, Unit Supervisor, Division of Facility and Provider Compliance (DFPC), 1645 Energy Park Drive, Suite 300, St. Paul, MN 55108-2970, appeared on behalf of DFPC. Mary Cahill, Planner Principal of the Compliance Monitoring Division, also attended the meeting.

The following persons participated in the meeting on behalf of Good Samaritan University Specialty Care Center: Sharon St. Mary, Executive Director; John Mielke, Medical Director; Nikki Tostenson, Director of Nursing; Kay Vescio, Assistant Director of Nursing; Mary Kamara, Certified Nursing Assistant; and Resident #13.

**FINDINGS OF FACT**

1. Resident #13 is a 72-year-old man who was admitted to the facility in 1987 and has resided there for the last 22 years. His diagnoses include spastic quadriplegia, multiple coronary vascular accidents, diabetes, and depression. Resident #13 is alert and communicative, and his insight, cognition, and judgment are generally intact.<sup>1</sup> He uses an electric wheelchair and enjoys taking trips outside the facility to shop or have meals with friends.

2. The resident's desire for independence has often conflicted with medical advice to avoid sitting for prolonged periods in his wheelchair so that he does not develop pressure ulcers.<sup>2</sup> The resident consequently has a history of pressure ulcers on his coccyx and buttocks, developed after sitting for excessive

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<sup>1</sup> Facility Ex. E-2; Facility Ex. D-23a.

<sup>2</sup> Comments of Resident #13;

periods of time in his wheelchair; there is no evidence in the record that he has ever developed a pressure ulcer as a result of resting in bed. In February 2005, he developed a pressure ulcer on his left ischial tuberosity that took 28 months to heal.<sup>3</sup>

3. In January 2006, the resident contacted a volunteer for the Ombudsman for Older Minnesotans to express his frustrations regarding the limitation on his daily activities resulting from the facility's adherence to wound care protocols.<sup>4</sup> At the time, his care plan called for him to be turned every two hours when in bed, and he was allowed to be up in his wheelchair for two hours per day, based on physician orders.<sup>5</sup> His Interdisciplinary Care Team met on January 31, 2006, and attempted to convince the resident to accept a plan allowing him to be up in his wheelchair twice a day, but for a shorter period (90 minutes). The resident declined to accept this proposal. The team discussed with the resident the risks and benefits of being up in the chair and enjoying life versus the potential medical issues that could arise should the wound worsen. Ultimately, the team determined that the resident could continue to be up in his wheelchair for two hours each day, and two times per week he could be up for longer periods, depending on the results of tissue tolerance tests. The team reviewed the resident's right to stay up in chair for longer periods, despite medical advice to the contrary, if he desired to do so.<sup>6</sup>

4. Tissue tolerance tests conducted a few days later showed that the resident's skin was not able to tolerate the pressure of sitting for two and one-half hours at a time. The resident was informed of the results. In the interests of increasing the resident's sense of self-control while complying as closely as possible with wound treatment protocols, the decision was made to allow a three-hour sitting period twice per week. Thus, the resident's schedule was that he could be up in the wheelchair for two hours each day, with the exception that twice per week he would be permitted to remain up for three hours.<sup>7</sup>

5. The resident's care plan was amended to provide that the resident could be up in his wheelchair for two hours each day, and twice per week he would be permitted to remain in the chair for three hours.<sup>8</sup> With regard to repositioning in bed, the resident's tissue tolerance results showed he met criteria for repositioning every two hours, which was the current plan of care.<sup>9</sup>

6. Throughout 2006 and 2007, the resident continued to make trips in his wheelchair outside the facility for lengthy periods, often four to five hours at a time and sometimes up to ten hours at a time. Staff made frequent notes of the resident's noncompliance, but also noted that he enjoyed his time up in the chair

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<sup>3</sup> Facility Ex. K-4.

<sup>4</sup> Facility Ex. F-9.

<sup>5</sup> Facility Ex. F-10.

<sup>6</sup> Facility Ex. I-13.

<sup>7</sup> Facility Ex. D-4; D-19; D-26.

<sup>8</sup> Facility Ex. H-4; H-5; D-4; F-12.

