

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

In the Matter of Mayo Clinic Health  
System – Fairmont;  
Survey Exit Date October 28, 2011

**RECOMMENDED DECISION**

This matter was the subject of an independent informal dispute resolution (IIDR) conducted by Administrative Law Judge Barbara L. Neilson on May 31, 2012. The OAH record closed at the conclusion of the conference that day.

Christine Campbell, Division of Compliance Monitoring, appeared on behalf of the Minnesota Department of Health (MDH or Department). Mary Cahill, Planner Principal with the Division of Compliance Monitoring; Maria King, Unit Supervisor; and Elizabeth Sandt, RN Surveyor, also participated in the conference on behalf of the Department.

Samuel Orbovich and Katherine A. Burkhart, Attorneys at Law, Fredrikson & Byron, P.A., appeared on behalf of Mayo Clinic Health System – Fairmont (the Facility). Kathleen Meyerle, Legal Counsel for the Mayo Clinic; Dawn Campbell, Facility Administrator; and Jacquie Jenkins, Director of Nursing at the Facility, also participated in the conference on behalf of the Facility.

Based on the exhibits submitted and the arguments made and for the reasons set out in the Memorandum below, the Administrative Law Judge makes the following:

**RECOMMENDED DECISION**

Tag F 309 is supported by the facts and should be affirmed, but 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: June 15, 2012

s/Barbara L. Neilson

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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

### Introduction

In October 2011, a surveyor for the Minnesota Department of Health conducted a recertification survey at the Mayo Clinic Health System – Fairmont (also known as the Lutz Wing Nursing Home). Following the completion of the survey on October 28, 2011, the surveyor issued a Summary Statement of Deficiencies to the Facility. In this proceeding, the Facility challenges the deficiency identified by Tag F 309, which alleges a violation of the quality of care standards set forth in 42 C.F.R. § 483.25.

The Department alleges that the Facility did not provide care/services for the highest well-being of two residents. Specifically, the Department asserts that: (1) Facility staff failed to regularly check Resident 37's dialysis port for potential bleeding and failed to check her blood pressure following each dialysis session; and (2) Facility staff failed to routinely monitor Resident 52 following a fall, causing the Resident's decline in medical condition and eventual death. Before deciding that the violation occurred, the surveyor reviewed records and interviewed certain Facility staff, including the MDS Coordinator and RN Supervisor with respect to Resident 37 and the Director of Nursing and a Registered Nurse who was on duty with respect to Resident 52.<sup>1</sup> There is no evidence that the surveyor interviewed the family members of either Resident.

The violation was cited at a scope and severity level of G, based upon the surveyor's conclusion that the deficiency was isolated in scope and, with respect to Resident 52, resulted in actual harm that was not immediate jeopardy. In particular, the surveyor found that the Facility's noncompliance resulted in a negative outcome that compromised the ability of Resident 52 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. If Resident 37 had been the only individual involved in the deficiency, the Department acknowledged that the violation would have been cited at a scope and severity level of D (which applies to a deficiency that is isolated in scope and resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy).<sup>2</sup> The

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<sup>1</sup> Exhibit E-8 – E-10, E-11 – E-12.

<sup>2</sup> Testimony of Christine Campbell.

Department noted that Appendix P of the State Operations Manual (SOM) includes the following guidance to surveyors regarding categorizing the scope and severity levels of deficiencies:

If the evidence gathered during a survey for a particular requirement includes examples of various severity or scope levels, surveyors should generally classify the deficiency at the highest level of severity, even if most of the evidence corresponds to a lower severity level. For example, if there is a deficiency in which one resident suffered a severity 3 while there were widespread findings of the same deficiency at severity 2, then the deficiency would be generally classified as severity 3, isolated.<sup>3</sup>

In this IIDR proceeding, the Facility asserts that the alleged violation should be reversed because there was no deficient practice by the Facility. The Facility alleges that it substantially complied with 42 C.F.R. § 483.25 in caring for both residents, its actions did not result in actual harm to Resident 52, and the declining medical condition of that resident was unavoidable. In the alternative, the Facility argues that the severity level should be reduced from Level G to a level consistent with the federal interpretive guidelines.

