MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, maintaining and improving the health of all Minnesotans

August 28, 2012

Rebecca K. Coffin
Voigt, Rode, and Boxeth LLC
2550 University Avenue West
Suite 190 South
St. Paul, MN 55114

sent via fax: August 28, 2012
(651) 209-6160

RE: [redacted] IIDR, OAH Docket 7-0900-22895-2

Dear Ms. Coffin:

This letter is in response to the Independent Informal Dispute Resolution (IIDR) requested by [redacted] regarding deficiencies issued as a result of a complaint investigation, exit date March 22, 2012 and follow up revisit, exit date March 28, 2012. [redacted] requested a review of Tags F225 and 226 issued at the initial complaint investigation. The IIDR was held before Administrative Law Judge Richard Luis. The Department received Judge Luis' recommended decision on August 10, 2012.

Decision

After careful review of Judge Luis' recommendation and the material submitted to the Judge in support of each party's position, I concur with Judge Luis' recommendation that the tags are valid, however, I do not agree that the scope and severity be changed to Level E. My determination is that F225 and F226 were issued correctly at scope and severity Level K and F respectively.

Rationale

Tag F225 requires that the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported *immediately* to the administrator of the facility *and* to other officials in accordance with state law through established procedures (including to the state survey and certification agency), and the facility must have evidence that all alleged violations are *thoroughly* investigated, and must prevent further potential abuse while the investigation is in progress.

The State Operations Manual (SOM) provides clarification for nursing homes that allegations of mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property, must be immediately reported to the state survey

agency, as well as the results of the investigation. There is a 3 step process required to ensure compliance with the regulation:
1) immediately report allegations to the administrator and state survey agency,
2) thoroughly investigate the allegation, and
3) submit to the survey agency the results of the investigation within 5 days.
The regulation requires immediate reporting of the allegation; that means reporting prior to the investigation. There is no provision to not report an allegation based on the facility's assumption that the allegation is likely false, or not reporting because an ensuing investigation proves the allegation unsubstantiated.

Resident #1 (R1) has dementia, and a history of mental health and behavioral issues. Resident 1 made an allegation of rape. R1 had never made this type of allegation before. The facility believed this to be another behavior related to her dementia and responded as follows:
LPN-A looked in R1's room for a man and did not find one and reviewed the allegation with a few staff. The LPN sent an email to the director of nursing (DON) and Nurse Manager and explained the allegation. The DON informed the LPN not to document the allegation in the medical record as they were still investigating. The LPN did not fill out an incident report because she believed those were only for skin tears and bruises. [redacted]s licensed social worker spoke to R1 the next day and R1 denied anyone had hurt her. The facility determined that no male caregivers had cared for R1 that evening and *believed* the rape did not happen based on the social worker's conversation with R1. The DON did not report the allegation of rape and did not see that it was documented in R1's medical record because she did not consider it to be an allegation at the time given R1's history of dementia and corresponding behaviors. When asked at the IIDR what constituted an allegation, the DON was unable to define what that meant.

[redacted]y did not report this allegation to the state survey agency, the Minnesota Department of Health (MDH). [redacted]y contends an investigation was completed. MDH contends an investigation was initiated; however it was not a thorough investigation as [redacted]y did not: notify police, family and the primary physician, nor did the facility examine R1 for any evidence of trauma/assault utilizing a physician or nurse in the emergency room in order to obtain any evidentiary evidence of an assault or in the alternate an examination by facility staff. Further, the facility did not interview all staff and any appropriate residents to determine resident's whereabouts preceding the allegation. The facility failed to consider what may have happened to R1 to make her feel/believe she had been raped. The facility believed it was not an allegation as the resident was confused and had behaviors.

Resident #2 (R2) has a diagnosis of Alzheimer's Dementia. R2 had a large bruise (4 cm x

7.5 cm) on the medial side of her left breast. F Tag 225 requires that injuries of an unknown source are immediately reportable. The SOM clarifies that "an injury should be classified as 'an injury of unknown source' when both of the following conditions are met – the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury (eg. the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time." MDH asserts this injury meets the definition of an injury of unknown source. No one saw the injury occur. The resident has dementia and is unable to report the source. The breast is not generally vulnerable to trauma. The facility claimed the breast is an area susceptible to trauma for this resident because of her behaviors of resisting cares. The DON affirmed at the IIDR meeting that the facility did not do an investigation as they knew the resident had behaviors and the bruise could be attributed to her resistance to cares. The DON stated the injury was not reported as it was not an unknown injury because it occurred as a result of her behaviors.

Resident #3 (R3) has a diagnosis of dementia. She had a large bruise on the back of her right thigh (6.5 cm x 3.5 cm). The bruise was noticed and reported by R3's family. The cause of the injury was unknown, it was not reported to MDH and an investigation was not completed. There was no investigation because staff determined, speculatively, that it was likely due to R3's behaviors of wandering and banging on closed doors and therefore the injury was not suspicious. When asked how wandering and banging on doors could cause a bruise on the back of the thigh, the DON stated that perhaps the resident backed into something or the resident's husband ran into her. The DON affirmed in her testimony that the facility did not do an investigation as they knew the resident had behaviors and the bruise could be attributed to her wandering. The DON stated the injury was not reported as it was not an unknown injury having occurred as a result of R3's behaviors.

