Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Green Oaks Health and Rehabilitation Center
(CCN: 675424),

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-810

Decision No. CR2861

Date: July 18, 2013

DECISION

Petitioner, Green Oaks Health and Rehabilitation Center, was not in substantial compliance with program participation requirements from July 7 through 26, 2011 due to violations of 42 C.F.R. §§ 483.13(c)(2) and 483.25(h).[1] There is a basis to impose enforcement remedies. The declaration of immediate jeopardy related to the violation of 42 C.F.R. § 483.25(h) was not clearly erroneous. The following enforcement remedy is reasonable: a civil money penalty (CMP) of $3,650 per day for July 7 and 8, 2011 and $450 per day for the period July 9 through 26, 2011, a total CMP of $15,400. Petitioner was ineligible to conduct a Nurse Aide Training and Competency Evaluation Program (NATCEP) for two years.

[1] References are to the 2010 revision of the Code of Federal Regulations (C.F.R.) in effect at the time of the survey, unless otherwise stated.

I. Background

Petitioner is located in Athens, Texas, and participates in Medicare as a skilled nursing facility (SNF) and the state Medicaid program as a nursing facility (NF). From July 6 through 8, 2011, Petitioner was subject to an abbreviated survey to investigate a complaint and a partial extended survey[2] by the Texas Department of Aging and Disability Services (state agency) and found not in substantial compliance with program participation requirements. CMS notified Petitioner by letter dated July 28, 2011, that it was imposing the following enforcement remedies: a CMP of $5,650 per day for July 7 and 8, 2011, and a CMP of $1,000 per day beginning July 9, 2011 and continuing until Petitioner returned to substantial compliance; a denial of payment for new admissions (DPNA) effective August 12, 2011, if Petitioner did not return to substantial compliance before that date; directed in-service training; and termination of Petitioner's provider agreement effective November 8, 2011, if Petitioner did not return to substantial compliance prior to that date. Petitioner returned to substantial compliance on July 27, 2011. CMS notified Petitioner by letter dated August 23, 2011, that: Petitioner returned to substantial compliance; the CMP would continue through July 26, 2011; and that the termination of Petitioner's provider agreement and the DPNA were rescinded. CMS notified Petitioner by letter dated December 13, 2011, that it was reducing the CMP to $3,650 per day for July 7 and 8, 2011 and to $450 per day for the period July 9 through 26, 2011. Joint Stipulation of Fact (Jt. Stip.); CMS Ex. 1; CMS Ex. 17; Tr. 45-46.

Petitioner requested a hearing before an administrative law judge (ALJ) on September 19, 2011. The case was assigned to me for hearing and decision on September 28, 2011, and an Acknowledgement and Prehearing Order was issued at my direction. On June 4, 5, and 6, 2012, a hearing was convened in Dallas, Texas. A transcript of the hearing was prepared. CMS offered CMS Exs. 1 through 17. CMS Exs. 1 through 13, 16, and 17 were admitted as evidence. Tr. 20-42. Petitioner offered Petitioner exhibits (P. Ex.) 1 through 16 that were admitted as evidence. Tr. 42-44. CMS called the following witnesses: Surveyor Clavion Hall and Surveyor Dee Ann Smith, Registered Nurse (RN).

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[2] The Statement of Deficiencies (SOD) states that an abbreviated standard survey was conducted to investigate a complaint against Petitioner. Centers for Medicare and Medicaid Services (CMS) Exhibit (Ex.) 4 at 1. An abbreviated standard survey is triggered by a complaint; a change of ownership, management, or director of nursing; or other indicator for a specific concern about a facility's compliance with participation requirements. 42 C.F.R. § 488.301. A partial extended survey was also conducted in this case based upon the surveyor's finding that Petitioner's noncompliance resulted in a substandard quality of care. Social Security Act (Act) § 1819(g)(2), 42 C.F.R. § 488.301; Transcript (Tr.) 178.

Petitioner called the following witnesses: Kellie Maddux, Certified Nurse Aide (CNA);[3] Sandy McGlaun, Licensed Vocational Nurse (LVN); Katherine Dunlap, RN, Petitioner's Director of Nursing (DON); Lisa Ferguson, Petitioner's Administrator; Pearl Merritt, RN, MSN, Ed.D; Jackie Stephens, RN, corporate nurse for Petitioner's owner and operator Southwest Long Term Care; and Cheryl Lynn Morgan, RN. The parties filed post-hearing briefs and post-hearing reply briefs (CMS Br., CMS Reply, P. Br., and P. Reply, respectively).

II. Discussion

A. Issues

Whether there is a basis for the imposition of an enforcement remedy; and,

Whether the remedy imposed is reasonable.

B. Applicable Law

The statutory and regulatory requirements for participation of a SNF in Medicare are at section 1819 of the Act and 42 C.F.R. pt. 483. Section 1819(h)(2) of the Act authorizes the Secretary of Health and Human Services (Secretary) to impose enforcement remedies against a SNF for failure to comply substantially with the federal participation requirements established by sections 1819(b), (c), and (d) of the Act.[4] The Act requires that the Secretary terminate the Medicare participation of any SNF that does not return to substantial compliance with participation requirements within six months of being found not to be in substantial compliance. Act § 1819(h)(2)(C). The Act also requires that the Secretary deny payment of Medicare benefits for any beneficiary admitted to a SNF, if the SNF fails to return to substantial compliance with program participation requirements within three months of being found not to be in substantial compliance – commonly referred to as the mandatory or statutory denial of payments for new admissions (DPNA). Act § 1819(h)(2)(D). The Act grants the Secretary discretionary authority to terminate a noncompliant SNF's participation in Medicare, even if there has been less than 180 days

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[3] The name "Maddox" appears in various documents in evidence but I find that those references are to CNA Maddux who testified at the hearing. Tr. 463.

[4] Participation of a NF in Medicaid is governed by section 1919 of the Act. Section 1919(h)(2) of the Act gives enforcement authority to the states to ensure that NFs comply with their participation requirements established by sections 1919(b), (c), and (d) of the Act.

of noncompliance. The Act also grants the Secretary authority to impose other enforcement remedies, including a discretionary DPNA, CMPs, appointment of temporary management, and other remedies such as a directed plan of correction. Act § 1819(h)(2)(B).

The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. "*Substantial compliance* means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301 (emphasis in original). A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act or the Secretary's regulations at 42 C.F.R. pt. 483, subpt. B. Noncompliance refers to any deficiency that causes a facility not to be in substantial compliance. 42 C.F.R. § 488.301. State survey agencies survey facilities that participate in Medicare on behalf of CMS to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335. The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406.

CMS is authorized to impose a CMP for the number of days of noncompliance – a per day CMP – or for each instance of noncompliance – a per instance CMP. 42 C.F.R. § 488.430. The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMPs, $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. § 488.438(a)(1)(i), (d)(2). "*Immediate jeopardy* means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301 (emphasis in original). The lower range of CMPs, $50 per day to $3,000 per day, is reserved for deficiencies that do not pose immediate jeopardy, but either cause actual harm to residents, or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). The only range for a per instance CMP is $1,000 to $10,000. 42 C.F.R. §§ 488.408, 488.438(a)(2).

Petitioner was subject to a partial extended survey in this case and a proposed CMP of more than $5,000, causing it to be ineligible to conduct a NATCEP for two years. Pursuant to sections 1819(b)(5) and 1919(b)(5) of the Act, SNFs and NFs may only use nurse aides who have completed a NATCEP. Pursuant to sections 1819(f)(2) and 1919(f)(2) of the Act, the Secretary was tasked to develop requirements for approval of NATCEPs and the process for review of those programs. Sections 1819(e) and 1919(e) of the Act impose upon the states the requirement to specify what NATCEPs they will approve that meet the requirements that the Secretary established and a process for

reviewing and re-approving those programs using criteria the Secretary set. The Secretary promulgated regulations at 42 C.F.R. pt. 483, subpt. D. Pursuant to 42 C.F.R. § 483.151(b)(2) and (f), a state may not approve and must withdraw any prior approval of a NATCEP offered by a SNF or NF that has been: (1) subject to an extended or partial extended survey under sections 1819(g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Act; (2) assessed a CMP of not less than $5,000; or (3) subject to termination of its participation agreement, a DPNA, or the appointment of temporary management. Extended and partial extended surveys are triggered by a finding of "substandard quality of care" during a standard or abbreviated standard survey and involve evaluating additional participation requirements. "Substandard quality of care" is identified by the situation where surveyors identify one or more deficiencies related to participation requirements established by 42 C.F.R. § 483.13 (Resident Behavior and Facility Practices), § 483.15 (Quality of Life), or § 483.25 (Quality of Care) that are found to constitute either immediate jeopardy, a pattern of or widespread actual harm that does not amount to immediate jeopardy, or a widespread potential for more than minimal harm that does not amount to immediate jeopardy and there is no actual harm. 42 C.F.R. § 488.301. The parties agree that Petitioner did not have an approved NATCEP at the time of the survey. Tr. 52. Pursuant to 42 C.F.R. § 498.3(b)(14) and (16), only the withdrawal of a previously granted approval to conduct a NATCEP triggers a right to review.

The Act and regulations make a hearing before an ALJ available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act §§ 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a de novo proceeding, i.e., "a fresh look by a neutral decision-maker at the legal and factual basis for the deficiency findings underlying the remedies." *Life Care Ctr. of Bardstown*, DAB No. 2479 at 33 (2012) (citation omitted); *The Residence at Salem Woods*, DAB No. 2052 (2006); *Cal Turner Extended Care Pavilion*, DAB No. 2030 (2006); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Emerald Oaks*, DAB No. 1800 at 11 (2001); *Anesthesiologists Affiliated*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. §§ 488.408(g)(1), 488.330(e), 498.3. However, the choice of remedies, or the factors CMS considered when choosing remedies, are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance determined by CMS, if a successful challenge would affect the range of the CMP that may be imposed or impact the facility's ability to continue to conduct a NATCEP. 42 C.F.R. § 498.3(b)(14), (d)(10)(i). The CMS determination as to the level of noncompliance, including the finding of immediate jeopardy, "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2); *Woodstock Care Ctr.*, DAB No. 1726 at 9, 38 (2000), *aff'd, Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See,*

e.g., *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). ALJ review of a CMP is subject to 42 C.F.R. § 488.438(e).