## **Factual Background**

### **Resident 37**

Resident 37 is a 92-year-old woman who was admitted to the Facility on February 17, 2009, with a diagnosis of renal failure syndrome.<sup>4</sup> As of the time the survey was conducted, Resident 37 had been diagnosed with end stage renal disease.<sup>5</sup> When the Resident first arrived at the Facility, she received dialysis through a shunt in her right forearm but, at some point, the shunt ceased working and a port was placed in her chest. She now receives dialysis through the port site three times each week (Monday, Wednesday, and Friday).<sup>6</sup>

On the days Resident 37 receives dialysis, she has breakfast at the Facility at approximately 5:15 a.m. and thereafter is taken to the Fairmont Hospital (which is connected to the Facility) at approximately 5:45 a.m. Her dialysis usually begins at 6:05 a.m. When the Resident returns to the Facility after dialysis, she typically has a second breakfast with her tablemates and arrives back in her room at approximately 9:15 a.m.<sup>7</sup>

The care plan that was in effect for Resident 37 as of the date of the survey included a goal that she would have dialysis three times a week and remain free of complications such as bleeding and hypotension by December 13, 2011.<sup>8</sup> The care

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<sup>3</sup> Exhibit C-3.

<sup>4</sup> Exhibits E-10, H-7.

<sup>5</sup> Exhibit H-7.

<sup>6</sup> Testimony of J. Jenkins; Exhibit 11-1.

<sup>7</sup> Exhibit 14; Testimony of J. Jenkins.

<sup>8</sup> Exhibit H-2.

plan noted that dialysis access was through the right side of the Resident's chest and included the following approaches:

Dialysis access (R) chest.

Monitor for any complications from dialysis such as bleeding from the shunt site. If shunt starts to bleed apply pressure, call dialysis or send to ER [emergency room] if dialysis not available. Monitor for complications after dialysis such as hypotension, hypovolemia, vomiting, increased weakness INFO (information only).

Monitor vital signs within 2 hours of return from dialysis INFO (information only).<sup>9</sup>

Resident 37's Treatment Administration Record (TAR) for October 2011 identified an order initiated July 5, 2010, which stated, "Check ~~shunt~~ port after Dialysis every week. Check to makes [sic] sure no signs of bleeding."<sup>10</sup> The TAR also included an order initiated on November 5, 2010, which stated, "Dialysis orthostatic BP [blood pressure] every week. Retake BP with/in 2 hours of return from dialysis."<sup>11</sup>

The TAR documentation showed that Resident 37 had received dialysis eleven times by the date of the surveyor's review in October 2011; however, Facility staff had only recorded having checked the Resident's port on one occasion in October. In addition, although staff had monitored the Resident's orthostatic blood pressure, there was no clear documentation that they had monitored her blood pressure two hours after she returned from dialysis.<sup>12</sup>

On October 27, 2011, the surveyor interviewed the Minimum Data Set Coordinator, who confirmed that Resident 37 received dialysis three times a week and that, upon her return from dialysis, the licensed staff were to monitor her access site for bleeding and check her blood pressure within two hours of her return to monitor for stability. The Facility's Registered Nurse Supervisor verified during her interview with the surveyor on October 27, 2011, that documentation did not reflect that the required monitoring had occurred.<sup>13</sup>

The surveyor found that the Facility had not consistently checked Resident 37's port for potential bleeding or checked Resident 37's blood pressure to monitor for stability following dialysis. As a result, she determined that the Facility violated 42 C.F.R. § 483.25, by failing to provide Resident 37 with the necessary care and services

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<sup>9</sup> Exhibit H-2 (care plan last reviewed Jan. 5, 2011). The Resident's current care plan was revised to include an explicit directive to check the Resident's port dressing 3 times a week to make sure there are no signs of bleeding and to require that "B/P" (rather than "vital signs") be monitored within 2 hours of return from dialysis. See Exhibit 11-1.

<sup>10</sup> Exhibit H-1.

<sup>11</sup> Exhibit H-1.

<sup>12</sup> Exhibit H-1.

<sup>13</sup> Exhibits E-11 – E-12.

to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<sup>14</sup>

During the IIDR, the Facility provided copies of Interdisciplinary Progress Notes from October 18, 2011, to January 13, 2012, containing notations by both the Hospital dialysis staff and the Facility staff. Those notes indicate that the Resident's blood pressure was taken after dialysis on October 19, 21, 24, 26, 28, and 31, 2011, as well as on November 2, 7, 9, 11, 14, 16, 21, 23, 25, 28, and 30, 2011; December 2, 7, 9, 12, 14, 16, 19, 21, 23, 26, 28, and 30, 2011; and January 2, 4, 6, 9, 11, and 13, 2012. These records do not specify the time the post-dialysis blood pressure was taken.<sup>15</sup> The Facility also provided copies of Progress Notes pertaining to the Resident during October 2011. Those notes show that the Resident's blood pressure was taken after she returned from dialysis on October 19, 2011 (at 10:00 a.m.) and October 28, 2011 (at 11:00 a.m.). Although other blood pressure readings were also reported, they were noted to have been taken at times that likely would not have fallen within two hours of the Resident's return from dialysis.<sup>16</sup>

