

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

In the Matter of Martin Luther Care Center;
Survey Exit Date March 9, 2009

RECOMMENDED DECISION

The above matter was the subject of an independent informal dispute resolution (IIDR) conducted by Administrative Law Judge Kathleen D. Sheehy on November 23, 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. Mary Cahill, Planner Principal with the Division of Compliance Monitoring, also participated in the conference.

Susan M. Voigt, Esq., and Stephanie Margolis, Esq., Voigt, Klegon & Rode, LLC, appeared for the Martin Luther Care Center. Jody Barney, Administrator; Carolee Alexander, Director of Nursing; Elijah Mokandu, LPN; and Tony Yeboah, Nursing Assistant, participated on behalf of Martin Luther Care Center. Scott Lindberg, Emergency Medical Services Instructor at Hennepin Technical College, also participated as an expert on behalf of the facility.

FINDINGS OF FACT

1. The Department of Health's Office of Health Facility Complaints (OHFC) conducted an abbreviated standard survey at Martin Luther Care Center in connection with a complaint investigation regarding the death of Resident #1 at the Facility on January 19, 2009.

2. On March 9, 2009, the OHFC issued a Summary Statement of Deficiencies to the Facility, citing several violations with a scope and severity of Level G, an isolated incident with actual harm that is not immediate jeopardy.¹

3. In this IIDR proceeding, the Facility disputes only Tags F 309 (quality of care) and F 353 (insufficient nursing staff).

Resident #1

4. Resident #1 was 83-year-old woman admitted to the Facility's Transitional Care Unit (TCU) at about 3:00 p.m. on January 18, 2009, five days after surgery to repair an abdominal aortic aneurysm. She was there to receive short-term physical and occupational therapy due to weakness after the surgery.

¹ See Ex. D.

At the time of her admission, she signed a form indicating that she wanted to be resuscitated in the event of a cardiopulmonary arrest.²

5. On January 18, 2009, there were 34 residents in the TCU. The TCU is located on the first floor of the facility. The rooms are located in three separate wings, with a centrally located nursing station. The nursing station is visible from the lobby.³

6. About one week prior to the Resident's admission, the building engineer inadvertently disconnected the Facility's dedicated telephone lines providing access to 911 services. As a result, no telephone in the Facility could be used to call 911. The error was discovered quickly, but repairs were expected to take a few weeks. In the meantime, staff members were instructed to call the Bloomington Police Department telephone number or to use their personal cell phones to call 911 in the event of an emergency. The telephone number for the Bloomington Police Department was posted at each nursing station.⁴

7. The clinical record reflects that during the evening shift on January 18, the Resident was alert and oriented, and the evening shift nurse described her as pleasant and cooperative. The surgical site was dry and intact. At 10:30 p.m., the Resident took Percocet and Tylenol for abdominal pain.⁵ At about 11:00 p.m., the evening shift nurse recorded the Resident's vital signs as respirations 20, oxygen saturation 95.0 (room air), blood pressure 166/85 (sitting), and pulse 110.⁶

8. Two Licensed Practical Nurses (LPNs) and two nursing assistants worked the night shift from January 18 to January 19, 2009. The LPNs are referred to as Nurse C and Nurse D in the Summary Statement of Deficiencies. Nurse C was assigned to care for the Resident. Nurse D was the nurse in charge that night. A registered nurse (RN) was on call, but was not in the building.

9. At 1:24 a.m. on January 19, 2009, the Resident activated her call light for assistance. The nursing assistant who answered the call light helped the Resident to the bathroom and then back to bed. She appeared to be fine at that time.⁷

10. At about 1:35 a.m. on January 19, 2009, Nurse C made a status note indicating that the Resident was alert and oriented and had received Percocet for pain.⁸ This notation was not accurate, in that Nurse C did not administer any pain medication to the Resident. In a subsequent interview,

² Ex. F-1 & F-2.

³ Facility Ex. 7.

⁴ Comments of Jody Barney.

⁵ Ex. F-11.

⁶ Facility Ex. 4.

⁷ Facility Ex. 1; Comments of Tony Yeboah.

⁸ Facility Ex. 9.

