Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
NHC Healthcare Athens,	)	Date: December 3, 2008
(CCN: 44-5099),	)	
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-08-152
	)	Decision No. CR1870
Centers for Medicare & Medicaid	)	
Services,	)	
	)	

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose a civil money penalty (CMP) of $800 per day against NHC Healthcare Athens (Petitioner or facility) for failure to comply substantially with federal requirements governing participation of long-term care facilities in Medicare and State Medicaid programs. I do not find reasonable CMS's determination to impose a CMP of $800 per day effective May 30, 2007 through October 11, 2007, but do find reasonable the imposition of the CMP for the period of June 5, 2007 through October 11, 2007.

I. BACKGROUND

This case is before me pursuant to a request for hearing filed by Petitioner dated November 27, 2007. Petitioner is a long-term care provider located in Athens, Tennessee that participates as a skilled nursing facility in the Medicare and State Medicaid programs.

The Tennessee Department of Health (State survey agency) concluded a complaint investigation and recertification survey of Petitioner's facility on September 28, 2007, finding that Petitioner was not in substantial compliance with federal Medicare requirements for nursing home participation. A Statement of Deficiencies (SOD) was issued to Petitioner with the date September 28, 2007.

By letter dated October 5, 2007, CMS informed Petitioner that based on the findings of the September 28 survey, it was imposing the following remedies:

- CMP in the amount of $800 per day effective May 30, 2007;
- Denial of Payment for New Admissions (DPNA), to become effective December 28, 2007; and
- Termination of the provider agreement, effective March 28, 2008.[1]

Petitioner timely requested a hearing before an administrative law judge (ALJ) indicating that it was challenging: the deficiency findings at 42 C.F.R. §§ 483.10(b)(11) (Tag F157), 483.25 (Tag F309), and 483.25(h) (Tag F323);[2] the findings and conclusions of the tags; the scope and severity of the deficiencies; and the reasonableness of the CMP. *See* Petitioner's Request for Hearing.[3]

The request for hearing was received in the Civil Remedies Division (CRD) of the Departmental Appeals Board (DAB or the Board) on December 3, 2007. The case was assigned to me on December 11, 2007 for hearing and a decision. On December 11,

---

[1] Petitioner came into substantial compliance on October 12, 2007; therefore, the DPNA penalty and termination were not effectuated. CMS Ex. 18.

[2] This is a "Tag" designation as used in the State Operations Manual (SOM), Appendix PP – Guidance to Surveyors for Long Term Care Facilities. The "Tag" refers to the specific regulatory provision allegedly violated and CMS's guidance to surveyors. Although the SOM does not have the force and effect of law, the provisions of the Social Security Act and regulations, if interpreted clearly, do have such force and effect. *State of Indiana by the Indiana Department of Public Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991); *Northwest Tissue Center v. Shalala*, 1 F.3d 522 (7th Cir. 1993). Thus, while the Secretary of Health and Human Services (Secretary) may not seek to enforce the provisions of the SOM, he may seek to enforce the provisions of the Act or regulations as interpreted by the SOM. The SOM is available on CMS's public website at http://www.cms.hhs.gov/Manuals/IOM/list.asp.

[3] Petitioner challenges three of the nine deficiency findings from the September 28, 2007 survey. P. Br. at 1. As a threshold matter, my review is limited to those issues that Petitioner has appealed and over which I have jurisdiction. Inasmuch as Petitioner does not challenge all the deficiencies cited in the September 28, 2007 SOD, those findings and remedies remain uncontested and are therefore final and binding against Petitioner. 42 C.F.R. § 498.20(b).

2007, I issued an initial prehearing order to the parties providing instructions on how to file their written submissions in preparation for an evidentiary hearing On June 25, 2008, Petitioner filed a Waiver of Right to Appear and Present Evidence asking that this matter be decided on the parties' written submissions. There being no objection to the request, Petitioner's waiver of oral hearing was granted and a briefing schedule was issued to the parties on July 1, 2008. The parties were also provided the opportunity to supplement their prehearing exchanges. *See* Order (July 1, 2008); 42 C.F.R. § 498.66 (waiver of right to appear and present evidence).

Pursuant to agreement of the parties and my July 1, 2008 Order, the parties filed additional briefs. CMS filed its brief (CMS Br.) on July 31, 2008, and Petitioner filed its brief (P. Br.) on August 28, 2008. Neither party opted to supplement its initial prehearing exchange and the record in this matter was closed on September 4, 2008. CMS offered 41 exhibits, identified as CMS Exs. 1-41. Petitioner offered 13 exhibits, identified as P. Exs. 1-13. In the absence of any objections, I admit CMS Exs. 1-41 and P. Exs. 1-13.

Based on the documentary evidence, the arguments of the parties, and the applicable law and regulations, I find that Petitioner was not in substantial compliance on the dates determined by the State survey agency and CMS. I further find that CMS was authorized to impose a CMP in the sum of $800 per day for the violation.

II. APPLICABLE LAW AND REGULATIONS

Petitioner is considered a long-term care facility under the Act and regulations promulgated by the Secretary. The statutory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Act, and at Title 42 C.F.R. Parts 483 and 488.

Sections 1819 and 1919 of the Act invest in the Secretary authority to impose CMPs and DPNAs against a long-term care facility for failure to comply substantially with participation requirements.

Pursuant to the Act, 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. The regulations at 42 C.F.R. Part 483 provide that facilities which participate in Medicare may be surveyed on behalf of CMS by State survey agencies in order to ascertain whether the facilities are complying substantially with participation requirements. 42 C.F.R. §§ 488.10-488.28. The regulations contain special survey conditions for long-term care facilities. 42 C.F.R. §§ 488.300-488.335. Under Part 488, a State or CMS may impose a CMP against a long-term care facility where a State survey agency ascertains that the facility is not complying substantially with participation requirements. 42 C.F.R. §§ 488.406, 488.408, 488.430. The CMP may

start accruing as early as the date the facility was first out of compliance through to either the date substantial compliance is achieved or the facility's provider agreement is terminated. 42 C.F.R. § 488.408.

CMS may impose a CMP for either the number of days a facility is not in substantial compliance with one or more participation requirements or for each instance that a facility is not in substantial compliance, regardless of whether or not the deficiencies constitute immediate jeopardy. 42 C.F.R. § 488.430(a). Thus, CMS may impose a per instance CMP ranging from $1000 to $10,000 for an instance of noncompliance regardless of whether the deficiency is at the immediate jeopardy level. 42 C.F.R. § 488.438(a)(2).

The regulations define the term "substantial compliance" to mean:

> [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.

"Substandard quality of care" is defined to mean:

> [O]ne or more deficiencies related to participation requirements under § 483.13, Resident behavior and facility practices, § 483.15, Quality of life, or § 483.25, Quality of care of this chapter, which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm

42 C.F.R. § 488.301.

Substantial noncompliance that is "immediate jeopardy" is defined as "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.

In determining the amount of the CMP, the following factors, specified at 42 C.F.R. § 488.438(f), must be considered:

1. the facility's history of noncompliance, including repeated deficiencies;
2. the facility's financial condition;
3. the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404; and
4. the facility's degree of culpability.

In a CMP case, CMS must make a prima facie case that the facility has failed to comply substantially with participation requirements. To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd, Hillman Rehabilitation Center v. U.S. Dept. of Health and Human Services*, No. 98-3789 (GEB) slip op. at 25 (D.N.J. May 13, 1999).

The Act and regulations make a hearing available before an ALJ to a long-term care facility against whom CMS has determined to impose a CMP. Act § 1128A(c)(2); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a de novo proceeding. *Anesthesiologists Affiliated, et al*, 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); *see also* 42 C.F.R. §§ 488.330(e) and 498.3. However, the choice of remedies by CMS or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge would affect the range of the CMP that could be collected by CMS or impact upon the facility's nurse aide training program. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i). CMS's determination as to the level of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2); *Woodstock Care Center*, DAB No. 1726, at 9, 38 (2000), *aff'd, Woodstock Care Center v. Thompson*, 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). While an ALJ may not review the CMS scope and severity determination, the Board has recognized that an ALJ must determine whether a deficiency poses "no greater risk to resident health or safety than the potential for causing minimal harm," which is the regulatory definition of substantial compliance under 42 C.F.R. § 488.301; *Beechwood Sanitarium*, DAB No. 1906, at 36-37 (2004). Review of a CMP by an ALJ is governed by 42 C.F.R. § 488.438(e).

III. ISSUES

The issues in this case are:

A. Whether the facility was complying substantially with federal participation requirements on the dates CMS determined to impose a CMP; and

B. Whether the amount of the penalty imposed by CMS of $800 per day is reasonable, if noncompliance is established.

IV. FINDINGS AND DISCUSSION

The findings of fact and conclusions of law (Findings) noted below in italics are followed by a discussion of each finding.

A. Petitioner was not in substantial compliance with federal participation requirements.

1. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.10(b)(11) (Tag F157) during the September 28, 2007 survey.

The applicable regulation at 42 C.F.R. § 483.10(b)(11) titled "Notice of changes" provides that a facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident resulting in injury, a significant change in the resident's status, a need to alter treatment significantly, or a decision to transfer or discharge the resident from the facility.

The surveyors allege in the SOD that Petitioner failed to comply with this provision when facility staff did not notify Resident 9's physician of her complaints of increased pain and swelling after she fell on May 30, 2007, and after the resident's family requested an additional x-ray to be taken. CMS Ex. 6, at 1-2; CMS Br. at 7.