There is no evidence that Resident 37 has ever suffered from infection, excessive bleeding at the dialysis site, or excessive blood pressure during her stay at the Facility.<sup>17</sup>

## **Resident 52**

Resident 52, an 87-year-old man, was admitted to the Facility on June 23, 2011, for a short-term rehabilitation stay after surgical repair of his left hip.<sup>18</sup> Prior to the surgery, the Resident had fallen and broken his hip while at home. He had also experienced another fall during the prior week.<sup>19</sup> After completing physical therapy, Resident 52 planned to return to the home where he lived with his daughter and grandchildren.<sup>20</sup> Resident 52 had his full cognitive ability.<sup>21</sup> He did not speak English and was unable to understand most verbal commands. When his granddaughter was present in the Facility, she translated statements made by Facility staff into Spanish for him and translated his responses for staff. In addition, his family wrote down several key phrases on paper in his room.<sup>22</sup>

During Resident 52's physical therapy on June 27, 2011, the Resident motioned that he had pain in his head and left hip and was unable to rate the pain.<sup>23</sup> During his

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<sup>14</sup> Exhibit E-10.

<sup>15</sup> Exhibits 13-1, 13-2; Testimony of J. Jenkins.

<sup>16</sup> Exhibits 17-1 – 17-3.

<sup>17</sup> Testimony of J. Jenkins.

<sup>18</sup> Exhibits 1-4 – 1-6, 1-8 – 1-9, 1-16, 2-1.

<sup>19</sup> Exhibits G-5, G-8, 1-1, 7-1.

<sup>20</sup> Exhibit 2-1.

<sup>21</sup> Testimony of J. Jenkins.

<sup>22</sup> Exhibit 9-3.

<sup>23</sup> Exhibit 8-8.

physical therapy on June 28, 2011, the Resident indicated that he was having increased pain and declined walking to lunch.<sup>24</sup>

During the evening of June 28, 2011, the Resident initiated an argument with his daughter by urging her to quit her job and care for him at home. The Resident's granddaughter indicated that it was a common occurrence for the Resident to argue with others if he did not get his way. The Resident's daughter told the Resident that she could not afford to quit her job and that would not be possible, and the Resident was very unhappy about this. He became agitated and would not allow Facility staff to assist him with bedtime cares or place a bed alarm.<sup>25</sup>

At 4:20 a.m. on June 29, 2011, Facility staff heard a noise and discovered the Resident on the floor in his room. He apparently had attempted to transfer himself from his bed to the bathroom. He was found lying on his back at the foot of the bed, under the over-bed table, with his shoulders and head leaning up against the wall. The call light was wrapped around his ankle and the Resident was clutching the back of his head. Although there were no obvious physical signs that the Resident had hit his head, Facility staff assumed that he had and initiated neurological checks at 4:30 a.m.<sup>26</sup> The Neurological Flow Sheet reveals that the nurse checked Resident 52's neurological status again at 4:45 a.m., 5:00 a.m., and 5:15 a.m. Following these initial 15-minute checks, the Resident's neurological status was monitored at 6:15 a.m. and 7:15 a.m., and was documented to be stable.<sup>27</sup> The Resident got up and ate breakfast.<sup>28</sup>

At approximately 10:14 a.m. on June 29, 2011, the Facility sent Resident 52's physician (Dr. Giri) a fax notifying her that the Resident had fallen that morning and hit his head. The fax indicated that the staff had noted no injuries, had initiated neurological checks, and would continue to monitor the Resident's condition. The physician returned the fax at approximately 4:23 p.m. with a notation of "ok'd."<sup>29</sup> There is no documentation that the Facility contacted the Resident's family prior to the evening of June 29. However, the Director of Nursing testified during the IIDR that the nurse on duty notified the Resident's family of the fall at some point during the morning, and told the surveyor that the Facility tried to contact the family numerous times that day.<sup>30</sup>

A nutrition professional accompanied the Resident to lunch at approximately noon on June 29 and completed a nutritional assessment of the Resident. Facility staff assisted the Resident with a bath and conducted a skin assessment at 1:45 p.m.<sup>31</sup> The Resident attended occupational therapy and physical therapy sessions between 2:00 p.m. and 4:30 p.m.<sup>32</sup> The Occupational Therapy notes indicated that he was provided

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<sup>24</sup> Exhibit 8-7.

<sup>25</sup> Ex. 2-1; Testimony of J. Jenkins.

<sup>26</sup> Exhibits G-8, 2-1 – 2-2, 3-1 – 3-2, 4-1 – 4-3, 7-2.

<sup>27</sup> Exhibits G-4 - G-6, G-11 – G- 17, 6-1.

<sup>28</sup> Testimony of J. Jenkins.

