Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Mabee Health Care Center
(CCN: 67-6015),

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-176

Decision No. CR2525

Date: April 9, 2012

DECISION

Petitioner, Mabee Health Care Center, challenges the determination of the Centers for Medicare & Medicaid Services (CMS) that it was not in substantial compliance with program participation requirements. Petitioner also challenges CMS's imposition of a civil money penalty (CMP) in the total amount of $44,250. For the reasons discussed below, I find Petitioner to have been in substantial compliance with program participation requirements at all relevant times. Therefore, there is no basis for CMS to impose remedies against Petitioner.

I. Background

Petitioner is a long-term care facility located in Midland, Texas. The Texas Department of Aging and Disability Services (TDADS or state agency) surveyed Petitioner on July 7, 2010, and found Petitioner to be out of substantial compliance with the participation requirement at 42 C.F.R. § 483.25(h) (Tag F323, scope and severity level G). By letter dated August 3, 2010, CMS notified Petitioner that it was imposing the following remedies: a per instance CMP of $2,000; a denial of payment for new admissions (DPNA) beginning August 18, 2010; termination of Petitioner's provider agreement

effective January 7, 2011, if substantial compliance was not achieved before that date; and withdrawal of approval for a Nurse Aide Training and Competency Evaluation Program (NATCEP). On July 29, 2010, the state agency conducted a follow-up survey. By letter dated August 20, 2010, CMS notified Petitioner that the survey found Petitioner to be out of substantial compliance with the participation requirements at 42 C.F.R. § 483.13(c)(1)(ii)-(iii),(c)(2)-(4) (Tag F225, scope and severity level E); 42 C.F.R. § 483.13(c) (Tag F226, scope and severity level E); 42 C.F.R. § 483.25(h) (Tag F323, scope and severity level E); and 42 C.F.R. § 483.75(f) (Tag F498, scope and severity level E). The notice informed Petitioner that the original $2,000 per instance CMP had been rescinded, but that CMS had imposed a CMP of $600 per day beginning June 9, 2010. The notice also stated that the termination, DPNA, and withdrawal of approval of NATCEP remedies mentioned in CMS's previous letter remained unchanged.

The state agency conducted another survey of Petitioner's facility on October 4, 2010. By letter dated October 19, 2010, CMS notified Petitioner that the survey found Petitioner to be out of substantial compliance with the participation requirement at 42 C.F.R. § 483.13(c) (Tag F226, scope and severity level E). The notice informed Petitioner that CMS was imposing a CMP of $150 per day beginning August 7, 2010 and continuing until further notice from CMS. With respect to the $600 per day CMP already imposed, the notice informed Petitioner that the CMP began June 9, 2010 and continued through August 6, 2010, for a total of $35,400. The notice stated that the other remedies previously imposed remained unchanged.

On October 26, 2010, CMS issued a final notice letter to Petitioner. This notice advised Petitioner of the following: the termination remedy was rescinded; the DPNA effective date was changed from August 18, 2010 to October 7, 2010, and based on Petitioner's date of substantial compliance, would not be effectuated; a CMP of $600 per day was imposed from June 9, 2010 through August 6, 2010, for a total of $35,400; and a CMP of $150 per day was imposed from August 7, 2010 through October 4, 2010, for a total of $8,850. The total amount of the CMP was $44,250.

Petitioner requested a hearing by letter dated October 4, 2010. The case was docketed as C-11-14 and assigned to me for hearing and decision on October 19, 2010.

On November 18, 2010, CMS filed what it entitled "Respondent's Partial Motion to Dismiss." By its Motion CMS sought the dismissal of Petitioner's "request for an appeal of CMS' scope and severity determinations for deficiency listed as F-323 for the following reasons . . . Petitioner cannot appeal the scope and severity of F-323 where CMS has imposed a per day civil money penalty that is not reviewable as a successful challenge to the CMP would not affect the range of the monetary penalties that CMS could collect." On December 8, 2010, Petitioner filed its response to CMS's partial motion to dismiss.

In my ruling dated January 3, 2011, I stated that there had been multiple surveys of Petitioner's facility between July and October 2010, Petitioner had engaged in state informal dispute resolution (IDR) proceedings, there had been several substantial changes in the positions of CMS and the state survey agency, and Petitioner had made an effort to win extraordinary relief from some CMS actions in United States District Court. I observed that all of these events had created a procedural history that was at best confusing. I viewed CMS's motion more as a motion *in limine* than as a motion to dismiss. I ruled that Petitioner may not challenge the assessment of the F-323 citation at a scope-and-severity level of G, and that no further evidence or argument on that issue would be received.

In the interim, Petitioner had filed another request for hearing on December 17, 2010, appealing the remedies imposed pursuant to CMS's notice letter of October 19, 2010. The case was docketed as C-11-176 and assigned to me for hearing and decision on December 28, 2010.

On January 5, 2011, I issued a Consolidation Order and Order Establishing Procedures and Schedule for Pre-hearing Exchanges. My Order stated that Docket No. C-11-176 involves the same survey cycle and involves common questions of law and fact as Docket No. C-11-14, and that neither party objected to the two cases being consolidated with each other. I therefore consolidated the two cases for hearing and decision. Docket No. C-11-14 was dismissed, and Petitioner's requests for hearing were consolidated under Docket No. C-11-176. The balance of my Order established procedures and schedules for the parties to observe as they prepared the case for hearing.

I conducted an in-person hearing in Midland, Texas on June 13-16, 2011. CMS offered exhibits (CMS Exs.) 1 through 4, 5 (pp. 1-2, 12-23 only), 6 through 11, 12 (including pp. 72A, 72B, and 72C), and 13 through 21,which I admitted into evidence. Transcript (Tr.) at 29, 89, 104-105. Petitioner offered exhibits (P. Exs.) 1 through 47, which I admitted. Tr. at 30-31.

CMS called the following witnesses: Surveyor Tracy West, R.N.; Surveyor Debra Adams; Surveyor Victoria Aupied, R.N.; and Captain Daniel McElroy, R.N. Petitioner called the following witnesses: Richard Hale, Executive Director of Manor Park, of which Petitioner is a part; Cheryl Cummins, R.N., Petitioner's Director of Nursing (DON); Laurel Dean, Certified Nurse Aide (CNA); Cara Brooks, Licensed Vocational Nurse (LVN); Betty Medlock, CNA; LaNell Honeyman, Petitioner's Administrator at the time of the surveys; and Cheryl Morgan, R.N. The parties filed post-hearing briefs (P. Br. and CMS Br.) and post-hearing reply briefs.

II. Issues

The issues in this case are:

1. Whether Petitioner was out of substantial compliance with participation requirements; and

2. Whether the remedies imposed are reasonable.

III. Applicable law

The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 (SNF) and 1919 (NF) of the Social Security Act (Act) and at 42 C.F.R. Part 483.[1] Section 1819(h)(2) of the Act vests the Secretary of Health and Human Services (Secretary) with authority 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.[2] Pursuant to 1819(h)(2)(C), the Secretary may continue Medicare payments to a SNF not longer than six months after the date the facility is first found not in compliance with participation requirements. Pursuant to 1819(h)(2)(D), if a SNF does not return to compliance with participation requirements within three months, the Secretary must deny payments for all individuals admitted to the facility after that date – commonly referred to as the mandatory or statutory DPNA. In addition to the authority to terminate a noncompliant SNF's participation in Medicare, the Act 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. Part 483, subpart B. 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,

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[1] All references are to the 2010 version of the Code of Federal Regulations (C.F.R.), which was in effect at the time of the survey, unless otherwise indicated.

[2] Section 1919(h)(2) of the Act gives similar 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.

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 may impose a CMP for the number of days a facility is not in substantial compliance or for each instance of noncompliance. 42 C.F.R. § 488.430(a). 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 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). "*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 a CMP, $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute 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). A per instance CMP may range from $1,000 to $10,000, and the range is not affected by the presence of immediate jeopardy. 42 C.F.R. § 488.438(a)(2).

The Act and regulations make a hearing before an administrative law judge (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. *The Residence at Salem Woods*, DAB No. 2052 (2006); *Cal Turner Extended Care*, 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); 42 C.F.R. §§ 488.330(e), 498.3. However, the choice of remedies, or the factors CMS considered when choosing remedies, is not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance that CMS determined, if a successful challenge would affect the range of the CMP that may be imposed or impact the facility's authority 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*, 363 F.3d 583 (6th Cir. 2003). 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 Ctr.*, DAB No. 1904 (2004), *aff'd,* 129 F. App'x. 181 (6th Cir. 2005); *Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Emerald Oaks*, DAB No. 1800; *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998); *see Hillman Rehab. Ctr.*, DAB No. 1611 (1997), *aff'd,* No. 98-3789, 1999 WL 34813783 (D.N.J. May 13, 1999).

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

1. Petitioner was in substantial compliance with the participation requirement at 42 C.F.R. § 483.25(h) (Tag F323).

July 7, 2010 Survey

42 C.F.R. § 483.25 requires that:

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

The subsection at 42 C.F.R. § 483.25(h) references accidents[3] and requires that:

> (h) *Accidents.* The facility must ensure that –
> (1) The resident environment remains as free of accident hazards as is possible; and

[3] The Board references the SOM in defining an accident as:

> "an unexpected, unintended event that can cause a resident bodily injury," excluding "adverse outcomes associated as a direct consequence of treatment or care (e.g., drug side effects or reactions)." SOM Appendix PP, Guidance to Surveyors, Part 2, SOP 483.25 Quality of Care (Rev. 274, June 1995 (SOM Guidance).

Woodstock Care Center, DAB No. 1726, at 4 (2000).

> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

In the case of *Meridian Nursing Center*, DAB No. 2265, at 3 (2009), the Board described the requirements of this subsection, stating:

> Section 483.25(h)(1) requires that a facility address foreseeable risks of harm from accidents "by identifying and removing hazards, where possible, or where the hazard is unavoidable because of other resident needs, managing the hazard by reducing the risk of accident to the extent possible." *Maine Veterans' Home – Scarborough*, DAB No. 1975, at 10 (2005). Section 483.25(h)(2) requires 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 mitigate foreseeable risks of harm from accidents." *Briarwood Nursing Center*, DAB No. 2115, at 11 (2007), citing *Woodstock Care Ctr. v. Thompson*, DAB No. 1726 (2000) (facility must take "all reasonable precautions against residents' accidents"), *aff'd*, *Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003).

The Board has also held that facilities "have the 'flexibility to choose the methods of supervision' to prevent accidents so long as the methods chosen are adequate in light of the resident's needs and ability to protect himself or herself from a risk." *Briarwood Nursing Center*, DAB No. 2115, at 5, citing *Liberty Commons Nursing and Rehab – Alamance*, DAB No. 2070, at 3 (2007).

In this case, the Statement of Deficiencies (SOD) for the July 7, 2010 survey alleges that Petitioner violated 42 C.F.R. § 483.25(h) because staff failed to provide adequate supervision and assistance devices to prevent an accident for Resident 1 (R1), who required staff assistance with transfers using an assistance device. CMS Ex. 3, at 1-2. The SOD alleges that two CNAs, CNA A and CNA B, transferred R1 without using a gait belt assistance device as required by facility procedures. The SOD alleges that the CNAs noticed a "bump" after the transfer; nursing notes documented that the hip looked displaced; and a hospital radiology report showed a fracture just below the screws of the repair of a previous fracture. CMS Ex. 3, at 2.

I find that the evidence presented by CMS is sufficient to establish a *prima facie* case of noncompliance, but that Petitioner has overcome CMS's *prima facie* case by a preponderance of the evidence.