Nurse C stated that she was referring to the medication given earlier on the evening shift.⁹

11. At or about 2:00 or 2:30 a.m., Nurse C went on break. Her break lasted until approximately 3:00 a.m. Nurse D was responsible for all the residents on the unit while Nurse C was on break.¹⁰ From about 2:30 to 3:00 a.m., one of the nursing assistants also went on break.¹¹

12. At 2:59 a.m., the Resident activated the call light again. Nurse D responded, and the Resident requested more pain medication.¹² Nurse D reviewed the Resident's chart and found the physician's order for Percocet for pain control. He administered Percocet to the Resident at 3:00 a.m., which he documented in the Pain Medication Flow Sheet.¹³ He did not make any observations of the Resident's abdomen, and he did not ask the Resident any questions about the character, intensity, or location of the pain.¹⁴

13. The Resident's vital signs were scheduled to be taken every four hours. They were taken at 11:00 p.m. on January 18, which means her vital signs should have been taken at or about 3:00 a.m. on January 19.¹⁵ It is unclear from the record when the Resident's vital signs were actually taken. At 3:33 a.m., Nurse C recorded the Resident's vital signs. The notations indicate that the Resident had respirations of 20, her oxygen saturation was 95.0 (room air), her blood pressure was 173/91 (lying down), and her pulse was 91.¹⁶

14. At some point between 3:00 a.m. and 4:40 a.m., the Resident experienced a sudden decline and cardiac arrest. There is little documentation in the medical record to confirm what the staff observed, or when they observed it, or what they did in response to it. At 4:38 a.m., Nurse C called the Bloomington Police Department to report that the Resident was having chest pain and was breathing, but was unresponsive.¹⁷

15. In an interview, Nurse C said she went to the Resident's room after returning from her break around 3:00 a.m. and learning that Nurse D had administered the pain medication. She found the Resident to be sleeping. At around 4:00 a.m. she returned to obtain vital signs. Why she would have returned to obtain vital signs at this time is unclear, since it appears she had just recorded a set of vital signs about a half hour previously. She found the Resident pale, short of breath, restless, and tossing in bed. Nurse C could not obtain a blood pressure reading. She said she went to the nurse's station and

⁹ Ex. G-4.

¹⁰ Ex. F-4; Comments of Elijah Mokandu. The Facility's records indicate that Nurse C was logged onto the computer between 1:01 a.m. and 2:10 a.m. See Facility Ex. 5.

¹¹ Comments of Tony Yeboah.

¹² Facility Ex. 1; Comments of E. Mokandu.

¹³ Facility Ex. 2.

¹⁴ Ex. F-4; Comments of E. Mokandu.

¹⁵ Facility Ex. 4.

¹⁶ *Id.* Facility records indicate that Nurse C was next logged onto the computer from 3:31 a.m. to 3:37 a.m. See Facility Ex. 5.

¹⁷ Facility Ex. 11 at 5 of 9.

informed Nurse D of the Resident's condition. She obtained a manual blood pressure cuff and Nitroglycerin and returned to the Resident's room. She found the Resident unresponsive, but said she did not start CPR because the Resident had a pulse and was breathing. She also said Nurse D came into the Resident's room at that time with a tank of oxygen and administered oxygen with a nasal cannula. She said Nurse D stayed with the Resident, while Nurse C ran to call for emergency personnel. She said she returned to the Resident's room and remained with her until emergency responders arrived.¹⁸ She said she checked the Resident's incision in the presence of the police officer who arrived first and found no bleeding. She said the Resident's skin was warm, and the Resident was having periods of apnea. She said she moved the roommate's bed against the wall, so the area would be more accessible for paramedics. After paramedics arrived she said she left the room to notify the Resident's family, but she found that Nurse D was already speaking with the Resident's spouse when she returned to the nurse's station.¹⁹

16. In a written statement and interview, Nurse D provided a materially different account. He said that at approximately 4:00 a.m. (in the interview) or between 4:00 and 4:30 a.m. (in the written statement) Nurse C reported to him that she was having difficulty obtaining the Resident's blood pressure. He said he went to the Resident's room and observed that her condition had changed significantly since he had administered the pain medication at 3:00 a.m.: the Resident was pale and breathing, but restless. He believed she needed oxygen. He immediately informed Nurse C to call 911, and he left the room to find the emergency oxygen tank. He could not find it, as it had apparently been used for another resident and had not been replaced. He ran to the north unit, but there was no emergency tank there either. He then ran to the oxygen room and got new tubing to use with an oxygen tank the Resident's roommate had been using. He said the Resident did not respond to his questions when he applied the oxygen and that he stayed with the Resident and she was still breathing when the police arrived. He did not obtain a complete set of vital signs or attempt to take the Resident's blood pressure, but said he monitored her pulse continuously until the police arrived. When asked why it took so long for Nurse C to call 911, Nurse D said the Facility's 911 service was out and staff were instructed to call the police department instead.²⁰