<sup>29</sup> Exhibits G-1, G-6, 5-1.

<sup>30</sup> Exhibit E-9; Testimony of J. Jenkins.

<sup>31</sup> Exhibit 7-2; Testimony of J. Jenkins.

<sup>32</sup> Exhibits 8, 9.

30 minutes of total treatment time that day.<sup>33</sup> The Physical Therapy notes indicate that the Resident motioned that he had pain in his head and left hip but was unable to rate the level of pain. The Resident was unable to take more than two steps, Although the Resident was unable to participate with walking due to pain, he continued working on basic seated exercises. The total physical therapy treatment time was 30 minutes.<sup>34</sup>

The Neurological Flow Sheet shows that the Resident's status was checked again at 3:15 p.m. on June 29, with no change in status recorded.<sup>35</sup>

According to the Nurses' Progress Notes, when Resident 52 was assisted to the supper table at 5:30 p.m., he was lethargic and would not verbally respond to staff. He did not eat his supper but sat quietly at the table with his eyes closed. After supper, the Resident was assisted out of his wheelchair and into a recliner. He did not bear any weight or participate in the transfer. A hooyer lift was used to complete his transfer into bed. Resident 52 was typically able to transfer and ambulate with the assistance of one staff person and a walker.<sup>36</sup>

Facility staff alerted the on-call physician (Dr. Hassan) to the change in the Resident's status, and Dr. Hasan came to Resident 52's room to see the Resident at approximately 6:15 p.m. Dr. Hasan noted that the Resident responded to tactile/painful stimulation by grimacing and moving his extremities. He advised that Resident 52 be seen in the Emergency Department if the family was in agreement. The Director of Nursing called the Resident's family at approximately 6:15 p.m., and the Resident's daughter, granddaughter, and two great-grandchildren came to the Facility to see the Resident at approximately 8:00 p.m.<sup>37</sup> The Resident did open his eyes and interact a bit with his great-grandchildren during the visit.<sup>38</sup> The Resident's family informed Facility staff of the argument between Resident 52 and his daughter the night before and said they thought the Resident was likely being stubborn because he was upset about the argument. They told Facility staff that the Resident at times would close his eyes, not talk, ignore them and "shut down" if he did not get his way. The family said that they wanted to wait until morning to see what the Resident's condition was like before they decided whether he should go to the Emergency Department.<sup>39</sup> There is no documentation in the nurses' progress notes that the family was informed of the Resident's possible head injury and the potential that he was experiencing bleeding in his brain. However, the RN who was on duty at the time told the surveyor that she had explained the situation to the family, and the family said they did not want the Resident to have the CT scan because they thought he would be afraid.<sup>40</sup>

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<sup>33</sup> Exhibit 9-8.

<sup>34</sup> Exhibit 8-6.

<sup>35</sup> Exhibits G-4, 6-1.

<sup>36</sup> Exhibits 2-2, 7-2.

<sup>37</sup> Exhibit E-9.

<sup>38</sup> Testimony of J. Jenkins.

<sup>39</sup> Exhibits G-6, G-8, 2-2, 7-2, 10-2; Testimony of J. Jenkins.

<sup>40</sup> Exhibit E-8.

The Progress Notes indicated that the Director of Nursing was present at the Facility at 10:00 p.m. on June 29, 2011. She was aware of the condition of the Resident and the plan of his family, and was in agreement with that approach.<sup>41</sup>

According to the Neurological Flow Sheet, at 11:15 p.m. on June 29, 2011, the Resident was noted to be lethargic and his pupils were more dilated and nonreactive.<sup>42</sup> The Director of Nursing agreed that this was a significant change in the Resident's condition.<sup>43</sup> She could not recall whether or not the physician or the family was notified of this change in status at the time, and there is no indication in the records that such notification occurred.<sup>44</sup>

When the licensed nurse took the Resident's vital signs at 1:00 a.m. on June 30, 2011, Resident 52 responded when she grasped his hands by squeezing her hands. In addition, when she manually opened his eye lids, he resisted somewhat, and his pupils were noted to be of normal size and reactive to light.<sup>45</sup>

At 6:45 a.m. on June 30, 2011, the Resident was in bed snoring, with his eyes closed. When a neurological check was conducted at 7:30 a.m., Resident 52 did not respond to voice commands; he was unable to respond to small stimulation but did moan with deep stimulation; and his pupils were fixed and dilated. When his head was lifted with the bed control, the Respondent coughed spontaneously and then swallowed. The charge nurse called Dr. Giri at approximately 8:00 a.m., and Dr. Giri indicated that the Resident should be seen in the Emergency Department if the family was agreement. At 8:10 a.m., the nurse called the Resident's granddaughter's home to update the family regarding the Resident's condition and Dr. Giri's indication that the Resident could be transferred to the Emergency Department if they desired. The Resident's daughter was in the Resident's room at that time, and the Resident's granddaughter asked to speak to her. The granddaughter arrived at the Facility shortly thereafter. The family agreed to send the Resident to the emergency department at 9:45 a.m.<sup>46</sup>

