

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

In the Matter of Evergreen Terrace

RECOMMENDED DECISION

This matter came before Administrative Law Judge Eric L. Lipman for an informal dispute resolution meeting on May 10, 2012. The meeting concluded on that date.

Christine R. Campbell, Northeastern District Office, appeared on behalf of the Minnesota Department of Health (“the Department”). Mary Cahill also attended the meeting on behalf of the Department.

Rebecca K. Coffin, Voigt, Klegon & Rode, LLC, appeared on behalf of Evergreen Terrace (“Evergreen” or “the facility”). The following persons also attended the meeting and made comments on behalf of the facility: Nancy Christenson, Jamie Templin, Spring Latimer and Nancy Tuders.

Based upon the submissions of the parties at the resolution meeting and the contents of the record, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

- (a) The Commissioner should further recommend that Tag F-157 be set aside, as the evidence does not establish a deficient practice.
- (b) The Commissioner should further recommend that Tag F-280 be set aside, as the evidence does not establish a deficient practice.
- (c) The Commissioner should further recommend that Tag F-309 be set aside, as the evidence does not establish a deficient practice.

Dated: May 24, 2012

s/Eric L. Lipman
ERIC L. LIPMAN
Administrative Law Judge

Reported: Digital recording, no transcript.

NOTICE

Under Minn. Stat. § 144A.10, subdivision 16 (d) (6), this recommended decision is not binding upon the Commissioner of Health. Further, pursuant to 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

This matter arises out of a state compliance survey conducted at Evergreen Terrace between November 8 and 16, 2011.¹

The Minnesota Department of Health (“MDH”) issued a Statement of Deficiencies following this survey. The statement designated a series of “F-Tags.” These tags set forth areas in which the Department asserts that Evergreen Terrace fell below the federal requirements for participation in the Medicare and Medicaid programs.² If sustained, any of these deficiencies could result in the application of sanctions to the facility.

General Statutory and Regulatory Background

Participation requirements for skilled nursing and other long-term care facilities in the Medicare program are set forth in 42 C.F.R. Part 483, Subpart B. Provisions governing the surveying of long-term care facilities and enforcement of their compliance with participation requirements are in 42 C.F.R. Part 488, Subparts E and F.

Federal Medicare and Medicaid authorities assure compliance with the participation requirements through regular surveys by state agencies. The survey agency reports any “deficiencies” on a standard form called a “Statement of Deficiencies.”³

A “deficiency” is a failure to meet a participation requirement in 42 C.F.R. Part 483.⁴ Deficiency findings are organized in the Statement of Deficiencies under alphanumeric “tags,” with each tag corresponding to a regulatory requirement in Part 483.⁵ The facts alleged under each tag may include a number of survey findings, which, if upheld, establish that a facility failed to meet the regulatory standards.

¹ MDH Exhibit F-1.

² See, 42 C.F.R. §§ 488.301 and 488.325 (a).

³ See, e.g., MDH Ex. F.

⁴ See, 42 C.F.R. § 488.301.

⁵ See, MDH Ex. G.

A survey agency's findings also include a determination as to the “seriousness” of each deficiency.⁶ The seriousness of a deficiency depends upon both its “scope” and its “severity.”⁷

When citing deficiencies, state surveyors use the CMS Guidance on Deficiency Categorization. The range of deficiencies is set out on three-column, four-level grid. Each square on the Grid has a letter designation. “A” is the least serious and “L” is the most serious. The fourth level of the grid (including designations J, K and L) is reserved for those deficiencies which place residents in immediate jeopardy.⁸

A facility becomes subject to remedial action under the participation agreement when it is not in “substantial compliance” with one or more regulatory standards.⁹ A facility is not in substantial compliance with a participation requirement if there is a deficiency that creates at least the “potential for more than minimal harm” to one or more residents.¹⁰

If a facility is found not to be in “substantial compliance,” CMS may either terminate the facility's provider agreement or allow the facility the opportunity to correct the deficiencies pursuant to a plan of correction.¹¹ Further, CMS may, based upon the severity of the deficiencies, impose an intermediate remedy, such as a monetary penalty, for each day in which the facility was not in substantial compliance with the terms of the participation agreement.¹²

Lastly, Minn. Stat. § 144A.10, subdivision 16, establishes a process for independent and informal resolution of disputes between survey agencies and health care providers with a participation agreement. In this request for Independent Informal Dispute Resolution, Evergreen Terrace submits three F-Tags for review.

Course of Treatment for Resident Number 1

Resident No. 1 was admitted to Evergreen Terrace in February, 2010. Upon admission she had a number of significant health conditions – including senile dementia with delusional features; congestive heart failure; depressive disorder; hypertension; psychosis and generalized anxiety.¹³

⁶ See, 42 C.F.R. § 488.404.

⁷ See generally, MDH Exs. A and B.