The standard of proof, or quantum of evidence required, is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a prima facie showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, 129 F. App'x 181 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800; *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998); *Hillman Rehab. Ctr.*, DAB No. 1611 (1997) (*remand)*, DAB No. 1663 (1998) (*aft. remand*), *aff'd*, *Hillman Rehab. Ctr. v. United States*, No. 98-3789 (GEB), 1999 WL 34813783 (D.N.J. May 13, 1999).

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold text followed by my findings of fact and analysis. I have carefully considered all the evidence and the arguments of both parties, although not all the evidence and arguments may be specifically discussed in this decision. I discuss the credible evidence given the greatest weight in my decision-making.[5] I also discuss, as appropriate, the specific evidence I find not credible or that has little or no probative value. The fact that evidence is not specifically discussed should not be considered sufficient to rebut the presumption that I considered all the evidence and assigned such weight or probative value to the credible evidence that I determined appropriate within my discretion as an ALJ. There is no requirement for me to discuss the weight given every piece of evidence considered in this case, nor would it be consistent with notions of judicial economy to do so.

The SOD for the survey completed on July 8, 2011, alleges that Petitioner violated the following participation requirements: 42 C.F.R. § 483.13(c)(1)(ii)-(iii), (c)(2)-(4) (Tag F225 at a scope and severity level (S/S) F, indicating no actual harm with the widespread potential for more than minimal harm)[6]; 42 C.F.R. § 483.13(c) (Tag F226 also at S/S F);

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[5] "Credible evidence" is evidence "worthy of belief." *Black's Law Dictionary* 596 (8th ed. 2004). The "weight of evidence" is the persuasiveness of some evidence compared to other evidence. *Id*. at 1625.

[6] The SOD does not allege facts that would constitute a violation of 42 C.F.R. § 483.13(c)(1)(ii)-(iii) and the parties have stipulated that a violation of those regulatory

(Footnote continued next page.)

and 42 C.F.R. § 483.25(h) (Tag F323 at a S/S J,[7] indicating an isolated instance of immediate jeopardy to resident health and safety). CMS Ex. 4; CMS Ex. 17. CMS alleges, based upon the survey that ended July 8, 2011, that Petitioner was not in substantial compliance with program participation requirements from July 7 through 26, 2011, due to violations of 42 C.F.R. §§ 483.13(c) (Tags F225 and F226) and 483.25(h) (Tag F323). CMS alleges that the violations of 42 C.F.R. § 483.13(c) were widespread and posed a risk for more than minimal harm and that the violation of 42 C.F.R. § 483.25(h) posed immediate jeopardy for Petitioner's residents.

I conclude that Petitioner did not violate 42 C.F.R. § 483.13(c) (Tag F226) based on failure to develop and implement policies and procedures prohibiting mistreatment, neglect, abuse, or misappropriation. However, Petitioner was not in substantial compliance with Medicare requirements due to violations of 42 C.F.R. §§ 483.13(c)(2) (Tag F225) for failure to report possible neglect or abuse, and 42 C.F.R. § 483.25(h) (Tag F323) for failure to eliminate or mitigate the risk for accidental injury to residents. I conclude that the declaration of immediate jeopardy related to the violation of 42 C.F.R. § 483.25(h) (Tag F323) was not clearly erroneous. I conclude that Petitioner's violations of 42 C.F.R. §§ 483.13(c)(2) and 483.25(h) provide a sufficient basis for CMS to impose a CMP of $3,650 per day for July 7 and 8, 2011, and $450 per day from July 9 through 26, 2011.

1. Petitioner violated 42 C.F.R. § 483.13(c)(2) (Tag F225).

2. Petitioner's violation of 42 C.F.R. § 483.13(c)(2) (Tag F225), posed a risk for more than minimal harm.

3. Petitioner's violation of 42 C.F.R. § 483.13(c)(2) (Tag F225), is a basis for the imposition of an enforcement remedy.

4. Petitioner did not violate 42 C.F.R. § 483.13(c) (Tag F226).

(Footnote continued.)

provisions are not at issue before me. Jt. Stip. ¶ 9. Thus, no further consideration is given to an alleged violation of 42 C.F.R. § 483.13(c)(1)(ii)-(iii).

[7] The scope and severity of Tag F323 was lowered after informal dispute resolution (IDR) from scope and severity K, a pattern of immediate jeopardy, to scope and severity J.

a. Facts

The findings of fact set forth here apply to all three deficiency citations as all three arise from the same facts surrounding the death of Resident 1.

Resident 1 was 90 years old when he expired on July 2, 2011. P. Ex. 16. Petitioner's report of the investigation of Resident 1's death provides undisputed facts. CMS Ex. 8 at 1-3; P. Ex. 3. DON Dunlap testified that the investigation documented in an incident report was started on July 2, 2011, because Resident 1 was found on the floor. Tr. at 696, 637-38. On July 2, 2011, CNA Kellie Maddux found Resident 1 on the floor in his room. LVN Nikki Mills was summoned, responded to the scene, and determined that Resident 1 had no pulse or other vital signs; he had no apparent injury and there was no bleeding; and he was warm to the touch. Resident 1 was pronounced dead at the scene at approximately Noon on July 2, 2011. CMS Ex. 8 at 1-3; P. Ex. 3 at 1-2, 16.

Petitioner collected statements from several staff as part of the investigation. CNA Christine Warden provided a statement dated July 6, 2011, in which she stated that she: put Resident 1 in his room in his wheelchair; turned on the chair alarm; told CNA Maddux where the resident was; assisted CNA Maddux with another resident; and then returned to work in her own hall. She learned after lunch that Resident 1 had died. P. Ex. 3 at 10. After learning of Resident 1's death on July 2, 2011, CNA Warden left the facility and did not return until July 6, 2011, when she gave her statement and her employment with Petitioner was terminated. DON Dunlap testified that CNA Warden was fired, in part, because she left Resident 1 unattended in his wheelchair in his room. Tr. 699, 703, 730.

CNA Kellie Maddux's statement dated July 2, 2011, is consistent with the statement of CNA Warden that CNA Warden assisted her with Resident 1 and that CNA Warden told her that Resident 1 was in his room unattended but with his alarm. CNA Maddux stated that after being told by CNA Warden that the resident was in his room unattended, she kept looking-in on him while providing care to other residents and he was sitting up. But then she found him on the floor and realized he was dead. P. Ex. 3 at 12. CNA Kellie Maddux testified at hearing that she regularly provided care for Resident 1 and he had a pressure alarm on his bed and his wheelchair and he had a history of turning off his alarms and also attempting to self-transfer. Tr. 468-69, 496-501. She recalled the in-service training in January 2011, and understood that if a resident had an alarm and they were taken to their room, they were to be placed in bed, unless they refused. Tr. 472, 503. She understood she was to follow the in-service to the best of her ability. Tr. 518-19. She testified that if she deviated from in-service training she was to report to her supervisor. Tr. 473, 507. She testified that Resident 1 had a high-low bed that could be adjust from high to low position and bed-side mats. Tr. 491. She testified that Resident 1 was in her line-of-sight when he was in his room at the relevant times on July 2, 2011,

and that it was easier to keep an eye on him in his room than it would have been had he been in the common areas of the facility. Tr. 482-83. However, she also testified that she was not on Resident 1's hall for an undetermined amount of time that morning and that when she returned to Resident 1's hall she found him on the floor. She admitted that when she left her hall she did not ask anyone to watch Resident 1. Tr. 480, 512. She testified that after finding Resident 1 on the floor, she checked his chair alarm and it was not on. Tr. 513. It is undisputed that she did not see him fall.

LVN Tiffany Poff's statement dated July 10, 2011 (eight days after Resident 1's death) indicates that CNA Maddux reported to her and LVN Simms that something was seriously wrong with Resident 1. LVN Poff states that when she entered the resident's room the resident was on the floor in front of his wheelchair in a fetal position with a sheet around the side of his head. LVN Poff observed that the pressure sensitive alarm in the resident's wheelchair was off. LVN Poff observed that Resident 1 had a hematoma between his eyes. P. Ex. 3 at 5-8. LVN Simms states in her July 10, 2011 statement that she accompanied LVN Poff to Resident 1's room. She noted that the resident was lying on the floor between his bed and his wheelchair. She noted that the tab alarm in his wheelchair was not sounding. She observed a large hematoma between his eyes. P. Ex. 3 at 13. LVN Simms also records in her statement that LVN Poff confronted CNA Warden about leaving Resident 1 in his room unattended in his wheelchair and that Resident 1 fell, suffered a large hematoma, and died. LVN Simms states that CNA Warden admitted that she did not test the alarm in the resident's wheelchair to determine if it was on. P. Ex. 3 at 13-14. CNA Sumpter's statement dated July 9, 2011, indicates that she also went to the resident's room to assist and she reported seeing a knot on the resident's forehead that had not been there in the morning. P. Ex. 3 at 9. CNA Tiffany Nix, who helped prepare Resident 1 for transport to the funeral home, reported in her statement dated July 8, 2011 (six days after Resident 1's death) that she had seen a small bruise between Resident 1's eyes. P. Ex. 3 at 3. RN Neal stated in her July 8, 2011 statement that she examined the resident prior to pronouncing him dead and saw no bruising. P. Ex. 3 at 4.