The Emergency Department physician diagnosed the Resident with a subdural hematoma (bleeding in the brain) and possible brain death. Resident 52 was determined not to be a surgical candidate. He was returned to the nursing home on comfort care and expired at 3:42 p.m. on June 30, 2011. Dr. Giri informed the family and Facility staff that the Resident had a chronic bleed in addition to the current bleed.<sup>47</sup>

Dr. Giri signed a Final Report regarding the Resident on July 13, 2011. With respect to the fall at the Facility, Dr. Giri noted that the Resident was found "leaning with

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<sup>41</sup> Exhibit G-6, 7-2.

<sup>42</sup> Exhibit G-4.

<sup>43</sup> Test. of J. Jenkins.

<sup>44</sup> Test. of J. Jenkins.

<sup>45</sup> Exhibits G-6, 7-2.

<sup>46</sup> Exhibits G-7, 2-2, 7-3.

<sup>47</sup> Exhibits G-7, G-9, 2-2, 7-3.

his head and neck backward against a wall,” but “denied having hit his head.”<sup>48</sup> Dr. Giri also noted:

It is likely that the patient might have had a worsening of his subdural with almost non recoverable condition given possible tentorial herniation which likely had caused respiratory failure. One of the questions that the family wanted to find out was whether if they had decided on sending the patient in earlier last night itself whether it would have made significant changes which to some extent would be debatable given the fact that the patient from history and from the nature of the subdural hematoma, appears to have had multiple injuries with subdurals even from before likely acute on chronic [sic]. It is also likely that some of the bleed could even have preexisted or presented along with his fall when he broke his left hip as well. However, neither the family nor the patient had volunteered any information that he had hit his head even at this time, given no obvious traumatic changes or bony deformities or development of subcutaneous hematomas or lacerations to the scalp. It is less likely that the patient may have hit his head directly. It could even have been indirect injury with a possible rupture of superficial blood vessels which could have aggravated his condition. . . .<sup>49</sup>

Dr. Giri noted that the Resident’s CT scan showed that he had “acute on chronic subdural bleed with significant midline shift and possible tentorial herniation.”<sup>50</sup>

On October 28, 2011, the surveyor interviewed the RN who was on duty at the time and the Director of Nursing. The Director of Nursing confirmed that the Facility staff had not followed protocol and that, after the initial checks, the checks had been completed at 8-hour intervals instead of 4-hour intervals. She admitted that there was no documentation indicating that the condition of the Resident was monitored between the hours of 7:15 a.m. and 3:14 p.m. on June 29, 2011, or between 1:00 a.m. and 7:30 a.m. on June 30, 2011. She confirmed that the progress note documentation had not been complete or clear throughout the event, and said she could see that it looked like Resident 52 had not been thoroughly monitored following the fall with possible head injury.<sup>51</sup>

Based upon her review of documents and interviews, the surveyor determined that the Facility had failed to monitor Resident 52’s medical condition and provide services for him related to injuries from a fall, and concluded that this resulted in harm for the Resident. The surveyor cited the Facility with a violation of 42 C.F.R. 483.25, which requires that the Facility 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.<sup>52</sup> The Department

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<sup>48</sup> Exhibit 10-1; *see also* Exhibits G-8, G-11, G-15, G-17.

<sup>49</sup> Exhibit G-9.

<sup>50</sup> Exhibit G-10.

<sup>51</sup> Exhibit E-10.

<sup>52</sup> Exhibits E-5 – E-6.

did not allege that the Facility violated any applicable requirements with respect to the occurrence of the fall itself.<sup>53</sup>

## Discussion

### Applicability of Tag F 309

Tag F 309 is based upon an alleged violation of 42 C.F.R. § 483.25. That regulation requires:

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.