At the time of the July 7, 2010 survey, R1 was an 84-year-old woman who was admitted to Petitioner's facility on June 2, 2010, following hospitalization for a stroke. CMS Ex. 6, at 146, 147, 153. Her multiple diagnoses included hypertension, congestive heart

failure, hypoparathyroidism, hyperlipidemia, depressive disorder, generalized pain, and constipation. CMS Ex. 3, at 2; P. Ex. 5, at 10-11; CMS Ex. 6, at 146; CMS Ex. 6, at 5-7.

R1's interdisciplinary care plan, dated June 2, 2010, noted that R1 required assistance in the form of "ext (extensive) x 1" for bed mobility, "ext x 1-2" for transfers, "ext x 1" for dressing, and "ext x 1-2" for toilet use. R1 used a wheelchair for locomotion. CMS Ex. 6, at 151.

According to the nursing notes, on June 9, 2010, R1 complained of pain in her right hip. P. Ex. 5, at 8; see P. Ex. 5, at 4. The attending physician, Dr. Vogel, ordered an x-ray, which showed a "suspected nondisplaced femoral neck transverse fracture." See P. Ex. 5, at 4, 8; see CMS Ex. 6, at 157. Dr. Vogel ordered R1 to be transferred to the ER for treatment. P. Ex. 5, at 4, 8; CMS Ex. 6, at 157, 159.

One of Petitioner's nurses prepared an Incident/Accident Report related to R1's hip fracture. P. Ex. 5, at 6; CMS Ex. 6, at 1, 152. On the report, she noted that the time of the event was "unknown" and described the resident's condition before the incident/accident as "normal." The report stated that no equipment was involved. In describing what happened, the nurse stated that the resident complained of hip pain, an x-ray was ordered, and it revealed a "nondisplaced femoral neck transverse fracture." According to the report, there were no witnesses to the event/action leading to the fracture. The report stated that the resident was taken to the hospital. P. Ex. 5, at 6; CMS Ex. 6, at 1, 152.

R1 was admitted to the hospital on June 9, 2010. CMS Ex. 6, at 153. Her history and physical examination report noted that she had complained of pain in her right hip for about two days, there was no definite known trauma, a mobile x-ray had revealed a hip fracture, and a re-x-ray at the ER confirmed the fracture. The report stated that R1 had been admitted for surgery. CMS Ex. 6, at 153. According to a radiology report, x-rays of R1's pelvis and right hip showed a "right femoral neck fracture." CMS Ex. 6, at 4, 156.

Petitioner reported the June 9 incident to TDADS on June 10, 2010. Its Administrator, LaNell Honeyman, completed a Provider Investigation Report dated June 14, 2010. P. Ex. 5, at 1-3; CMS Ex. 6, at 68-70, 237-39. Ms. Honeyman characterized the incident as an "unexplained injury," and indicated that the date and location of the incident were unknown. The report stated that R1 had a history of falls. No alleged perpetrators or witnesses to the incident are named in the report. Ms. Honeyman attached an Investigation Summary to the report. Under "Investigation Findings," she wrote "no explanation of injury forthcoming." P. Ex. 5, at 3; CMS Ex. 6, at 70, 239.

Following the surgical repair of her right hip, R1 returned to Petitioner's facility. Dr. Vogel's telephone order dated June 14, 2010, states the following: "readmit to SNF DX

Right Hip Fx, PT, OT, ST to evaluate and treat. Resume previous meds, treatment, and diet." CMS Ex. 3, at 4; CMS Ex. 6, at 160.

The record shows that R1 received physical therapy and occupational therapy starting June 15, 2010. P. Ex. 5, at 7; P. Ex. 8, at 1. R1 also received speech therapy. P. Ex. 5, at 7. R1's weekly progress report for physical therapy, covering the period 6/16 – 6/21/10, stated, among other things, that R1 went to the physician on June 21, 2010, and received orders to start walking and to bear weight down to her right lower extremity. CMS Ex. 6, at 63, 163. In describing R1's physical therapy, the report stated, among other things, that she was seen for "in standing frame x 10 minutes to improve endurance. Seen for transfers from w/c to ex. mat & vice versa [with] max [assist] @ 2. Supine to/from sit [with] max. strengthening exercises to B LE's [lower extremities] & oc's/tactile cues to improve ROM, especially [right] LE." The report stated further that "[p]t. will continue to benefit from PT services to restore functional mobility through improve [sic] bed mobility, transfers, LE strengthening, balance, endurance, gt [gait] and safety." R1's barriers to progress were noted to be her low endurance, strength, and balance. CMS Ex. 6, at 63, 163.

According to the nursing notes, on June 26, 2010, a nurse observed that R1's right hip "looks as if it's out of place," and indicated that R1complained of hip pain. The nurse noted that R1 had recently had surgery for a right hip fracture. She reported that R1's hip was "angled abnormal" and R1 was "unable to straighten leg out fully." According to the nursing notes, R1's daughter said that R1's hip "did not look like this yesterday." No edema or redness was present at the hip. R1's daughter requested an x-ray, and R1's physician ordered that R1 be sent to the ER. R1 was sent to Midland Memorial Hospital.

The ER examination report stated that R1 complained of right hip pain from an unknown source. A family member who provided her history stated that when Petitioner's staff picked R1 up from her wheelchair, "her right hip leg was internally rotated." CMS Ex. 6, at 174. The examination report stated that there was no report of trauma or a fall. It noted that R1 was a fall risk and had had hip surgery on June 21. CMS Ex. 6, at 177. In noting R1's past medical history, the report lists R1's diagnoses, including hypertension, CVA, pneumonia, dementia, and COPD. CMS Ex. 6, at 175. A physical examination showed, among other things, a "right hip deformity with internal rotation and crepitus." CMS Ex. 6, at 177.

X-rays taken of R1's right hip on June 26, 2010, showed an "acute intertrochanteric right hip fracture" and "three threaded pins are seen spanning a prior subcapital hip fracture which remains intact." CMS Ex. 6, at 178-79.

R1 was transferred from Midland Memorial Hospital to another hospital (UMC-Lubbock) because specialty care was unavailable at Midland Memorial Hospital. CMS Ex. 6, at 179. (see CMS Ex. 6, at 243-35). A CT was performed on or about June 27, 2010, and

the report stated that R1 had a right femoral fracture "just below the level of where the orthopedic screws exit" and noted, among other things, that R1 had "diffuse osteopenia." P. Ex. 4, at 3; CMS Ex. 6, at 202, 236; CMS Ex. 3, at 4.

One of Petitioner's nurses prepared an Incident/Accident Report following the June 26, 2010 incident. The report noted that the event occurred at 12:15 p.m. and stated that the resident's condition prior to the event was "normal." According to the report, the resident complained in pain to her right hip and that she was unable to extend her leg all the way down. The facility sent her to the hospital ER for evaluation and treatment. There were no witnesses to the event. CMS Ex. 6, at 13, 187.

Petitioner reported the June 26 incident to TDADS on June 30, 2010, and Administrator Honeyman completed a Provider Investigation Report dated July 2, 2010. P. Ex. 6, at 1-3; CMS Ex. 6, at 8-10; 181-83. Ms. Honeyman characterized the incident as an "injury of unknown source." The report revealed that on June 9, R1 had had the "same sort of unexplained injury." No alleged perpetrators or witnesses to the incident are named in the report. Under "Description of the Allegation," Ms. Honeyman stated, "[f]amily relayed information from dr. in Lubbock that was contrary to report from local hospital (verbal report). Lubbock claims it was a new injury rather than failed surgery." In describing R1's injury, Ms. Honeyman stated, "[f]emur fracture below previous fracture – according to family." As with the injury that occurred on June 9, under "Investigation Findings," Ms. Honeyman wrote "no explanation found." She attached an Investigation Summary to the report. P. Ex. 6, at 4-5; CMS Ex. 6, at 11-12, 184-85.

In an interview conducted on the day of the survey, CNA A stated that on June 26, 2010, she and another CNA, CNA B, did a two-person transfer of R1 from her bed to a wheelchair at 10:30 a.m., and again did a two-person transfer of R1 from her wheelchair to her bed between 12:15 p.m. and 12:30 p.m. According to CNA A, on both transfers, they went under R1's arms, and grabbed the elastic part of her pants to stand, pivot, and transfer her. CNA A stated that they did not use a gait belt on either transfer. CNA A stated that R1 did not complain of pain, but after they removed R1's pants when she was in bed, they noticed a "bump" on the side of R1's leg and hip. CMS Ex. 3, at 5.

I note that the allegation in the SOD cites Petitioner for a failure to provide adequate supervision and assistance devices to prevent "an accident" for R1, and the "accident" to which the SOD refers appears to be the June 26, 2010 hip fracture suffered by R1. CMS Ex. 3, at 2. Despite the fact that the SOD focuses on the second hip fracture, CMS discusses both the June 9 and June 26 hip fractures suffered by R1 in its briefing. According to CMS, Petitioner failed to fully assess the cause of R1's hip fractures, identifying them only as injuries of unknown origin, and failed to identify what interventions were necessary to prevent future injuries. CMS contends further that

Petitioner's aides, when transferring R1, used an improper transfer technique given her physical condition and failed to use a gait belt.[4]

In support of its position, CMS offered the testimony of Surveyor Tracy West, who was the only surveyor involved in the July 7, 2010 survey. When asked to explain his findings of deficient practices, Surveyor West testified that R1, whose diagnoses included osteopenia and osteoporosis, was at "high risk for injuries and accidents" and that Petitioner failed to adequately assess the risk factors, failed to put new interventions in place after the first hip fracture and failed to modify those interventions to prevent further accidents, and failed to supervise R1. Tr. at 44, 67, 99.

Surveyor West testified, moreover, that "a significant part of" Petitioner's deficient practice under Tag F323 was the failure to use a gait belt when transferring R1. Tr. at 99. According to Surveyor West, Petitioner's own policy regarding transfers from a bed to a chair and vice versa required using a gait belt. Tr. at 72-73, 75, 145. He testified that from his interview with a CNA, he learned that the CNAs did not use a gait belt when they transferred R1, and instead held on to R1's elastic waist band. Tr. at 90-94, 150-51. In Surveyor West's opinion, the CNAs "did not do a correct transfer" and put R1 at greater risk for a fall or possibly a hip fracture. Tr, at 95-96, 150-51, 154. I note that Surveyor West admitted that he did not personally observe any transfers of R1.[5] Tr. at 100, 140.

In its defense, Petitioner argues that R1 received proper supervision and assistance at all times. Petitioner asserts that the records show that R1's hip fractures of June 9 and June 26 did not result from any fall or accident, or from any actions of its staff. Petitioner argues, moreover, that R1 was transferred properly and that her second hip fracture had nothing to do with the manner in which she was transferred by its aides.

As I stated above, I find that Petitioner has overcome CMS's *prima facie* case by a preponderance of the evidence. Contrary to the argument CMS urges, I find no evidence that any sort of accident hazard existed, or even that R1 suffered an accident or fall. I agree with Petitioner that its staff did all that it reasonably could be expected to do in caring for R1.

The record shows that when R1 was admitted to Petitioner's facility on June 2, 2010, Petitioner's staff assessed R1's assistance and safety needs for her interdisciplinary care

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[4] Surveyor West testified that a gait belt is a sturdy device that goes around a resident's waist to help steady the resident while he or she is being transferred. Tr. at 73-74, 92, 148. He stated that a gait belt would not be used if a resident cannot bear weight with his or her legs or is unable to stand. Tr. at 74.