17. At the IIDR conference, Nurse D stated that he was doing rounds on the residents assigned to him some time after 4:00 a.m. when Nurse C came to him to say that she could not obtain a blood pressure reading on Resident #1. He said Nurse C did not express any concern about the Resident's condition, she just said she could not obtain a blood pressure reading. Nurse D said he stopped what he was doing and immediately went to Resident #1's room, where he immediately determined that her condition had changed for the worse. He said he also looked for an emergency tank in the oxygen room, but could not find

¹⁸ Ex. F-3.

¹⁹ Ex. F-2 and F-3.

²⁰ Ex. G-5 and G-6.

one there either. He said he returned to the Resident's room with new tubing in less than five minutes. He also said he told the nursing assistant, who was with him, to tell Nurse C to call 911 at that time. He said he stayed with the Resident until the police officer arrived, then left to find Nurse C to answer the police officer's questions about what had happened. Nurse C was at the nurse's station when he left the Resident's room.²¹

18. The first emergency responder to arrive, at 4:40 a.m., was a police officer. His version of events differs from that of Nurse C and Nurse D. When he arrived at the facility, the front door was unlocked. There was no one there to greet him, but he was familiar with the facility and went to the TCU nurse's station. He observed a man, who the officer believed to be a male nurse, standing in the hall outside the resident's room. The man walked into the Resident's room with the officer. No other staff members were present. The police officer checked the Resident and found she had no pulse and was not breathing. He immediately initiated artificial ventilation and continued it until the paramedics arrived a few minutes later. He did not see a female nurse in the Resident's room at any time.²²

19. At 4:41 a.m., someone called the Resident's spouse to advise him of her decline.²³

20. At 4:42 a.m., paramedics arrived. They entered the building and approached the TCU nurse's station, where Nurses C and D were talking. They were directed to the Resident's room. The paramedics confirmed that the Resident was not breathing and had no pulse. They placed EKG leads to determine whether the Resident had any cardiac activity. One paramedic ran back to the truck to get airway supplies. When she returned to the building and ran past the nurse's station, she asked the nurses how long the resident had been "down," and they responded "Only since we called you." After finding no cardiac activity, the paramedics pulled the resident onto the floor and started performing CPR. A paramedic noticed that the Resident's legs were mottled, her abdomen was distended, and bruising was present throughout the entire abdomen. The paramedics performed CPR for 20 to 30 minutes, until a hospital physician advised them to discontinue. At 5:05 a.m., the Resident's time of death was called. One paramedic observed rigor in the Resident's hands. Some time before leaving the building, one of the paramedics asked Nurse C "When was the last time you saw her?" Nurse C responded "3:00 a.m."²⁴

21. According to the ambulance run sheet completed by paramedics, the Resident had no blood pressure, pulse, or respirations at the time they arrived. The Resident was cyanotic, pale, and cool, and had suffered a cardiac

²¹ Comments of E. Mokandu.

²² Ex. G-7.

²³ Facility Ex. 10; Comment of E. Mokandu.

²⁴ Ex. G-7 and G-8.

arrest prior to their arrival. They estimated that she had been in full cardiac arrest for more than 20 minutes.²⁵

22. At 5:01 a.m., Nurse C made a progress note indicating that she went to the Resident's room to do the 3:00 a.m. vital signs and found the Resident pale, short of breath, restless, and tossing side to side in bed. The Resident had her hand on her chest. The note indicates vital signs were taken as follows: temperature 97.4, pulse 91, respirations 24, oxygen saturation 92% on room air, unable to get blood pressure reading.²⁶ The note describes the following action taken:

Put on oxygen @2L per NC. Attempted to give Nitro, but pt. become unresponsive, CPR attempted. NOc supervisor notified. Noc sup. notified pt. husband re. pt medical status. Bloomington police called, EMT and paramedic took over to finish CPR.²⁷

21. In the later interview, Nurse C stated that when she wrote in this note that "CPR [was] attempted," she meant that the emergency responders attempted CPR. Both Nurse C and Nurse D said that they did not initiate CPR on the Resident because she still had a pulse until the time emergency responders arrived.