As reflected in Appendix PP of the SOM, the intent of 42 C.F.R. § 483.25 is to ensure that “the resident obtains optimal improvement or 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.”<sup>54</sup> “Highest practicable physical, mental, and psychosocial well-being” is defined as “the highest possible level of functioning and well-being, limited by the individual’s recognized pathology and normal aging process” and is “determined through the comprehensive resident assessment and by recognizing and competently and thoroughly addressing the physical, mental or psychosocial needs of the individual.”<sup>55</sup> The SOM instructs the survey team to “[d]etermine if the facility is providing the necessary care and services based on the findings of the comprehensive assessment and plan of care” and, if services and care are being provided, “determine if the facility is evaluating the resident’s outcome and changing the interventions if needed.”<sup>56</sup>

The Department contends that the situation involving Resident 37 was appropriately cited as a violation of Tag F 309 because she did not receive appropriate clinical monitoring following her dialysis treatment. The Department emphasizes that the Resident’s care plan expressly required that the port used for dialysis be monitored for potential bleeding and that her blood pressure and other vital signs be monitored within two hours after her return from dialysis for hypotensive events and other complications. The Department asserts that hypotensive events are a common side effect of dialysis, and that bleeding from the port would be a critical event requiring immediate medical attention if it should occur. The Department asserts that the required monitoring of Resident 37’s blood pressure and port did not occur, and alleges that licensed facility staff responsible for the care of Resident 37 confirmed this to the surveyor. The Department also maintains that guidance issued by the Center for Medicaid and State Operations/Survey and Certification Group (CMS) in 2004 and 2010 supports its position that long-term care facilities remain responsible for the overall care

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<sup>53</sup> Testimony of C. Campbell; Testimony of J. Jenkins.

<sup>54</sup> Exhibit F-1.

<sup>55</sup> *Id.*

<sup>56</sup> Exhibit F-2.

provided to residents who receive dialysis and surveyors appropriately should examine whether such facilities have monitored the resident's response to dialysis as well as the access site.<sup>57</sup>

The Facility denies that its staff ever told the surveyor that they did not appropriately monitor Resident 37's port and blood pressure after dialysis. Based upon the discussion set forth in the Statement of Deficiencies issued by the surveyor, the Administrative Law Judge agrees that it appears that, at most, Facility staff merely acknowledged that documentation of such monitoring was incomplete.

The Facility contends that appropriate monitoring of the dialysis access site and the Resident's blood pressure did, in fact, occur and that it substantially complied with 42 C.F.R. § 483.25. Although the wording in the care plan was not changed from "shunt" to "port" when the dialysis access site changed, the Facility contends that its staff continued to check the port in the same fashion they had previously checked the shunt site.<sup>58</sup> The Facility points out that the Resident's port is prominently located near the middle of her chest and contends that the port would be clearly visible to any staff member taking the Resident's vital signs.<sup>59</sup> It contends that the prominence of the port and the daily care required to keep the site clean ensured that staff would notice any bleeding of the site right away, either during the provision of routine cares or during assessments and checking of vitals. Despite the Resident's dementia diagnosis, the Facility contends that she has the ability to tell Facility staff if there is something wrong and has done so in the past.

The Facility's Director of Nursing also testified during the IIDR meeting that it is her understanding that Facility staff does, in fact, monitor the Resident's blood pressure within two hours after the Resident returns from dialysis. She indicated that it is routine for blood pressure and other vital signs to be taken every day at 11:00 a.m., when medication is dispensed. The Facility asserted that staff would always look at the port when they took the Resident's vital signs and would immediately notice if the port site was bleeding. It also contended that the port would be conspicuous during the provision of routine cares, such as dressing, toileting or transferring. The Facility also provided Interdisciplinary Progress Notes completed by both Facility staff and hospital dialysis personnel that show pre- and post-dialysis blood pressure readings for some of the dates the Resident would have received dialysis between October 19, 2011, and January 13, 2012.

After careful review of the record and the arguments of the parties, the Administrative Law Judge concludes that the Tag F 309 deficiency was properly cited with respect to Resident 37. The Interdisciplinary Progress Notes provided by the Facility do not include any entries for several dates in early October 2011 when it appears that the Resident would have received dialysis (Oct. 3, 5, 7, 10, 12, and 14)

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<sup>57</sup> See, e.g., Exhibits H-11, H-13, H-40, and H-44.

<sup>58</sup> Exhibits 14, 15. The Department acknowledged during the IIDR that the deficiency finding was based upon an alleged failure by Facility staff to check the dialysis site and blood pressure, and not on the Facility's failure to change the wording from "shunt" to "port." Testimony of C. Campbell.

<sup>59</sup> Exhibit 16.

despite the fact that the surveyor focused on the Resident's treatment during that time frame, nor do they verify that her blood pressure was monitored on November 4, November 18, or December 5, all of which are dates when it appears that the Resident would have received dialysis. Moreover, even if the Resident's blood pressure and other vital signs were taken promptly at 11:00 a.m. each day, the Facility has not provided convincing evidence that this would have occurred within two hours of the time the Resident returned to the Facility from dialysis. No information was provided regarding the length of time the Resident's dialysis usually takes. Because the testimony suggested that the Resident typically went to a second breakfast after dialysis and then went back to her room at around 9:15 a.m., it is logical to assume that she returned to the Facility from dialysis prior to 8:45 a.m.