Resident 9, a 91-year-old female at the time of the survey, was admitted to Petitioner's facility on December 4, 1998, with diagnoses of urinary tract infection, schizophrenia, osteoporosis, osteoarthritis, gastritis, unsteady gait, and cataracts. P. Ex. 7, at 1. Nursing reports in the resident's clinical record covering the period from 1998 to 2005 indicate that she experienced chronic pain due to both osteoarthritis and osteoporosis for which she received pain medications. P. Ex. 7, at 2-12; P. Ex. 9, at 1-16. The resident's minimum data set (MDS) assessment dated April 10, 2007, notes the resident as having severely impaired cognitive skills, with long and short term memory impairment. CMS Ex. 29, at 60. The MDS further notes that Resident 9 was totally dependent on staff for personal hygiene, and required two-person physical assistance with bed mobility and transfers. *Id.* at 61. The resident's care plan dated April 19, 2007, lists pain as the number one priority problem for the resident due to degenerative joint disease, osteoarthritis, and osteoporosis – with the need for narcotic analgesics for relief. *Id.* at 39; P. Ex. 8, at 1. Her care plan also indicates that she had a history of falls, and interventions listed include "[m]onitor for s/s [signs and symptoms] of pain and notify MD of need for alterations in medications." CMS Ex. 29, at 46-47.

On May 30, 2007, Resident 9 experienced an unwitnessed fall in her room. CMS Ex. 29, at 58. The resident was found lying on her left side with her left arm under her. *Id.* She sustained injuries which included a large dark blue raised contusion above her left eye, a small bruise on top of her left wrist, and a 3 cm x 3 cm skin tear (location of the skin tear is not specified in the report). *Id.* The resident's clinical record also notes that the resident was unable to perform range of motion to her left arm, left shoulder, left hip, and left leg. *Id.*

The record reflects that when the resident's grandson was called regarding Resident 9's accident, he said he felt like "she needed x-rays now instead of tomorrow." CMS Ex. 29, at 58. The record further reflects that the physician was still at the facility and staff notified the physician of the grandson's concerns. *Id.* at 59. The record also reflects the physician's response: "[S]he states that there is no radiologist to read them tonight and even if they were taken tonight they would not be read until the AM." *Id.* at 59.[4] The medication administration record reveals that Resident 9 received an injection of Demerol on May 30, 2007 at 6:15 PM, and on May 31, 2007 at 8:00 AM. X-rays were ordered for the following morning. *Id.* at 29, 31, 34, 58.

The resident's clinical record notes facility staff promptly notified both the physician and the resident's family. The fall incident is reported to have occurred at 5:30 PM on May 30, the resident's physician was notified at 6:00 PM that day and the resident's grandson was notified at 6:30 PM that day. CMS Ex. 29, at 58. The resident's physician had an opportunity to examine Resident 9 the same day and ordered pain medication. *Id.* On May 31, 2007, the resident had x-rays of her left pelvis, left humerus, left wrist, facial bones, and left femur, and no apparent fractures were noted. *Id.* at 51-53. The x-ray report dated May 31, noted "intact severely osteopenic pelvis and left hip." *Id.* at 51.

On June 1, 2007, the resident's family requested that the x-rays be rechecked as Resident 9 was complaining of pain in her pelvic area. CMS Ex. 29, at 7. Routine morphine is noted as being given. *Id.* However, the clinical record does not note that the physician was notified of the family's request for another x-ray. Nursing notes from June 1, and June 2 through June 4, 2007 reveal that the resident complained intermittently of general discomfort and, at times, of severe pain in her left hip:

> 1. On June 1, 2007 at 6:00 PM, general discomfort is noted with the resident and medication is given. Later that day, at 10:05 PM, family reports that the resident's

---

[4] The attending physician, Dr. Vickie A. Turnbough, states in an affidavit dated May 12, 2008: "I ordered that the Resident be transported to the hospital for x-rays in the morning because I knew there was no radiologist present to review the x-rays that evening." *See* P. Ex. 5, ¶9 (Affidavit of Vickie A. Turnbough, M.D.).

pelvic area is hurting, and the note states "[r]outine morphine given." CMS Ex. 29, at 7.

2. On June 2, 2007 at 2:20 AM, Resident 9 is noted as "resting quietly in bed [with] eyes close. Will continue to monitor." CMS Ex. 29, at 7. Later that day, at 12:20 PM, the resident is noted as having "[increased] pain left side." *Id.* at 8. Tylenol 500 was administered for increased pain. *Id.* At 10:10 PM the resident was repositioned by staff for pain management and safety - there is no note of reported discomfort. *Id.* at 8.

3. On June 3, 2007 at 6:50 PM, Resident 9 is noted as "yelling in pain . . . [complained of] severe pain in left hip . . . gave pain med . . . adjusted position in bed." Later that day, at 8:20 PM, staff paged the physician due to Resident 9's stating "hurts real bad." The note further states "yelling constantly, for med for pain . . . physician did not return page." CMS Ex. 29, at 10.

4. On June 4, 2007 at 12:15 AM, Resident 9 is reported as "[c]ontinues to have bruising and pain [left] side;" the nursing note, recorded at 4:05 AM, reports "[h]as been quiet . . . [and] up;" and at 5:50 AM Resident 9 is reported as "[i]n good spirits, laughing + cooperative." CMS Ex. 29, at 10.

5. On June 5, 2007 at 2:00 PM, the note reveals Resident 9 as having an elevated temperature (100.8), heart rate, and respiration. The note further reveals that the resident's physician was contacted and a urinalysis with culture and sensitivity test was ordered. CMS Ex. 29, at 9. At 10:20 PM that same day, staff attempted to lift Resident 9's left leg to catheterize the resident for a urine specimen, and she is noted as having cried out when her left leg was moved – her left hip joint area was noted as swollen and warm to the touch. *Id.*

6. On June 6, 2007 at 2:05 AM, there is no noted change with the resident; the nursing note indicates that staff will continue to monitor the resident (CMS Ex. 29, at 9); and at 7:45 AM, the physician was called regarding the resident's complaint of increased pain and swelling of her left hip, and an order was given to send Resident 9 to the emergency room for further evaluation. *Id.*

An x-ray was taken of the resident's pelvis and left hip on June 6, 2007, and the x-ray report shows "[a]cute comminuted intertrochanteric fracture of the left femur and mild varus deformity in this patient with history of re-injury." CMS Ex. 29, at 57. The radiologist compared the June 6 x-ray to the May 31 x-ray and noted that "[n]o fracture can be seen in the left femur on the previous radiographs even in review." *Id.*

According to the SOD, on September 26, 2007 the surveyors met with the facility's Resident Care Coordinator who confirmed that Resident 9's physician was not notified of the family's request for another x-ray until June 6, 2007, and according to the SOD, the coordinator also verified that Resident 9 continued to complain of pain and yell out in pain from May 30 through June 6, 2007. CMS Ex. 6, at 5.

It is clear from the record that when Resident 9 sustained her injury on May 30, staff immediately consulted with the resident's physician and provided proper notice to the resident's family in accordance with the regulatory requirement. Those events are not in dispute. Rather, CMS contends that facility staff's failure on June 5, 2007 to immediately notify the resident's physician of her change in status is a violation of the regulatory requirement of 42 C.F.R. § 483.10(b)(11). The resident's clinical record shows that on June 5, 2007 at 10:20 PM staff were unable to catheterize Resident 9. When they attempted to lift her left leg for a urine specimen the resident cried out in discomfort. Staff also noted that her left hip joint area was swollen and warm to the touch. The surveyors determined this to be a significant change in Resident 9's status which warranted immediate notification of the resident's physician.

Petitioner admits that staff did not immediately notify the physician, and that the physician was not contacted by staff until June 6, 2007 at 7:45 AM. P. Br. at 9. Petitioner claims that facility nursing staff used professional judgment in determining that there was no significant change in Resident 9's status based on her chronic issue with pain. In this regard, Petitioner maintains that x-rays indicated there was no demonstrated fracture as a result of the May 30-fall. *Id.* at 8. Petitioner also asserts that, according to Resident 9's physician, the resident experienced no significant pain or additional harm as a result of the alleged delay in notification. *Id.* at 9. In a sworn statement dated May 12, 2008, Dr. Turnbough states that she has been Resident 9's treating physician since prior to her 1998 admission, and "[t]he Resident's pain behavior from May 30 through the night of June 5 was not out of the ordinary, nor was it unexpected given the blunt trauma experienced on May 30." P. Ex. 5, ¶11. Furthermore, she states that she "would not have expected to be notified of the Resident's pain behaviors." *Id.* She adds that even if she had been notified of the Resident's condition on the night of June 5, she would not have ordered further x-rays given the previous x-ray findings and the Resident's customary complaints of pain. *Id.* ¶12. Dr. Turnbough also states that she would not have ordered any intervention that night, including any additional pain medication, for the temporary exacerbation of pain when the leg was moved, as the Resident was already receiving sufficient pain medication and was achieving adequate pain control. *Id.* ¶13. Lastly, she contends that "[t]he Resident experienced no significant additional pain or harm between 10:20 PM on June 5 and the next morning when I was notified of the Resident's condition." *Id.* ¶14.

Petitioner characterizes Resident 9's complaints of increased pain and staff assessment of increased swelling as a clinical complication. Petitioner also claims that even if I determine there was a slight delay in physician notification, there was no identifiable consequence to the resident according to the attending physician. As a result, the severity level of the deficiency should be reduced. P. Ex. 5, at 13, 14; P. Br. at 20. The surveyors determined that Petitioner's noncompliance was at a scope and severity level of "G," representing actual harm that is not immediate jeopardy. CMS Ex. 6, at 1.

What is at issue here is the time period in which a facility must notify the physician of the resident's status (i.e. "immediately") as well as what constitutes "significant change" in a resident's status. The regulation defines the term "significant change" in a resident's status to mean "a deterioration in health, mental, or psychosocial status in *either* life-threatening conditions *or* clinical complications." 42 C.F.R. § 483.10(b)(11)(i)(B) (emphasis added). CMS's official interpretation of the regulation, set forth in the SOM and discussed similarly in the preamble to the regulation, reads:

> For purposes of § 483.10(b)(11)(i)(B), life-threatening conditions are such things as a heart attack or stroke. Clinical complications are such things as development of a stage II pressure sore, onset or recurrent period of delirium, recurrent urinary tract infection, or onset of depression. A need to alter treatment "significantly" means a need to stop a form of treatment because of adverse consequences (e.g. an adverse drug reaction), or commence a new form of treatment to deal with a problem (e.g., the use of any medical procedure, or therapy that has not been used on that resident before.).