⁸ *Id.*

⁹ See, 42 C.F.R. § 488.400.

¹⁰ See, 42 C.F.R. § 488.301.

¹¹ See, 42 C.F.R. §§ 488.402, 488.406 and 488.412.

¹² See, 42 C.F.R. §§ 488.406, 488.408 and 488.440.

¹³ See, Evergreen Ex. 1 (October 2011 Physician's Orders).

Resident No. 1's Care Plan was adjusted at regular intervals during her stay at Evergreen Terrace. Her Care Plan was revised on September 14, 2011. Additionally, following a visit with her physician on October 10, 2011, Resident No. 1's regimen of anti-psychotic medications was adjusted.¹⁴

Thursday, October 13, 2011

At approximately 4:00 p.m. on October 13, 2011, Resident No. 1's daughter-in-law approached the Nurse Manager of Evergreen Terrace and stated that Resident No. 1 had fallen sometime before but had not told any of the Evergreen staff about this fall.¹⁵

The progress notes do not reveal any earlier signs of a fall or reports that a fall had occurred.

Following an evaluation of Resident No. 1 at Grand Itasca Clinic and Hospital, Resident No. 1 was diagnosed with six (6) fractured ribs on her left side. She was prescribed hydrocodone for pain and the discharge instructions stated that there should be "follow-up in clinic or ER if worse or not improving."¹⁶

Resident No. 1 was discharged to Evergreen that same evening, and treated with pain medication and an ice pack – although the Resident refused the latter.

Resident No. 1 was placed on Evergreen's 24-Hour Nursing Reporting system. This system scheduled reviews of Resident No. 1's condition by nursing at set intervals. While Resident No. 1 was already subject to a series of checks at 15-minute intervals, due to the Resident's psychiatric issues, the items assessed during these checks were broadened in the days following Resident No. 1's fall. The broadened areas of inquiry were Resident No. 1's pain level, the efficacy of her pain medication, signs of shortness of breath and the resident's oxygen saturations ("O₂ Sats").¹⁷

Friday, October 14, 2011

On October 14, Evergreen's interdisciplinary team (IDT) met to review Resident No. 1's status and care. The team discussed Resident No. 1's fall and the types of interventions that should be implemented. Resident No. 1's medication regimen was adjusted following the team's meeting.¹⁸

¹⁴ See, Evergreen Ex. 3 (October 10, 2011 Physician's Note).

¹⁵ Evergreen Ex. 4 (Progress Notes).

¹⁶ Evergreen Ex. 5 (Grand Itasca Discharge Instructions); Evergreen Ex. 6.

¹⁷ Evergreen Ex. 7 (24 Hour Reports); Testimony of Nancy Christenson.

¹⁸ Evergreen Ex. 4 (Progress Notes); Evergreen Ex. 8 (October 2011 Medication Administration Records); Evergreen Ex. 9 (Physician's Orders).

As the Evergreen nursing staff assisted Resident No. 1 with her cares, dispensed pain medication and completed its series of 15-minute checks, Resident No. 1 appeared to be stable.¹⁹

Saturday, October 15, 2011

Throughout most of the day on October 15, 2011, Resident No. 1 was in stable condition, although experiencing pain.²⁰

At approximately 10:00 p.m. on that day, Resident No. 1 was noted to have shortness of breath. Resident No. 1's levels of oxygen saturation – or "O₂ Sats" – were measured to be 66 percent on room air. 2.5 liters of oxygen was then administered through a nasal cannula, consistent with Resident No. 1's standing orders on the administration of oxygen. With this intervention, her "O₂ Sats" rose to 91 percent.²¹

Under the facility's procedures, administration of oxygen to a patient, consistent with an earlier standing order from a physician, does not oblige a separate notification to the patient's physician.²² Resident No. 1 had a standing order providing for the administration of higher levels of oxygen.²³

Sunday, October 16, 2011

At approximately 4:00 a.m. on October 16, 2011, Melissa Fieldsend, LPN, checked on Resident No. 1. Fieldsend listened to Resident No. 1's lung sounds and raised the head of her bed so as to assist her with breathing. Resident No. 1's lung sounds were not unusual.²⁴

During that day, Resident No. 1 appeared sleepy and lethargic. The nursing staff assessed Resident No. 1's condition – which included a review of the effectiveness of Resident No. 1's pain medication, vital signs and lung sounds.²⁵

Based upon this apparent change in affect, Jamie Templin, R.N. telephoned the on-call physician. Nurse Templin reported that although Resident No. 1's vital signs were stable, her lung sounds were clear and she was using oxygen, she still had decreased alertness.²⁶

¹⁹ Evergreen Exs. 4 and 7.

²⁰ Evergreen Exs. 4, 7 and 8.

²¹ Evergreen Ex. 4, at 5 of 13.

²² Evergreen Exs. 4 and 10.

