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STATE OF WISCONSIN
BEFORE THE NURSING HOME ADMINISTRATORS EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
JAMES P. IGNARSKI, NHA	:	LS0711151NHA
RESPONDENT.	:	

[Division of Enforcement Case #03 NHA 024]

The parties to this action for the purposes of Wis. Stat. § 227.53 are:

James P. Ignarski
404 Westwood Drive
Chippewa Falls WI 54729

Division of Enforcement
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Department of Regulation & Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Nursing Home Administrators Examining Board. The Board has reviewed the attached Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. James P. Ignarski ("Respondent") was born on January 20, 1961, and is licensed to practice nursing home administration in the state of Wisconsin pursuant to license number 1879. This license was first granted on June 20, 1983.

2. Respondent's most recent address on file with the Wisconsin Nursing Home Administrators Examining Board is 404 Westwood Drive, Chippewa Falls, WI, 54729.

3. At all times relevant to this action, Respondent was working as the nursing home administrator at Lakeside Nursing and Rehabilitation, Chippewa Falls, Wisconsin.

4. Respondent was the administrator of record of Lakeside Nursing and Rehabilitation in Chippewa Falls, Wisconsin, between July 1, 1996, and August 25, 2003.

5. The Bureau of Quality Assurance, Department of Health and Family Services ("BQA") is the agency of the State of Wisconsin responsible for the inspection of long term care facilities for compliance with and enforcement of federal and state regulations governing the operation of long term care facilities.

6. BQA reports the results of its inspections of long term care facilities such as Lakeside Nursing and Rehabilitation using a form and reporting criteria standardized by and required by the United States Department of Health and Human Services. The reporting criteria are keyed to 42 C.F.R. part 483, the federal law which specifies the minimally acceptable standards of care to be provided to residents of long term care facilities that receive Medicare funds for providing services to residents.

7. Under the reporting system required by U.S. DHHS, specific deficiencies in the quality of care provided by long term care facilities to residents, and in the operation of long term care facilities, are the subject of specific "tags" which function as references to specific sections of the Code of Federal Regulations.

8. In the September 2002 survey report, BQA issued statements of deficiency against Lakeside on tags

   a. F 225, for non-compliance with 42 C.F.R. 483.13(c)(1)(ii), related to staff treatment of residents.
   b. F 240, for non-compliance with 42 C.F.R. 483.15, related to the residents' quality of life for failure to respect privacy and dignity of residents.
   c. F 250, for non-compliance with 42 C.F.R. 483.15(g), related to medically related social services for failure to provide required medically related social services.
   d. F 252, for non-compliance with 42 C.F.R.483.15(h)(1), for failure to ensure a safe, clean environment.
   e. F 280, for non-compliance with 42 C.F.R. 483.20(k)(2), for failure to develop and maintain a comprehensive plan of care for residents.
   f. F 314, for non-compliance with 42 C.F.R. 483.25(c), for failure to prevent the development of or treat pressure sores.
   g. F 318, for non-compliance with 42 C.F.R. 483.25(e)(2), related to quality of care provided to residents, for failure to ensure that residents received range of motion exercises to increase limited range of motion or prevent further decrease in already limited range of movement.
   h. F 324, for non-compliance with 42 C.F.R. 483.25(h)(2), for failure to ensure that residents received adequate supervision and assistive devices to prevent accidents.

9. DHHS has developed, and requires that BQA use, an enforcement grid to describe the severity and scope of deficiencies in compliance with the standards of operation of long term care facilities required under Medicare regulations and 42 C.F.R. part 483. Figure 1.

10. BQA assessed the harm level of the worst of the failures of compliance detected during the September 2002 inspection as Level 2, no actual harm to residents, but a potential for more than minimal harm that does not rise to the level of immediate jeopardy to resident health or safety.

11. BQA assessed the scope of the deficiencies in compliance detected by the September 2002 inspection as "isolated", meaning that the non-compliance affected or involved only one or very limited numbers of residents or staff.

12. Respondent signed a Plan of Correction for Lakeside on October 18, 2002, representing that Lakeside

> has conducted a nursing department inservice that specifically identified the daily maintenance of necessary treatment and services to promote healing in any resident who has developed a pressure sore. This inservice also identifies the necessity for daily monitoring to ensure that the treatment and services are consistently maintained. The inservice also identified the established protocols relative to identifying treatment and services to ensure that all existing and new residents are assessed and clinical interventions are maintained to promote necessary healing to prevent infection and development of new pressure sores.

13. The previous most recent documented nursing inservice at Lakeside on pressure sores had been conducted in November 2001.