[5] Surveyor West testified that he observed three transfers during the survey, but did not observe any transfers involving R1. Tr. at 100.

plan. CMS Ex. 6, at 151. The care plan reflects that R1 required assistance in the form of "ext (extensive) x 1" for bed mobility and for dressing. R1 required "ext x 1-2" for transfers and toilet use. The care plan noted that R1 needed adaptive/safety equipment and that staff needed to educate R1 and her family in the area of safety awareness. CMS Ex. 6, at 151.[6] Upon R1's admission, Petitioner's staff also completed another form specifically addressing R1's level of functioning for various ADLs. On this document, staff noted that R1 required a one-person assist with transfers and that she was weak. CMS Ex. 6, at 85.

In responding to CMS's claims that its staff failed to identify the cause of R1's hip fractures, Petitioner offered the testimony of DON Cheryl Cummins. When asked to explain a "pathological or spontaneous fracture," DON Cummins testified that it is "a fracture that can occur from just general everyday day-to-day use of bones, especially in people who have osteopenia, osteoporosis, are frail, elderly, tiny body frame, malnutrition, chronic smoking, chronic drinkers." Tr. at 518. DON Cummins testified that R1 had been a smoker in the past, had chronic obstructive pulmonary disease (COPD), was very thin, malnourished, and had diagnoses of both osteopenia and osteoporosis. Tr. at 518-19. She stated that R1 came to Petitioner's facility with a history of prior fractures, noting that R1 had fallen in March 2010 and suffered rib fractures. Tr. at 519-20, 532. DON Cummins confirmed also that R1 was taking antidepressants, and could be at higher risk for pathological or spontaneous fractures because of their side effects. Tr. at 520.

DON Cummins testified that she investigated both the June 9 and June 26 hip fractures, and that her investigations included interviewing the nursing staff and R1's sitters. Tr. at 535- 38. When asked whether she was ever able to identify any "accident" that could have explained either fracture, DON Cummins testified that she was not able to identify a fall, a drop, or any other accident that may have occurred. Tr. at 524. DON Cummins stated that no one she interviewed, including R1's sitters or her daughter, were aware of any falls or whether R1 had ever been dropped. Tr. at 536, 540. DON Cummins testified that with respect to the first fracture, she was not able to identify anything other than osteoporosis that would have accounted for the fracture. Tr. at 524. With respect to the second fracture, DON Cummins stated that she was not able to identify anything "external" that would have caused the fracture. Tr. at 525, 542.

According to DON Cummins, because Petitioner was not able to determine how R1's June 9 fracture occurred, this event was reported to TDADS as an "injury of unknown origin," for which reporting is required. Tr. at 536. DON Cummins testified that they

[6] On R1's care plan, staff listed a particular adaptive or safety device that would be provided to R1, but I am unable to determine what was provided because whatever was written appears to have been highlighted, and the highlighting appears on my copy of the exhibit as a very heavy black line, making it unreadable. CMS Ex. 6, at 151.

assumed R1's fracture was related to her osteoporosis and her multiple diagnoses, but they decided to err on the side of caution and reported her fracture. Tr. at 536-37. After reviewing Petitioner's report, the state agency cleared Petitioner on a "desk review" of the report. Tr. at 537. DON Cummins testified that they investigated R1's second hip fracture using the same process that they used with the first fracture and also reported the injury to TDADS. Tr. at 537-38.

In support of its position that R1 was transferred properly, Petitioner points to the testimony of DON Cummins and CNA Laurel Dean, who was one of the CNAs that performed the allegedly improper transfer of R1 that is at issue in the SOD. DON Cummins testified that a resident's transfer needs may change throughout the day. Tr. at 530-31. With respect to gait belts, she stated that there can be problems associated with their use during transfers. Tr. at 531. According to DON Cummins, a gait belt would be contraindicated for a resident with certain physical problems, such as breathing problems, a recent surgery, or recent rib fractures. Tr. at 531-32. DON Cummins testified that R1 came to Petitioner's facility with a history of rib fractures, that she had COPD, and that she had undergone surgery for her first hip fracture, all of which would have been reasons not to use a gait belt when transferring her. Tr. at 533-34.

CNA Dean testified that she had cared for R1 on perhaps one other occasion prior to working with her around June 26, 2010, which is the date of R1's second hip fracture. Tr. at 664, 672. She stated that she did not believe that it was safe to use a gait belt with R1 since R1 had recently had hip surgery. Moreover, because R1 was very frail, CNA Dean did not want to risk injuring her ribs by using a gait belt. Tr. at 666-67. CNA Dean testified that she discussed with the nurses that she was going to perform a two-person transfer rather than use a gait belt. Tr. at 666-67. According to CNA Dean, the allegation in the SOD that she lifted R1 up by the elastic waistband of her pants when she and the other CNA performed the transfer on June 26 is not true. Tr. at 668. CNA Dean testified that she or the other CNA hung on to R1's waistband to steady her as they pivoted her during the transfer. Tr. at 668-69, 673. She expressed her opinion that the waistband was safer than the gait belt because "it had more give." Tr. at 668-69. According to CNA Dean, during the two-person transfer, R1 was able to pivot and had no complaints of pain. Tr. at 670. CNA Dean believed that their method of transfer was the safest way to transfer R1. Tr. at 671. According to CNA Dean, there was nothing in R1's care plan stating that a gait belt was required for a transfer. Tr. at 678. She testified that R1 never fell during the transfers nor did she or the other CNA drop R1 during the transfers. Tr. at 679.

I note that in her written statement that appears in the record as P. Ex. 2, Ms. Dean wrote that when she and the other CNA put R1 back to bed after lunch on June 26, she noticed that R1's right hip "appeared very swollen, knee bent in." Ms. Dean stated that she asked the ADON to examine R1, and the ADON assessed her and sent R1 to the hospital. P. Ex. 2.

I find DON Cummins and CNA Dean to be credible witnesses. I accept DON Cummins' testimony that she investigated both hip fractures sustained by R1 and was unable to identify any fall, accident, or drop that befell R1. It is noteworthy that on cross-examination Surveyor West was unable to identify any particular event in the history of R1's care that could have been characterized as an "accident." Tr. at 133-34. Even Surveyor West conceded that R1 never fell and that R1 was never dropped during a transfer. Tr. at 133-34.[7]

Moreover, I see no evidence in the record that Petitioner failed to keep R1's environment as free of accident hazards as possible. Although CMS appears to suggest in its briefing that the transfer of R1 on June 26 caused her hip fracture ("While there is no conclusive evidence that the stand and pivot technique used to transfer R1 caused the injury, the probability is high given the circumstances surrounding R1's injury." CMS Br. at 17), this claim is inconsistent with the testimony of its witness, Surveyor West, who admitted that he never claimed in the SOD that the transfer caused the fracture. Tr. at 153. Based on Ms. Dean's credible testimony and the fact that Surveyor West did not even observe the transfers of R1, I cannot find that R1 was transferred using inappropriate techniques. Even though the CNAs did not use a gait belt when they transferred R1, I am persuaded by Ms. Dean's testimony that it would not have been safe to use one given R1's frail physical condition. Moreover, I find credible Ms. Dean's testimony that she discussed doing a two-person transfer with the nurses prior to transferring R1.

There can be little doubt that R1's osteoporosis and osteopenia made her more susceptible to suffering a fracture even without any external trauma. Consistent with the testimony of DON Cummins, Surveyor West testified that R1's osteoporosis and osteopenia could potentially have detrimental consequences, such as putting her at risk for fractures. Tr. at 78, 99. On cross-examination, Surveyor West agreed that if someone has osteoporosis and osteopenia, he or she would be "at higher risk and . . . more prone to a pathological fracture, a spontaneous fracture, or a stress fracture, even without trauma." Tr. at 117-18. Surveyor West further acknowledged on cross-examination that in someone who has osteoporotic, severely demineralized bones, movement, even if perfectly normal, can cause a fracture. Tr. at 119-20. Based on the testimony of both Surveyor West and DON Cummins, it is thus not an unlikely scenario that both of R1's hip fractures were spontaneous or pathological fractures.

The record shows that Petitioner's staff did all that it reasonably could be expected to do in caring for R1 and that her hip fractures were not the result of any accidents or accident hazards. I find that Petitioner established by a preponderance of the evidence that it was in compliance with 42 C.F.R. § 483.25(h).

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[7] Surveyor West stated also that he found no evidence of abuse or neglect. Tr. at 138.

2. Petitioner was in substantial compliance with the participation requirements at 42 C.F.R. § 483.13(c)(2)-(4) (Tag F225) and 42 C.F.R. § 483.13(c) (Tag F226) .

July 29, 2010 Survey

The SOD for the July 29, 2010 survey alleges that Petitioner was not in compliance with the following Medicare participation requirements: 42 C.F.R. § 483.13(c)(1)(ii)-(iii), (c)(2)-(4) (Tag F225);[8] 42 C.F.R. § 483.13(c) (Tag F226); 42 C.F.R. § 483.25(h) (Tag F323); and 42 C.F.R. § 483.75(f) (Tag F498). CMS Ex. 9.

Tags F225 and Tags F226

The citations under Tags F225 and F226 both involve Resident 1 (R1) and Resident 2 (R2), and the allegations of noncompliance under these two tags are essentially based on the same facts and circumstances.[9] P. Br. at 30. Hence, I shall discuss these deficiencies together, first with respect to R1 and then with R2.

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). The facility "must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source . . . are reported immediately to the administrator of the facility and to other officials in accordance with State law." 42 C.F.R. § 483.13(c)(2). The facility "must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse" during the investigation. 42 C.F.R. § 483.13(c)(3). The facility must ensure that the results of all investigations are "reported to the administrator or his designated representative and to other officials in accordance with State law . . . within 5 working days of the incident." 42 C.F.R. § 483.13(c)(4). The SOD alleges under Tag F225 that Petitioner violated 42 C.F.R. § 483.13(c)(1)(ii)-(iii), (c)(2)-(4) because Petitioner failed to investigate thoroughly injuries of unknown origin sustained by Resident 1 (R1) and Resident 2 (R2) and failed to report an injury of unknown origin sustained by R2. CMS Ex. 9, at 2. The SOD alleges that Petitioner "fail[ed] to thoroughly investigate when [R1] was found to have a fractured leg and the date and cause of the injury was [sic] unknown," and "fail[ed] to investigate or report

[8] Although the SOD, at Tag F225, alleges that Petitioner violated the Medicare participation requirement at 42 C.F.R. § 483.13(c)(1)(ii)-(iii), the surveyors made no factual allegations in the SOD with respect to this requirement, and neither party addressed this requirement. Therefore, I do not discuss 42 C.F.R. § 483.13(c)(1)(ii)-(iii).

[9] The resident referred to as "R1" in the July 29, 2010 survey is not the same person as the R1 identified in the July 7, 2010 survey.

when [R2] was found to have a broken hip and the date and cause of the injury was [sic] unknown." CMS Ex. 9, at 2-3.

The SOD alleges under Tag F226 that Petitioner violated 42 C.F.R. § 483.13(c) because Petitioner failed to implement its abuse policies and procedures with respect to R1 and R2 in that it failed to implement or follow the policy regarding investigation of injuries of unknown origin.

I find that the evidence presented by CMS is sufficient to establish a *prima facie* case of noncompliance with respect to Tags F225 and F226, but that Petitioner has overcome CMS's *prima facie* case by a preponderance of the evidence.