²³ Evergreen Ex. 10.

²⁴ Evergreen Ex. 4; Evergreen Ex. 12 (Statement of Melissa Fieldsend).

²⁵ See, Evergreen Ex. 4 (Progress Note entry on 10/16/11 at 13:35); Evergreen Exs. 9 and 13.

²⁶ Evergreen Exs. 4, 5, 9 and 13.

The on-call physician directed Evergreen to: continue Resident No. 1's current schedule of administering Tylenol; decrease the number of Percocet doses she was receiving to one tablet every four hours, as needed; administer Thuprofen 200 milligrams twice each day; and to use Tylenol 325 mg every four hours for pain. Additionally, the on-call physician directed that Resident No. 1 be seen by her nurse practitioner later that same week.²⁷

Evergreen implemented the physician's directives and continued to monitor Resident No. 1's condition at 15-minute intervals throughout the day.²⁸

Monday, October 17, 2011

Early in the morning on October 17, Melissa Fieldsend, L.P.N., checked on Resident No. 1 and the resident appeared stable.²⁹

Later that day, Resident No. 1 was noted by nursing staff to be sitting up in her rocking chair and she was both alert and pleasant.³⁰

The nursing staff did note, however, that Resident No. 1 was taking her oxygen cannula off, resulting in much lower levels of oxygen saturation. The staff encouraged Resident No. 1 to take deep breaths and to maintain use of the oxygen equipment. Additionally, Evergreen staff contacted Resident No. 1's son to inform him that his mother was removing her oxygen apparatus after staff exit her room. Resident No. 1's son indicated that he would contact his mother and remind her of the need to use her oxygen equipment.³¹

The IDT reviewed Resident No. 1's condition during its October 17th meeting. The team determined that because Resident No. 1 had not made any suicidal comments to staff, or exhibited any signs of suicidal ideation, it was appropriate to reduce the frequency of the staff's monitoring checks of Resident No. 1 from once every 15 minutes to once every 30 minutes.³²

²⁷ Evergreen Exs. 4, 9 and 13.

²⁸ Evergreen Exs. 4 and 7.

²⁹ Evergreen Exs. 4 and 12.

³⁰ Evergreen Exs. 4 and 15; Testimony of Spring Latimer.

³¹ Evergreen Exs. 4, 7 and 12.

³² Evergreen Exs. 4.

Tuesday, October 18, 2011

At the IDT meeting on October 18, Resident No. 1's condition was again reviewed. Spring Latimer, R.N., the Nurse Manager, requested a dietician assess Resident No. 1 because of her decreased intake.³³

A dietician recommended a nutritional supplement be added to Resident No. 1's diet and the appropriate orders for this result were later issued.³⁴

Still later that day, Nurse Latimer tried to listen to Resident No. 1's lung sounds, but was unable to do so because Resident No. 1 was unwilling to take deep breaths. Further, Resident No. 1 appeared much more lethargic than she was on the previous day and she was now complaining about rib pain. Based upon this assessment, Nurse Latimer concluded that Resident No. 1 had a change in condition, as those terms are used in 42 CFR § 483.10 (b) (11) (i) (B).³⁵

Nurse Latimer contacted Resident No. 1's primary physician by facsimile to update her on Resident No. 1's pain level, sedation, decreased appetite and oxygen use. In the facsimile transmission Nurse Latimer requested a return call from the physician with further suggestions or orders. When Ms. Latimer did not receive a return call from Resident No. 1's physician, she telephoned the clinic directly.³⁶

After conferring with Nurse Latimer, Resident No. 1's physician directed that Resident No. 1 be sent to the emergency room for further evaluation.

Following an examination and chest x-ray of Resident No. 1, emergency room staff of Grand Itasca Hospital diagnosed Resident No. 1 with a hemothorax (blood around lungs) secondary to rib fractures, hypoxia secondary to rib fractures, acute blood loss anemia and acute renal failure.³⁷

Tag F157 – Prompt Notification of a Significant Change in Condition

Under the quality of care regulations, the facility must immediately “consult with the resident’s physician” when there is... “a significant change in the resident’s physical, mental, or psychosocial status (i.e. a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);” or “a need to alter treatment significantly”³⁸

³³ *Id.*

³⁴ Evergreen Exs. 9 and 13.

³⁵ Evergreen Exs. 4 and 15; Test. of S. Latimer.

³⁶ *Id.*

³⁷ *Id.*

³⁸ 42 CFR § 483.10 (b) (11) (i) (B).