Resident 1 suffered from Parkinson's disease and was assessed as at risk for injury due to tremors and involuntary muscle movement. P. Ex. 4 at 2. He suffered from atrial fibrillation with chest pain and irregular pulse; anemia with weakness; dementia; macular degeneration or glaucoma; and he required assistance from one or two staff for his activities of daily living. CMS Ex. 7 at 1, 54; P. Ex. 4 at 3, 5, 6; P. Ex. 16. Resident 1 had executed a do not resuscitate (DNR) order. Tr. 47. Resident 1 was assessed as having a history of falls and at high risk for falls. P. Ex. 10. The interventions listed on his care plan dated October 2, 2010, included: encouraging to request staff assistance; ensuring the call-light was in reach and answered promptly; therapy evaluation and treatment; anticipating needs to provide prompt assistance; assuring lighting was adequate and that his area was clutter free; and encouraging attendance of activities as

tolerated. CMS Ex. 7 at 55-56; P. Ex. 4 at 7-8. Resident 1 had unobserved falls on January 25, January 30, and February 5, 2011. CMS Ex. 8, at 20-23, 24-25, 27, 28-29.

Five care plans dated August 3, 2010, August 17, 2010, January 25 and 30, 2011 and February 5, 2011, all of which refer to falls the resident suffered in his room, are in evidence. All five of the care plans list the same 12 interventions that primarily focus upon what to do if the resident falls: notify the physician; assess for injuries; do not move until assessment, including vital signs, is completed; treat as ordered by the physician; complete a new fall assessment; monitor for the cause of the fall and eliminate the cause if possible; assess need for safety equipment or change in footwear; initiate a rehabilitation screen; assess for change in physical condition such as an infection; assess for a bowel and bladder program; assess for changes in the environment; and notify the family. CMS Ex. 7 at 68-70, 72-73; P. Ex. 4 at 9-11. Although not listed in any of the fall care plans offered by Petitioner, Resident 1's physician had ordered on September 1, 2010, that a chair alarm be used when he was up in his wheelchair to alert staff and to remind Resident 1 to request assistance with transfers. P. Ex. 5 at 1. Orders dated September 14 and December 30, 2010, required alarms for both the wheelchair and the bed that were to be checked every shift. CMS Ex. 7 at 4; P. Ex. 5 at 2, 5-10. DON Dunlop testified that Resident 1 had interventions to prevent falls or reduce the risk for injury from falls that included: a high-low bed, bed-side mats, a toileting schedule, therapy, and pressure alarms for his bed and chair. Tr. 565-66. None of the printed care plans in evidence listed the interventions DON Dunlop testified were in use for Resident 1. However, she explained that the care plans in evidence as P. Ex. 4 at 9, 10, and 11, are simply stock forms and interventions are also found in the physician orders and the "AccuNurse" system, Petitioner's digital records system. CMS Ex. 7 at 55-56, 68-70, 72-73; P. Ex. 4 at 7-11; Tr. 568-73. The evidence does not show that new interventions were adopted and implemented by the interdisciplinary team (IDT) to address Resident 1's fall risk, his ability to turn-off his alarm, or his attempts to self-transfer following the January 25, January 30, and February 5, 2011 falls, except the instruction from the January 31, 2011 in-service training, not to leave a resident with a chair alarm unattended in a wheelchair in the resident's room. It is undisputed that the resident had no falls between February 5 and July 2, 2011.

The regulations at 42 C.F.R. pts. 483 and 488 and the State Operations Manual (SOM) CMS pub. 100-07, app. PP, Guidance to Surveyors Long Term Care Facilities Tag F279 (rev. 70 eff. Jan. 7, 2011)[8] do not specify a format for a care plan. Accordingly, I review

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[8] The SOM does not have the force and effect of law. However, the provisions of the Act and regulations interpreted by the SOM clearly do have such force and effect. *Ind. Dept. of Pub. Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991); *Northwest Tissue Ctr. v. Shalala*, 1 F.3d 522 (7th Cir. 1993). Thus, while the Secretary may not seek to enforce

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all the clinical evidence in an attempt to identify all care planned interventions in effect at a given time, including physician orders, records of instructions to staff for the delivery of care and services, records of the delivery of care and services, and similar records. In addition to the specific care and services planned for a resident as reflected in the resident's clinical records, I consider the policies and procedures that a SNF adopts that control or affect the delivery of care and services. Petitioner's policies, practices, and procedures are additional evidence that defines or identifies the care plan adopted by the IDT responsible for care planning as, logically, the IDT determines the specific care and services necessary for a particular resident in the context of the facility's generally applicable policies, practices, and procedures. For example, if Petitioner announced a policy that no resident with an alarm in his or her wheelchair will be left unattended in their wheelchair in their room, the IDT could logically conclude that it is not necessary to specifically order such an intervention for every resident with an order for an alarm in their wheelchair because Petitioner had adopted the requirement as a policy. Petitioner had a policy dated January 1, 2007, that established a policy and procedure for fall risk assessment and management (fall policy). CMS Ex. 11; P. Ex. 1. Although not specified in its fall policy, Petitioner educated staff on June 1, 2010, that staff must stay with any resident with a tab alarm while the resident is in the bathroom and/or uses the toilet. P. Ex. 2 at 1. Further, on January 31, 2011, Petitioner advised staff that if a resident with an alarm is taken to the resident's room, the resident must be placed in bed and not left unattended. The wording of the in-service training report can be interpreted to mean that the resident must not be left unattended even after being placed in bed, but given the context I construe the policy to be that if a resident with a chair alarm is to remain in his or her room, he or she must be placed in bed and not left unattended in the chair. CMS Ex. 12; P. Ex. 2 at 4. Resident 1's physician ordered an alarm for Resident 1's wheelchair. Therefore, based on Petitioner's policies announced in in-service trainings on June 1, 2010 and January 31, 2011, Resident 1, who had a physician's order for an alarm in his chair, was not to be left unattended in the bathroom or while using the toilet and he was not to be left unattended in his wheelchair in his room. DON Dunlap testified that Resident 1 was known to turn off the alarm in his wheelchair. She agreed that the in-service training announcement on January 31 was intended to address falls that Resident 1 experienced in January 2011. Tr. 594-97, 608, 624-25. She testified that the direction that residents with a chair alarm must not be left unattended in their wheelchair in their room, but instead must be put to bed, was not practical as staff cannot make a resident go to bed; the instruction was a guideline; and staff was expected to follow the in-service instruction but staff also had to use good judgment in applying the instruction. Tr. 602-

(Footnote continued.)

the provisions of the SOM, she may seek to enforce the provisions of the Act or regulations as interpreted by the SOM.

04, 628-29, 704-05. She admitted, however, that the general practice was to put residents with chair alarms in their bed rather than leave them unattended in their wheelchair. Tr. 607.

Petitioner had a policy that prohibited abuse, neglect, and misappropriation of resident property. CMS Ex. 9; P. Ex. 12. Petitioner's policy defines neglect as "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." CMS Ex. 9 at 3; P. Ex. 12 at 3. Petitioner's policy requires that any employee who becomes aware of an allegation of abuse, neglect, or misappropriation will report to a supervisor, the DON, or the Administrator immediately. The policy requires that Petitioner report to the state agency in accordance with state law. CMS Ex. 9 at 9; P. Ex. 12 at 9.

It is not disputed that Administrator Ferguson was informed by staff about the July 2, 2011 incident involving Resident 1, but she did not immediately report the incident to the state agency. Administrator Ferguson testified that three nurses called her on July 2, 2011, about the incident. Administrator Ferguson testified that she did not immediately notify the state agency about Resident 1 because she did not believe she had to. Tr. 743-51, 755, 759, 771-72. Administrator Ferguson testified that the fact that Resident 1 was left in his room unattended did not affect her decision about calling the state agency. However, she testified that if she had been advised that Resident 1 had an injury, such as the hematoma reported by some staff, she would have reported the incident to the state agency. Tr. 786. Administrator Ferguson testified that DON Dunlap could also have reported to the state agency (Tr. 806-07) but DON Dunlap did not do so as she was on vacation at the time. Tr. 634, 710, 747. DON Dunlap testified that Administrator Ferguson usually made the final decision regarding whether an incident was reported to the state agency. Tr. 721.

b. Analysis Related to Tag F225

Section 1819(c)(1)(A)(ii) of the Act requires that a SNF protect its residents and promote their "right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms." The Secretary has provided by regulation that a "resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." 42 C.F.R. § 483.13(b). The regulations require that a facility develop and implement written policies and procedures prohibiting mistreatment, neglect, and abuse of residents and the misappropriation of residents' property. 42 C.F.R. § 483.13(c). Under section 483.13(c), the facility must "[n]ot use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion." 42 C.F.R. § 483.13(c)(1)(i).

The surveyors allege generally that Petitioner violated 42 C.F.R. § 483.13(c)(2), (3), and (4), because Petitioner failed to thoroughly investigate and report the death of Resident 1. The surveyors allege specifically that Resident 1 had a history of falls; he was to have a personal alarm in his wheelchair; he was not to be left unattended in his wheelchair in his room; he was left unattended; he was found on the floor; his alarm was not sounding; Petitioner did not report to the state or thoroughly investigate; and Petitioner's failure placed 55 residents at risk for abuse or neglect. CMS Ex. 4 at 1-3. The requirements of 42 C.F.R. § 483.13(c)(2), (3), and (4) are:

> (2) 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).
>
> (3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.
>
> (4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.[9]

The evidence shows that Petitioner conducted a thorough investigation and maintained the records of that investigation. There was no allegation of abuse, only neglect, and the surveyors do not allege in the SOD that there was a failure to protect residents during the

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[9] The SOD does not specifically allege that Petitioner violated 42 C.F.R. § 483.13(c)(4) by failing to report the results of its investigation to the state agency within five working days of the incident. CMS Ex. 4 at 2. To the extent that the allegations of the SOD may be read broadly to include the allegation that Petitioner failed to timely report the results of its investigation, I conclude it is unnecessary to address that allegation because I conclude that there is a violation of 42 C.F.R. § 483.13(c)(2). Furthermore, by my calculation, the time for filing the report of investigation did not expire until July 11, 2011, after the survey was completed. Tr. 154-57.