<sup>9</sup> Facility Ex. D-20.

and that it enhanced his spirits.<sup>10</sup> The facility's medical director continued to advise the resident to limit his time in the chair to 1.5 hours two times per day and repeatedly advised him about the consequences of noncompliance.<sup>11</sup> Toward the end of November 2007, the resident advised the facility that he no longer wanted the facility's medical director to see him on wound rounds.<sup>12</sup> The facility's medical director complied with the resident's request.<sup>13</sup>

7. The same pattern continued in 2008, in which the resident would sit for four to five hours at a time when off the unit or on an outing, and staff members would repeatedly explain the likely effect on his skin.<sup>14</sup> In July 2008, he was referred to occupational therapy for evaluation of wheelchair positioning. He was educated on tilting the position of the chair to decrease pressure.<sup>15</sup>

8. The facility conducted tissue tolerance tests on June 17, 2008, using a tool called the Positioning Data Collection Tool. The assessment protocol for evaluating pressure while the resident was sitting was performed properly; the assessment protocol for evaluating pressure while lying on the left and right side was not performed properly.<sup>16</sup>

9. In September 2008, the facility completed a Braden Scale assessment of the resident, which was scored as 15. This score placed him at risk for the development of pressure ulcers, and the intervention guide suggests frequent turning, for example every two hours, is appropriate for this level of risk.<sup>17</sup>

10. A Minimum Data Set (MDS) completed on September 17, 2008, reflected that the resident had a stage 2 pressure ulcer and described interventions of a pressure-relieving device for chair and bed, a turning/repositioning program, and other preventative skin care.<sup>18</sup>

11. The resident's care plan, as of September 24, 2008, called for turning and repositioning the resident with the assistance of 1-2 staff, but no interval of time was specified. It also provided that the resident would be encouraged to lie down after being in the wheelchair for 90 minutes, "per tissue tolerance tool." It described many other interventions, including use of an alternating pressure air loss mattress, provision of education as needed when the resident did not comply with recommendations for time up in the chair; referral to a nurse manager or social services for care refusal; and other interventions calculated to encourage the resident to participate in leisure activities within the facility.<sup>19</sup>

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<sup>10</sup> Facility Ex. H-7; F-13; H-10.

<sup>11</sup> Facility Ex. D-21; D-22.

<sup>12</sup> Facility Ex. H-14.

<sup>13</sup> Comment of Dr. Mielke.

<sup>14</sup> Facility Ex. H-16; D-31; D-16, H-18, H-38.

<sup>15</sup> Facility Ex. E-18, H-38, H-39.

<sup>16</sup> DFPC Ex. E-6; Comment of Marci Martinson.

<sup>17</sup> Facility Ex. E-8, E-11.

<sup>18</sup> Facility Ex. E-1.

<sup>19</sup> Facility Ex. F-2 through F-6; F-28.

12. In October 2008, the resident developed an open area over the site of the former wound on the left ischium. Staff encouraged him to limit sitting to no more than two hours each day. Nonetheless, the resident continued to be noncompliant with this advice.<sup>20</sup>

13. On December 1, 2009, the resident went on a shopping trip outside the facility and was in his chair for most of the day.<sup>21</sup>

14. That evening the DFPC commenced a survey of the facility. On the morning of December 2, 2009, the resident had a new open area on the coccyx.<sup>22</sup>

15. The nursing assistant assignment sheet for that day provided that the resident was to be turned and repositioned every 1.5 hours, and the resident was to be tilted back every hour when he was up in his wheelchair.<sup>23</sup> The most current physician order called for the resident to be turned every two hours.<sup>24</sup>

16. During all days of the survey, surveyors observed that when the resident was lying in bed, he was lying on his back. When surveyors questioned the resident's nursing assistant about his turning schedule, she indicated that the resident was able to turn and reposition himself.<sup>25</sup>

17. There are inconsistencies between Resident #13's care plan, the nursing assignment sheets, and physician's orders with regard to the frequency of turning while the resident is in bed. The care plan does not specify an interval; the nursing assignment sheets called for turning every 1.5 hours; and the physician orders call for turning and repositioning every two hours. In addition, it does not appear the nursing assistant believed it necessary to turn the resident every 1.5 hours because she believed he could reposition himself. This is inconsistent with all assessments of the resident, which indicate he needs assistance in turning and repositioning while in bed.

18. The DFPC cited the facility as follows for violation of Tag F314,

Resident #13 had a history of recurrent pressure ulcers on the buttocks/coccyx area. The resident was not observed to be repositioned on his sides while in bed and sustained harm when he developed a newly opened stage II pressure ulcer during the survey.<sup>26</sup>

19. Based on this finding, the surveyors rated the scope and severity of the deficiency for resident #13 at level G, actual harm, isolated.

20. The DFPC also cited the facility for violations of Tag F314 with regard to Resident #6, Resident #1, Resident #7, Resident #12, Resident #16,

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<sup>20</sup> Facility Ex. H-23-H-25.

<sup>21</sup> DFPC Ex. E-9.

<sup>22</sup> DFPC Ex. E-8.

<sup>23</sup> DFPC Ex. E-8.

<sup>24</sup> Facility Ex. F-1 (10/2/08).

<sup>25</sup> DFPC Ex. E-8.

<sup>26</sup> DFPC Ex. E-5.