See SOM, Appendix PP, "Survey Protocol for Long-term Care Facilities," Tag 157; *see also* 56 Fed. Reg. at 48,833 (Sept. 24, 1991).

The regulation does not limit the term "significant change in . . . status" to mean only a "life threatening condition," nor does it equate the term "significant change" with "medical emergency." Rather, the regulation directs a facility to consult with the physician immediately, not only where a resident's "significant change" is in a "life-threatening" condition, but also when the change involves non-emergency clinical complications such as a need to alter treatment significantly. In its preamble to the 1991 final rule, CMS stated: "We are clarifying the wording of this provision to indicate that in all cases, whether or not there is a medical emergency, the facility must notify the resident; his or her physician; and any legally-appointed representative or an interested family member, if

known." 56 Fed. Reg. 48,826, 48,832-33 (1991).[5] It is important to recognize that CMS did not restrict the immediate notification requirement to situations involving life-threatening emergencies. Rather, the requirement applies to each type of circumstance wherein the physician is to be consulted.

Petitioner relies on the Board's decision in *Park Manor* to support its assertions. In *Park Manor,* the Board ruled that the facility was in substantial compliance when, after the facility's initial consultation with the resident's physician regarding symptoms of a urinary tract infection, the facility failed to contact the physician over the next few days as to the resident's reduction in oxygen saturation, decreased ability to ambulate, unresponsiveness, and a mottling of the lower extremities. The Board further noted that "judgment must be used in determining whether a change in the resident's condition is significant enough to warrant notification." *Park Manor Nursing Home*, DAB 1926, at 7 (2004). Petitioner points out that in *Park Manor*, the resident's record established that some of the symptoms cited by CMS to establish a "significant change" had already appeared before physician notification, and other symptoms were consistent with the resident's overall condition. P. Br. at 7, citing *Park Manor* at 8. Petitioner analogizes the facts in *Park Manor* to the case at hand and argues that with Resident 9, there was not a "significant change" requiring notification of her attending physician as there was "no new pain or pain behavior that would be inconsistent with the patient's overall chronic condition and having sustained recent blunt trauma." *Id.* at 7-8. I construe Petitioner's reliance on *Park Manor* as a professional nursing judgment argument advanced by facility staff as to whether Resident 9 was exhibiting "new pain or pain behavior."

The preamble as well as prior Board decisions have addressed the role of professional nursing judgment under the notification of changes regulation. Specifically, CMS stated in the preamble:

> We recognize that *judgment must be used* in determining whether a change in the resident's condition is significant enough to warrant notification, and accept the comment that only those injuries which have the *potential for needing physician intervention* must be reported to the physician.

56 Fed. Reg. at 48,833 (1991) (emphasis added).

---

[5] The February 1989 draft of the rule originally gave a facility "up to 24 hours in which to notify the resident's physician and the legal representative or family." Several commentators objected to the 24-hour period, stating that "a resident could be dead or beyond recovery in that time . . . ." In response, CMS stated: "We agree and have amended the regulation to require that the physician and legal representative or family be notified immediately." *See* 54 Fed. Reg. 5316 (Feb. 2, 1989).

Additionally, the Board has previously noted that "[t]he regulatory history acknowledges that nursing judgment may be involved in evaluating what is significant for a particular resident . . . and supports a conclusion that the potential need for physician intervention is a factor in whether notice is required." *Park Manor Nursing Home*, DAB No. 2005, at 29 (2005); *aff'd, Park Manor Ltd. v. HHS*; 495 F.3d 433 (7th Cir. 2007).

Petitioner avers that the resident's signs and complaints of pain on June 5 were not indicative of a significant change in her status, but rather, were consistent with her history of chronic pain. However, the record does not support Petitioner's assertions. On June 5 at 2:00 PM, the record establishes that Resident 9 had an elevated temperature of 100.8, and an elevated heart rate and respiration. The resident cried out in pain even with the slightest move when staff attempted to catheterize her for a urine specimen. This clearly was not typical of her prior history of chronic pain due to osteoarthritis. When staff could not carry out the physician's order for a urinalysis to address the resident's elevated temperature, heart rate and respiration, that in itself was cause to contact the physician. However, coupled with their inability to obtain the urinalysis was the resident's symptoms of increased pain and swelling of her left hip – also a reason in and of itself to have contacted the resident's physician. Here, the resident was providing staff clear messages that something was wrong with her, and based on the clinical record, these reports were not similar to her reports of chronic pain in the past. Rather, they were a clear departure from the resident's clinical picture and level of discomfort previously reported.

The regulatory requirement at issue is included in the section titled "Resident rights," and the requirement makes inconsequential any inconvenience to the resident's physician or to the facility staff when compared to the protection and facilitation of the rights of the resident. *See* 56 Fed. Reg. 48,826, 48,834. (1991). Additionally, it is clear from the language of the regulation and its history that the requirement of the regulation to consult means more than to simply notify. Consultation requires a dialogue with and a responsive directive from the resident's physician as to what actions are needed. I find unavailing the statement Dr. Turnbough made in her affidavit that even if she had been notified of Resident 9's condition on the night of June 5, she would not have ordered further x-rays given the previous x-ray findings and the resident's customary complaints of pain. *See* P. Ex. 5, at ¶12. The record clearly shows that on June 6 when Dr. Turnbough was called at 7:45 AM, she issued an order for Resident 9 to be sent to the emergency room for further evaluation. *See* CMS Ex. 29, at 9. Even if after being contacted the evening of June 5, Dr. Turnbough did not order any intervention as she indicated she likely would not have, this statement does not relieve facility staff of their responsibility to notify the physician of Resident 9's clinical condition and complaints of increased pain pursuant to 42 C.F.R. § 483.10(b)(11). In other words, the facility's duty to notify the physician is not contingent on how the physician may respond to the notification, but rather, on the existence of the facts that mandate such notification. Consequently, Dr. Turnbough's

statement that she would not have ordered additional intervention does not cancel the facility's duty to notify.

Petitioner argues that CMS has failed to establish that there was a significant impact to the resident or that the resident's physician would have ordered any additional intervention had she been contacted sooner by staff. As such, according to Petitioner, CMS has failed to show the potential for more than minimal harm. Petitioner relies on my analysis and ruling in *Homestead of Denison*, DAB CR830 (2001). In that case the facility was alleged to have failed to notify the resident's physician of a significant change associated with symptoms of a urinary tract infection, elevated temperature, and the resident's complaints of nausea. However, the facts in that case are dissimilar to the facts in the case now before me. In *Homestead*, I found that the resident's vital statistics were not indicative of any distress. However, here the nursing notes for June 5 reveal that Resident 9 was under distress – she had a reported temperature of 100.8, her left hip joint area was "swollen + is very warm to touch," and "she crie[d] out when [left] leg moved" upon catheterization. *See* CMS Ex. 29, at 9. Also, in *Homestead* the facts clearly showed that there was not a significant change in the resident's status which merited a call to the physician. Here, although Resident 9 had a history of chronic pain and was care planned and medicated for that pain, the symptoms identified in the nursing notes, both as to frequency and intensity of her complaints to staff, trigger an inference of acute rather than chronic pain. That denotes a significant change in the resident's medical status that became evident on the evening of June 5 when staff attempted to lift the resident's left leg to catheterize her.

For the reasons discussed above, Petitioner's reliance on *Homestead* to support its assertions is misplaced. Furthermore, Petitioner's argument that Resident 9 experienced no significant pain or additional harm as a result of the delay in notification of the physician is not supported by the clinical record. I find that staff's failure to notify Resident 9's attending physician was likely to cause harm to the resident. It has already been established that the resident continued to experience pain and discomfort the evening of June 5, when staff delayed notifying the resident's attending physician of her change in medical status. CMS determined Petitioner's failure to comply with this regulatory requirement to be an isolated incident of actual harm that is not immediate jeopardy. I find it reasonable for CMS to determine that facility staff's delay in notifying the attending physician to report Resident 9's medical status and to obtain further clarification and instruction from the physician perpetuated a situation where the resident continued to experience acute pain (i.e. "she cries out when [left] leg moved" upon catheterization) as opposed to chronic pain, and that the failure to timely notify and consult with the physician contributed to actual harm to Resident 9. *See* CMS Ex. 29, at 9. On June 6, when Resident 9 was transported to the hospital for further evaluation, it was determined that corrective surgery was needed. It is not necessary to establish that the bone fracture noted on the x-rays of June 6 was sustained during the May 30-fall; in fact, the clinical

evidence establishes that when the radiologist compared the June 6 x-ray to the May 31 x-ray, it was noted that no fracture could be noted in the left femur. *Id.* at 57. Rather, my finding is based on the change in Resident 9's medical status given her increased reports of the intensity of her pain and particularly when facility staff were unable to lift her left leg to catheterize her for a urine specimen ordered by her physician due to her elevated temperature, heart rate and respiration. Those symptoms should have alerted staff that indeed there was a significant change in the resident's status and of the need to immediately contact her physician for further consultation. Staff's failure to do so resulted in actual harm to the resident.

Based on the record before me and the regulatory provisions of 42 C.F.R. § 483.10(b)(11), I find that on June 5 at 10:20 PM, staff should have contacted Resident 9's physician when they were unable to catheterize the resident per the physician's instructions, and when Resident 9 cried out in pain when her left leg was moved. This constituted a significant change in the condition of the resident, and, as such, staff were required to notify Resident 9's physician. Failing to consult with the resident's physician immediately resulted in a violation of this regulatory provision.

Accordingly, for the reasons discussed, I determine that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.10(b)(11) when facility staff failed to contact Resident 9's attending physician the evening of June 5, 2007 to report a significant change in her medical condition.

2. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25 (Tag F309) as of the September 28, 2007 survey.

The applicable regulation at 42 C.F.R. § 483.25 titled "Quality of care" provides 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.

Petitioner was cited for failure to provide quality of care to Resident 9 at a scope and severity level of "G," signifying an isolated incident of actual harm that is not immediate jeopardy. CMS Ex. 6, at 7. CMS contends that the facility ignored the resident's complaints of pain and failed to provide relief, resulting in harm to the resident. CMS Br. at 12. Petitioner claims that the resident was receiving sufficient pain medication and was achieving adequate pain control. P. Br. at 11.