investigation. Even if the allegations of the SOD are construed broadly to include an alleged failure to protect residents, the evidence shows that CNA Warden, who left Resident 1 unattended, left the facility after the incident on July 2, 2011, and she only returned to prepare her statement and be terminated. I find no violation of 42 C.F.R. § 483.13(c)(3). CMS Ex. 8 at 1-3; P. Ex. 3. While the investigation may not have met the expectation of the surveyors, the regulation and the SOM provide no standard for thoroughness, legal or otherwise, to which Petitioner was bound to comply. Petitioner's staff began the investigation almost immediately as reflected by P. Ex. 3. The investigation shows that on July 2, 2011, CNA Warden left Resident 1 in his room, in his wheelchair, and unattended, contrary to Petitioner's policy and practice that residents with alarms in their chair should not be left unattended. The statements collected during the investigation show that staff recognized that there was a violation of Petitioner's policy and practice against leaving residents with alarms in wheelchairs unattended. Whether or not CNA Warden turned on or off the resident's alarm or whether or not it malfunctioned are not questions that need be resolved. Leaving the resident unattended in his room in his wheelchair violated his care plan as it was understood and applied in light of Petitioner's policy and practice. Leaving the resident alone in his room in his wheelchair arguably amounted to neglect because there was failure to deliver services necessary to prevent physical harm,[10] i.e., appropriate supervision. Whether or not Resident 1 died before he fell or after he hit the floor is also a fact issue that need not be resolved, as there is no dispute he was alive when CNA Warden left him unattended in his room in his chair. The investigation permitted the essential factual findings of who, what, when, where, how, and why. The investigation that Petitioner's staff conducted was timely and thorough enough to identify necessary remedial action by Petitioner. There is no allegation in the SOD that the report of the investigation was not delivered to the state agency within five working days as required by state and federal law. Accordingly, I find no violation of 42 C.F.R. § 483.13(c)(4).

I nevertheless conclude that there was a regulatory violation because it is undisputed that Petitioner's Administrator and DON failed to report the alleged incident of neglect immediately to the state agency as required by 42 C.F.R. § 483.13(c)(2).[11] I further conclude that the violation posed a risk for more than minimal harm.

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[10] Neglect is defined by the regulations to be "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 488.301.

[11] The regulation includes two reporting requirements: (1) immediately following the allegation to the administrator and state; and (2) upon the completion of the investigation within five days to the administrator and state. 42 C.F.R. § 483.13(c)(2) and (4). The
(Footnote continued next page.)

The federal regulation requires that all allegations of mistreatment, neglect, or abuse be reported to officials in accordance with state law. 42 C.F.R. § 483.13(c)(2). The pertinent Texas Administrative Code provisions applicable to the operation of long-term care facilities require that all alleged violations involving mistreatment, neglect, or abuse be reported immediately to the facility administrator and to other officials in accordance with Texas law, specifically 40 Tex. Admin. Code § 19.602. 40 Tex. Admin. Code § 19.601(c)(2) (2006). A facility owner or employee "who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect, or exploitation caused by another must report the abuse, neglect, or exploitation." 40 Tex. Admin. Code § 19.602(a) (2004). "The person reporting must make the telephone report immediately on learning of the alleged abuse, neglect, exploitation, conduct, or condition." 40 Tex. Admin. Code § 19.602(b)(1). The facility is required to conduct an investigation and report the results no later than the "fifth working day after the oral report." 40 Tex. Admin. Code § 19.602(b)(2).

The Texas statute in effect at the time of the initial determination by CMS provided:

> A person, including an owner or employee of an institution, who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse or neglect caused by another person shall report the abuse or neglect in accordance with this subchapter.

Tex. Health & Safety Code § 242.122(a) (1989). The statute required that a person "make an oral report immediately on learning of the abuse or neglect" and "make a written report to the same agency not later than the fifth day after the oral report is made."[12] Tex. Health & Safety Code § 242.122(c) (1989).

The Texas statute and regulation and 42 C.F.R. § 483.13(c)(2) require that a report of neglect be made immediately. CMS has adopted as a matter of policy in the SOM, app. PP, Tag F225 that "immediately" means as soon as possible but not more than 24 hours after discovery of the allegation. The SOM also states the CMS policy that a state cannot

(Footnote continued.)

focus in this case is upon the requirement of 42 C.F.R. § 483.13(c)(2) to report immediately following the allegation.

[12] Tex. Health & Safety § 242.122(a) and (c) were recodified at Tex. Health & Safety Code § 260A.002(a) and (c), effective September 28, 2011, without substantive changes.

override the obligation of a SNF to fulfill the requirements of 42 C.F.R. § 483.13(c); the state cannot alter the types of allegations that must be reported under 42 C.F.R. § 483.13(c); and any time frame for reporting by the state does not supersede the immediate reporting requirement under 42 C.F.R. § 483.13(c). SOM, app. PP, Tag F225.

CMS made a prima facie showing of noncompliance due to a violation of 42 C.F.R. § 483.13(c)(2). Staff reported to Administrator Ferguson that CNA Warden left Resident 1 in his wheelchair unattended in his room, contrary to his care plan and facility policy and practice not to leave residents with chair alarms unattended in their rooms. There is no dispute that staff recognized CNA Warden's error and notified the Administrator of the alleged neglect by CNA Warden. Administrator Ferguson testified that she was called by LVN Poff on July 2, 2011, following the discovery of Resident 1. She also testified that she was aware of the July 2, 2011 statement of CNA Kellie Maddux (P. Ex. 3 at 12). Tr. 744-46, 750. The evidence shows that Administrator Ferguson failed to recognize and treat the reports she received as allegations of neglect by CNA Warden. There is no dispute that Administrator Ferguson failed to report to the state agency immediately as required by both Texas and federal law the alleged neglect by CNA Warden. I conclude that Administrator Ferguson's failure to report to the state agency immediately was a violation of 42 C.F.R. § 483.13(c)(2). I further conclude that Administrator Ferguson's failure to recognize an allegation of neglect and to notify the state agency immediately posed a risk for more than minimal harm to other residents in the facility subject to physical or mental harm due to neglect.

Petitioner has focused upon the narrow allegation in the SOD that it failed to report the death of Resident 1 to the state (CMS Ex. 4 at 2) rather than the broader allegation of the SOD under Tag F225 that Petitioner failed to report an incident of alleged neglect to the state.[13] P. Br. at 2-16. Petitioner cites the October 3, 2006 state agency letter with the subject-line "Provider Letter #06-32 – Guidelines for Reporting Incidents"[14] in support of

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[13] The surveyors did not allege in the SOD that Petitioner violated 42 C.F.R. § 483.13(c) (Tag F224) due to neglect of Resident 1. The surveyors' allegations under Tag F225 are that Petitioner failed to report and investigate the incident involving Resident 1 on July 2, 2011, in violation of 42 C.F.R. § 483.13(c)(2), (3), and (4). CMS Ex. 4 at 1-7. The surveyors' allegations were clear enough to give Petitioner notice of what to defend in this case. Petitioner's focus upon the requirement to report a death is a tactical choice rather than due to any confusion arising from the allegations of the SOD.

[14] There was testimony that the Provider Letter has been updated, but no evidence that the substantive provisions changed. Tr. 192. Neither party offered a copy of an updated Provider Letter.

its argument that there was no obligation to report Resident 1's death. P. Br. at 4. Petitioner argues that there is no requirement under either Texas law or federal law to report a death to the state agency. P. Br. at 5. Petitioner argues that under Provider Letter #06-32, which both parties recognize is not the law, it is only required to report a death if unusual circumstances cast doubt on whether or not the death was due to natural causes. P. Br. at 6; P. Ex. 11 at 2. Petitioner argues that it complied with Provider Letter #06-32 because there was no evidence that raised a question as to whether or not Resident 1 died from natural causes and his death was not required to be reported to the state agency. P. Br. at 6. Dr. Pearl Merritt testified as an expert on behalf of Petitioner. She serves on the Texas Department of Aging and Disability Services Long-Term Care Advisory Committee, which consults on the Provider Letter regarding reporting. Dr. Merritt opined that the incident regarding Resident 1 was not reportable because it was not suspicious. P. Reply Br. at 10; Tr. 819, 838, 840, 880, 886, 888. Another of Petitioner's expert witnesses, RN Cheryl Lynn Morgan, agreed with Dr. Merritt. She did not find Resident 1's death to be suspicious, and she did not think it was reportable under Provider Letter #06-32, or that there is a basis for citing a violation. P. Reply Br. at 9-10; Tr. 972, 984. None of Petitioner's experts addressed the requirement to report an allegation of neglect to the state agency.

I agree with Petitioner that the state agency Provider Letter #06-32 is not the law and not enforceable in this proceeding against Petitioner. The law applicable in this case is found in the Act; the federal regulations, and the state statute and regulations set forth in this decision. The issue is whether or not Petitioner failed to report to the state agency in violation of a requirement under the applicable law, not a policy letter issued by the state agency. I also agree with Petitioner that CMS has cited no federal or state law that requires reporting a death to the state agency that may be enforced against Petitioner.[15] 5 U.S.C. §§ 551(4), 552(a)(1). But federal and state law clearly require immediate reporting when there is a failure to deliver services necessary to prevent or avoid harm to a resident. Petitioner does not rebut the CMS prima facie showing that Petitioner's administrator failed to report the allegation that CNA Warden left Resident 1 unattended in his room, in his wheelchair, which is an allegation of neglect. Petitioner has also failed to establish an affirmative defense to excuse its violation of 42 C.F.R. § 483.13(c)(2).

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[15] I do not mean to suggest that the reporting requirements established by 42 C.F.R. § 483.13(c)(2) do not encompass instances of maltreatment, neglect, or abuse, including injuries of unknown source, when a death is involved. But this regulation requires reporting based upon alleged acts or evidence of such acts, not only when there is resulting injury or death.