Resident #4 (R4) has a diagnosis of dementia. A facility injury report indicated that R4 had a bruise on the right eyelid that went up to the right eyebrow. The injury was of unknown source, and met the definition of injuries of unknown source as detailed by CMS. The injury was un-witnessed, the resident was unable to report how the bruises occurred and the face is an area generally not susceptible to trauma. The facility speculated the cause of the injury to likely be the result of R4 hitting her head/face on a side rail when staff was repositioning her, that she was rolled too forcefully. There was no further follow up. The DON affirmed the incident was not reported to MDH as the nurse on duty believed it to be from the side rails. The DON also indicated there was no further investigation as the nurse believed the bruising to be from the side rail yet acknowledged there had not been a specific incident noted to have occurred creating the injury.

Resident #5 (R5) has a diagnosis of Alzheimer's dementia. A facility injury report indicated that R5 had a bruise and swelling of his right wrist, hand and fingers. The cause of the injury was documented as unknown. The location of the bruises is not suspicious, and documentation indicates it does not clearly meet the definition of injuries of unknown source as detailed by CMS in F Tag 225. This example should be deleted from the findings on the Form 2567.

Resident #6 (R6) was receiving hospice services and per facility documentation had intermittent confusion related to his decline. R6 had three large bruises on his chest and shoulders. The origin of the bruises was unknown. Over a week later he had a skin tear on his left hand and bruising and the skin tear on his right forearm and the origin of the bruises was also unknown. The bruises on the hands and forearms are not suspicious in location or size. Although the bruising on the chest could be considered suspicious in location and size, the supporting documentation regarding the physical condition of R6 does not support them being injuries of unknown source as defined by CMS. This example should be deleted from the findings on the Form 2567.

Resident examples 1,2, 3 and 4 are valid examples of [redacted]s failure to report and thoroughly investigate allegations and potential incidents of abuse. R1 made an allegation of rape; it was her first such allegation. By definition rape is sexual abuse, reporting and comprehensive investigation is required. The facility's failure to take R1's report as a serious allegation of rape, thereby completing a thorough investigation, meant critical evidence was not gathered to rule out or affirm the allegation made by R1. Residents 2, 3 and 4 had injuries that met the definition of injuries of unknown source. The injuries required reporting and thorough investigation. All of the residents had dementia and were unable to account for the sustained injuries. The injuries were un-witnessed and in suspicious locations. When asked what injuries would be considered injuries of unknown source, the DON stated she was unsure. The facility policy for abuse/neglect provided the CMS definition of injuries of unknown source without further clarification. As identified and reported in the Appendix Q, exhibit E-5 from the IIDR meeting, a trigger for an immediate jeopardy for abuse is suspicious bruising around the breast or genital area, and/or black eyes. The facility admits to not notifying the state agency and not completing investigations on the injuries of unknown source as they were able to identify behaviors that may have caused the injury. Speculation is not investigation.

The failure of [redacted]y to comprehensively investigate an allegation of rape placed Resident #1, as well as other cognitively impaired residents, at ongoing risk for serious injury or harm. The failure of the facility to identify the injuries sustained by R2, R3, and R4 as injuries of unknown source, thereby requiring reporting to the state agency and a thorough investigation, placed all cognitively impaired residents at ongoing

risk for injuries of unknown source and potential abuse. The identified risks placed all cognitively impaired residents at ongoing immediate risk for serious injury or harm. With the deletion of Residents 5 and 6 and the retention of Residents 1 -4, the deficiency is appropriately cited at Level K, a pattern deficiency that is immediate jeopardy, a situation in which immediate corrective action is necessary because the facility's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility.

Tag F226 requires that the facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. [redacted]v failed to operationalize its policies related to abuse and neglect as demonstrated by the examples cited in F225. In addition, [redacted]v did not adequately develop its policy to ensure all appropriate incidents were identified, reported, and investigated. Examples include lack of a structured system to provide staff direction on how to identify a reportable allegation or incident, how to report, and how to conduct a thorough investigation of allegations and incidents. A facility's failure to develop and operationalize a policy related to abuse/neglect is a widespread problem as every resident in the facility could be impacted. In addition, residents have the potential for no more than minimal harm should the policy not be appropriately developed and/or implemented. The deficiency is appropriately cited at Level F, a widespread deficiency that results in no more than minimal physical, mental and/or psychosocial discomfort to the resident and/or has the potential (not yet realized) to compromise the resident's ability to maintain and/or reach his/her highest practicable physical, mental and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.

This concludes the IIDR process. As noted in the Department of Health's Information Bulletin 04-07, the final decision of the Department of Health is not binding on the Centers for Medicare and Medicaid.

Sincerely,

Nancy Lyner for

Edward P. Ehlinger, M.D., MSPH
Commissioner
P.O. Box 64975
Saint Paul, Minnesota 55164-0975

cc: Judge Richard Luis
Tamika J. Brown, CMS Region V
Deb Holtz