The Facility also did not provide persuasive evidence that the Resident's port was routinely checked for bleeding after dialysis. There is only one documented check entered for October 3, 2011, on the Resident's Treatment Administration Record. Even if the Resident's port was incidentally within view when her vital signs were taken, the care plan imposes a more specific obligation to monitor bleeding from the site. Because the Resident has dementia and may not notice or report symptoms, it cannot be assumed that she will be able to report a concern. The care plan indicates that the Resident was independent in transfer, dressing, toileting, and personal hygiene and needed only limited assistance with bathing on Tuesdays each week (which is not a day that the Resident undergoes dialysis).<sup>60</sup> As a result, it is not necessarily the case that a bleeding issue would be noted during the provision of cares.

With respect to Resident 52, the Department asserts that the Facility failed to routinely monitor the Resident's condition after he fell and hit his head and contends that the Resident later died from the effects of a head injury. The Department emphasizes that Facility policy stated that an unwitnessed fall would receive the same treatment as a witnessed fall with a potential head injury, and directed staff to "do vital signs and neuro checks (every 15 minutes x 1 hour, then every 30 minutes x 1 hour, then every hour x 2, then every 4 hours for 48 hours after the fall incident) with a focused assessment or per physician order." The Department alleges that the Facility did not monitor Resident 52 according to the standards of practice reflected in the Facility policy, and asserts that "[t]his lack of timely monitoring impacted the facility's ability to appropriately identify any change in neurological status in a timely manner" and, in turn, "resulted in delayed medical care" for Resident 52.<sup>61</sup> Although a change of condition was identified and reported to the Resident's physician, the Department contends that "responsible family members were not provided comprehensive information to facilitate informed treatment decisions" and asserts that the Facility's "failure to educate the family on the consequences of an undiagnosed and untreated head injury and provide the risks and benefits of that care resulted in an inability of the

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<sup>60</sup> Exhibit H-4.

<sup>61</sup> Department's IIDR Submission at 5.

family to provide informed consent for medical treatment.” According to the Department, this resulted in harm to the Resident.<sup>62</sup>

During the IIDR, the Department provided excerpts from two articles that discuss the care of patients with head injuries. These articles warn that the complications following a head injury may include acute subdural or intracerebral hematoma, chronic subdural hematoma, brain edema, and epidural hematoma. Chronic subdural hematoma is described as “a late complication that may not develop until some weeks after trauma” and may be difficult to diagnose because of the time lapse between the injury and the onset of symptoms.<sup>63</sup> One of the articles stresses the need for “[r]epeated neurologic examinations for baseline information and determination of extent of brain damage and whether or not patient is progressing or deteriorating,” specifies that a neurologic flow sheet and Glasgow Coma Scale should be kept, and states that the nursing assessment should include “repeated and specific documentation of clinical findings including level of responsiveness (consciousness), eye opening, verbal response, quality of breathing, size and reaction of pupils, and vital signs.”<sup>64</sup> The other article also emphasizes the need for careful assessment of the individual’s state of consciousness, breathing pattern, pupil size and reaction to light, and motor activity in the limbs and states that “[t]hese functions, BP, pulse, and temperature should be recorded at least hourly, since any deterioration demands prompt attention.”<sup>65</sup>

The Facility argues that it substantially complied with 42 C.F.R. § 483.25 in caring for Resident 52. It points out that 42 C.F.R. § 483.25 does not specify how frequently neurological checks must occur, and contends that it would be improper under analogous case law for the Department to base the deficiency solely upon the Facility’s failure to strictly adhere to its internal policy regarding for conducting neurological checks. The Facility emphasizes that its staff did, in fact, keep a neurological flow sheet. It asserts that trained staff diligently monitored and assessed the Resident at least once every hour beginning immediately after the Resident’s fall, and provides a timeline that estimates the time of interactions with the Resident by nursing staff, the dietitian, the occupational and physical therapists, and physicians between his fall on June 29 and his death on June 30. Based upon this timeline, the Facility alleges that its staff properly assessed/monitored the Resident at least once every hour.

The Facility further contends that there has been no showing that its actions resulted in “actual harm” to Resident 52 and asserts that the declining medical condition of Resident 52 was unavoidable and entirely outside the control of the Facility. To support its assertions, the Facility underscores Dr. Giri’s finding that the Resident had multiple injuries with subdurals even before any acute injury occurred and that it was not likely that the Resident hit his head directly. The Facility emphasizes that the event that

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<sup>62</sup> *Id.*

<sup>63</sup> Exhibit J-3 (“Trauma of the Head and Spine: Head Injury,” The Merck Manual of Diagnosis and Therapy (15<sup>th</sup> ed., Merck and Co., Inc.)).