Petitioner argues that the surveyors erred by citing the deficiency under Tag F225 at a scope and severity of F, which indicates that the deficiency was widespread. 42 C.F.R. § 488.404(b); P. Br. at 16-17. The surveyors' determination of scope and severity is not subject to review in this case as that determination has no impact upon the remedy that may be imposed or the withdrawal of approval of Petitioner to conduct a NATCEP. 42 C.F.R. § 498.3(b)(14); Tr. 48-55. I am, however, required to consider the severity of a deficiency when determining the reasonableness of a proposed enforcement remedy. 42 C.F.R. § 488.404. For the purpose of assessing whether the enforcement remedy is reasonable, I accept Petitioner's argument that the single violation related to Resident 1 is an isolated deficiency and not a widespread deficiency.

c. Analysis Related to Tag F226

A SNF is required to "develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property." 42 C.F.R. § 483.13(c) (Tag F226). There is no dispute that Petitioner had the required policy. CMS Ex. 9; P. Ex. 12. There is no allegation that the policy failed to satisfy the requirements of the regulation. In this case, the surveyors allege that Petitioner failed to implement its written policy and that the failure to implement violated 42 C.F.R. § 483.13(c) (Tag F226). The surveyors' conclusion is based upon the alleged failure of Petitioner to investigate and report the death of Resident 1. CMS Ex. 4 at 7. I have concluded that there was no violation based on the adequacy of Petitioner's investigation. However, I have concluded that there was a deficiency due to Petitioner's failure to report the allegation of neglect related to Resident 1 that occurred at about the time of his death on July 2, 2011. I conclude that the single incident of failure to report is not a sufficient basis to conclude that Petitioner failed to implement its policy prohibiting mistreatment, neglect, abuse, and misappropriation.

The Board has often held that "multiple or sufficient examples of neglect may support a reasonable inference that a facility has failed to develop or implement policies and procedures that prohibit neglect." *Dumas Nursing and Rehab., L.P.*, DAB No. 2347 at 15 (2010), citing *Barn Hill Care Ctr.*, DAB No. 1848 at 10 (2002)); *Emerald Oaks*, DAB No. 1800 at 18; *Liberty Commons Nursing & Rehab Ctr. - Johnston*, DAB No. 2031 (2006) (applying holding), *aff'd, Liberty Commons Nursing & Rehab Ctr. - Johnston v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007). The focus is not simply on the number or nature of the instances of mistreatment, neglect, abuse, misappropriation, or failure to follow the facility policy. Rather the focus is whether the facts related to such instances demonstrate an underlying breakdown in the facility's implementation of the provisions of its anti-neglect policy. *Pinecrest Nursing & Rehab. Ctr.*, DAB No. 2446 at 8 (2012); *Oceanside Nursing & Rehab. Ctr.*, DAB No. 2382 at 11 (2011); *Columbus Nursing & Rehab. Ctr.*, DAB No. 2247 at 27 (2009) (holding that an issue under section 483.13(c) is "whether the circumstances presented, viewed as a whole, demonstrate a systemic problem in implementing policies and procedures" to prevent neglect).

The surveyors did not allege that neglect actually occurred in this case. However, it is alleged and the evidence shows that the Administrator violated the facility policy because she failed to report an allegation of neglect immediately. I conclude that the facts related to the failure to report do not demonstrate an underlying or systemic problem with implementation of the facility policy prohibiting neglect, abuse, mistreatment, misappropriation and established procedures for reporting and investigating alleged incidents. The facts related to the single incident, including the Administrator's testimony at hearing, show that she focused upon the death of Resident 1 not upon the conduct of staff immediately preceding his death. Her focus was whether or not the death of Resident 1 was unusual or unexpected and, having concluded it was not, she stopped her examination of the facts. Administrator Ferguson simply failed to examine why Resident 1 was in his room, in his wheelchair, unattended, and why his alarm was off or malfunctioned. As a result, she failed to recognize the allegation of neglect and to timely report it, even though the incident was thoroughly investigated. Given the facts of this case and this single incident, I find no systemic failure or problem of implementation. Accordingly, I conclude Petitioner did not violate 42 C.F.R. § 483.13(c) as alleged under Tag F226.

5. Petitioner violated 42 C.F.R. § 483.25(h) (Tag F323).

6. Petitioner's violation of 42 C.F.R. § 483.25(h) (Tag F323), posed a risk for more than minimal harm.

7. Petitioner's violation of 42 C.F.R. § 483.25(h) (Tag F323), is a basis for the imposition of an enforcement remedy.

The general quality of care regulation, 42 C.F.R. § 483.25, requires that a facility ensure that each resident receives necessary care and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. The quality of care regulation imposes specific obligations upon a facility related to accident hazards and accidents.

> The facility must ensure that –
>
> > (1) The resident environment remains as free of accident hazards as is possible; and
> > (2) Each resident receives adequate supervision and assistance devices to prevent accidents

42 C.F.R. § 483.25(h). CMS instructs its surveyors that the intent of 42 C.F.R. § 483.25(h)(1) and (2) is "to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and

assistive devices to each resident to prevent avoidable accidents." The facility is expected to: identify, evaluate, and analyze hazards and risks; implement interventions to reduce hazards and risks; and monitor the effectiveness of interventions and modify them when necessary. SOM, app. PP, Tag F323.

The Board has provided interpretative guidance for adjudicating alleged violations of 42 C.F.R. § 483.25(h)(1):

> The standard in section 483.25(h)(1) itself - that a facility "ensure that the environment is as free of accident hazards as possible" in order to meet the quality of care goal in section 483.25 -- places a continuum of affirmative duties on a facility. A facility must determine whether any condition exists in the environment that could endanger a resident's safety. If so, the facility must remove that condition if possible, and, when not possible, it must take action to protect residents from the danger posed by that condition. [Footnote omitted.] **If a facility has identified and planned for a hazard and then failed to follow its own plan, that may be sufficient to show a lack of compliance with [the] regulatory requirement.** In other cases, an ALJ may need to consider the actions the facility took to identify, remove, or protect residents from the hazard. Where a facility alleges (or shows) that it did not know that a hazard existed, the facility cannot prevail if it could have reasonably foreseen that an endangering condition existed either generally or for a particular resident or residents.

Maine Veterans' Home – Scarborough, DAB No. 1975 at 6-7 (2005) (emphasis added).

The Board has also explained the requirements of 42 C.F.R. § 483.25(h)(2) in numerous decisions. *Golden Living Ctr. – Riverchase*, DAB No. 2314 at 6-7 (2010); *Eastwood Convalescent Ctr.*, DAB No. 2088 (2007); *Century Care of Crystal Coast*, DAB No. 2076 (2007*), aff'd*, 281 F. App'x 180 (4th Cir. 2008); *Liberty Commons Nursing & Rehab - Alamance*, DAB No. 2070 (2007); *Golden Age Skilled Nursing & Rehab. Ctr.*, DAB No. 2026 (2006); *Northeastern Ohio Alzheimer's Research Ctr.*, DAB No. 1935 (2004); *Woodstock Care Ctr.*, DAB No. 1726. The regulation does not make a facility strictly liable for accidents that occur, but it does require that a facility take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigates foreseeable risks of harm from accidents. *Woodstock Care Ctr. v. Thompson*, 363 F.3d at 589 (noting a SNF must take "all reasonable precautions against residents' accidents"). A facility is permitted the flexibility to choose the methods of supervision it uses to prevent accidents, but the chosen methods must be

adequate under the circumstances. Whether supervision is "adequate" depends in part upon the resident's ability to protect himself or herself from harm. Based on the regulation and the cases in this area, CMS meets its burden to show a *prima facie* case, if the evidence demonstrates that the facility failed to provide adequate supervision and assistance devices to prevent accidents, given what was reasonably foreseeable. *Alden Town Manor Rehab. & HCC*, DAB No. 2054 at 5-6, 7-12 (2006). CMS policy provides that an "accident" is:

> [A]ny unexpected or unintentional incident, which may result in injury or illness to a resident. This does not include adverse outcomes that are a direct consequence of treatment or care that is provided in accordance with current standards of practice (e.g. drug side effects or reaction).

SOM, app. PP (rev. 27 eff. Aug. 17, 2007).

The surveyors' allege that Petitioner violated this regulation because Petitioner failed to provide supervision to prevent Resident 1 from falling from his wheelchair. The surveyors also allege that the deficiency posed immediate jeopardy on July 7 and 8, 2011, though obviously not for Resident 1 who died on July 2. CMS Ex. 4 at 12-20. CMS argues that Resident 1 was assessed as being at high risk for falls and the specific risk of him falling from his wheelchair was foreseen; the IDT had adopted an alarm for use in the resident's wheelchair as an intervention to alert staff if the resident attempted to self-transfer or was falling; and Petitioner had adopted as a general policy and practice the intervention that residents with a chair alarm were not to be left unattended in their room in their wheelchair. CMS alleges Petitioner violated the regulation because the supervision provided by the alarm was ineffective as the alarm did not function and no staff was present supervising Resident 1 when he toppled from his wheelchair. CMS Br. at 7-13.

The pertinent facts are not in dispute. Resident 1 was assessed as having a history of falls and at high risk for falls. P. Ex. 10. Several interventions were ordered by the IDT to address his risk for falls. CMS Ex. 7 at 55-56, 68-70, 72-73; P. Ex. 4 at 7-11. None of the printed care plans in evidence listed interventions such as alarms, a specialized bed, mats, side-rails, non-slip footwear or other interventions typically found in care plans intended to mitigate or eliminate the risk for falls or to mitigate the risk for injury due to a fall. CMS Ex. 7 at 55-56, 68-70, 72-73; P. Ex. 4 at 7-11. But on September 1, 2010, Resident 1's physician had ordered that a chair alarm be used when the resident was up in his wheelchair, in order to alert staff and remind the resident not to attempt to self-transfer. CMS Ex. 7 at 4; P. Ex. 5 at 1-2, 5-10. Petitioner had also announced policies to staff regarding the supervision required for residents with an order for an alarm in their wheelchair and that policy was followed and a practice in the facility. CMS Ex. 12; P. Ex. 2 at 1, 4. Based on Petitioner's policies announced in in-service trainings on June 1,

2010 and January 31, 2011, Resident 1, who had a physician's order for an alarm in his chair, was not to be left unattended in the bathroom or while using the toilet and he was not to be left unattended in his wheelchair in his room. On July 2, 2011, Resident 1 was left in his room, in his wheelchair, unattended, and he fell from his wheelchair and the alarm in his chair failed to sound. The facts establish a prima facie showing of a violation of 42 C.F.R. § 483.25(h). Resident 1 was assessed as at risk for falls from his wheelchair. Therefore, a fall by Resident 1 was foreseeable. The IDT adopted the intervention of a chair alarm but the chair alarm was not effective on July 2, 2011, because it did not sound. The fact that Resident 1 may have already been dead when the alarm should have sounded is not relevant. The IDT had not specifically ordered a level of supervision for Resident 1 that appeared in any care plan, physician order, or instruction to staff, in evidence. However, I infer that the IDT knew of the policies of the facility announced in in-service training of staff that a resident with a chair alarm was not to be left unattended in the chair in either the bathroom or the resident's room. Petitioner's staff failed to provide the level of supervision required by Petitioner's policy when Resident 1 was left unattended in his room and in his wheelchair on July 2, 2011.