R1

At the time of the July 29, 2010 survey, R1 was a 97-year-old woman who was admitted to Petitioner's facility on April 19, 2010. CMS Ex. 9, at 6; see P. Ex. 27, at 2; CMS Ex. 12, at 51. Her diagnoses included senile dementia, osteoporosis, hypothyroidism, depressive disorder, nutrition deficiency, generalized pain, and a history of a fractured carpal bone. CMS Ex. 9, at 6; P. Ex. 26, at 14; CMS Ex. 12, at 12. R1 was in the Alzheimer's/dementia special care unit, known as the Younger Unit. P. Ex. 31, at 7; CMS Ex. 12, at 56.

R1's Minimum Data Set, with an assessment reference date of April 26, 2010, shows, among other things, that R1 had short-term and long-term memory problems, moderately impaired cognitive skills, and needed "one person physical assist" with bed mobility, transfers, and walking. P. Ex. 31, at 3-4; CMS Ex. 12, at 52-53. R1's primary mode of locomotion was her wheelchair. For transfers, R1 was to be lifted manually. P. Ex. 31, at 5; CMS Ex. 12, at 54.

A nursing note dated July 13, 2010 at 10:33 a.m. stated that R1's left leg "has 1+ edema and slightly warm to touch. No redness noted. A black scab cover small heal s/t [skin tear.] No drainage noted. Place in recline [with] bilateral feet elevated. Will monitor lt. leg." CMS Ex. 9, at 6; P. Ex. 32, at 2; CMS Ex. 12, at 7, 62. A nurse reassessed R1's leg later at 12:50 p.m. and her nursing note states "yellow pus noted @ old wound site small circle of redness noted surrounding area . . . ." The nurse contacted R1's physician for a treatment order. CMS Ex. 9, at 6; P. Ex. 32, at 2; CMS Ex. 12, at 7, 62. Nursing notes dated July 14 and 15, 2010, indicate that the wound was being treated. In the July 15, 2010 entry at 2:51 p.m., a nurse wrote that R1's "lt leg has 3+ pitting edema. Yellow and purplish bruising to outer lower leg and ankle, half of black scab remain to bed of wound [with] redness surround area . . . Received new order for X-ray to ankle, lower leg, and knee of lt leg. . . ." CMS Ex. 9, at 6-7; P. Ex. 32, at 3; CMS Ex. 12, at 8, 63.

On July 15, 2010, an X-ray was taken of R1's left tibia and fibula, and it revealed a "[d]istal tibial diaphyseal stress fracture." CMS Ex. 9, at 6; P. Ex. 26, at 6, 8; CMS Ex. 12, at 4, 6.

Following the July 15, 2010 incident, Petitioner's staff prepared an incident/accident report. The report stated that R1's left lower leg had slight swelling and discoloration, and that R1 moved her leg without obvious pain or difficulty. R1's physician gave a telephone order for a leg and knee x-ray and DVT study. The x-ray showed a "distal tibia diaphyseal fx" and R1's physician ordered an immobilizer, which was applied. CMS Ex. 9, at 7; P. Ex. 26, at 1; CMS Ex. 12, at 13.

Petitioner reported the incident to TDADS on July 16, 2010, and Administrator Honeyman completed a Provider Investigation Report. P. Ex. 26, at 3-5; CMS Ex. 12, at 1-3. The report stated the date of the incident is "unknown" and characterized the incident as an "injury of unknown origin." CMS Ex. 9, at 7; P. Ex. 26, at 3; CMS Ex. 12, at 1. With its Provider Investigation Report, Petitioner also attached an Investigation Summary. P. Ex. 26, at 12; CMS Ex. 12, at 10.

The SOD alleged that no staff interviews were documented as part of Petitioner's investigation. CMS Ex. 9, at 7. According to the SOD, there were no witness statements from staff who worked the shift prior to when signs of R1's injury were discovered on July 13, 2010. CMS Ex. 9, at 8. The SOD alleged further that there was no evidence of any investigation into the transfer methods for R1 or any environmental observations that may have been relevant. CMS Ex. 9, at 9.

The Immediate Needs Care Plan, dated June 21, 2010, showed that R1 fell with no apparent injury, and explains that she fell because she was "trying to get OOB [out of bed] [without] assistance." According to the care plan, required interventions included reviewing medications and assessing for orthostatic hypotension. The care plan also listed the following possible interventions: performing neuro checks, checking R1's vital signs and range of motion, using a bed in the lowest position with the wheels locked, a bed alarm, and hip protectors. P. Ex. 27, at 5; CMS Ex. 12, at 18.

CMS contends that R1's leg fracture and leg wound were injuries of unknown origin and that Petitioner failed to investigate both injuries thoroughly, as required by the regulations. CMS argues that Petitioner assumed that R1's fracture was related to her history of osteoporosis. As CMS's witness Surveyor Debra Adams stated in her testimony, Petitioner "did not thoroughly investigate the injury to attempt to determine what had happened to [R1] . . . and they did have an investigation, but it was not thorough, and it did not encompass all potential witnesses that had access to that resident in the time period." Tr. at 170.

Petitioner asserts that its staff responded appropriately to R1's injuries and thoroughly investigated them in accordance with the regulations and its own facility policy. P. Br. at 29. Petitioner argues that R1's fracture cannot truly be characterized as an "injury of unknown source." P. Br. at 29. Petitioner asserts that R1's fracture was a stress fracture that resulted from the normal use of her leg during normal daily activities and the fact that she had osteoporosis. P. Br. at 29. Petitioner claims that its staff reported R1's fracture to the state agency as one of "unknown source" out of "an abundance of caution" since it did not result from a fall or other trauma." P. Br. at 17, 29.

Contrary to what CMS argues, I find that Petitioner did respond appropriately to R1's injuries and conducted an investigation in a diligent manner. It is also evident from the record that Petitioner's staff, in their care-planning for R1, instituted appropriate interventions to address her risk for falls and fractures.

When R1 was admitted to Petitioner's facility on April 19, 2010, Petitioner's staff completed a Fall Risk Assessment on that date. P. Ex. 29; CMS Ex. 12, at 29-30. The assessment noted that R1 had fallen in the last thirty days and ninety days, under unknown circumstances. It stated that she had a history of a hip fracture and two left wrist fractures. P. Ex. 29; CMS Ex. 12, at 29-30. According to the "summary" section at the end of the assessment, R1 had a history of falls, poor balance, an unsteady gait, poor safety awareness due to cognitive impairments, used a wheelchair for mobility, had macular degeneration and was hard of hearing without devices. The summary also noted that staff would transfer and assist R1 with all ADLs and includes the following interventions: "wear hip savers . . . keep wheelchair close by, lock brakes before transferring, bed in lowest position, keep pathways clear and well lit." P. Ex. 29 at 2; CMS Ex. 12, at 29.

R1's care plan dated April 19, 2010, noted, among other things, that R1 had high potential/risk for falls. P. Ex. 27, at 2; CMS Ex. 12, at 15. Another part of R1's April 19, 2010 care plan, which appears to have been updated on July 27, 2010, indicated that she was at risk for fracture due to her diagnosis of osteoporosis and previous fracture of her left wrist. P. Ex. 27, at 4; CMS Ex. 12, at 17. The care plan listed the following approaches: provide gentle care when assisting resident; observe for swelling, tenderness, bruising; avoid exercises that may increase risk for fractures; encourage appropriate footwear; administer medication per physician's orders; and apply brace to left wrist as needed/tolerated. P. Ex. 27, at 4; CMS Ex. 12, at 17.

On April 26, 2010, Petitioner's staff completed another document, known as a Resident Assessment Protocol worksheet, that addressed R1's risk for falls. P. Ex. 31, at 11; CMS Ex. 12, at 60. This worksheet noted that R1 has a "history of falls and is at risk for falls due to confusion, poor safety awareness [related to] Dx. Senile Dementia." The worksheet stated further that "[b]ed and chair alarm placement to alert staff when

attempting to get up unassisted and W/C locked during transfer. Bed in lowest locked position and bedside floor mat in place." P. Ex. 31, at 11; CMS Ex. 12, at 60.

Further evidence of efforts by Petitioner's staff to minimize R1's risk of fracture is found in an interdisciplinary care plan progress note dated May 18, 2010. This progress note stated, among other things, that the following interventions were in place: use of a bed/chair alarm, use of a low bed, placement of a bedside mat, use of a rocking recliner, use of hip savers, and the monitoring of R1's medications for side effects. P. Ex. 27, at 1; CMS Ex. 12, at 14. The record also shows that physical therapy was initiated in late April 2010 to increase R1's strength and promote her functional mobility, but this was discontinued after approximately six weeks because R1 reached a plateau. P. Ex. 28.

With respect to R1's leg wound, the record shows that, on July 13, 2010, CNA William Russell reported to charge nurse Lisa Hunt that he had noticed some bruising and/or swelling of R1's left leg. Tr. at 554-55, 573, 629-30, 634; P. Ex. 16, at 5; CMS Ex. 11, at 6. A nurse assessed R1's left leg, and noted there was edema, that it was slightly warm to touch, and that there was no redness evident. P. Ex. 32, at 2; CMS Ex. 12, at 62. The nurse noted that there was a small black scab on R1's left calf; no drainage was present. R1 was placed in a recliner with both her feet elevated, and the nurse stated that her left leg would be monitored. P. Ex. 32, at 2; CMS Ex. 12, at 62; see P. Ex. 16, at 5. When the nurse checked R1's left leg about an hour later, she noticed that there was yellow pus at the scab site with a "small circle of redness" in the surrounding area. She contacted R1's physician for a treatment order. P. Ex. 32, at 2-3; CMS Ex. 12, at 7-8; see P. Ex. 16, at 5. Petitioner's nursing staff continued to check R1's leg during the night and, at 8:00 p.m., documented that there was slight redness to the left leg, with no drainage noted. R1 had no complaints of pain or discomfort. At midnight, a nursing note states that R1 had no signs or symptoms of pain in her left leg. According to a nursing note at 3:15 p.m. on July 14, 2010, a treatment order was received for R1's wound, which consisted of cleaning the wound, applying triple antibiotic ointment, and putting R1 on oral antibiotics. A nursing note dated July 15, 2010, at midnight, stated that the wound was dry and intact with the scab in place, and that a culture would be done later that morning. A nursing note written around 2:51 p.m. on July 15, 2010, stated that a culture was obtained, the wound was cleaned, and triple antibiotic ointment was applied. The note also stated that R1's left leg has "3+ pitting edema," her outer lower leg and ankle has "yellow and purplish bruising," and there was redness in the surrounding area. The nurse informed R1's physician of the new discoloration and edema. The physician ordered an x-ray of R1's left ankle, lower leg and knee and a deep vein thrombosis study. P. Ex. 32, at 3; CMS Ex. 12, at 8.

The record shows that Petitioner's staff updated R1's care plan on July 15, 2010, to reflect the treatment and plan for R1's leg wound. P. Ex. 27, at 3. The care plan describes the location of R1's wound as "L lower leg posterior calf area" and noted that

on July 15 an order for a wound culture was obtained and antibiotic therapy was started. P. Ex. 27, at 3.

The x-ray taken of R1's left tibia and fibula on July 15, 2010, revealed a "[d]istal tibial diaphyseal stress fracture." CMS Ex. 9, at 6; P. Ex. 26, at 6, 8; CMS Ex. 12, at 4, 6. R1's physician ordered an immobilizer for R1's left leg and ordered that R1 see an orthopedist as soon as possible. P. Ex. 32, at 4.