22. The Facility's policy on checking residents during the night shift is that residents who do not require toileting or repositioning assistance will be visually checked for safety every hour.²⁸ The Facility's policy on CPR is that CPR will be performed on a resident suffering cardiac and/or respiratory arrest if the resident does not have a do-not-resuscitate (DNR) order and the resident has been determined not to be clinically dead according to the following assessment procedure: two nurses must find the absence of respiration, absence of any pulse, pupils are fixed and dilated, and the absence of response to pain. If the resident is breathing or has a pulse, if the pupils are not fixed and dilated, or if the resident responds in any way to pain, CPR should be initiated immediately and not stopped. Emergency responders are to be called if CPR is started.²⁹

23. Resident #1's death certificate identified the cause of death as "natural causes." No autopsy was performed.

24. Nurse C resigned her employment with the Facility and did not cooperate with the Facility's request to participate in the IIDR conference.

25. Based on interviews and record review, the Division concluded that the Facility failed to provide the necessary care and services to attain or maintain

²⁵ Ex. G-3 and G-4.

²⁶ These vital signs are different than those reflected on the nurse's census sheet. According to the census sheet, the last set of vital signs taken of the Resident were temperature 96.6, pulse 95, respirations 20, and oxygen saturation 94% on room air. The notation for blood pressure is blank. See Facility Ex. 6. The actual time is not indicated on the census sheet or in the progress note.

²⁷ Facility Ex. 9.

²⁸ Facility Ex. 3.

²⁹ Facility Ex. 12.

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, and Tag F 353 (insufficient nursing staff).

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 and Tag F 353 are supported by the facts and should be affirmed.

Dated: December 8, 2009

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.”³⁰

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

³⁰ 42 C.F.R. § 483.25.

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 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.³¹

The OHFC contends that the Resident's decline cannot be considered unavoidable. It contends the staff failed to adequately assess the Resident's condition by examining the wound and questioning the Resident about the location and intensity of her pain when the medication was administered at 3:00 a.m.; that it failed to ensure that supplemental oxygen was available in the event of an emergency; that staff members failed to call 911 on a timely basis and failed to appropriately assist emergency responders; and that they failed to initiate CPR when warranted.

In response, the Facility argues that Nurse D performed an adequate assessment of the Resident when he checked her chart, found the order for pain medication, noticed that the pain medication had been effective earlier, and administered the medication. Nurse D did not document any observations of the Resident's condition or note any specific questions about the nature or location of her pain. It cannot be determined from the record exactly how much time passed between the time the medication was administered and the time the resident was found in distress, with her hand on her chest and her abdomen distended and bruised, but it could not have been more than one hour and forty-five minutes. Under these circumstances, the minimal assessment of the Resident's condition performed at 3:00 a.m. was not adequate and justifies the deficiency citation.

The Facility also argues that because oxygen was eventually made available to the resident during her medical emergency, it should not have been cited for failure to ensure that supplemental oxygen was available. Nurse D stated that the emergency tanks kept on two different units and in the oxygen room were not available because they had been used and not replaced. He had to obtain new tubing before he could provide oxygen to the Resident using the roommate's oxygen supply. In his estimation, it took less than five minutes to find the tubing and return to the Resident's room. Assuming that this estimate is accurate, even though there is no documentation to support it, Nurse D was not able to give the Resident supplemental oxygen as quickly as he could have, if the Facility had kept the emergency oxygen tanks appropriately stocked on each unit. Nor was he, or anyone else, available to monitor the Resident's condition

³¹ Ex. F.

while he was searching for the oxygen. The failure to have emergency oxygen readily available is a deficiency that was properly cited.

In addition, the Facility contends that it should not have been cited for failing to timely summon and appropriately assist emergency medical personnel. It proffers a timeline of the events based on its contention that Nurse C actually took one set of vital signs at the start of the night shift at about 11:00 p.m. on January 18, at about the same time the evening shift nurse took the Resident's vital signs, and that she started taking the scheduled 3:00 a.m. vital signs at approximately 3:37 a.m. If Nurse C had started taking vital signs of several residents at that time, and worked her way down the hall to the Resident's room, she may have arrived at the Resident's room at about 4:10 a.m., suggesting there was at most 28 minutes between the time when Nurse C found the Resident in distress and the call to 911.