I further conclude that Petitioner has failed to rebut the prima facie case or to establish an affirmative defense.

Petitioner argues that an alarm does not prevent a fall. P. Br. at 22. However, as Petitioner's expert, RN Morgan, explained, the effectiveness of an alarm depends upon the proximity of staff. Tr. 981. If staff is in a resident room, or close to the room, the sounding of an alarm may permit staff enough time to stop the fall. The sounding of an alarm may also remind a resident not to attempt to rise from the bed or the chair. Even if an alarm does not prevent a fall, it may signal staff of a fall and permit a quicker first response. A significant consideration here is that the physician, who is part of the IDT, ordered the alarm. The physician order specifically stated that the purpose of the alarm was to alert staff and to remind the resident to request assistance for transferring. P. Ex. 5 at 1. The fact that the alarm did not sound when Resident 1 fell from his chair shows that the alarm was either not on or it malfunctioned, and in either case that intervention was not effective at the time of the fall. Although Petitioner asserts that the alarm had been checked and was working earlier on July 2, Petitioner has not presented evidence to show why the alarm did not function when the resident fell or that alternative interventions should have been adequate despite the failure of the alarm. Furthermore, Petitioner's witnesses agree that Resident 1 had the ability to turn off the alarm in the chair and that he had done so on an unspecified number of occasions. Tr. 469, 595, 623. But Petitioner points to no intervention to address the problem of Resident 1 disabling his alarm, which would render the alarm an ineffective intervention. Contrary to Petitioner's argument, it is not sufficient for a facility to assess a resident and then care plan interventions. P. Br. at 23. The facility is also obliged to assess the effectiveness of interventions to mitigate or eliminate a perceived accident risk and to modify existing interventions or adopt new interventions as necessary to protect its residents.

Petitioner also attempts to disavow the in-service trainings at which staff was instructed not to leave residents with chair alarms unattended in the bathroom or their room. CMS Ex. 12; P. Ex. 2 at 1, 4. Petitioner asserts that the training, specifically the training on January 31, 2011, was not facility protocol or the standard to which Petitioner should be held. P. Br. at 15, 23-24. Petitioner's assertion before me is clearly inconsistent with the evidence that shows staff was trained on June 1, 2010 and January 31, 2011, that residents with an alarm were not to be left unattended in the bathroom and or in their chair in their room. If this was not Petitioner's policy and practice, why would staff be instructed that it was? Petitioner elicited opinion testimony from Dr. Merritt, RN Stephens, and RN Morgan to support an argument that the policy announced in the in-service on January 31, 2011, was not practical. Tr. 827, 915-16, 974-75. However, those opinions merit little weight given the fact that staff followed the policy for approximately six months from January 31, 2011 until Resident 1 fell on July 2, 2011. According to the evidence before me, the implementation of the policy was the only new intervention to address Resident 1's fall risk during the period January 31 to July 2, 2011. When staff failed to comply with that intervention, Resident 1 fell. Therefore, the intervention implemented by the January 31, 2011 in-service must be credited for effectively preventing a fall by Resident 1 from February 5 to July 2, 2011. It is also important to understand that Petitioner's instruction to staff may have been relied upon by the IDT in determining appropriate interventions for Resident 1. If the IDT understood the policy and practice was as announced in the in-service trainings, the IDT may have relied upon that general policy or practice rather than ordering a specific intervention of increased supervision. Accordingly, I conclude that Petitioner must be bound by its announced policy or protocols, even though not reduced to writing or issued in a formal fashion.

Petitioner asserts that there was nothing it could do to prevent Resident 1's fall from his chair and his death. Whether or not Resident 1 died due to his fall from his wheelchair or before his fall is not an issue that I need to resolve. Petitioner assessed Resident 1 as at risk for falls and the evidence shows it was foreseeable that he could fall from his wheelchair. Petitioner had two interventions for supervision of Resident 1, the chair alarm and the presence of staff when he was up in his chair in his room. The chair alarm did not work and Petitioner has failed to show why. Also, no staff was present while he was up in his chair in his room, thus, that intervention was not implemented.

Petitioner's failure to ensure the interventions requiring supervision were effectively implemented, supports the conclusion that Petitioner failed to take all reasonable steps to prevent an accidental fall from the wheelchair, or to mitigate the risk for harm due to such an accident. Accordingly, I conclude that Petitioner violated 42 C.F.R. § 483.25(h). I also conclude that the violation posed a risk for more than minimal harm as there is no dispute by Petitioner that a fall from a wheelchair to the floor poses a risk for physical injury, particularly for an elderly resident with or without co-morbidities.

8. The declaration of immediate jeopardy related to the noncompliance with 42 C.F.R. § 483.25(h) (Tag F323) was not clearly erroneous.

The surveyors concluded that the violation of 42 C.F.R. § 483.25(h) posed immediate jeopardy that began July 7, 2011, and was abated on July 8, 2011. CMS Ex. 4 at 13, 18-20. CMS proposes to impose a CMP in the higher range of CMPs that may be imposed for immediate jeopardy on July 7 and 8, 2011.

The CMS determination of immediate jeopardy must be upheld, unless Petitioner shows the declaration of immediate jeopardy to be clearly erroneous. 42 C.F.R. § 498.60(c)(2). CMS's determination of immediate jeopardy is presumed to be correct, and Petitioner has a heavy burden to demonstrate clear error in that determination. *Yakima Valley Sch.*, DAB No. 2422 at 8-9 (2011); *Cal Turner Extended Care Pavilion*, DAB No. 2384 at 14; *Brian Ctr. Health & Rehab./Goldsboro*, DAB No. 2336 at 9 (2010) (citing *Barbourville Nursing Home*, DAB No. 1962 at 11 (2005), *aff'd*, *Barbourville Nursing Home v. U.S. Dep't of Health & Human Servs.*,174 F. App'x 932 (6th Cir. 2006)); *Maysville Nursing & Rehab. Facility*, DAB No. 2317 at 11 (2010); *Liberty Commons Nursing & Rehab Ctr. - Johnston*, DAB No. 2031 at 18-19. Once CMS presents evidence supporting a finding of noncompliance, CMS does not need to offer evidence to support its determination that the noncompliance constitutes immediate jeopardy, rather, the burden is on the facility to show that that determination is clearly erroneous. *Cal Turner Extended Care Pavilion*, DAB No. 2384 at 14-15; *Liberty Commons Nursing & Rehab Ctr. - Johnston*, 241 F. App'x 76 at 3-4.

"*Immediate jeopardy*" under the regulations refers to "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. §§ 488.301, 489.3 (emphasis in original). In the context of survey, certification, and enforcement related to SNFs and NFs under the regulations, a conclusion by the state agency and CMS that noncompliance with program participation requirements poses immediate jeopardy to facility residents, triggers specific regulatory provisions that require enhanced enforcement remedies, including authority for CMS to impose a larger CMP than may be imposed when there is no declaration of immediate jeopardy. 42 C.F.R. §§ 488.408(e), 488.438(a)(1)(i), (c), and (d). The regulations also require termination of the facility's provider agreement on an expedited basis or the removal of the immediate jeopardy through appointment of temporary management. 42 C.F.R. §§ 488.410, 488.440(g), 488.456, 489.53(d)(2)(B)(ii).

Pursuant to 42 C.F.R. § 498.3(d)(10), a finding by CMS that deficiencies pose immediate jeopardy to the health or safety of a facility's residents is not an initial determination that triggers a right to request a hearing by an ALJ or that is subject to review. Rather, a finding of noncompliance that results in the imposition of an enforcement remedy, except

the remedy of monitoring by the state, does trigger a right to request a hearing and is subject to review. 42 C.F.R. §§ 488.408(g); 498.3(b)(8) and (13). Furthermore, the level of noncompliance, i.e., the scope and severity, is subject to review only if a successful challenge would: (1) affect the amount of CMP that may be imposed, i.e. the higher range of CMP authorized for immediate jeopardy; or (2) affect a finding of substandard quality of care that rendered the facility ineligible to conduct a NATCEP. 42 C.F.R. § 498.3(b)(14) and (16). Pursuant to 42 C.F.R. § 498.60(c)(2), in reviewing a CMP, the ALJ must uphold the CMS determination of the level of noncompliance unless it is clearly erroneous. The phrase "clearly erroneous" is not defined by the Secretary.