The nursing notes for July 16-28, 2010, show that R1's leg wound continued to be monitored and treated, with no signs or symptoms of infection noted. P. Ex. 32, at 4-10. While the nurses observed that there was still bruising and discoloration, it is unclear whether this bruising was related to R1's leg wound or to her leg fracture. In any event, a nursing note dated July 26, 2010, stated, "Skin assessment showed healed wound. No redness noted to LLE [left lower extremity.] Fading bruising noted to front of the leg. Had no s/s of pain or facial grimacing when reapplying uniboot and sock." P. Ex. 32, at 9. A nursing note dated July 27, 2010, at 12:15 p.m., stated that R1's boot was removed for treatment, and the left posterior extremity was "healing appropriately." P. Ex. 32, at 10. On July 28, 2010, at 11:00 a.m., a nurse wrote that R1 was "resting in recliner [with] chair alarm @ this time. . . . Tx complete to LLE healing appropriately." P. Ex. 32, at 10.

To explain Petitioner's response to the discovery of R1's leg fracture, Petitioner offered the testimony of DON Cummins and Administrator Honeyman. DON Cummins testified that she and Ms. Honeyman conducted an investigation and that Ms. Honeyman prepared a Provider Investigation Report that was submitted to TDADS; in its report to TDADS, the facility reported R1's leg fracture as an injury of unknown origin. Tr. at 544, 559, 562, 565-66, 659; P. Ex. 26, at 3-5; CMS Ex. 12, at 1-3.

DON Cummins stated that she, Ms. Honeyman, and Assistant Administrator Barbara Moore examined R1, and that she and Ms. Honeyman interviewed all staff members on all shifts who had had contact with R1. Tr. at 560, 565. When they interviewed CNA Russell, he stated that R1 had more trouble with her weight bearing status on July 15, and that he had seen a bruise on her left lower leg. Tr. at 555, 634. DON Cummins confirmed that they interviewed six other CNAs, and obtained written statements from three of them. Tr. at 560, 648-49; see P. Ex. 26, at 16-18. She stated that she and Ms. Honeyman also interviewed R1's son. Tr. at 570-71, 573. According to DON Cummins, R1's son stated that he hadn't seen anything that would suggest a source or a reason for R1's fracture and he was not surprised at it, believing it was related to her diagnoses. Tr. at 570-71. DON Cummins testified that she, Ms. Honeyman, and Ms. Moore reviewed all events leading up to the incident and talked to staff to determine if there was anything anyone had seen or heard that would indicate why R1 had a fracture. Tr. at 571-72. She stated that the ADON, Carolyn Belcher, prepared an incident report that was sent to TDADS with the Provider Investigation Report. Tr. at 572.

DON Cummins testified that, from their investigation, they were unable to determine what happened or when R1's leg fracture occurred, and the reason they reported R1's leg fracture to TDADS was "[t]o err on the side of caution." Tr. at 544, 633, 642. She stated that because R1 had a hard time bearing weight on July 15, they believed the fracture may have occurred at that time. Tr. at 633-34. DON Cummins stated that R1's fracture was a stress fracture, which is "not always readily apparent." Tr. at 633. DON Cummins testified that they were unable to determine whether R1 had ever been dropped or had fallen or that any accident had occurred. Tr. at 544, 561.

Administrator Honeyman testified that even though they believed that R1's leg fracture did not appear to be of suspicious nature, they decided to be cautious and report it to TDADS anyways because of its unknown origin. Tr. at 784-85. Ms. Honeyman testified that, to her knowledge, R1 had not fallen or been dropped, or experienced any external trauma. Tr. at 785. She confirmed that the x-ray report revealed that R1 had suffered a stress fracture, but that beyond this fact, there was no explanation for her fracture. Tr. at 784. According to Ms. Honeyman, nothing from her interviews with the CNAs led her to a source of external trauma or any other external event that would have accounted for R1's fracture. Tr. at 787. She testified that R1's son told her he had not seen anything that could explain the fracture, and that he was not surprised that it had happened since R1 had suffered stress fractures in the past. Tr. at 788, 791. Ms. Honeyman testified that she never found an explanation for R1's fracture, and she did not believe that R1's leg wound and fracture were related. Tr. at 788-89.

Contrary to CMS's claim that Petitioner did not conduct a thorough investigation, I find that the credible testimony of DON Cummins and Administrator Honeyman shows that they diligently carried out an investigation to determine what happened once they discovered R1's leg fracture. That they were unable to determine whether an accident or any other external trauma had occurred was consistent with R1's x-ray report, which stated that she had suffered a stress fracture. As DON Cummins testified, a stress fracture "is one that occurs from normal use of the bones." Tr. at 557. R1 had a history of past stress fractures, which made it even more likely that she had suffered another one. Based on Petitioner's investigation, there was nothing to suggest that R1's injury was of a suspicious or truly unknown nature that warranted reporting to the state agency. However, acting in an abundance of caution, DON Cummins and former Administrator Honeyman submitted a report to the state agency, reporting R1's fracture as an incident of unknown origin. The fact that they were unable to determine what happened or the specific date R1's fracture occurred does not mean that their investigation was less than thorough. It simply means that their exhaustive investigation produced no evidence to negate the supposition of a stress fracture sustained in the absence of trauma. Moreover, I find that Petitioner identified R1 as being at high risk for falls and appropriately addressed her risk for fall and fractures by implementing several interventions. As for R1's leg wound, the record shows that Petitioner's staff closely monitored the wound and

treated it over the course of several days. I find that with respect to R1 Petitioner established by a preponderance of the evidence that it was in compliance with 42 C.F.R. § 483.13(c)(2)-(4) (Tag F225).

Further, the record does not support CMS's allegation that Petitioner was not in compliance with 42 C.F.R. § 483.13(c) (Tag F226) because it failed to implement or follow its policy regarding investigation of injuries of unknown origin. CMS Ex. 9, at 12. I note that Petitioner correctly points out that 42 C.F.R. § 483.13(c) pertains only to policies regarding mistreatment, neglect, abuse, and misappropriation of property, and does not contain any language relating to the development and implementation of policies pertaining to injuries of unknown source:

> The facility must 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).

Petitioner argues that, nevertheless, it did have a policy regarding investigation of injuries of unknown origin that accompanies its abuse policies and procedures, and that it was in place since at least 2009. P. Ex. 19, at 5, 10-11. Petitioner contends further that its staff followed its policy regarding injuries of unknown origin in investigating R1's leg fracture. I find that, as part of its abuse policies and procedures, Petitioner did have a policy in place that addressed unexplained injuries. P. Ex. 19. Based on my conclusion that Petitioner's staff conducted a thorough investigation into R1's leg fracture, there is no basis to conclude that Petitioner failed to follow its abuse policies and procedures with respect to R1. I find that, with respect to R1, Petitioner established by a preponderance of the evidence that it was in compliance with 42 C.F.R. § 483.13(c) (Tag F226).

R2

At the time of the July 29, 2010 survey, R2 was an 82-year-old man who was admitted to the Younger Unit of Petitioner's facility on April 28, 2010.[10] His diagnoses included dementia, senile, hypopotassemia, hypertension, psychosis, anxiety state, generalized pain, and edema. CMS Ex. 9. at 3; see P. Ex. 13, at 1; CMS Ex. 13, at 38.

As stated in the SOD, R2 fell on June 12, 2010. CMS Ex. 9, at 3-4. Petitioner completed an incident/accident report after the incident. The SOD states that the incident report documented that R2 stood up from the dining table, and when a CNA asked him to have a seat, R2 "took a swing" at the CNA, lost his balance and fell, landing on his left side. R2

[10] According to Petitioner, R2 and his wife had been residents of the independent living portion of the complex of which Petitioner's facility is a part. P. Br. at 22.

sustained skin tears to his left elbow and left ear. CMS Ex. 9, at 3-4; P. Ex. 10, at 1; CMS Ex. 13, at 1.

In an initial fall assessment dated June 12, 2010, the nurse described the incident, noted that R2 was not in pain, and stated that he had suffered skin tears to his left forearm and left ear. The assessment indicated that R2's physician was notified. P. Ex. 11, at 1; CMS Ex. 13, at 3.

Petitioner addressed R2's fall in an "immediate needs care plan" dated June 12, 2010. The care plan noted that R2 had a fall resulting in minor injury to his left ear and left elbow. As an intervention, the care plan directed staff to assess for infection, dehydration, constipation, and pain. Other possible interventions were performing neuro checks, checking vital signs, and checking range of motion. P. Ex. 11, at 2; CMS Ex. 13, at 4.

R2 apparently fell again on June 15, 2010. CMS Ex. 9, at 4. Petitioner completed an incident/accident report, which stated that a CNA reported finding R2 sitting on the floor. P. Ex. 10, at 2; CMS Ex. 13, at 2. A nurse assessed R2, and no injuries were observed. The report noted that R2 was examined on June 18, 2010, and he "continues to complain of rt knee pain." Staff wrote that they would continue to monitor R2 as they kept hospice informed of his progress. CMS Ex. 9, at 4; P. Ex. 10, at 2; CMS Ex. 13, at 2.

In an initial fall assessment dated June 15, 2010, at 9:00 p.m., the nurse wrote that she had been informed by the CNA that R2 was sitting on the floor. The nurse assessed R2, found no apparent injuries, and stated that R2 had no complaints of pain or discomfort. The assessment reflected that R2's physician was notified. P. Ex. 11, at 12; CMS Ex. 13, at 14.

Petitioner addressed R2's fall in an "immediate needs care plan" dated June 15, 2010. Staff stated that R2 fell with no apparent injury and that interventions would consist of assessing R2 for orthostatic hypotension and performing a skin assessment. Other possible interventions selected were performing neuro checks, checking vital signs and range of motion, and using hip protectors. P. Ex. 11, at 13; CMS Ex. 13, at 15.

Petitioner's staff also updated R2's care plan on June 15, 2010. The care plan noted that R2 fell on June 12, and that he was at risk for a fall-related injury as evidenced by his wandering/pacing, and his previous fall. Among the interventions put in place were: use fall risk screen to identify risk factors; observe for drug side effects; provide environmental adaptations such as a low bed, adequate glare-free lighting, and area free of clutter; remind R2 to sit on the side of his bed for a few minutes before transferring/standing when rising from a lying position; educate/remind R2 to request assistance prior to ambulation; and provide appropriate footwear. P. Ex. 24, at 11-12; CMS Ex. 13, at 93-94.

R2 apparently fell again a day later, on June 16. In an initial fall assessment dated June 16, 2010, at 11:30 a.m., the nurse wrote that a CNA had notified her that R2 was on the floor of his room. The nurse found R2 sitting on his buttocks in his room. She stated that R2 could not verbalize what happened and that the fall was unwitnessed. R2 had no apparent injuries. P. Ex. 11, at 17; CMS Ex. 13, at 19.

A nursing note dated June 19, 2010 at 1300 (1:00 p.m.), stated that R2 complained of pain in his right leg when turning side to side, and later that day, at 1700 (5:00 p.m.), a nursing note indicated that R2 had signs and symptoms of pain and discomfort to the right knee. CMS Ex. 9, at 4; P. Ex. 12, at 3; CMS Ex. 13, at 28. A nursing note dated June 20, 2010 at 1:00 a.m. stated that R2 continued to complain of right knee pain upon movement. Another note several hours later, at 5:00 a.m., stated that R2 "continues to attempt to get out of the bed but when he moves his right leg, the pain on this right leg discourages him from self- transferring from the bed." CMS Ex. 9, at 4; P. Ex. 12, at 4; CMS Ex. 13, at 29. Another June 20, 2010 nursing note at 9:30 a.m. stated that hospice was obtaining an order for an x-ray. CMS Ex. 9, at 4; P. Ex. 12, at 4; CMS Ex. 13, at 29. The nurse noted that R2 was "moaning in pain." P. Ex. 12, at 4; CMS Ex. 13, at 29. Later that day, a note written at 1300 (1:00 p.m.), stated that R2's right knee x-rays were negative. CMS Ex. 9, at 4; P. Ex. 12, at 5; CMS Ex. 13, at 30; see P. Ex. 17, at 2; CMS Ex. 13, at 83.