Although it is possible that this was the sequence of events, this proposed timeline is speculative in the absence of any indication from Nurse C that this is actually what happened. But even assuming that this time-frame were accurate, there is still a 28-minute gap between the time the Resident was found in distress and the time of the call placed to 911. There is no explanation for this delay, since the nurses maintain they called 911 very quickly after discovering the Resident's change in status. In the alternative, if Nurse C had checked on the Resident after returning from her break at about 3:00 a.m., which is what she told police, but did not discover the Resident in distress until attempting to take vital signs just minutes before calling 911, then it would appear that Nurse C failed to take the Resident's vital signs every four hours and would also be in violation of the Facility's policy requiring a visual safety check of residents each hour during the night shift. In either event, the Facility was properly cited for the delay in summoning emergency responders.

Finally, the Facility maintains the care and interventions provided to the Resident were appropriate and that it should not have been cited for failing to initiate CPR because the Resident was still breathing and had a pulse when emergency responders arrived. The Facility offered comments by an emergency services instructor, suggesting that the Resident likely had a pulse when the first police officer arrived, because he started ventilating the Resident but did not immediately initiate CPR. The problem here is that the same officer radioed to his partner and paramedics that the Resident was in cardiac arrest, and both paramedics and the responding police officer reported that the Resident was not breathing and had no pulse when they arrived. The police officer also reported that no one was monitoring the Resident's pulse or breathing when he arrived, and the paramedics reported that the Resident had been in full cardiac arrest for about 20 minutes prior to their arrival.

Moreover, the Facility's witnesses contradicted each other on a number of important points. Nurse C's own progress note, made after the paramedics

arrived, suggests that Facility staff members did in fact “attempt” CPR and that the paramedics “took over” the effort upon their arrival. This is inconsistent with statements made during their interviews. Both Nurse C and Nurse D claim to have been with the Resident before emergency personnel arrived and that the other nurse did not stay. Nurse D says that Nurse C was not concerned about the Resident’s condition when she was unable to obtain a blood pressure reading, but that he nevertheless went to the Resident’s room immediately to follow up. According to him, Nurse C provided no assistance during this emergency, contrary to the progress note she made. On the record available here, the OHFC has demonstrated that the Facility was properly cited for failing to initiate CPR when warranted.³² Tag F 309 is supported by the facts and should be affirmed.

Tag F 353 is based upon an alleged violation of 42 C.F.R. § 483.30, which provides that a facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The intent of this regulation is to assure that sufficient staff members are available to provide and monitor the delivery of resident care and assess resident condition changes. The State Operations Manual indicates that compliance with state-mandated staffing ratios does not preclude a deficiency citation based on insufficient staff, if the facility is not providing needed care and services to residents on a 24-hour basis.

Although the Facility was in compliance with state-mandated staffing ratios, it is clear that this level of support was insufficient to provide adequate care on the night in question. Nurse D, the charge nurse on duty, indicated at several points during the IIDR meeting that he did not do more to assess the Resident when she requested pain medication, that he did not attempt to take the Resident’s blood pressure himself, and that he did not document anything regarding the Resident’s status during this emergency because he was busy with his own assignment. In addition, this Resident’s medical emergency appears to have coincided, to some extent, with overlapping employee break schedules that resulted in half of the staff members on the unit being unavailable for a substantial period of time. After careful consideration of the record, the Administrative Law Judge concludes that the OHFC has demonstrated that Tag F353 is supported by the facts and should be affirmed.

K.D.S.

³² The Facility was not able to obtain access to the most critical evidence of noncompliance—the interviews of paramedics and police officers conducted by the OHFC investigator, or to the ambulance run sheet on which paramedics noted their belief that the Resident had been in full arrest for about 20 minutes prior to their arrival. The Facility is consequently forced to accept as true and accurate the summaries of this evidence contained in the 2567 and the maltreatment determination. This denial of access is based on a CMS policy precluding disclosure of these materials except through a Freedom of Information Act request.