The fact that a resident has experienced a condition previously, should not blind the facility to an exacerbation of that condition or the onset of a new one. In this case, Resident 9 had resided at the facility for an eight-year period, and throughout that period

of time her clinical record notes chronic pain due to osteoarthritis with multiple pain medications prescribed. Although Resident 9 had sustained blunt trauma on May 30, the x-rays taken May 31 showed no fracture. When the resident demonstrated a period of distress from pain, staff attempted to manage what they determined to be the resident's chronic pain with a PRN order for pain medication. At times, the resident was not in distress from May 30 through June 4, 2007 (*see* June 2 at 2:20 AM and 10:10 PM; June 4 at 4:05 AM and 5:50 AM), and at other times Resident 9 is noted as "yelling in pain;" complaining of "severe pain in left hip;" noted as stating "hurts real bad;" and "yelling constantly, for med for pain" CMS Ex. 29, at 10. However, as previously discussed in detail under Tag F157, on June 5, 2007 the resident was providing staff with clear signals that her pain was no longer chronic, thus constituting a significant change. Resident 9 was in pain and staff should have immediately contacted her physician to report their inability to follow through with the physician-ordered urinalysis. Staff's failure to do so resulted in the resident suffering continued pain and in a delay in obtaining the needed urine specimen, thus further compromising the resident.

Petitioner states that CMS cannot conclude that it failed to provide the necessary care to reduce pain after a fall with injury, as the radiologist's review of the x-rays revealed no orthopedic injury. P. Br. at 10. Petitioner claims that the resident was receiving multiple pain medications from May 30 to June 6 pursuant to both existing and new physician orders which also included as-needed medications. *Id.*; CMS Ex. 29, at 11-16.

Petitioner relies on *Northeast Center* to defend its position. In *Northeast Center,* the facility was alleged to have failed to provide appropriate pain control for a resident. The ALJ found that the resident was assessed for pain, care planned for managing chronic complaints of pain, and regularly administered Tylenol and Percocet which were reported to not always have eliminated the resident's pain, but did reduce it to manageable levels. *Northeast Center for Special Care*, CR1237, at 25 (2004). I find Petitioner's reliance on *Northeast Center* is unavailing as this case addresses different facts from those addressed in *Northeast Center*. In that case the resident's pain was reduced to manageable levels whereas Resident 9's pain was not so reduced. Nursing notes clearly reveal that Resident 9 continued to exhibit repeated incidents of severe pain over a period of several days until corrective surgery was performed to repair her fractured left femur. *See* CMS Ex. 29, at 7-10.

In interpreting and applying the regulatory standard for physician notification, I recognize the role of professional nursing judgment and that nursing notes establish that staff responded to and documented incidents of Resident 9's complaints of pain. The record also shows that staff provided Resident 9 with pain medication in attempting to relieve her discomfort. The parties do not dispute that Resident 9 was routinely receiving Tylenol 500 mg – two tablets every four to six hours as needed until June 5, 2007 when it was

increased to: 650 mg of Tylenol; Oxycodone ER, 20 mg in the AM and 40 mg in the PM; and a Lidoderm 5% patch at 9:00 AM removed at 9:00 PM.[6] CMS Ex. 6, at 9; P. Br. at 10. However, that still does not negate the fact that staff's failure to contact the physician on June 5 only serves to highlight their failure to provide Resident 9 with the necessary care her condition warranted.

I also note that the record does not support the statement Dr. Turnbough made in her affidavit – that no additional intervention was warranted because the resident was "already receiving sufficient pain medication and was achieving adequate pain control." P. Ex. 5, ¶13; *see also* P. Ex. 29, at 7-10 (nursing notes outlining Resident 9's complaints of pain from June 1 through June 6, 2007). What Dr. Turnbough speculates in hindsight differs from what she actually did. Once reached by staff and notified of the resident's status on June 5, Dr. Turnbough immediately requested that staff bring the resident to the emergency room for further medical evaluation and intervention. However, whether a physician takes action or not once he or she is informed of a resident's status does not relieve staff of their responsibility of notifying the physician of the resident's condition. And, in the case before me, Petitioner had a policy which required staff to notify various administrative personnel if the physician could not be reached. Staff failed to do so on June 5.

I find that staff failed to properly respond to Resident 9's condition on June 5 when they ignored her complaints of pain and failed to contact her physician. I further find that this failure was a violation of the regulatory requirement at 42 C.F.R. § 483.25, and agree with CMS's determination that the violation was an isolated incident of actual harm that is not immediate jeopardy.

Accordingly, based on my findings, I conclude that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25 (Tag F309) as determined by surveyors as of the September 28, 2007 survey.

3. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h) (Tag F323) as of the September 28, 2007 survey.

The applicable regulation at 42 C.F.R. § 483.25(h) titled "Accidents" provides that the facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. In interpreting and applying section 483.25(h), the Board has been consistent in holding that providers are not strictly liable as insurers or unconditional guarantors of good outcomes in the delivery of services to facility residents. Rather, the

---

[6] Oxycodone is a narcotic alkaloid related to codeine, used as an analgesic and a sedative. *See Stedman's Medical Dictionary* 595 (2001).

Board has determined that the quality of care provisions of section 483.25 impose an affirmative duty upon providers to deliver services designed to achieve the best possible outcomes to the highest practicable degree. *Woodstock Care Center*, DAB No. 1726, at 25 (2000), *aff'd*, *Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). This interpretation is based upon the legislative history of the Act and regulations which reflect that Congress and the Secretary chose to focus upon the desired ends or results of care, thus allowing facilities to meet the requirements for individual care in a variety of ways. *See* Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203 (Dec. 22, 1987); 54 Fed. Reg. 5316 (1989).

The specific manner by which facilities are to deliver care and services is not prescribed by 42 C.F.R. § 483.25(h)(2). A facility is permitted to determine the means to achieve the regulatory end, which is the prevention of accidental injury of facility residents. Therefore, in order to evaluate Petitioner's compliance with section 483.25(h)(2), it is necessary to examine whether the facility provided adequate supervision designed to meet the residents' assessed needs and to mitigate foreseeable risks of harm to them. *Northeastern Ohio Alzheimer's Research Center*, DAB No. 1935 (2004); *Tri-County Extended Care Center*, DAB No. 1936 (2004).

The level and kind of supervision provided to a resident is reviewed in order to determine whether it was sufficient to prevent any untoward events. The regulation at 42 C.F.R. § 483.25(h)(2) requires that a facility provide *both* "assistance devices" *and* "adequate supervision" to prevent accidents. Whether the supervision or assistance devices are adequate depends on what kind of measures would be determined to prevent potential accidents from occurring given the known or reasonably foreseeable risks. For instance, in *Woodstock*, the Board considered whether the facility had notice of, or should reasonably have anticipated, the risk of the types of events that occurred and whether any reasonable means were available to prevent them without violating the residents' rights. *Woodstock*, DAB No. 1726, at 26-27. In the case before me, the question has to be answered as to whether the facility did "everything in its power to prevent accidents." *Odd Fellow and Rebekah Health Care Facility*, DAB No. 1839, at 6-7 (2002), quoting *Asbury Center at Johnson City*, DAB No. 1815, at 12 (2002) and *Koester Pavilion*, DAB No. 1750, at 25-26 (2000).

Based on the regulation and the cases addressing this provision, CMS will meet its burden in establishing a prima facie case if it: (1) presents evidence that an accident occurred (with or without harm to a resident); or (2) shows that Petitioner failed to do what it could to supervise residents or provide assistance devices to minimize risks that could lead to accidents. If CMS establishes a prima facie case, the burden shifts to Petitioner and the record will then be considered in terms of where the preponderance of the evidence lay.

Following review of the medical record, observations, and interviews with Petitioner's staff, the surveyors determined that Petitioner failed to comply with the requirements of this regulation at the scope and severity level of "H," which designates a pattern of actual harm that is not immediate jeopardy. CMS Ex. 6, at 14. Specifically, Petitioner was cited under this tag due to its alleged failure to ensure that eight residents received adequate supervision and assistance devices to prevent accidents. CMS alleges that Petitioner failed to ensure that safety devices were in place or were operating properly for five residents (Resident 1, Resident 9, Resident 11, Resident 13, and Resident 23), and failed to provide adequate supervision during transfers to three residents (Resident 8, Resident 15, and Resident 26). CMS Br. at 12; CMS Ex. 6, at 14. The surveyors allege that the pattern of identified deficiencies resulted in actual harm to facility residents. CMS Ex. 6, at 14.

(a) CMS's Allegations That Petitioner Failed to Ensure Safety Devices Were in Place or Operating Properly for Five Residents (Resident 1, Resident 9, Resident 11, Resident 13, and Resident 23).

Resident 1

Resident 1, a 91-year-old female, was admitted to the facility on March 18, 2005 with diagnoses of advanced dementia, osteoporosis, and depression. CMS Ex. 27, at 5, 28. The SOD notes that an MDS assessment dated February 22, 2007, reveals short and long term memory problems with severely impaired cognitive skills for daily decision making, and total dependence requiring two-person physical assistance for transfers. CMS Ex. 6, at 14. A side rail assessment completed by the Director of Nursing, and dated May 9, 2007, notes "[p]atient is completely dependent for all mobility in bed and transfers to chair. BOTH side rails up." CMS Ex. 27, at 26 (emphasis in original). The resident's plan of care dated March 1, 2007, and updated May 8 and June 7, indicates a need for half-padded side rails for mobility with floor mats at bedside and alarm on the resident's bed. *Id.* at 5. Her care plan, under Falls/Injury, notes the need for assistance of two staff during transfers, a bed alarm to her bed to alert staff of any attempts to transfer unassisted, and half-padded side rails as well as floor mats. *Id.* at 10.