Nursing notes from June 20-24, 2010, reflect that R2 received routine and as needed pain medication. CMS Ex. 9, at 4. P. Ex. 12, at 4-8; CMS Ex. 13, at 29-33.

According to a nursing note dated June 24, 2010 at 1300 (1:00 p.m.), R2's son reported that R2 had signs/symptoms of discomfort. A nursing note written at 2000 (8:00 p.m.) stated that an order was obtained for an x-ray of R2's right hip. CMS Ex. 9, at 5; P. Ex. 12, at 8; CMS Ex. 13, at 33. The nurse wrote that R2 was non-weight bearing, and that he complained of pain. R2 had hip protectors in place. P. Ex. 12, at 8; CMS Ex. 13, at 33. The x-rays of R2's right hip showed a "suspected femoral neck fracture" and "advanced osteoarthrosis." P. Ex. 17, at 1; CMS Ex. 13, at 82. On July 13, 2010, R2 had hip x-rays taken again, and the results showed a "right femoral neck fracture with mild displacement." P. Ex. 17, at 3; CMS Ex. 13, at 84.

Petitioner's staff updated R2's care plan on June 24, noting that he had a femoral neck fracture of the right hip. The handwriting on the care plan suggests that R2 had an x-ray on June 20, 2010. But June 20 was the date of his knee x-ray, and so it appears that this entry was an error and should have read June 24, which was the date of his hip x-ray. Under interventions, staff stated that R2 had a new order for no weight bearing. CMS Ex. 9, at 5; P. Ex. 24, at 12; CMS Ex. 13, at 94.

R2's treating physician, Dr. McLarey, who is also Petitioner's hospice physician, examined R2 on July 13, 2010. His progress note stated, among other things, that R2 was experiencing trouble with walking and hip pain, and that a hip x-ray "has shown a probable fracture of his right hip." As part of his assessment, the physician stated that R2 had "[d]ebility with recent fall and fracture of hip, according to x-ray." CMS Ex. 9, at 3; CMS Ex. 13, at 47.

What CMS alleges with respect to R2 is that Petitioner made no attempt "to discover what actions/inactions or other factors may have led to R2's injuries other than the one CNA statement regarding falling at the dining table." CMS Br. at 9; see CMS Ex. 9, at 5. CMS asserts that, in an interview, the DON stated that there was no need to conduct an investigation or report the incidents to the state agency because the facility assumed R2's injury resulted from one of his falls. CMS Br. at 9; see CMS Ex. 9, at 5-6.

Petitioner contends that its staff appropriately assessed R2 as being a fall risk and instituted interventions to reduce his risk of falls. Petitioner asserts that its staff conducted a proper investigation to determine the cause of R2's hip fracture. Petitioner asserts further that because its staff was able to determine the source of R2's hip fracture from its investigation, his injury was not reportable to TDADS as an injury of unknown source. P. Br. at 26.

As I discuss below, I am persuaded that the record shows that Petitioner investigated R2's hip fracture and that it was reasonable for Petitioner's staff to conclude that his broken hip resulted from one of his falls. Therefore, contrary to what CMS argues, Petitioner was not required to report R2's hip fracture to the state agency. It is also evident from the record that Petitioner's staff implemented several interventions to address R2's risk for falls.

It is undisputed that R2 was assessed at high risk for falls. Tr. at 313. 578. The record shows that Petitioner completed a fall risk assessment for R2 when he was admitted on April 28, 2010. P. Ex. 24, at 1-4; CMS Ex. 13, at 85-86. According to the assessment, R2 had a history of falls. He wandered and paced, and had poor safety awareness related to his dementia. P. Ex. 24, at 2. His family stated that R2 had fallen in the last 180 days under unknown circumstances. P. Ex. 24, at 3; CMS Ex. 13, at 85. R2 exhibited the following physical and cognitive limitations: a decline in functional status, impaired hearing and vision, impaired judgment/decision-making, confusion/disorientation at all times, signs of anxiety, lack of familiarity with surroundings, and a decline in cognitive skills. P. Ex. 24, at 3-4; CMS Ex. 13, at 85-86.

In an interdisciplinary care plan progress note dated May 18, 2010, the interdisciplinary care team noted that R2 was a fall risk and listed the following fall interventions: provide redirection when pacing or wandering, monitor for agitation and anxiety; monitor for toileting; and monitor medications for effectiveness and any side effects. P. Ex. 24, at 10.

As stated above, R2 fell in Petitioner's dining room on June 12, 2010. According to Petitioner's incident/accident report, R2 was sitting at the table, stood up, and when the CNA asked him to sit down, he "took a swing" at the CNA, which caused R2 to lose his balance and fall, landing on his left side. P. Ex. 10, at 1; CMS Ex. 13, at 1. The CNA summoned a nurse who assessed R2 and notified his treating physician and his family. R2 sustained skin tears to his left elbow and left ear. P. Ex. 10, at 1; CMS Ex. 13, at 1. According to the fall assessment, R2 had no complaints of pain. Staff initiated "Neuro checks for 72 hours," as well as "72 hours Nursing Notes." P. Ex. 11, at 1; CMS Ex. 13, at 3.

In addition to increasing the level of supervision of R2 following his fall, Petitioner addressed R2's fall in an "immediate needs care plan" dated June 12, 2010. As an intervention, the care plan directed staff to assess for infection, dehydration, constipation, and pain. Other possible interventions were performing neuro checks, checking vital signs, and checking range of motion. P. Ex. 11, at 2; CMS Ex. 13, at 4.

On June 15, 2010, R2 apparently suffered another fall. According to the incident/accident report, a CNA reported finding R2 sitting on the floor. P. Ex. 10, at 2; CMS Ex. 13, at 2. As with R2's earlier fall on June 12, Petitioner's staff responded by completing an "immediate needs care plan" that noted, among other possible interventions, that R2 would have hip protectors. Besides this care plan, Petitioner's staff also updated R2's interdisciplinary care plan on June 15, 2010. On this care plan, Petitioner's staff indicated that the following interventions would be put in place: use fall risk screen to identify risk factors; observe for drug side effects; provide environmental adaptations such as a low bed, adequate glare-free lighting, and area free of clutter; remind R2 to sit on the side of his bed for a few minutes before transferring/standing when rising from a lying position; educate/remind R2 to request assistance prior to ambulation; and provide appropriate footwear. P. Ex. 24, at 11-12; CMS Ex. 13, at 93-94.

The record shows that, on June 16, R2 was again found on the floor of his room. According to the initial fall assessment for this incident, there were no witnesses to his fall and R2 had no apparent injuries. R2 could not verbalize what happened. P. Ex. 11, at 17; CMS Ex. 13, at 19.

Although R2 did not complain of pain following any of his falls on June 12, June 15, or June 16, he began complaining of pain in his right leg and knee a few days later, on June 19, 2010. Petitioner's staff responded by obtaining an order for an x-ray, and the nursing notes reflect that x-rays taken of R2's knee on June 20, 2010, were negative. As noted in the record, R2's treating physician prescribed R2 pain medication. R2 continued to complain of pain, and on June 24, 2010, Petitioner's staff obtained an order for an x-ray of R2's right hip. The x-rays of R2's right hip showed a "suspected femoral neck

fracture" and "advanced osteoarthrosis." P. Ex. 17, at 1; CMS Ex. 13, at 82. On July 13, 2010, another hip x-ray was taken which confirmed the fracture that was suspected on the June 24th x-ray. P. Ex. 17, at 3; CMS Ex. 13, at 84.

Ms. Brooks testified that she interviewed the nurse aide involved in the June 12 dining room incident and also interviewed the nurse aides who were taking care of R2 on June 16. Tr. at 693. According to Ms. Brooks, interventions in place for R2 to minimize his risk for falls consisted of alarms, appropriate shoes or non-skid socks, and hip protectors. Tr. at 696.

DON Cummins testified that after a resident has a fall, Petitioner's staff then follows a protocol whereby that resident is placed on increased monitoring. DON Cummins stated that staff would monitor the resident "every shift for 72 hours" and document this in fall monitoring notes. Tr. at 581; see P. Ex. 11 at 3-6. DON Cummins stated that R2 was placed on increased monitoring after his June 12 fall. Tr. at 581.

DON Cummins testified further that, in investigating R2's hip fracture, she consulted with Dr. Younger, an orthopedic surgeon. Tr. at 592. She said that she had been curious as to why R2 had a hip fracture when he complained of knee pain, and Dr. Younger explained that "dementic patients frequently . . . can't tell you where it hurts, but if they rub their knee they need to – you need to probably x-ray the knee and the hip." Tr. at 591. DON Cummins testified that after talking to Dr. Younger, she concluded that R2's hip fracture was related to his falls. Tr. at 591-92. DON Cummins stated further that the July 13, 2010 progress note by R2's treating physician, Dr. McLarey, also helped to "solidify [her] belief that the fracture came from the falls." Tr. at 596. She stated that she talked to Petitioner's nurses and nurse aides, as well as R2's family, during her investigation. Tr. at 593. According to DON Cummins, her investigation did not reveal any other incidents other than the three fall incidents that staff had documented. Tr. at 596. DON Cummins testified that because she knew what caused R2's hip fracture and had an explanation for it, his injury was not a reportable incident, and this is why Petitioner did not report it to TDADS. Tr. at 593, 598.

The testimony of Administrator Honeyman corroborates DON Cummins's testimony. Ms. Honeyman testified that there was no question in her mind that R2's fracture resulted from his falls. She noted that R2 had a history of falls before he was admitted to Petitioner's facility. Tr. at 798. Ms. Honeyman stated that she consulted with Dr. Younger, and he said that "always, always in the case of young children and non-communicative adults, if they complain of knee and you don't find a problem with the knee, go to the hip." Tr. at 803. She testified that Dr. McLarey's July 13, 2010 progress note also confirmed her belief that Petitioner did not have to report R2's fracture to the state authorities. Tr. at 804. Ms. Honeyman testified that she, Barbara Moore, and DON Cummins all were of the opinion that because they had an explanation of what caused

R2's fracture, the injury did not meet the criteria for reporting to TDADS. Tr. at 804, 806.

I find that, as with the incidents involving R1, Petitioner's staff diligently investigated R2's hip fracture to determine what happened. According to DON Cummins, their investigation turned up no other incidents other than the three fall incidents that staff had documented. As part of the investigation, staff consulted with R2's treating physician, Dr. McLarey, and an orthopedic surgeon, Dr. Younger. Their medical opinions, together with the fact that R2 had a history of falls and had fallen three times over the course of five days, led staff to the reasonable belief that R2's broken hip was caused by one of his falls. Because Petitioner was able to identify an explanation for R2's hip fracture through its investigation, Petitioner did not report his injury to TDADS as an injury of unknown source. I find Petitioner's conclusion that R2's hip fracture was fall-related to be a reasonable explanation and thus I agree with Petitioner that it was not required to report R2's injury to the state agency. The record shows, moreover, that Petitioner appropriately addressed R2's risk for falls by implementing several interventions. I find that, with respect to R2, Petitioner established by a preponderance of the evidence that it was in compliance with 42 C.F.R. § 483.13(c)(2)-(4) (Tag F225).