Many appellate panels of the Board have addressed "immediate jeopardy."[16] In *Mississippi Care Ctr. of Greenville*, DAB No. 2450 at 15 (2012), the Board commented:

> CMS's determination that a deficiency constitutes immediate jeopardy must be upheld unless the facility is able to prove that the determination is clearly erroneous. 42 C.F.R. § 498.60(c)(2); *Woodstock Care Center*. The "clearly erroneous" standard means that CMS's immediate jeopardy determination is presumed to be correct, and the burden of proving the determination clearly erroneous is a heavy one. *See, e.g.*, *Maysville Nursing & Rehabilitation Facility*, DAB No. 2317, at 11 (2010); *Liberty Commons Nursing and Rehab Center — Johnston*, DAB No. 2031, at 18 (2006), *aff'd*, *Liberty Commons Nursing and Rehab Ctr. — Johnston v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007). When CMS issued the nursing facility survey, certification, and enforcement regulations, it acknowledged that "distinctions between different levels of noncompliance . . . do not represent mathematical judgments for which there are clear or objectively measured boundaries." 59 Fed. Reg. 56,116, 56,179 (Nov. 10, 1994). "This inherent imprecision is precisely why CMS's immediate jeopardy determination, a matter of professional judgment and expertise, is entitled to

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[16] Decisions often cited include: *Lakeport Skilled Nursing Ctr.*, DAB No. 2435 at 6 (2012); *Liberty Health & Rehab of Indianola, LLC*, DAB No. 2434 at 13, 18-19 (2011); *Yakima Valley Sch.*, DAB No. 2422 at 8; *Lutheran Home at Trinity Oaks*, DAB No. 2111 (2007); *Daughters of Miriam Ctr.*, DAB No. 2067 (2007); *Britthaven of Havelock*, DAB No. 2078 (2007); *Koester Pavilion*, DAB No. 1750; *Woodstock Care Ctr.*, DAB No. 1726.

> deference." *Daughters of Miriam Center*, DAB No. 2067, at 15 (2007).

The Board's statement that the CMS immediate jeopardy determination is entitled to deference is subject to being misunderstood to limit ALJ and Board review of immediate jeopardy beyond what was intended by the drafters of the regulations. In the notice of final rulemaking on November 10, 1994, the drafters of 42 C.F.R. § 498.60(c)(2), discussing the merits of the reviewability of deficiency citations, selection of remedy, and scope and severity, commented:

> We believe that a provider's burden of upsetting survey findings relating to the level of noncompliance should be high, however. As we indicated in the proposed rule, distinctions between different levels of noncompliance, whether measured in terms of their frequency or seriousness, do not represent mathematical judgments for which there are clear or objectively measured boundaries. Identifying failures in a facility's obligation to provide the kind of high quality care required by the Act and the implementing regulations most often reflect judgments that will reflect a range of noncompliant behavior. Thus, in civil money penalty cases, whether deficiencies pose immediate jeopardy, or are widespread and cause actual harm that is not immediate jeopardy, or are widespread and have a potential for more than minimal harm that is not immediate jeopardy does not reflect that a precise point of noncompliance has occurred, but rather that a range of noncompliance has occurred which may vary from facility to facility. While we understand the desire of those who seek the greatest possible consistency in survey findings, an objective that we share, the answer does not lie in designing yardsticks of compliance that can be reduced to rigid and objectively calculated numbers. Survey team members and their supervisors ought to have some degree of flexibility, and deference, in applying their expertise in working with these less than perfectly precise concepts. **For these reasons, we have revised the regulations to require an administrative law judge or appellate administrative review authority to uphold State or HCFA findings on the seriousness of facility deficiencies in civil money penalty cases unless they are clearly erroneous.**

59 Fed. Reg. at 56,179 (emphasis added). It is clear from this regulatory history that the drafters of 42 C.F.R. § 498.60(c)(2) ensured that the state agency or CMS determination that there was immediate jeopardy would receive deferential consideration, by adopting the clearly erroneous standard of review. Thus, caution must be exercised to ensure that the Board's decision in *Mississippi Care Center of Greenville, Daughters of Miriam Center,* and other decisions that have mentioned deference relative to immediate jeopardy not be read to require deference for the determination that there was immediate jeopardy beyond that imposed by adoption of the clearly erroneous standard. Giving or requiring that the immediate jeopardy determination be given deference in addition to applying the "clearly erroneous standard" would be contrary to the intent of the drafters of the regulation; would significantly limit the review of the determination by an ALJ and the Board; and would impermissibly deny an affected party the due process right to review intended by the drafters of the regulation.

In the foregoing quotation from *Mississippi Care Center of Greenville,* that panel of the Board states that the clearly erroneous standard means that the "immediate jeopardy determination is presumed to be correct, and the burden of proving the determination clearly erroneous is a heavy one." DAB No. 2450 at 15. Similar formulations have been used in other Board decisions when referring to the "clearly erroneous standard." However, the Board's characterization of the "clearly erroneous standard" in *Mississippi Care Center* and other cases does not define the standard. The "clearly-erroneous standard" is described in Black's Law Dictionary as a standard of appellate review applied in judging the trial court's treatment of factual issues, under which a factual determination is upheld unless the appellate court has the firm conviction that an error was committed. *Black's Law Dictionary* 269 (18th ed. 2004). The Supreme Court has addressed the "clearly erroneous standard" in the context of the Administrative Procedures Act (APA). The Court described the preponderance of the evidence standard, the most common standard, as requiring that the trier-of-fact believe that the existence of a fact is more probable than not before finding in favor of the party that had the burden to persuade the judge of the fact's existence. *In re Winship*, 397 U.S. 358, 371-72 (1970); *Concrete Pipe & Prods. of Cal., Inc. v. Constr. Laborers*, 508 U.S. 602, 622 (1993). The "substantial evidence" standard considers whether a reasonable mind might accept a particular evidentiary record as adequate to support a conclusion. *Consolidated Edison*, 305 U.S. 197, 229 (1938); *Dickinson v. Zurko*, 527 U.S. 150, 162 (1999). Under the "clearly erroneous" standard a finding is clearly erroneous even though there may be some evidence to support it if, based on all the evidence, the reviewing judge or authority has a definite and firm conviction that an error has been committed. *United States v. United States Gypsum Co.*, 333 U.S. 364, 395 (1948); *Dickinson*, 527 U.S. at 162; *Concrete Pipe*, 508 U.S. at 622. The clearly erroneous standard has been characterized by the Court as being stricter than the substantial evidence test and significantly deferential. The Court stressed in discussing the clearly erroneous standard the importance of not simply rubber-stamping agency fact-finding. The Court also

commented that the APA requires meaningful review.[17] *Dickinson*, 527 U.S. at 162 (citations omitted); *Concrete Pipe*, 508 U.S. at 622-23.

Various panels of the Board have recognized other principles applicable to the review of the immediate jeopardy issue. A finding of immediate jeopardy does not require a finding of actual harm, only a likelihood of serious harm. *Dumas Nursing and Rehab., L.P.*, DAB No. 2347 at 19, (citing *Life Care Ctr. of Tullahoma*, DAB No. 2304 at 58, *aff'd, Life Care Ctr. of Tullahoma v. Sebelius*, 453 F. App'x 610 (2011)). The definition of immediate jeopardy at 42 C.F.R. § 488.301, does not define "likelihood" or establish any temporal parameters for potential harm. *Agape Rehab. of Rock Hill*, DAB No. 2411 at 18-19 (2011). The duration of the period of immediate jeopardy is also subject to the clearly erroneous standard. *Brian Ctr. Health & Rehab./Goldsboro*, DAB No. 2336 at 7-8. There is a difference between "likelihood" as required by the definition of immediate jeopardy and a mere potential. The synonym for likely is probable, which suggests a greater degree of probability that an event will occur than suggested by such terms as possible or potential. *Daughters of Miriam Ctr.*, DAB No. 2067 at 10. Jeopardy generally means danger, hazard, or peril. The focus of the immediate jeopardy determination is how imminent the danger appears and how serious the potential consequences. *Woodstock Care Ctr.*, DAB No. 1726 at 39.

What is the meaning of serious injury, harm, or impairment as used in the definition of immediate jeopardy found in 42 C.F.R. § 488.301? How does serious injury, harm, or impairment compare with "actual harm?" On the first question the Board recognized in *Yakima Valley School*, DAB No. 2422 at 8, that the regulations do not define or explain the meaning of the term "serious" as used in the definition of immediate jeopardy.[18] The

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[17] The Board's characterization of the clearly erroneous standard as being highly deferential to the fact-finding by the state agency surveyor and CMS, and even triggering a rebuttable presumption, is entirely consistent with the Supreme Court's characterization of the standard. However, the Court's cautions about ensuring meaningful review rather than rubber-stamping agency decisions shows it is important for the ALJ and the Board not to be tempted to simply defer to the surveyor, the state agency, or CMS on the immediate jeopardy issue.

[18] Appendix Q of the SOM also fails to provide surveyors a working definition of the term "serious" that they can use to determine whether harm, injury, or impairment is serious when deciding whether or not to declare immediate jeopardy. The Act does not define the phrase "immediately jeopardize" and does not introduce the concept of serious harm, injury, or impairment as the basis for finding immediate jeopardy. Thus, one is not in error concluding that absent a definition of the term "serious" in the Act, the regulations, the SOM, or decisions of the Board, it is essentially up to individual

(Footnote continued next page.)

Board suggested that the definitions may be unimportant because the Board has held that, under the clearly erroneous standard, once the state agency or CMS declares immediate jeopardy there is a presumption that the actual or threatened harm was serious and the facility can only rebut the presumption of immediate jeopardy by showing that the harm or threatened harm meets no reasonable definition of the term "serious." *Id.* (citing *Daugthers of Miriam Ctr.*, DAB No. 2067 at 9). In *Daughters of Miriam Center*, the Board discussed that the ALJ attempted to define "serious" finding meanings such as dangerous, grave, grievous, or life-threatening. The Board noted that the ALJ stated that serious harm is outside the ordinary, requiring extraordinary care, or having lasting consequences. The Board further noted that the ALJ stated that a serious injury may require hospitalization, or result in long-term impairment, or cause severe pain, as opposed to harm, injury, or impairment that is temporary, easily reversible with ordinary care, does not cause a period of incapacitation, heals without special medical intervention, or does not cause severe pain. The Board did not endorse or adopt the ALJ's definitional exercise but concluded that it was simply unnecessary in the context of that case. The Board reasoned, as already noted, that the facility bore the burden to rebut the presumption by showing that the actual or threatened harm met no reasonable definition of serious. *Daughters of Miriam Ctr.*, DAB No. 2067 at 9.