14. BQA performed an inspection of Lakeside in April 2003, in response to a complaint by the family of a resident.

15. In the report of the April 2003 inspection, BQA issued statements of deficiency against Lakeside on tags

a. F 157, for non-compliance with 42 C.F.R. 483.10(b)(11), for failure to notify a resident's family and physician of the resident's significant change in condition.
b. F 278, for non-compliance with 42 C.F.R. 483.20(g), for failure to maintain accurate assessment of a resident's condition.
c. F 309, for non-compliance with 42 C.F.R. 483.25, for failure to provide necessary care and services to a resident to permit the resident to attain or maintain the highest practicable well-being in accordance with a comprehensive plan of care.
d. F 314, for non-compliance with 42 C.F.R. 483.25(c), for failure to prevent or treat pressure sores.
e. F 323, for non-compliance with 42 C.F.R. 483.24(h)(1), for failure to ensure that the resident environment remains as free of accident hazards as possible.
f. F 490, for non-compliance with 42 C.F.R. 483.75, for failure of Lakeside administration to use its resources to implement the plan of correction Respondent represented Lakeside had implemented in response to the statement of deficiency issued by BQA in September 2002 under tag F 314.

16. The basis for the April 2003 statement of deficiency at tag F 314 included a resident who was admitted without pressure sores in December 2002, but who was discharged from Lakeside on April 3, 2003, to a hospital for treatment of multiple pressure sores, including pressure sores extending through all levels of skin and muscle to bone and tendon.

17. The basis for the April 2003 statement of deficiency at tag F 490 was that Lakeside had not conducted a nursing staff inservice on pressure sores after the September 2002 survey.

18. BQA assessed the scope and severity of the harm of Lakeside's deficiency related to Respondent's failure to implement the plan of correction he represented had been implemented in response to the September 2002 statement of deficiency at tag F 314 as a pattern of actual harm that is not immediate jeopardy to the health of residents.

19. BQA performed an inspection of Lakeside in September 2003, as a follow-up to the April 2003 complaint inspection, and in response to a complaint about Lakeside.

20. In the report of the September 2003 inspection of Lakeside, BQA issued statements of deficiencies on tags

a. F 157, for non-compliance with 42 C.F.R. 483.10(b)(11), for failure to notify residents' families and physicians of significant changes in the residents' conditions.
b. F 203, for non-compliance with 42 C.F.R. 483.12(a)(4)-(6), for failure to provide a resident's family with the required notifications of the resident's involuntary discharge from Lakeside.
c. F 250, for non-compliance with 42 C.F.R. 483.15(g), for failure to provide required medically related social services to a resident.
d. F 281, for non-compliance with 42 C.F.R. 483.20(k)(3)(i), for failure to provide nursing services that met professional standards of quality.
e. F 314, for non-compliance with 42 C.F.R. 483(25)(c), for failure to prevent or treat pressure sores.
f. F 322, for non-compliance with 42 C.F.R. 483.25(g)(2), for failure to ensure that residents fed by a naso-gastric or gastrostomy tube received appropriate care.
g. F 324, for non-compliance with 42 C.F.R. 483.25(h)(2), for failure to provide adequate supervision and assistance devices to prevent accidents.
h. F 353, for non-compliance with 42 C.F.R. 483.30(a)(1) and (2), for failure to maintain sufficient staffing.
i. F 497, for non-compliance with 42 C.F.R. 483.75(e)(8), for failure to perform performance evaluations of certified nurses assistants (CNA) at least annually.
j. F 514, for non-compliance with 42 C.F.R. 483.75(l)(1), for failure to maintain complete, accurate, organized, and accessible clinical records on each resident.
k. F 521, for non-compliance with 42 C.F.R. 483.75(o)(2) and (3), for failure to have an effective quality assurance program to develop, implement and monitor plans of action to correct identified deficiencies.

21. On the September 2003, statement of deficiencies, BQA assessed the scope and severity of the harm of Lakeside's non-compliance with 42 C.F.R. 483.25(c), tag F 314, as a pattern of immediate jeopardy to the health or safety of residents of Lakeside.

22. On the September 2003, statement of deficiencies, BQA assessed the scope and severity of the harm of Lakeside's non-compliance with 42 C.F.R. 483.10, tag F 157, as a pattern of immediate jeopardy to the health and safety of residents of Lakeside.

23. On the September 2003 statement of deficiencies, BQA assessed the scope and severity of the harm of Lakeside's non-compliance with 42 C.F.R. 483.20(k)(3)(i), tag F 281, as a pattern of actual harm that was not immediate jeopardy to the residents of Lakeside.

24. On the September 2003 statement of deficiencies, BQA assessed the scope and severity of the harm of Lakeside's non-compliance with 42 C.F.R. 483.75(o)(2) and (3), tag F 521as a pattern of actual harm that was not immediate jeopardy to the health and safety of residents of Lakeside.