The record notes that Resident 1 had a history of falls. On April 15, 2007 at approximately 8:15 PM, she was found on the floor in her room and sustained a bruise to her right arm. The record reveals that the bed alarm had sounded at the nurses station. CMS Ex. 27, at 33. The Post Fall Nursing Assessment also indicates that the low bed, the alarm which sounded, and the fall mat were in place. *Id.* at 35. On April 16, 2007, the resident was found on the floor; a notation in the record states that the bed exit alarm was in use. *Id.* at 33.

On July 7, while providing care during bedtime to Resident 1, a certified nurse assistant (CNA) disarmed the resident's bed alarm to prevent it from sounding and disturbing the resident, and also lowered the side rails in order to provide the resident with necessary care. CMS Ex. 27, at 15, 21. The CNA is reported to have taken two steps back from the resident's bed in order to obtain a brief from the nearby closet, and upon turning around, found the resident on the floor. *Id*. at 15.

Surveyor notes indicate that on September 26, 2007, two staff were interviewed by the surveyor. Although the first, the facility Administrator, stated that he could understand why the floor mats were not down if the staff member was working with the resident (CMS Ex. 27, at 24), the second, Jamey Payne, RN, stated to the surveyor that the CNA showed poor judgment as she should have pulled the side rails up and should have put the alarm on, if the alarm was supposed to be clipped to the resident or under the resident, before leaving the resident's bedside. *Id.* This was not disputed by Petitioner and, as such, appears that its own staff concurred that the CNA showed poor judgment.

The SOD indicates that on September 26, 2007, the surveyor also interviewed the CNA involved in the incident. CMS Ex. 6, at 16. CMS provided as CMS Ex. 27, a copy of a written statement from the CNA who was providing care for Resident 1 at the time of the July 7-fall. The statement was signed on September 26 or 29, 2007,[7] and states:

> I as [sic] [Resident 1] if she was ready to go to bed then I ask Kelie to help me put her to bed and she said yes so then we went to [Resident 1's] room a Kelie showd [sic] me how to put her to bed. Then I proceseed [sic] to take [Resident 1] close [sic] off of her and then + see she was wet and went to her closet a [sic] got a brief and turn around and saw is [sic] was in the floor and called for help. Tony came in and asset [sic] the damage + determain [sic] that a sling was need [sic]. I left the side rails down + no alarm or mats on floor. I assitanted [sic] with that a [sic] then left.

CMS Ex. 27, at 15.

A Post Fall Nursing Assessment dated July 7, 2007, reveals that the "[resident] had just been put to bed" and further notes under a category titled "Other safety devices in use": "Alarm (alarm not sounding)." The assessment also reveals that the resident's "bed was only slightly higher than low position." CMS Ex. 27, at 19-20.

---

[7] It appears the writer noted both dates, September 26 and September 29, so it is difficult to discern which she intended.

The radiologist's report of x-rays taken on July 7 states "not definite fracture of the resident's right knee," and a follow-up study was recommended if the resident were to continue with persistent pain. However, an x-ray of the resident's left shoulder taken on the same day shows "a slight impaction fracture of the humeral neck." CMS Ex. 27, at 32. The surveyors determined that the facility's deficient practices caused the resident to suffer harm. CMS Br. at 14.

Petitioner claims that Resident 1 received appropriate supervision and the side rail was down so the CNA could provide the resident with necessary personal care. Petitioner further avers that the alarm was off to prevent it from sounding and disturbing the resident while the care was provided. P. Br. at 13. Petitioner argues that the CNA was in very close proximity to the resident and this should be deemed to constitute appropriate supervision. *Id.* at 14. Petitioner argues that in *Burton*, the Board concluded that although it was foreseeable that a resident would attempt to transfer without assistance, the degree of supervision would negate a finding of noncompliance with 42 C.F.R. § 483.25(h). *Burton Health Care Center,* DAB No. 2051 (2006).

As Petitioner has pointed out, and the Board in *Burton* has noted, the relevant inquiry is whether the supervision Petitioner provided was adequate under the circumstances. *Burton* at 10. The question goes to whether Petitioner provided supervision in accordance with the resident's assessment and plan of care. As the Board stated in *Burton*, "if [Petitioner] failed to provide the type of supervision that it had determined was required to meet the resident's needs, this would support a conclusion that this incident violated 483.25(h)(2)."

As the Board stated in *Burton,* a facility is allowed the flexibility to choose the methods it deems appropriate to prevent accidents, but the methods chosen must be adequate under the circumstance, and what is considered adequate supervision for a resident actually depends on the resident's ability to protect himself/herself from harm. *Burton* at 6-7, citing *Woodstock Care Center*, DAB No. 1726 (2000), *aff'd, Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003).

The quality of care regulations at 42 C.F.R. § 483.25 require that services must be provided in accordance with a resident's assessment and plan of care. *See, e.g.*, *Coquina Center*, DAB No. 1860 (2002) (upholding deficiency findings where a facility failed to follow steps in a plan of care that were directed at preventing accidents). In *Burton*, the Board specifically mentions that the CNA turned away "momentarily to get a brief stored on a cart near the door." The Board in citing the ALJ's decision concluded that based on the evidence, the petitioner had implemented interventions intended to minimize the foreseeable risk of falls to the resident, that the interventions were adequate to prevent the resident from making unassisted transfers to stabilize himself, and it was not foreseeable "given evidence that Resident 36 was coherent and capable of following instructions, that

during the brief time that the aide turned to retrieve a brief, Resident 36 would not ask for assistance but would rather attempt a self-transfer." *Burton* at 9, citing ALJ Decision at 11-12 (*see Burton Health Care Center*, DAB CR1330 (2005)).

Here, Petitioner's staff did not comply with its own care plan for Resident 1 on July 7, and failed to act reasonably to prevent her from falling. The resident was identified as a fall risk and had a history of attempted transfers unassisted. Her care plan required that her bed alarm be on, and the side rails up while she was in bed. During the incident in question, the resident had just been put to bed. Also, although there is no mention if the resident was awake or asleep, I note that the CNA had never put this resident to bed. Further, the CNA had asked for assistance from another CNA, who showed her how to put Resident 1 to bed as a one-person assist rather than the two-person assist required in the resident's plan of care. The CNA who had provided assistance promptly left the room, leaving the CNA on her own.

Thus, the facts in this case and *Burton* are distinguishable. Here, the CNA did not provide the level of supervision as required in the resident's plan of care. Furthermore, the SOD reveals that facility management admitted to the surveyors that the CNA used poor judgment. Petitioner has not refuted this assertion. Additionally, Petitioner has failed to advance a justifiable reason for the CNA's failure to implement the interventions that it determined were necessary to minimize Resident 1's risk of falls. The CNA did not comply with the facility's own care plan for the resident on July 7, and thus failed to act reasonably to prevent the resident from falling. Although it is possible for a nursing facility to show that there was a justifiable reason for the violation, Petitioner has not advanced a justifiable reason for its failure to implement the interventions that it had determined were necessary to minimize the resident's risk of falls.

The fact that Petitioner adopted these interventions due to the resident's history of falls, shows that there was a foreseeable risk and that Petitioner believed the interventions reasonable and adequate. I conclude that Petitioner's staff violated 42 C.F.R. § 483.25(h) by failing to ensure that its staff implemented the interventions outlined in Resident 1's plan of care on July 7.

Resident 9

The pertinent clinical record statistics for Resident 9 have previously been discussed under deficiency tags F157 and F309. Thus, I will not repeat that information here.

Petitioner maintains that the resident's plan of care required a low bed position and a bed alarm. P. Br. at 15. As previously discussed in this decision, on May 30, 2007, the resident sustained a fall. CMS Ex. 29, at 58. The allegation in the SOD made by the surveyors for this tag states that there was no documentation that Petitioner had investigated the circumstances surrounding the resident's fall and Resident 9's safety devices were observed by the surveyor as not in place during the September survey. CMS Ex. 6, at 19, 22-24.

As to the facility staff's failure to investigate the May 30-fall, Petitioner claims that this allegation is contradicted by the record. According to Petitioner, there is a Post Fall Nursing Assessment dated May 30 that reveals that she was in a low bed and that an alarm was sounding at that time. CMS Ex. 6, at 19; CMS Ex. 29, at 58. Petitioner has submitted an affidavit of LPN Ann Davis (P. Ex. 6.), and, according to Ms. Davis, when she reported to the resident's room on May 30, she found that the resident's bed was in the low position. Ms. Davis further claims that she conducted a post-fall investigation and assessment. Allegedly, she was advised by the CNA who first arrived at the resident's room, that the alarm was sounding. P. Ex. 6, at 2-4. Based on this, Petitioner argues that the required devices were provided. Consequently, Petitioner advocates that there should be no deficiency. P. Br. at 16. However, Petitioner admits that on September 25, the surveyor personally observed that the resident's bed was not in the low position and the alarm was present, but not working. P. Ex. 1, at 22. Petitioner states that "[w]hile this may constitute a deficiency, CMS has shown no actual harm to the Resident as a result." P. Br. at 16.

CMS also alleges that the facility failed to ensure that safety devices were in place. CMS Ex. 6, at 15. CMS asserts that facility staff were to keep the resident's bed in the lowest position, as well as the bed and chair alarm turned on in order to notify staff if the resident attempted to get up unassisted. CMS Ex. 29, at 47, 58. However, on September 25, 2007, the surveyor observed Resident 9 in her bed and noted that the bed was not in the low position. The surveyor further noted that the bed alarm was not working when Resident 9 moved off the alarm pad. CMS Ex. 6, at 22; CMS Br. at 16.