Further, I find no basis to conclude that Petitioner was not in compliance with 42 C.F.R. § 483.13(c) (Tag F226) with respect to R2 and apply the same reasoning I set forth above in my F226 discussion relating to R1. As I stated above, Petitioner did have a policy in place that addressed unexplained injuries. P. Ex. 19. Based on my conclusion that Petitioner's staff conducted a thorough investigation into R2's hip fracture, there is no basis to conclude that Petitioner failed to follow its abuse policies and procedures with respect to R2. I find that, with respect to R2, Petitioner established by a preponderance of the evidence that it was in compliance with 42 C.F.R. § 483.13(c) (Tag F226).

3. Petitioner was in substantial compliance with the participation requirement at 42 C.F.R. § 483.25(h) (Tag F323) .

The SOD alleges under Tag F323 that Petitioner violated 42 C.F.R. § 483.25(h) because it failed to provide supervision and assistive devices to prevent accidents for R1 and R2, failed to monitor direct care to ensure staff were using proper transfer techniques, and failed to have an ongoing process to evaluate fall hazards and risks. CMS Ex. 9, at 18. As part of this citation, the SOD lists the following examples:

a. Petitioner failed to identify the most effective and safe method to transfer R1, who had a history of falls, fractures, and osteoporosis;
b. Petitioner failed to monitor and supervise direct care staff to ensure that they were competent to employ safe transferring techniques;
c. Petitioner failed to educate/train, and monitor staff for the use of assistive devices, such as gait belts; and

d. Petitioner failed to investigate all injuries or have a process to investigate injuries and failed to have a process to evaluate accident and injury data in order to fully evaluate fall hazards and risks.

CMS Ex. 9, at 18.

Petitioner responds that CMS has not identified any "accident" or "accident hazard" sufficient to support a citation under Tag F323. Petitioner contends that its staff provided proper supervision and assistance devices at all times to R1 and R2, and did not cause either of their fractures. Moreover, Petitioner asserts that its staff properly investigated their injuries. P. Br. at 31, 34.

I note that, under F323, most of the SOD's factual allegations involving R1 and R2 are the same allegations that formed the basis of the alleged deficiencies under Tags F225 and F226 (see *supra*, at 12-26). Therefore, I do not repeat them here. I find that the evidence is sufficient to establish a *prima facie* case of noncompliance under Tag F323, but that Petitioner has overcome CMS's *prima facie* case by a preponderance of the evidence.

R1

With respect to R1, I have already discussed the facts pertaining to this resident in my discussion of Tags F225 and F226 above. Much of my discussion under Tag F323 is based on my previous discussion of R1 under Tags F225 and F226. As I stated above, I found that Petitioner's staff identified R1 as being at high risk for falls (P. Ex. 31, at 11; CMS Ex. 12, at 15) and addressed this risk in her care-planning with appropriate preventive measures.

Moreover, I found that there was no failure by Petitioner's staff to investigate R1's leg fracture. The evidence established that DON Cummins and former Administrator Honeyman carried out a diligent investigation, but were unable to determine what happened or when R1's leg fracture occurred. As DON Cummins testified, they were unable to determine that R1 had ever been dropped or had fallen or that any accident had occurred. Tr. at 544, 561. That Petitioner's staff was unable to determine whether any external trauma had occurred was consistent with R1's x-ray report, which stated that she had suffered a stress fracture. Even though there was nothing to suggest that R1's leg fracture was of a suspicious or truly unknown nature that warranted reporting to the state agency, Petitioner reported R1's injury as an incident of unknown origin "[t]o err on the side of caution." Tr. at 544.

As for CMS's claims that Petitioner's staff failed to identify the most effective and safe way to transfer R1 and failed to monitor transfers, I am persuaded that Petitioner's staff appropriately addressed R1's needs with respect to transfers. CMS argues that R1's care

plan did not have any interventions that addressed R1's transfer needs or methods. See CMS Ex. 9, at 23-24. However, the record indicates otherwise. At the time of R1's admission on April 19, 2010, Petitioner's nursing staff completed a Fall Risk Assessment, which noted, among other things, that R1 had a history of falls, poor balance, an unsteady gait, and poor safety awareness due to her cognitive impairments. P. Ex. 29, at 2. The assessment stated further, "[s]taff will transfer, assist [with] all ADLs. . . . keep w/c close by, lock brakes before transferring. Bed in lowest position. Keep pathways clear and well lit." Further, R1's care plan dated April 19, 2010, under Approaches, explicitly instructed staff to "provide gentle care when assisting resident." P. Ex. 27, at 4. This approach was continued on July 27, 2010. P. Ex. 27, at 4. The instructions and interventions described in these documents are all meant to ensure R1's safety during transfers. It is clear that Petitioner's staff did not take R1's safety or supervision lightly, and sought to keep her environment as free of accident hazards as possible.

There is an allegation in the SOD that the surveyor observed two CNAs transfer R1 from her wheelchair to her bed. According to the SOD, the CNAs did not use a gait belt, and put their arms underneath each of R1's arms, and also grabbed her clothing. The SOD alleges that the CNAs' hands slid up R1's body, moving her skirt around her waist. As R1was released, her skirt was twisted around her waist, exposing her from the waist down. CMS Ex. 9, at 25-26.

In response, Petitioner contends that its aides utilized proper transfer techniques that were consistent with the facility's transfer policy. P. Br. at 35. Petitioner asserts that R1 never fell or had an accident. P. Br. at 32-33. Petitioner contends, moreover, that there is no requirement that a gait belt be used at all times. According to Petitioner, in the absence of a specific order pertaining to transfers (which R1 did not have), its aides have the discretion to determine whether it is safe to transfer a resident with or without a gait belt. P. Br. at 19 n5.

I am persuaded by the testimony of Petitioner's witness, LVN Cara Brooks, who stated that the CNAs are in the best position sometimes to know what a resident needs in terms of transfer because they are with the resident "non-stop day in, day out." Tr. at 697-98. Ms. Brooks testified that, as the charge nurse, she communicates with the CNAs about a resident's transfer needs. Ms. Brooks stated that residents may need one type of transfer in the morning and another type in the evening depending on their physical and mental conditions. Tr. at 698. She stated further that some residents on the Younger unit are frightened of gait belts, and because they have a different perception of reality, may for example perceive a gait belt to be a snake. Tr. at 698. The fact that the CNAs did not use a gait belt when transferring R1 does not constitute proof that they transferred R1 using an improper technique. DON Cummins testified that the CNAs were proficient in transfer techniques because they had all passed a competency exam. Tr. at 603. In light of DON Cummins' testimony and the fact that R1 was not injured or did not suffer any

pain during the transfer, I do not find that improper or unsafe transfer techniques were used with R1.

R2

With respect to R2, I have already discussed the facts pertaining to this resident in my discussion of Tags F225 and F226 above. CMS urges me to find a deficiency under F323 based on the fact that R2 had three fall incidents and sustained a right hip fracture. CMS argues that "Petitioner failed to reevaluate the risks and hazards as to why R2 had fallen and to determine which interventions were not working and what needed to change to prevent future falls . . . Petitioner just assumed that the hip fracture occurred as a result of one of the falls without determining why he was sustaining these falls." CMS Br. at 28.

R2's fall activity and hip fracture, in and of themselves, do not suffice to prove that Petitioner's supervision of R2 was somehow inadequate. As I stated in my discussion under Tags F225 and F226, Petitioner's staff properly investigated R2's hip fracture to determine how it occurred and concluded that his fracture resulted from his recent falls. Although Petitioner's staff could not determine which of R2's three falls caused his fracture, it seems far more likely than not that his injury happened as a result of the dining room fall incident, in which he engaged in combative behavior toward a CNA, lost his balance, and fell on his side. I agree with Petitioner that its staff was not required to report R2's hip fracture to the state agency since a plausible explanation existed for the injury, and no neglect or abuse was involved in the incident.

I thus find no basis to conclude that Petitioner failed to provide supervision and assistive devices to prevent accidents for R2. Petitioner appropriately addressed R2's risk for falls, and provided him with adequate supervision, which included various interventions after his second fall incident. I cannot identify any accident hazards that existed on the dates of his falls, and it is obvious that Petitioner cannot be held responsible for R2's aggressive behavior in the dining room.

With respect to the allegation that there was a failure to educate and train staff in the use of assistive devices, Petitioner asserts that staff education and training do not fall under a Tag F323 citation. Nevertheless, Petitioner contends that it has an aggressive staff training program that deals with topics such as resident transfers, lifting procedures, fall prevention, and resident safety. Inasmuch as Petitioner is correct that the regulation at 42 C.F.R. § 483.25(h) (Tag F323) does not address staff training or competency in using assistive devices, it is unnecessary for me to address CMS's contention.

As for CMS's claim that Petitioner failed to have a process to evaluate accident and injury data, Petitioner contends that this also is not the proper subject matter for a Tag F323 citation. Petitioner asserts, nevertheless, that CMS's contention is incorrect. Petitioner argues that it has produced documentation that shows, among other things, that

it tracks falls by unit (Mabee versus Younger), by hall, and by shift, and whether the fall occurred with an injury or was associated with restraints. P. Br. at 34; P. Ex. 22. According to DON Cummins, Petitioner's staff tracks falls monthly and discusses every fall at their meetings. Tr. at 614. I note that, on cross examination, CMS's surveyor, Ms. Adams, acknowledged that she had seen Petitioner's documentation for tracking falls when she was at the facility and admitted that the documents showed that Petitioner's staff tracked falls in different ways. Tr. at 369-71.

The evidence shows that R1 and R2 were properly supervised, that their fractures did not result from Petitioner's actions or inactions, and that Petitioner's staff properly investigated their injuries. I find that Petitioner established by a preponderance of the evidence that it was in compliance with 42 C.F.R. § 483.25(h) (Tag F323).

4. Petitioner was in substantial compliance with the participation requirement at 42 C.F.R. § 483.75(f) (Tag F498) .

42 C.F.R. § 483.75(f) requires that:

> The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

The SOD alleges under Tag F498 that Petitioner violated 42 C.F.R. § 483.75(f) because it failed to ensure that five nurse aides were able to demonstrate competency in skills and techniques necessary to perform transfers, and cited examples involving R3, R4, and R5:

a. CNAs C and D failed to use a sit-to-stand mechanical lift properly, resulting in R3 hitting his foot on the lift and bearing his weight on his shoulders, putting him at risk for injury;[11]
b. CNA E failed to use proper lifting techniques to gently lift R4 from her chair and jerked her from the chair, and failed to coordinate R5's lift with a lifting partner which resulted in pain for the resident.[12]

Surveyor Adams testified that she observed transfers of R3, R4, and R5, and that she cited a deficiency based on the nurse aides "employing improper lifting techniques,

[11] In the SOD, the first example with CNAs C and D mentions "Resident #2," which appears to be a typographic error since R2 is not one of the three residents involved in this citation. I have therefore substituted "Resident 2" with "R3."