Resident #28, Resident #22, and Resident #5. These residents did not have pressure ulcers at the time of the survey, but surveyors found similar inconsistencies between the care plans for these residents and the assessments (or lack thereof) used to evaluate their turning or sitting schedules. These were cited at a reduced severity level, no actual harm but potential for more than minimal harm that is not 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 Administrative Law Judge recommends that the citation with regard to F-tag 314 (Resident #13) is supported by the facts, except as follows: the finding that the resident “sustained harm when he developed a newly opened stage II pressure ulcer during the survey” should be deleted, and the severity level should be reduced to no actual harm, with the potential for more than minimal harm that is not immediate jeopardy. The findings with regard to other residents are supported by the facts and should be affirmed as to scope and severity.

Dated: October 30, 2009.

s/Kathleen D. Sheehy

KATHLEEN D. SHEEHY  
Administrative Law Judge

Reported: Digitally recorded, no transcript prepared

### **NOTICE**

Under Minn. Stat. § 144A.10, subd.16 (d)(6), this recommended decision is not binding on the Commissioner of Health. Under Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this recommended decision.

### **MEMORANDUM**

Tag F 314 is based upon an alleged violation of 42 C.F.R. § 483.25(c), which provides that based upon a resident’s comprehensive assessment, the facility must ensure that (1) a resident who enters a facility without pressure sores does not develop pressure sores unless the resident’s clinical condition

demonstrates that the sores were unavoidable, and (2) a resident with pressure sores receives the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.<sup>27</sup>

A pressure sore is considered “unavoidable” only if the facility documents that it has (1) evaluated the resident’s clinical condition and pressure ulcer risk factors; (2) defined and implemented interventions that are consistent with resident needs, resident goals, and recognized standards of practice; (3) monitored and evaluated the impact of the interventions; and (4) revised the interventions as appropriate.<sup>28</sup>

The facility argued that it has properly evaluated the resident and monitored and revised interventions appropriately, given the resident’s well documented decision to risk skin breakdown in order to engage in the leisure activities that give meaning to his life. It is true that the resident’s tolerance for sitting has been closely monitored over his many years in the facility, and the DFPC does not maintain that there is anything wrong with this aspect of the resident’s care.<sup>29</sup>

The evaluation and response to his toleration of bed rest, however, is not as well documented. The most recent tissue tolerance test was not properly completed for supine rest on the left and right sides. In addition, it is unclear from the care plan what the resident’s turning and repositioning schedule was supposed to be, because no time interval is specified. Moreover, surveyors did not observe that the resident was ever turned or repositioned while in bed.

It appears from the record that because the resident’s history was to develop pressure sores from sitting in his chair, and because the resident did not like to comply with the recommended turning schedule while in bed, the staff was not as careful about evaluating his tolerance for bed rest, did not incorporate those evaluation results into the care plan, and did not adhere as closely to the care plan or the physician’s orders for turning and repositioning the resident while in bed. While this response may have been based on the facility’s genuine desire to accommodate the resident’s refusal of treatment, that refusal is not properly documented in the resident’s care plan or in the medical record.<sup>30</sup> Absent this documentation, the resident’s development of a pressure sore during the survey cannot be considered “unavoidable,” and the DFPC properly cited a deficient practice.

It does not follow, however, that because a pressure ulcer must be considered “avoidable” for purposes of determining whether there was a deficient

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<sup>27</sup> 42 C.F.R. § 483.25(c).

<sup>28</sup> Ex. F-1 & F2.

<sup>29</sup> DFPC agrees that the most recent tissue tolerance test properly evaluated the resident’s tolerance for sitting. The citation is focused on the turning and repositioning schedule while the resident is in bed.

<sup>30</sup> See 42 C.F.R. § 483.20(k)(1) (care plan must describe any services furnished to the resident, as well as services that would otherwise be required under § 483.25 but are not provided due to the resident’s exercise of rights, including the right to refuse treatment under § 483.10(b)(4)).

practice, the practice must necessarily be considered the cause of any actual harm. The State Operations Manual defines “actual harm” as *a finding of noncompliance that results in a negative outcome* that has compromised the resident’s ability to maintain and/or reach his highest practicable physical, mental, and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services (emphasis added). This standard requires a determination of causation that is independent of whether the outcome was avoidable or not; a finding of actual harm requires evidence that the deficient practice actually caused the harm.

The facility has presented essentially uncontroverted evidence that the resident’s skin breakdown on December 2, 2008, was the result of his extended shopping trip on December 1, 2008, during which he was up in his chair for most of the day. The record is replete with evidence documenting the resident’s decision to risk this outcome for the sake of his mental health. The Administrative Law Judge cannot conclude that the facility’s deficient practice with regard to turning and repositioning the resident while in bed played any part in the development of the pressure ulcer during the survey. Pursuant to Minn. Stat. § 144A.10, subd. 16(d)(5), the finding of actual harm should be deleted and the severity of the deficiency reduced.

**K.D.S.**