25. Over the course of less than one year, in three consecutive inspections, Lakeside was issued three statements of deficiency for failing to prevent or treat pressure sores.

26. Of the three statements of deficiency issued to Lakeside in September 2002, April 2003, and September 2003, for failure to prevent or treat pressure sores, the last two, from two separate but consecutive inspections, were assessed as immediate jeopardy to the health and safety of residents of Lakeside.

27. By written response to both the September 2002 and April 2003 statements of deficiency at tag F 314, Respondent represented to BQA that Lakeside, under his administration, would implement a plan of correction to ensure that Lakeside would take appropriate precautions to prevent the development of pressure sores by residents of Lakeside, and would take appropriate steps to treat pressure sores when residents developed them despite precautions.

28. Despite the clarity of the repeated statements of deficiency on tag F 314, prevention and treatment of pressure sores, from each of three consecutive inspections of Lakeside, and Respondent's repeated written

representations that appropriate changes had been made and would be monitored by Lakeside management to ensure compliance with the law and the protection of residents' health and safety, Respondent failed to take effective action to cure Lakeside's threat to the health and safety of its residents and non-compliance with 42 C.F.R. 483.25(c).

29. Of the two statements of deficiency issued to Lakeside in April 2003 and September 2003, for failure to notify residents' families or physicians of significant changes in residents' conditions, only the first one was assessed at a scope and severity of harm less than a pattern of immediate jeopardy.

30. Through a written response to the April 2003 statement of deficiency, Respondent represented to BQA that Lakeside, under his administration, would implement a plan of correction to ensure that families and physicians of residents would be notified of significant changes in residents' conditions.

31. Despite the clarity of the statement of deficiency on tag F 157, failure to notify family or physician of significant changes in a resident's condition, and Respondent's written representation that appropriate changes had been made and would be monitored by Lakeside management to ensure compliance with the law, Respondent did not take effective action to cure Lakeside's non-compliance with 42 C.F.R. 483.10(b)(11).

CONCLUSIONS OF LAW

1. The Wisconsin Nursing Home Administrators Examining Board has jurisdiction to act in this matter, pursuant to Wis. Stat. § 456.10, and is authorized to enter into the attached Stipulation and Order, pursuant to Wis. Stat. § 227.44(5).

2. Respondent was the nursing home administrator of record while Lakeside Nursing and Rehabilitation engaged in conduct that constituted a pattern of serious violations of federal regulations, as defined by Wis. Admin. Code § NHA 1.02(5m)and is therefore subject to discipline pursuant to Wis. Stat. § 456.10(1)(d).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that:

1. The license of James P. Ignarski, NHA, to practice nursing home administration in the State of Wisconsin is hereby SUSPENDED for a period of one year.

IT IS FURTHER ORDERED that:

2. a. Following the period of license suspension Ordered in paragraph 1, Respondent's license shall be LIMITED by the condition that he complete forty-eight (48) hours of continuing education meeting the requirements of Wis. Admin. Code § NHA 3.02(1m) before the statutory license renewal date next occurring after the end of the period of license suspension.

b. No less than twenty-four (24) of the continuing education credits required under paragraph 2.a. shall be in the topics of ethics and professional responsibilities of long term care administrators to the residents of long term care facilities.

c. Respondent shall obtain pre-approval from the Board or its designee for each contact hour he intends to count toward the requirement of paragraph 2.b. The Board or its designee may exercise discretion to accept or reject in whole or in part the contact hours for any course nominated by Respondent towards compliance with paragraph 2.b., and Respondent shall be bound by that decision, excepting that the Board or its designee may not unreasonably exercise its discretion.

d. Respondent is solely responsible for all costs associated with compliance with the requirements of this

paragraph.

e. For purposes of this Order, the Board's designee is

Department Monitor
Wisconsin Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Ave.
P.O. Box 8935
Madison, WI 53708-8935
Fax: (608) 266-2264
Telephone: (608) 267-3817
department.monitor@drl.state.wi.us

IT IS FURTHER ORDERED that:

3. Respondent shall, within 360 days from the date of this Order, pay costs of this proceeding in the amount of $10,206.00 (Ten Thousand Two Hundred Six) dollars. Payment shall be made payable to the Wisconsin Department of Regulation and Licensing, and mailed to:

Department Monitor
Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935
Telephone (608) 267-3817
Fax (608) 266-2264

4. Violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to pay costs as ordered or fails to comply with the ordered continuing education the Respondent's license (#1879) SHALL BE SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Order.

5. This Order is effective on the date of its signing.

Wisconsin Nursing Home Administrators Examining Board

By: Mary Ann Clark 11/15/07
A Member of the Board Date