I agree with Petitioner in that the evidence establishes that facility staff did investigate the circumstances surrounding Resident 9's fall on May 30, and documented the results in a Post Fall Nursing Assessment dated May 30, 2007. *See* CMS Ex. 29, at 58-59. CMS on the other hand, has provided a sufficient basis to establish that Petitioner failed to ensure Resident 9's safety devices were properly operating during the September 2007 survey. CMS has established, and Petitioner has not rebutted, that on September 25, the resident's bed was not in the low position as required by her care plan and the bed alarm, although in place, was not working when the resident was moved off the alarm pad. Petitioner admits to this violation, but contends that the resident did not sustain any harm resulting from the non-operable alarm pad on September 25. I find that Petitioner's assertion that the resident suffered no harm is unavailing. Providing an assistive device to a resident who is at risk of

falls is not enough; Petitioner must also ensure that the device is properly operating. Here, CMS has met its burden in establishing that Petitioner failed to do what it could to ensure that Resident 9, who was at risk of falls from her bed and had a history of falls while at Petitioner's facility, had an operable alarm pad. If Petitioner's weekly alarm checks are not sufficient to ensure this, then Petitioner needs to reevaluate its quality assurance checks for resident alarms in order to check them on a more frequent basis. I do not find here that Petitioner has done everything in its power to prevent accidents for Resident 9 given that on September 25, both safety interventions for Resident 9 were observed by the surveyor as not in place.

Resident 11

According to the SOD, Resident 11 was admitted to the facility on September 7, 2007, with diagnoses of Alzheimer's disease, pneumonia, osteoporosis, adult failure to thrive, and osteoarthritis. CMS Ex. 6, at 23. The SOD further notes that an MDS dated September 14, 2007, reveals that the resident required extensive assistance of two persons for transfers. *Id.* An interim care plan dated September 7, 2007, reveals a potential for falls with interventions of both a bed exit and a chair alarm. CMS Ex. 30, at 5. During the survey, Resident 11 was observed in bed by the surveyors on September 25, 2007 at 10:45 AM, and there was no bed alarm in place. CMS Ex. 6, at 23. The surveyor observed Resident 11 again at 4:40 PM that day and found the resident lying on the bed, and the bed alarm was not in place. *Id*. On September 28, 2007 at 2:36 AM, when the surveyors observed the resident lying on the bed, they noted an alarm had been placed in the resident's bed. *Id.*

Petitioner admits that the resident's care plan required the use of a bed alarm. Petitioner also does not dispute that the alarm was not present during the surveyor's direct observations. P. Br. at 16. Petitioner simply states that "[w]hile this may constitute a deficiency, there was no actual harm to the Resident." *Id.* Petitioner is correct, CMS has not established that Resident 11 sustained any harm as a result of not having the bed alarm in place on September 25, 2007 during the 10:45 AM and 4:40 PM observations. But, as I have already addressed, for a determination of noncompliance with a participation requirement, CMS does not have to establish actual harm. CMS does need to establish that Petitioner failed to do what it could to provide assistance devices to minimize the risks that could lead to accidents, and I find that CMS has met its burden here.

Resident 13

According to the SOD, Resident 13 was admitted to the facility on April 9, 2007, with diagnoses of gait instability, dementia, rheumatoid arthritis, congestive heart failure, and chronic airway obstruction. CMS Ex. 6, at 23; CMS Ex. 31, at 1. Resident 13 is also reported as having short and long term memory deficits and severely impaired cognitive

skills. He required limited assistance of one person with transfers and walking, and is reported to have had unsteady standing balance. CMS Ex. 6, at 23; CMS Ex. 31, at 18. A care plan dated April 26, 2007, lists falls and injury as a problem area and that the resident has a potential for falls due to: "gets up by self, gait instability." *Id.* at 22. A bed alarm was listed as an approach to alert staff when the resident tried getting up unassisted. *Id.*

On May 26, 2007, Resident 13 was found on the floor at 2:20 PM. CMS Ex. 31, at 18. The Post Fall Nursing Assessment reveals that the resident was "found in [sic] floor in liquid stool." CMS Ex. 31, at 14. The assessment does not note if any safety devices were in use. *Id.* On May 26, Resident 13 fell again. *Id.* at 12. The Post Fall Nursing Assessment dated May 26 at 9:40 PM, reveals that the resident was "on the floor wearing socks and brief intact." *Id*. The assessment notes that the resident self-reported that he "fell when I turned to come out of bathroom" which was located in his room. *Id.* The assessment specifically notes "alarm not sounding." *Id*. On September 26 the surveyor interviewed the Resident Care Coordinator who confirmed that Resident 13's bed alarm was not in place at the time of the May 26-fall at 9:40 PM. CMS Ex. 6, at 24. As a result of the fall, Resident 13 sustained harm, a small purple bruise on his left hip. CMS Ex. 31, at 12. Another Post Fall Nursing Assessment dated June 6, failed to document what safety devices were in use when the resident fell in the shower room; however, no injury was noted. *Id.* at 16.

Petitioner does not dispute that the resident's care plan identified the need to use a bed alarm. P. Ex. 1, at 24. Petitioner also does not dispute that Resident 13 sustained two falls on May 26. Petitioner states that a Post Fall Nursing Assessment was available, although it "simply omitted any reference to the alarm." P. Br. at 16, citing CMS Ex. 31, at 14. Petitioner avers that it would be speculative for the surveyor to conclude the alarm was not in place. *Id.* In relation to the second fall, Petitioner states that the Post Fall Nursing Assessment does indicate that the alarm was not sounding. P. Br. at 16, citing CMS Ex. 31, at 12. Petitioner argues that the fact the alarm was not sounding does not indicate noncompliance given that batteries will eventually fail and the facility had an appropriate program in place to check the batteries on a weekly basis. P. Br. at 16, citing CMS Ex. 31, at 22. However, Petitioner fails to provide any evidence of its weekly battery checks verifying that Resident 13's alarm battery was actually checked and verified to be working.

Petitioner further asserts that there was no actual harm alleged by the surveyor, and, as such, there is no basis for CMS to now determine harm. I disagree with Petitioner. CMS has established through documentary evidence that an accident did occur and that as a result of Resident 13's fall on May 26 at 9:40 PM he sustained a 1 mm purple bruise on his left hip and a 2 cm reddened area on his left hip was also reported. *See* CMS Ex. 31, at 12. Petitioner has failed to successfully rebut CMS's showing.

I find that Petitioner has failed to overcome CMS's showing of noncompliance. I determine that Petitioner failed to do what it could to minimize the risk of accidents, and Petitioner's failure caused actual harm to Resident 13.

Resident 23

According to the SOD, Resident 23 was admitted to the facility on August 7, 2007, with diagnoses of Alzheimer's disease, hypertension and hypothyroidism. CMS Ex. 6, at 24; CMS Ex. 33, at 1. The resident's interim care plan dated August 8, 2007, notes the risk of falls as a potential problem, and one approach identified the use of a "bed exit/chair alarm." CMS Ex. 33, at 10.

Petitioner confirms that the resident's care plan required the use of a bed alarm. P. Br. at 17. On September 25, 2007, the resident was found on the floor. *Id.* at 17. The SOD notes a Post Fall Nursing Assessment, dated September 25, 2007 at 2:15 AM, that states: "bed alarm was in use, but apparently was not on." CMS Ex. 6, at 25. Petitioner does not dispute the statement in the assessment; rather, Petitioner states that the evidence suggests that the battery had become inoperative since the last weekly check. P. Br. at 17. Therefore, argues Petitioner, there is no deficiency. *Id.* at 17. Petitioner further contends that since there was no injury and there was no actual harm alleged by the surveyor (CMS Ex. 6, at 14, 24, 25), there is no basis for CMS to determine that harm occurred. P. Br. at 17.

A Post Fall Nursing Assessment dated September 25, confirms Resident 23 was found on the floor. CMS Ex. 33, at 5. Resident 23 is reported to have fallen when "trying to get to bedside commode." *Id*. The assessment reveals the resident communicated that "she hurt everywhere." *Id.* The assessment also notes "bed alarm was in use, but apparently was not on." *Id.* According to the SOD, the Resident Care Coordinator was interviewed during the survey and confirmed the alarm was not working. *Id.* at 4. Petitioner has not provided any evidence to refute this.

The Post Fall Nursing Assessment confirms that there was an accident and that Resident 23 experienced pain as a result of the accident. CMS Ex. 33, at 5. Additionally, the resident's care plan required a bed alarm; the fall assessment reveals that on September 25, the bed alarm was "apparently not on;" and the Resident Care Coordinator confirms that it was not working. I find that Resident 23 suffered actual harm as a result of the September 25 incident. *Id.* at 4-5. I conclude that Petitioner failed to provide Resident 23 with the necessary assistance devices as identified in her plan of care to minimize her risk of falls and that this failure was a violation of the requirements of 42 C.F.R. § 483.25(h).

(b) Petitioner failed to provide adequate supervision for transfers for two of three residents (Residents 15 and 26).

Resident 8

According to the SOD, Resident 8 was admitted to the facility on September 4, 2007, with diagnoses of dementia and osteoporosis. CMS Ex. 6, at 16-17; *see also* CMS Ex. 28, at 18. An MDS assessment dated September 12, 2007, notes the resident suffered from severely impaired cognition, had difficulty with long and short term memory, was non-ambulatory, and required total care for activities. CMS Ex. 28, at 35, 37, 38.

CMS alleges that Petitioner violated the regulation based on the surveyor's determination that Petitioner failed to provide adequate supervision to the resident during a transfer on September 19, 2007 at 10:00 AM. CMS Ex. 6, at 17-14. Petitioner claims that no transfer was occurring at the time, that the resident was in the shower room in a shower chair while under the supervision of a CNA, and that the level of supervision was consistent with the resident's MDS. P. Br. at 15, citing CMS Ex. 28, at 45. Petitioner states that the CNA was standing in front of the resident, and when the CNA reached out for a towel, the resident reached for the CNA and then fell forward onto the CNA. P. Ex. 1, at 15. Petitioner relies on the Board's decision in *Burton* to support its position that the resident was closely supervised and that a deficiency is not warranted. P. Br. at 15; *see also Burton Health Care Center*, DAB No. 2051. To further support its assertions, Petitioner has submitted as P. Ex. 13, a photo to show the proximity of the CNA to the resident when the fall occurred. P. Ex. 13.

In its brief, CMS raises an objection as to authenticity of P. Ex. 13. CMS Br. at 15. I need not address CMS's objection to Petitioner's exhibit as I do not rely on the photo in reaching my determination as to whether the CNA provided the necessary supervision to Resident 8 on September 19; rather, I rely on the resident's clinical record as a basis for my finding.