[12] I note that, in discussing this alleged deficiency in its posthearing brief (P. Br. at 35), Petitioner discusses the transfer involving R1; however, the SOD alleges that Petitioner's CNAs employed improper transfer techniques with respect to only R3, R4, and R5. Therefore, I do not discuss the transfer involving R1 under this deficiency tag.

transfer techniques." Tr. at 230. With respect to R3, Surveyor Adams stated that his private sitter expressed concerns to her about how staff handled him during transfers. Tr. at 230-31. Surveyor Adams testified that she observed CNAs C and D improperly using a "sit-to-stand lift device" called a SARA lift when they transferred R3. Tr. 231, 234. According to Surveyor Adams, R3's feet have to be placed on the base of the device, and the CNAs "kind of hit his foot on the bottom of the device, and he kind of hollered out." Surveyor Adams stated that the CNAs put a sheepskin strap around R3's back and then proceed to lift him with the device. Surveyor Adams stated that "they lifted him pretty fast" and in the process, the strap slid up his body and R3 "dropped his weight onto the strap and sort of hung from the strap." She stated that the CNAs did not readjust R3 and lowered him to the bed, and R3 "just fell back onto the bed" because neither of the CNAs helped guide him down. Tr. at 321-32. In Surveyor Adams' opinion, this was an inappropriate transfer because R3's hanging from the strap placed him at risk for a "soft tissue or bone injury in the shoulder" and the failure to guide his release put him at risk for falling off the bed. Tr. at 232, 234-35.

With respect to R4's transfer, Surveyor Adams testified that R4 was seated in a wheelchair and CNA E transferred her from her wheelchair to a stationary chair. She stated that the CNA properly applied the gait belt, but the CNA reached around her back and jerked her up from the seated position to a standing position. Tr. at 233, 235. As for R5, Surveyor Adams testified that CNA E and LVN A transferred R5 from a chair to a wheelchair. She stated that the CNA properly applied the gait belt, but the CNA "jerked her up." According to Surveyor Adams, there was no coordination between the CNA and the LVN, and the CNA "did most of the work." Tr. at 234. She said that R5 "was hollering" but she didn't know if it was from pain or fear. Tr. at 234.

Petitioner disputes whether the surveyor actually observed any CNAs performing transfers and contends that the surveyor's observations are unreliable. P. Br. at 37-38. With respect to R3, Petitioner argues that the surveyor did not personally observe any of the incidents that were conveyed by R3's private sitter, so relying on those alleged incidents as the basis for a deficiency is improper. P. Br. at 35-36. Petitioner contends that there is no evidence that the CNAs did anything wrong when they transferred R3 with the SARA lift. Petitioner contends further that the surveyor improperly relied on comments and noises made by the Resident in describing the resident as frightened. P. Br. at 35-36. With respect to R4, Petitioner contends that the CNA in question did not jerk R4 when executing the transfer. Petitioner claims that there is no basis on which to conclude that the transfer was painful to R4. P. Br. at 36. With respect to R5, Petitioner disputes that there was a lack of coordination between the CNA and LVN when they transferred her, arguing that R5 "was not a two person transfer." Petitioner claims that there is no evidence that the transfer caused any pain to R5. P. Br. at 36-37.

Petitioner has not offered any evidence that directly rebuts Surveyor Adams' testimony relating to her personal observations of the resident transfers. Petitioner instead offered

the testimony of DON Cummins, who stated that each of the CNAs in question under Tag F498 had passed a competency exam that tested, among other things, their proficiency in transfer techniques. Tr. at 603.

Based on Surveyor Adams' testimony, it appears that R3, R4, and R5 were "mishandled" by the CNAs during their transfers. However, I find DON Cummins to be credible and accept her testimony that the CNAs possessed competent skills in the area of transfers. I note also that there is no allegation by CMS that any of these residents suffered pain or injury during the transfers. In fact, Surveyor Adams admitted on cross-examination that during the survey, she never saw any resident dropped during a transfer. Tr. at 373. Given the fact that R3, R4, and R5 did not suffer any harm or pain, I find that any mishandling by the CNAs that may have occurred during their transfers did not pose a risk for more than minimal harm. Therefore, I conclude that Petitioner was not out of compliance with 42 C.F.R. § 483.75(f).

5. Petitioner was in substantial compliance with the participation requirement at 42 C.F.R. § 483.13(c) (Tag F226) .

October 4, 2010 survey

The SOD dated October 4, 2010, alleges that Petitioner violated the Medicare participation requirement at 42 C.F.R. § 483.13(c) (Tag F226). As I have discussed above, the regulation at 42 C.F.R. § 483.13(c) requires 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).

With respect to this citation, the SOD alleges that, based on interview and record review, Petitioner failed to follow its own abuse policy by not obtaining a written statement from an alleged perpetrator, CNA A, who became the subject of an extremely vague accusation of abuse by R1.

According to the SOD, Petitioner documented an incident of alleged abuse in a Provider Investigation Report dated September 2, 2010. The report stated that R1 claimed that a CNA (CNA A) hit her on the hand during her shower. R1 could not recall when it happened and could not describe how the CNA struck her. R1's allegation remained consistent on her second interview. The report describes R1's injury as "very small, light bruise to back of hand – no swelling." According to the report, both charge nurses on duty assessed R1 for signs of physical abuse and noted two small light bruises to the back side of her right hand. The report states that "[t]he alleged perpetrator was released from duty pending the outcome of the investigation. The Administrator went to the facility to gather the necessary statements and to begin the investigation. The doctor was notified by phone." CMS Ex. 16, at 2; P. Ex. 36, at 1-3; CMS Ex. 19, at 2-4.

Administrator Honeyman wrote an Investigation Summary. CMS Ex. 19, at 5-7. Ms. Honeyman stated that R1was severely impaired cognitively, suffered from delusions, had a diagnosis of Alzheimer's disease, was confused to place and time, and had daily episodes of disorientation. CMS Ex.16, at 3; P. Ex. 36, at 4; CMS Ex. 19, at 5. She stated that "[a]ll of the charge nurses, most of the CNA's on the unit and the ADON were interviewed . . . None of them could recall or report any incident of mistreatment by [CNA A]." CMS Ex. 16, at 3; P. Ex. 36, at 4-5; CMS Ex. 19, at 5-6. According to Ms. Honeyman, many of the staff said that R1 had "accused them of things that weren't true." Ms. Honeyman noted that she attempted to interview other residents regarding the work habits and treatment rendered by CNA A, but there were no reliable historians since all are "mid-to-late stage dementia patients." CMS Ex. 16, at 4; P. Ex. 36, at 5; CMS Ex. 19, at 6. She interviewed R1's responsible party/Power of Attorney (who was a relative and was the one who had reported the alleged abuse), who stated that "she knows that [R1] believes a lot of things that are not true." When Ms. Honeyman interviewed R1, R1 told her the bruise on her hand happened when "Betty Black" hit her during her shower. Ms. Honeyman stated that R1could not say when the shower occurred or how "Betty Black" had hit her. She noted that R1 also mentioned someone named "Etta," but there was no one named Etta employed by the facility. CMS Ex. 16, at 4; P. Ex. 36, at 6; CMS Ex. 19, at 7.

The SOD references Petitioner's Abuse Prevention policy and procedure dated September 1, 1999 (revised on November 9, 2007), and noted that, with respect to investigating, that policy reads: "All allegations will be investigated by the Administrator and/or Department Head. . . . Accused abusers will write their own statement as close to the report as possible and before being walked off the campus. It will be completed by the interviewing team." CMS Ex. 16, at 2; CMS Ex. 14, at 3. The SOD states that Petitioner's policy was signed by the Administrator, who is Petitioner's Abuse Prevention Coordinator. CMS Ex. 16, at 2; CMS Ex. 14, at 3.

Petitioner points out that the regulation associated with Tag F226 is 42 C.F.R. § 483.13(c), which requires a facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Thus, according to Petitioner, CMS's allegation that it failed to thoroughly investigate an allegation of abuse cannot be cited under Tag F226. Petitioner contends further that even if CMS relied on the proper tag, the evidence shows that Petitioner did thoroughly investigate the incident involving R1 and the CNA, and that Petitioner did develop and implement its abuse prohibition policies. Petitioner asserts that it conducted the abuse investigation in accordance with the version of its facility policy in effect at the time. P. Br. at 42.

Apparently, at the survey, Petitioner's DON or someone on staff mistakenly gave the surveyor a 2007 facility policy on abuse investigation that was not the most recent policy in effect at the time of the survey. P. Ex. 34; P. Br. at 41-42. Petitioner's 2007 policy

required that, in investigations of possible abuse, a written statement be obtained from the alleged perpetrator prior to the perpetrator being suspended from duty. P. Br. at 41. Petitioner contends that its current policy, revised in December 2009, does not require a written statement from the alleged perpetrator. Thus, Petitioner argues that the fact that its management did not obtain a written statement from CNA A, the alleged perpetrator accused of abusing R1, conforms to its applicable policy and does not constitute a failure to thoroughly investigate the alleged abuse.

In examining the incident of alleged abuse involving CNA A and R1, it is important to consider that R1 gave very incomplete – and perhaps inaccurate – information when making her accusation. The record shows that R1 told her responsible party/power of attorney (who was R1's relative) that a CNA had hit her on the hand during her shower. R1 stated the CNA was "Betty Black."[13] Both Administrator Honeyman and DON Cummins testified that there is no person named "Betty Black" working at Petitioner's facility, but there is an African-American aide named Betty Medlock who occasionally cares for R1. Tr. at 605-06; 755-56. Based on this, they determined that the CNA to whom R1 was referring was perhaps Betty Medlock. Tr. at 606. The charge nurses Cara Brooks and Erica Ortiz then interviewed Ms. Medlock, who denied the allegation. Tr. at 606. 686-87, 730-31, 782. According to Ms. Brooks, they did not take a written statement from Ms. Medlock. Tr. at 689-90. Administrator Honeyman ordered that Ms. Medlock be sent home pending the outcome of the facility's investigation of the alleged abuse. Tr. at 688, 731, 756. Petitioner reported the incident to the state agency. Tr. at 757-58; P. Ex. 36, at 1-3; CMS Ex. 19, at 2-4. Petitioner's investigation determined that the allegation was unfounded and Ms. Medlock returned to the facility after being out three days. Tr. at 734.

I find that Petitioner's staff responded to R1's allegation of abuse by doing the best it could be expected to do under the circumstances. It should be understood that R1's physical and cognitive deficits left her allegation uncertain for two fundamental reasons: not only was R1unable to identify the subject CNA in any useful way, but her very claim that an act of abuse had occurred was open to some question. Nevertheless, the record shows that Administrator Honeyman, DON Cummins, and the nursing staff took R1's allegation seriously and conducted a thorough investigation. By temporarily suspending Betty Medlock, and then diligently attempting to determine what might have actually happened, Petitioner's staff went well beyond the need to get a written statement from Ms. Medlock, who was never actually identified as the person to whom R1 referred. I

[13] Petitioner's witness, LVN Cara Brooks, who was R1's charge nurse at the time, testified that R1's power of attorney stated that R1 had also mentioned another person named "Etta." Ms. Brooks testified that there is no one named Etta on Petitioner's staff. Tr. at 683-84.

find that Petitioner established by a preponderance of the evidence that it was in compliance with 42 C.F.R. § 483.13(c) (Tag F226).

6. CMP's of $600 and $150 per day respectively, are unreasonable based on the facts of this case as there are no violations and therefore no basis for the imposition of CMP's.

The remedy determinations made by CMS in this case are premised on the findings of noncompliance made during the three surveys. I have found that Petitioner was in compliance with applicable participation requirements. Consequently, there is no basis for CMS to impose remedies against Petitioner.

V. Conclusion

For the reasons set forth above, I conclude that Petitioner was in substantial compliance with Medicare participation requirements at issue in this case, and therefore, no enforcement remedy may be imposed by CMS.

/s/
Richard J. Smith
Administrative Law Judge