<sup>64</sup> Exhibits I-1 – I-2 (“Nursing Management of the Patient with a Head Injury,” The Lippincott Manual of Nursing Practice (5<sup>th</sup> ed., J.B. Lippincott Co.)).

<sup>65</sup> Exhibit J-4.

caused the bleed was the fall, and points out that the Department has not cited the Facility for any violation relating to the fall itself. In addition, As a result, the Facility urges that the deficiency be reversed and a finding made that there was no deficient practice.

After careful review, the Administrative Law Judge concludes that the Tag F 309 with respect to Resident 52 is also supported by the record as a whole and should not be rescinded. Where there has been a lack of improvement or decline in the condition of a resident, the SOM indicates that the survey team must determine if the lack of improvement or decline was unavoidable or avoidable. A determination of unavoidable decline may only be made if all of the following are present: an accurate and complete assessment; a care plan that is implemented consistently and based on information from the assessment; and evaluation of the results of the interventions and revising the interventions as necessary.<sup>66</sup>

Based upon the documentation and testimony provided, there was a proper basis for the Department to find that the Facility failed to ensure that accurate and complete assessments of the Resident were obtained and that the interventions were revised as necessary, particularly during the evening of June 29 and early morning hours of June 30. The testimony of Facility staff during the IIDR meeting indicated that Dr. Hasan visited the Resident at approximately 6:15 p.m. on June 29 and the Resident's family arrived at approximately 8:00 p.m.<sup>67</sup> Despite the Resident's decline during and after supertime, Facility staff only performed two neurological checks during the 13 hours that elapsed between the time of Dr. Hasan's visit and the time the Resident was taken to the Emergency Department: one at 11:15 p.m. and another at 7:15 a.m. the following morning. Moreover, the Director of Nursing acknowledged that there was a further significant change in the Resident's condition at 11:15 p.m., when the Resident was noted to be lethargic and his pupils more dilated and nonreactive, but there is no evidence that either the Resident's physician or the Resident's family was notified to ascertain whether it would be advisable to revise the approach to be taken. Under these circumstances, the Administrative Law Judge cannot find that the Resident's decline was unavoidable, and concludes that the Department's finding of a deficiency is warranted.

### **Scope and Severity Level**

As noted above, the Department cited the violation of 42 C.F.R. § 483.25 at a scope and severity level of G, based upon the surveyor's conclusion that the deficiency was isolated in scope and, with respect to Resident 52, resulted in actual harm that was not immediate jeopardy. The Department indicated that, if Resident 37 had been the only individual involved, the violation would have been cited at a D level, which applies to a deficiency that is isolated in scope and resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy. Based upon the language of

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<sup>66</sup> Exhibit F-2.

<sup>67</sup> This differs significantly from the estimated timeline set forth in the Facility's IIDR submission.

the final report issued by Dr. Giri, the Facility argues that the severity level should be reduced because no “actual harm” resulted from the Facility’s actions.

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 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 SOM and Program Letter instructions, it appears that the Department’s determination that Resident 52 suffered actual harm is a “survey finding” that may be disputed by the Facility in this IIDR.

The Interpretive Guidelines for skilled nursing facilities defines level 3 “actual harm” deficiency determinations as follows:

Level 3 is 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 consequences to the resident.<sup>68</sup>

In her final report, Dr. Giri noted that the Resident’s family had asked whether sending the Resident to the emergency room earlier than the morning of June 30, 2011, would have changed the outcome. Dr. Giri indicated that this “would be debatable” because the Resident “appears to have had multiple injuries with subdurals even from before likely acute on chronic.” She also said that it was “likely that some of the bleed could even have preexisted or presented along with this fall when he broke his left hip as well.” She questioned whether the Resident even hit his head directly when he fell on June 29, 2011, and stated that there “could even have been indirect injury with a possible rupture of superficial blood vessels which could have aggravated his condition.” Dr. Giri’s discussion of preexisting bleeds may explain why Resident 52 motioned to his physical therapist that he had pain in his head on June 27, two days before his fall in the Facility.<sup>69</sup>

In light of Dr. Giri’s report, it is not possible to conclude that the Facility’s failure to conduct more extensive neurological monitoring during the evening of June 29 and the morning of June 30 caused actual harm to the Resident. Accordingly, the Administrative Law Judge concludes that a severity level of G is not warranted and recommends instead a severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy).

#### **B. L. N.**

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<sup>68</sup> State Operations Manual, CMS Pub. 100-07, Appendix P, Part I, Section IV, “Deficiency Categorization.”

<sup>69</sup> Exhibit 8-8.