Applying the clearly erroneous standard to the record before me related to the noncompliance I have found based on the violation of 42 C.F.R. § 483.25(h), I have no definite and firm conviction that an error has been committed in the declaration of immediate jeopardy. I conclude that Petitioner has failed to show that the declaration of immediate jeopardy for the deficiency under 42 C.F.R. § 483.25(h) was clearly erroneous.

Petitioner argues that CMS has failed to show that the surveyors strictly complied with the procedures for declaring immediate jeopardy. P. Br. at 25. Petitioner's argument is without merit. The regulation is clear that Petitioner bears the burden of showing that the declaration of immediate jeopardy is clearly erroneous. The procedures followed by the surveyors are not at issue except to the extent deviation from procedures might reflect upon the credibility of their testimony or their findings and conclusions reflected in the SOD if placed in issue, but they are not in this case.

(Footnote continued.)

surveyors, and whatever unpublished guidance they receive from their superiors or CMS officials, to exercise their individual discretion and judgment to decide that there was immediate jeopardy, which subjects a facility to the maximum imposable CMPs.

Petitioner argues that Resident 1 was not in immediate jeopardy at the time of the survey as he was already dead and there is no reference to other residents. P. Br. at 25. Contrary to Petitioner's argument, the surveyors alleged in the SOD that there were seven other residents at risk for accidents and injury due to Petitioner's noncompliance. CMS Ex. 4 at 13, 20. A fair reading of the allegations of the SOD are that at least seven of Petitioner's residents were at risk for likely serious harm, injury, impairment, or death due to Petitioner's noncompliance under Tag F323. The seven residents were identified by the fact that all had personal alarms. CMS Ex. 4 at 20. Petitioner also acknowledged at hearing that there were other residents in the facility at risk for falls. Tr. 38-39. Petitioner has not shown that the declaration of immediate jeopardy was clearly erroneous as to any of its residents who had personal alarms or were at risk for falls on July 7 and 8, 2011. The range of serious injuries, harm, or impairment that residents could suffer due to falls from their wheelchairs, beds, or toilets, absent effectively implemented interventions, are obvious, and include contusions, fractures, head injuries, and resulting death. The immediacy or likelihood that serious injury, harm, impairment, or death will result in the near future is evident from the number of residents at risk and the fact that Resident 1 fell from his chair when unsupervised. Whether or not Resident 1 died due to the fall or suffered no injury from the fall is not determinative as the potential for serious harm, injury, impairment, or death is sufficient.

Petitioner asserts that for purposes of determining immediate jeopardy, it had no culpability. P. Br. at 26. Petitioner is in error. The evidence shows that staff was trained not to leave a resident with an alarm unattended in the bathroom or his or her room. The evidence shows that CNA Maddux challenged CNA Warden for leaving Resident 1 unattended and that other staff was aware that Resident 1 should not have been left unattended. Petitioner has not shown that after Resident 1's fall it took action to ensure that its policy not to leave a resident unattended was enforced or that other effective interventions were implemented for the other residents with alarms and at risk for falls. Absent specific interventions listed in an identifiable care plan, physician orders, or some other document accessible to staff, staff needs to rely upon Petitioner's policies regarding the delivery of care and services. Petitioner's failure to clarify and enforce it policy not to leave at risk residents unattended or to implement an equally effective intervention, left staff without the guidance that they needed to ensure that at risk residents were not subject to imminent risk to fall with serious injury, harm, impairment, or death. Petitioner also failed to produce evidence that it determined why Resident 1's alarm did not sound when he fell from his chair. Petitioner's failure to take remedial action related to its policy and failure to investigate the lack of effectiveness of Resident 1's alarm shows an indifference which is culpability. The fact that staff responded promptly when Resident 1 was found dead does not mitigate Petitioner's culpability for failure to act to ensure residents with similar risks were not in immediate jeopardy.

Petitioner also argues that it is inconsistent for the surveyors to declare immediate jeopardy for the deficiency under Tag F323 when immediate jeopardy was not declared

for the deficiency under Tag F225. This argument does not address Petitioner's burden and is of no merit. I note, however, that there is no inconsistency. The deficiency under Tag F225 was based on the Administrator's failure to report the alleged neglect to the state agency as specifically required by the regulation. The deficiency did not bear directly upon the quality of care delivered to residents as did the deficiency under Tag F323. Furthermore, Petitioner did do the required investigation and the surveyors were apparently satisfied that there was no citable instance of actual neglect of Resident 1. Although the surveyors could have viewed the facts related to Tag F225 differently and cited immediate jeopardy, they did not do so. The surveyors' failure to cite immediate jeopardy for Tag F225 does not reflect adversely upon their credibility or discretion.

Accordingly, I conclude that Petitioner failed to meet its burden to show that the declaration of immediate jeopardy was clearly erroneous.

9. The enforcement remedies of $3,650 per day for July 7 and 8, 2011 and $450 per day for the period July 9 through 26, 2011 are reasonable.

10. Petitioner was ineligible for two years to be approved to conduct a NATCEP due to the imposition of a CMP in excess of $5,000 and the extended survey, as a matter of law.

I have concluded that Petitioner violated 42 C.F.R. §§ 483.13(c)(2) (Tag F225) and 483.25(h) (Tag F323); that the violation of 42 C.F.R. § 483.13(c)(2) posed a risk for more than minimal harm to one or more facility residents; and that the violation of 42 C.F.R. § 483.25(h) posed immediate jeopardy for two days. If a facility is not in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, including a CMP. CMS may impose a per day CMP for the number of days that the facility is not in compliance or a per instance CMP for each instance that a facility is not in substantial compliance, whether or not the deficiencies pose immediate jeopardy. 42 C.F.R. § 488.430(a); 42 C.F.R. § 488.438(a)(2). I conclude that there is a basis for the imposition of a per day CMP in this case from July 7 through July 26, 2011.

If I conclude, as I have in this case, that there is a basis for the imposition of an enforcement remedy and the remedy proposed is a CMP, my authority to review the reasonableness of the CMP is limited by 42 C.F.R. § 488.438(e). The limitations are: (1) I may not set the CMP at zero or reduce it to zero; (2) I may not review the exercise of discretion by CMS in selecting to impose a CMP; and (3) I may only consider the factors specified by 42 C.F.R. § 488.438(f) when determining the reasonableness of the CMP amount. In determining whether the amount of a CMP is reasonable, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of non-compliance, including repeated deficiencies; (2) the facility's financial condition;

(3) the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404(b), the same factors CMS and/or the state were to consider when setting the CMP amount; and (4) the facility's degree of culpability, including but not limited to the facility's neglect, indifference, or disregard for resident care, comfort, and safety and the absence of culpability is not a mitigating factor. The factors that CMS and the state were required to consider when setting the CMP amount and that I am required to consider when assessing the reasonableness of the amount are set forth in 42 C.F.R. § 488.404(b): (1) whether the deficiencies caused no actual harm but had the potential for minimal harm, no actual harm with the potential for more than minimal harm, but not immediate jeopardy, actual harm that is not immediate jeopardy, or immediate jeopardy to resident health or safety; and (2) whether the deficiencies are isolated, constitute a pattern, or are widespread. My review of the reasonableness of the CMP is de novo and based upon the evidence in the record before me. I am not bound to defer to the CMS determination of the reasonable amount of the CMP to impose but my authority is limited by regulation as already explained. I am to determine whether the amount of any CMP proposed is within reasonable bounds considering the purpose of the Act and regulations. *Emerald Oaks*, DAB No. 1800 at 12-13; *CarePlex of Silver Spring*, DAB No. 1683 at 14–18 (1999); *Capitol Hill Comm. Rehab. and Specialty Care Ctr.*, DAB No. 1629 (1997).

First considering the factors listed in 42 C.F.R. § 488.404(b), I conclude that the violations of 42 C.F.R. §§ 483.13(c)(2) and 483.25(h) involved a single incident involving a single resident and the deficiencies are, therefore, isolated. The violation of 42 C.F.R. § 483.13(c)(2) posed a risk for more than minimal harm with no actual harm or immediate jeopardy, as already discussed. The violation of 42 C.F.R. § 483.25(h) posed immediate jeopardy but the evidence does not show actual harm, only the likelihood of serious injury, harm, impairment, or death. Pursuant to 42 C.F.R. § 488.438(f), I find that both deficiencies were serious. CMS has presented evidence of prior instances of noncompliance. Petitioner was cited for noncompliance under Tag F323 with no actual harm or immediate jeopardy in July 2008. Petitioner was previously cited for noncompliance under Tag F225 in November 2010. CMS Ex. 16 at 1, 10-11. Petitioner has presented no evidence of its financial status or argued that it is unable to pay the CMP. Petitioner is culpable, particularly regarding the noncompliance under Tag F323 for the reasons already discussed.

A CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of a CMP, $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. § 488.438(a)(1)(i), (d)(2). I conclude that the CMP of $3,650 per day proposed by CMS for the two days of immediate jeopardy is reasonable. The lower range of CMPs, $50 per day to $3,000 per day, is reserved for deficiencies that do not pose immediate jeopardy, but either cause actual harm to residents, or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). I conclude that the

$450 per day CMP proposed for the period of noncompliance from July 9 through 26, 2011, is reasonable. Both CMP amounts are at the low-end of the authorized ranges.

The CMP approved in this case exceeds $5,000 and Petitioner was subject to an extended survey. Therefore, Petitioner was ineligible to be approved to conduct a NATCEP for two years by operation of law. Because Petitioner had no approved NATCEP at the time of the survey, no further review is authorized for reasons previously discussed.

III. Conclusion

For the foregoing reasons, I find Petitioner was not in substantial compliance with program participation requirements from July 7 through 26, 2011, due to violations of 42 C.F.R. § 483.13(c)(2) and 483.25(h). A CMP of $3,650 per day for July 7 and 8, 2011 and $450 per day for the period July 9 through 26, 2011, a total CMP of $15,400, is a reasonable enforcement remedy in this case. Petitioner was ineligible to be approved to conduct a NATCEP for two years by operation of law.

/s/
Keith W. Sickendick
Administrative Law Judge