The September 19-incident occurred in the shower and a Post Fall Nursing Assessment, dated September 19, 2007, reveals that the resident was: "reaching forward toward staff while staff was reaching for towel. [Resident] fell forward to floor with staff supporting, left side of head and knee landing on floor and right sided [sic] continued to be support by staff." The resident is reported to have sustained a "long gash, approx. 3-4 inches," the injured area was reported as "[b]leeding," and a "sm. abrasion on right knee" was also noted. CMS Ex. 28, at 16. Resident 8 was transported to the hospital for evaluation, and sutures were subsequently applied. *Id.* at 17.

During the survey, CNA 2 was interviewed on September 26, and stated to the surveyor that Resident 8 was placed in the shower chair by a lift and three CNAs. CMS Ex. 9, at 18. The CNA further reported that one CNA was then left to attend to Resident 8. *Id.* The CNA reported that she turned around "to reach for a towel I had in another shower chair." *Id.* She also admitted that she was aware that Resident 8 had a habit of reaching out. *Id.* Resident 8 was care planned for potential falls, and her care plan notes "[m]onitor closely when up in shower chair." CMS Ex. 28, at 22. During the interview, the CNA informed the surveyor that she was aware prior to showering Resident 8 that she "may try to come out of chair, may try to slip out of shower chair.'' CMS Ex. 6, at 18. The CNA reported that CNAs are told verbally how to care for residents. The CNA further stated to the surveyor that the resident needs two people to give her a shower and that it is "not safe to give [resident] a shower alone." *Id*. The facility's Residential Care Coordinator stated to the surveyors during the survey that Resident 8 needed "hands on" and that the resident "did not receive adequate supervision at the time of the fall." CMS Ex. 28, at 8; CMS Ex. 6, at 18.

Petitioner states that the Board's decision in *Burton* "clearly supports [Petitioner's] position;" however, Petitioner fails to analogize the facts in this case to that of the resident in *Burton* or to discuss how *Burton* supports its case. P. Br. at 15. Petitioner further states that in the pending matter the resident was "closely supervised" and that the injuries sustained by Resident 8 – a gash to the left forehead and a small abrasion of the right knee – were of "limited consequence," and thus, the assessment of actual harm is unwarranted pursuant to the SOM. P. Br. at 15, citing *Burton Health Care Center*, DAB No. 2051, at 8.

I find that CMS has established that there was an accident, that the resident sustained an injury, and that there is a reasonable inference that proper supervision was not provided, particularly based upon the interview with the facility's Residential Care Coordinator. However, in reviewing the resident's care plan and MDS assessment (CMS Ex. 28, at 22, 45), I note that the facility properly identified the resident's risk for falls, and developed interventions. In reviewing the Post Fall Nursing Assessment which described the September 19-incident and was written within a few hours of the incident, I do not see where the CNA failed to follow the interventions established for Resident 8. When the CNA stepped back to reach for a towel on another shower chair, the resident reached out. I find credible the assertion that the CNA then immediately moved to support the resident as much as possible during the fall.

CMS notes that there was a significant disparity between the weight of the resident (194 pounds) and the weight of the CNA (120-125 pounds); however, CMS fails to explain the significance of this disparity. CMS Br. at 16, n.8. I infer from CMS's statement that CMS finds it unlikely that the CNA would attempt to block the fall of the resident who weighed more than she did. Thus, CMS suggests that I should not find credible the assertion that the CNA immediately exerted an effort to support Resident 8's fall. I disagree and find it more

likely than not, based on the evidence before me, that the CNA did immediately attempt to block the resident's fall. I also find that, as in the facts with the resident in *Burton*, the CNA here "momentarily" stepped away and was providing appropriate supervision while Resident 8 was in the shower chair as required by the resident's plan of care.

I have taken into consideration that Resident 8 was a high risk for falls (CMS Ex. 28, at 64) and she had a history of falls based on a September 12, 2007 risk assessment (CMS Ex. 28, at 61). Also, I do not discount that on September 26, the CNA and the Residential Care Coordinator, in looking back at the incident, stated that additional staff in the room supervising the resident could have prevented the fall, or that the resident needed "hands on care." However, the resident was not unattended and I cannot find in the clinical record where it is noted that the resident required two people supervising while she was showering, or where the resident required "hands-on supervision" while showering. If the CNA had failed to provide the type of supervision that Petitioner had determined was required to meet Resident 8's needs, this would support a conclusion that this incident violated 42 C.F.R. § 483.25(h). However, in the pending matter I find that the CNA implemented the identified interventions intended to minimize the foreseeable risk of falls to the resident, and that the interventions were adequate to prevent the resident from falling. The regulation requires that a facility provide adequate supervision in order to prevent accidents, and, as discussed earlier in this decision, the regulation does not require that a facility be an insurer or unconditional guarantor of good outcomes in its delivery of services to its residents.

Consequently, I conclude that based on the September 19-incident with Resident 8, although CMS has established a prima facie case, Petitioner has successfully rebutted the alleged failure to provide the resident with appropriate supervision on the morning of September 19, 2007.

Resident 15

According to the SOD, Resident 15 was admitted to the facility on March 4, 1997,[8] with diagnoses of Alzheimer's disease, dementia, hypertension, osteoarthritis, and delusions. CMS Ex. 6, at 25. The resident's plan of care dated July 27, 2007, notes in the Falls/Injury category that the resident requires "[a]ssistance of staff with all transfers and ambulation" and "[b]ed and chair alarms to alert staff when [resident] attempts to rise unassisted." CMS Ex. 32, at 12.

---

[8] Resident 15's plan of care indicates an admission date of September 25, 2006; however, I note that the specific date of admission is not relevant to my review.

A Post Fall Nursing Assessment[9] notes that on August 24, 2007, a CNA was attempting to transfer Resident 15 from her wheelchair to the bed and during the transfer, the resident began to slide down. The CNA then lowered the resident to the floor to prevent injury. CMS Ex. 32, at 10. The assessment further notes "instructed CNAs to call for assist with transfer because condition fluctuates regarding patient ability to assist." *Id.* at 11.

Although a copy of the resident's MDS was not provided as an exhibit, the SOD states that the MDS assessment, dated July 18, 2007, reveals the resident required assistance of two persons with transfers. The SOD also notes that when the surveyor interviewed the facility's Resident Care Coordinator on September 26, 2007, she confirmed that the resident required a two-person assist with transfers, and also confirmed that Resident 15 did not receive a two-person assist with her transfer on August 24, 2007. CMS Ex. 6, at 25-26. Petitioner admits in its brief that the resident required assistance of two persons with transfers, but relies on ALJ Kessel's decision in *JFK Hartwick at Edison Estates* to support its assertion that the facility should not have been found in violation of the regulation. P. Br. at 17. In *JFK Hartwick at Edison Estates,* a resident was injured while being transferred from bed via a lift. *JFK Hartwick at Edison Estates*, DAB CR840, at 4 (2001). One CNA was operating the lift even though the facility's internal policy required a two-person assist to operate the lift. *Id.* According to Petitioner, ALJ Kessel indicated this evidence did not show that the facility provided insufficient training to the nursing assistant or inadequately supervised either the nursing assistant or the resident. *Id.* Petitioner contends that the ALJ concluded that "there is no basis to find Petitioner liable if the evidence only establishes an isolated error by a member of Petitioner's staff which occurred despite – and not because of – the way that Petitioner instructed and supervised its staff." P. Br. at 17, citing *JFK Hartwick at Edison Estates* at 4. Petitioner argues that because CMS did not prove that the facility knew or should have known that its staff was not complying with its directive concerning use of the lift, there was no finding for a basis of noncompliance. *Id.* at 5. Petitioner claims that CMS has offered no such proof in the matter pending before me. P. Br. at 18. Petitioner further avers that since there was no injury, and no actual harm was alleged by the surveyor (CMS Ex. 6, at 14, 26), there is no appropriate basis for CMS to now determine harm occurred. P. Br. at 18.

I do not find persuasive Petitioner's reliance on Judge Kessel's decision in *JFK Hartwick.* In the case before me, Petitioner acknowledges that Resident 15 required the assistance of two persons with transfers, but on August 24, 2007, a single CNA attempted to transfer the resident from a wheelchair to her bed. When the transfer was in progress, the resident began to slide down, and the CNA had to lower her to the floor. P. Br at 17. Petitioner's lack of

---

[9] The Post Fall Nursing Assessment completed for the August 24, 2007 incident is neither signed nor dated; however, I still rely on the report as there has been no objection raised as to its authenticity. *See* CMS Ex. 32, at 10.

knowledge as to whether the facility knew that its staff was not complying with its policies does not shield it from responsibility. It is commonplace for a facility to become aware of its staff's failure to follow directives only after an incident of noncompliance has come to pass. Therefore, a facility cannot seek to distance itself from staff wrongdoing based on ignorance. The Board has held that "a facility cannot avoid . . . remedies by attempting to disavow the acts of and omissions of its own staff and administration since the facility elected to rely on them to carry out its commitments." *Beverly Health Care Lumberton*, DAB No. 2156 (2008), *petition to reopen denied*, Ruling No. 2008-5, at 6-7. Thus, it is not relevant to a finding of noncompliance that Petitioner was unaware what its staff was doing. The facility may have adopted appropriate policies to provide for the welfare of its residents; however, the best articulated policies and procedures are of little value if not properly and timely implemented and understood by each staff member.

CMS posits what it calls a reasonable interpretation of the record that Resident 15 suffered harm as a result of visible bruising, pain, or both. CMS Br. at 19. Although that may be conjecture on the part of CMS, I note that even though the resident's record does not reveal any specific injury, there was the potential for injury. Clearly the resident's plan of care identifies her as having a "gait instability, and use of psychoactive medications" which identify her as a fall risk. CMS Ex. 32, at 12.

CMS made a deficiency finding of scope and severity level of "H" (a pattern of actual harm that is not immediate jeopardy), which is a Level 3 deficiency.

The SOM defines Level 3 as follows :

> Level 3 is noncompliance that results in a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. This does not include a deficient practice that only could or has caused limited consequences to the resident.