The state surveyors determined that this requirement was not met in this instance because “the facility failed to promptly consult with and update [Resident No. 1’s] physician when Resident No. 1 had a significant change in condition and continued to decline following 6 rib fractures.” Specifically, the surveyors asserted that “[a] physician was not notified on 10/17/11 in relation to Resident No. 1’s continued respiratory status concerns, including decreased oxygen saturations requiring continuous oxygen, shortness of breath, and difficulty breathing and continued complaints of severe pain.”³⁹

The dispute in this case, therefore, devolves to when Resident No. 1’s hemothorax, hypoxia, blood loss and renal failure would have been apparent to nursing staff that were maintaining substantial compliance with the applicable standards.

In the view of the Administrative Law Judge, the facility has the better reading of the record. As Dr. Pehi explained in his submissions, and Nancy Tuders confirmed during the hearing, it is difficult to diagnose a person with a hemothorax, or to determine that fluid built up in the lungs, without the kind of tests that occurred at Grand Itasca Hospital and Clinic. Before October 18, the day on which Resident No. 1 was sent to the hospital, it would not have been apparent to nursing staff (who were maintaining substantial compliance with the applicable standards) that Resident No. 1 had conditions other than the earlier-diagnosed broken ribs.⁴⁰ Tag 157 should be set aside.

Tag F209 – Prompt Revision of the Care Plan

Under the quality of care regulations, the facility must “develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.” The comprehensive assessment must be completed within 14 days following a resident’s readmission “following a temporary absence for hospitalization or for therapeutic leave,” and the care plan associated with that resident is to be updated within seven days of the completion of the assessment.⁴¹

In this case, Resident No. 1 was discharged from Evergreen Terrace to Grand Itasca Hospital and Clinic on October 13, 2011, and returned back to Evergreen from the hospital later that same evening. Despite the brevity of this hospital stay – it appears that her readmission to Evergreen does qualify as a “return to the facility following a temporary absence for hospitalization or for therapeutic leave” under 42 C.F.R § 483.20 (b) (2) (i). Accordingly, the facility was not obliged under the regulations

³⁹ MDH Ex. F-3 and F-6 (CMS Form 2567).

⁴⁰ Evergreen Ex. 11; Test. of Nancy Tuders; *compare generally*, 56 Fed. Reg. 48826, 48833 (Sept. 26, 1991) (Preamble to the Final Rule on Resident’s Rights) (“We recognize that judgment must be used in determining whether a change in the resident’s condition is significant enough to warrant notification, and accept the comment that only those injuries which have the potential for needing physician intervention must be reported to the physician”).

⁴¹ 42 C.F.R § 483.20 (b) (2) (i) and 42 C.F.R § 483.20 (k).

to update its care plan to reflect a newly completed comprehensive assessment until early November of 2011 – well after the dates on which the surveyors assert that the care plan was incomplete.

More importantly, Evergreen continually updated its care and interventions for Resident No. 1 during the five-day time period between the two hospital visits. It placed Resident No. 1 on 24-hour reports, reviewed her condition on 15 or 30-minute intervals, presented her status for review to the facility’s Interdisciplinary Team and updated the Nursing Assistant Care Cards to reflect the latest interventions. Tag 209 should be set aside.

Tag F309 – Services for the Resident’s Highest Practicable Well-Being

Under the quality of care regulations, the facility must provide “the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing, in accordance with the comprehensive assessment and plan of care.” The regulations further require that the facility ensure that each resident obtain optimal improvement or does not deteriorate ... within the limits of recognized pathology and the normal aging process.”⁴² The interpretative guidance on this regulation instructs surveyors 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. If services and care are being provided, [the surveyors are to] determine if the facility is evaluating the resident's outcome and changing the interventions if needed.”⁴³

The state surveyors determined that “the facility failed to provide each resident with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being” because Resident No. 1 “had a significant change.” Moreover, the facility “failed to complete on-going comprehensive assessments ... in order to identify potential complications and failed to ensure that the resident received further medical attention in a timely manner.”⁴⁴

In the view of the Administrative Law Judge, the best reading of the record is that Evergreen Terrace staff closely monitored Resident No. 1’s condition, modified the range of interventions it made to meet new conditions and called for additional medical resources early (and often) following significant changes. Evergreen Terrace did what is obliged by 42 C.F.R. § 483.25.

In this context, it is important to closely read the record, as it might have appeared to Evergreen staff, as those events were occurring. The best reading of the record is to read the progress notes without knowing the diagnosis that was yet to come on October 18. From this vantage point, one doubts that nursing staff could have

⁴² 42 C.F.R. § 483.25.

⁴³ MDH Ex. I-2.

⁴⁴ MDH Ex. F-12 (CMS Form 2567).

inferred October 16 or 17 that Resident No. 1's pain followed from fluid in the lungs, instead of broken ribs. Tag 309 should be set aside.

Conclusion

The Administrative Law Judge recommends that the Commissioner further recommend that the "G" level deficiency issued under F-Tag 157, the "D" level deficiency under F-Tag 280 and the "K" level immediate jeopardy deficiency issued under F-Tag 309, be set-aside.

E. L. L.