SOM, Appendix P at 72; *see also* P. Ex. 10, at 1-2.

By not following the MDS assessment that called for a two-person assist with transfers, Resident 15 *could have* suffered a negative outcome that compromised her ability to maintain and/or reach her highest practicable physical, mental, and psychosocial well-being.

I conclude that CMS has established, and Petitioner has not rebutted, that an accident occurred (with or without harm) as a result of facility staff's failure to provide the type of supervision Petitioner itself determined was required to meet the resident's needs. This finding supports a conclusion that this incident violated 42 C.F.R. § 483.25(h).

Resident 26

According to the SOD, Resident 26 was admitted to the facility on February 23, 2007, with diagnoses of multiple sclerosis, quadriplegia, osteoporosis, and depression. CMS Ex. 6, at 26. Resident 26's care plan dated March 15, 2007, reveals that a two-person assist with lift was required for all transfers. CMS Ex. 34, at 24, 30. A Post Fall Nursing Assessment dated August 24, 2007, shows that Resident 26 was being transferred in a lift when a CNA assisting with the transfer let go of her legs in order to retrieve a washcloth. *Id.* at 35. The lift seat is reported to have shifted, resulting in the resident falling forward and out of the lift seat. *Id.* The assessment further notes that Resident 26 sustained a "small bruise inner L arm, small abrasion to R back/side rib cage area and 3 CM bruised area on R lower abdomen." *Id.* The assessment notes "plan to have 2 CNAs to transfer Pt." *Id.* at 36. The SOD reports that the facility's Administrator and the Resident Care Coordinator were interviewed by the surveyors on September 27, 2007, when each confirmed that Resident 26 did fall and that the CNA used poor judgment by walking away. *Id.* at 42. According to the surveyor's notes, the Administrator informed the surveyor that the "resident did not have 2 person assist at time of fall." *Id.* The surveyors also report having interviewed Resident 26 regarding the August 24 incident. Following is the resident's account of the incident as transcribed by the surveyor:

> "was using hoyer lift (personal) sling did not come up between my legs, I did not pay attention to tell the CNAs what to do. 2 CNAs assist sling up to [sic] far on bottom as CNA raising lift to get bottom high enough to get in chair - sling to [sic] high on bottom slung forward - as leaned forward sling slipped up the back. Gracefully sat down on floor. One CNA walked away to get a washcloth - she was the one driving the lift. Other CNA was beside me + she is the one that caught my fall."

CMS Ex. 34, at 41.

Petitioner does not dispute that Resident 26 required the assistance of two persons for transfers. P. Br. at 18. Petitioner asserts that Resident 26 was receiving the assistance of two persons with the transfer as required, so the deficiency should be rescinded. *Id.* Petitioner further avers that there was no actual harm alleged by the surveyor and, as such, there is no basis for CMS to now determine that harm occurred. *Id.* citing CMS Ex. 6, at 14, 27.

I disagree with Petitioner as to whether the resident was receiving the assistance of two staff. Rather, I find that Resident 26 was not continuously receiving the assistance of two persons while she was being transferred on August 24, 2007, as reported by the Post Fall Nursing Assessment, Resident 26's account of the incident, and the confirmation of both the facility's Resident Care Coordinator and Administrator. Although it is accurate to say that there were two CNAs within close proximity to the resident, the fact is the transfer was still occurring and the clinical record is clear that one of the CNAs let go of the resident's legs in order to retrieve a washcloth. The resident then fell forward and out of the lift seat. The resident's care plan does not say that two persons are required for *part* of the transfer process; rather, it is clear that a two-person assist is required for the complete transfer which did not happen on August 24, 2007 with Resident 26. Therefore, facility staff were not following the resident's assessed needs and care plan as required, and this failure was a violation of the provisions of 42 C.F.R. § 483.25(h).

In summary, for the reasons outlined above, I find that CMS has established that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h) as of the September 28, 2007 survey. Although I did not confirm each allegation found by the surveyors, I find there were sufficient violations which I did confirm that amply justify CMS's determination of noncompliance with Tag F323, at the scope and severity level of "H," signifying a pattern of actual harm that is not immediate jeopardy.

V. PETITIONER'S CHALLENGE TO THE LEVEL OF NONCOMPLIANCE IS UNSUCCESSFUL.

According to Petitioner, the facts indicate that the scope assessment for Tag F323 should be reduced from the designated "H" scope and severity level to a "D" level deficiency. P. Br. at 18. A "D" level scope and severity is assigned to deficient practices which are isolated and cause no actual harm with the potential for more than minimal harm. Petitioner maintains that the SOM guidance to surveyors advises that the finding of a "pattern" is inappropriate unless more than a very limited number of residents are affected. *Id.* citing P. Ex. 10, at 2. Petitioner states that all eight of the residents did not sustain actual harm as a result of the alleged deficient practice; therefore, there could be no finding of a "pattern" of deficiencies resulting in actual harm, and thus, the designated deficiency scope should be deemed "isolated." *Id.*

CMS claims that based upon the deficient practices identified under Tag F323, the surveyors determined that harm occurred to three residents and thus assessed a scope at the level of "H" which indicated a pattern. CMS Br. at 19. CMS further claims that even if I determine a specific number of residents must be involved in order to find a pattern, it contends that such a finding would not affect the range of the CMP, and, therefore, only

would be material as to whether the facility can operate a Nurse Aide Training and Competency Evaluation Program (NATCEP). CMS Br. at 20.

As previously noted, the regulation allows a petitioner to challenge the level of noncompliance only if a successful challenge would affect the ***range*** of the CMP CMS could collect or a finding of substandard quality of care that results in the loss of its NATCEP. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i) (emphasis added); *see also Woodland Village Nursing Center v. CMS*, DAB No. 2053 (2006), *aff'd, Woodland Village Nursing Center v. HHS*, No. 07-6005 (5th Cir. 2007). Petitioner has not presented any evidence that it has a nurse aide training program or that it is seeking approval for such a program. The record shows, and Petitioner has not refuted, that as of September 28, 2007, Petitioner did not have an approved nurse aide training program. CMS Ex. 13, at 1.

In the pending matter, under Tag F323, CMS has established both actual harm and the likelihood of harm based on Petitioner's deficient practices. There are no bright-line rules as to the number of cases of harm it would take to justify a "pattern," since the determination as to whether harm did or could occur is very fact specific, and each case and incident should be assessed accordingly. However, that is not an issue that I need to address in this decision as, in the case before me, actual harm has been established. Therefore, a scope and severity level of "D"(no actual harm) as Petitioner requests, cannot be justified. Assuming, *arguendo*, that the scope and severity level was reduced to a "G," indicating harm that is an isolated, one-time occurrence, the regulations require remedies for deficiencies at the level of G and H, and those remedies include a CMP in the range of $50 to $3000 per day. 42 C.F.R. § 488.408. Here, CMS is imposing a $800 per day CMP which is at the lower range of what it can impose, and, as such, the harm which occurred to the residents alone is a sufficient basis for the enforcement remedy imposed by CMS. As a result of Petitioner's deficient practices, Resident 1 fell and sustained a bruise to her right arm; Resident 8 fell and sustained a 3-4 inch gash requiring sutures and an abrasion to his right knee; Resident 13 fell, injuring his left hip; Resident 23 fell out of bed and reported that "she hurt everywhere;" and Resident 26 fell out of the hoyer lift and sustained a bruise to her left arm, an abrasion to her rib cage, and a bruise to her lower abdomen.

Petitioner's reliance on the SOM guidance to surveyors to assert that the surveyors incorrectly assessed a severity level of "H" (actual harm that is not immediate jeopardy), is unavailing. I note that consistent with the SOM guidance, CMS accurately determined that Petitioner's deficient practice which resulted in actual harm to several of the residents at issue did not constitute the type of harm that could or has caused limited consequences to the residents. P. Ex. 10, at 2.

The SOM, under the section titled "Guidance on Scope Levels," defines the scope levels accordingly:

> Scope is isolated when one or a very limited number of residents are affected and/or one or a very limited number of staff are involved, and/or the situation has occurred only occasionally or in a very limited number of locations.
>
> Scope is a pattern when more than a very limited number of residents are affected, and/or more than a very limited number of staff are involved, and/or the situation has occurred in several locations, and/or the same resident(s) have been affected by repeated occurrences of the same deficient practice. The effect of the deficient practice is not found to be pervasive throughout the facility.[10]

SOM, Appendix P at 72; *see also* P. Ex. 10, at 2.

For the reasons already discussed, as a result of Petitioner's deficient practice, I find that five of the eight residents at issue under this tag sustained actual harm (Resident 1, Resident 8, Resident 13, Resident 23, and Resident 26). I determine that CMS appropriately applied the SOM guidance when the surveyors assigned a scope of "pattern" rather than "isolated." Therefore, even if Petitioner could challenge CMS's level of noncompliance, in the matter before me, I find ample evidence in the record for the surveyors to have justified a scope and severity level of "H" under deficiency Tag F323.

VI. THE AMOUNT OF THE CMP IS REASONABLE, BUT THE PERIOD OF NONCOMPLIANCE DETERMINED BY CMS IS UNREASONABLE.

Having determined that CMS had a basis for finding Petitioner was not complying substantially with the federal participation requirements set forth at 42 C.F.R. §§ 483.10(b)(11) (Tag F157), 483.25 (Tag F309), and 483.25(h) (Tag F323) during the September 28, 2007 survey, I now determine whether the amount of the penalty imposed by CMS of $800 per day is reasonable. The regulations require that I review de novo whether the amount of the CMP is reasonable by considering the four factors specified in 42 C.F.R. § 488.438(f). These four factors are: (1) the facility's history of noncompliance, including repeated deficiencies; (2) the facility's financial condition; (3)

---

[10] A deficiency is pervasive when it is widespread in the facility. *See* SOM, Appendix P at 72.

the scope and severity of the deficiencies, the relationship of one deficiency to other deficiencies, a facility's prior history of noncompliance with reference to the deficiency at issue (factors specified in 42 C.F.R. § 488.404); and (4) the facility's degree of culpability.

Petitioner did not challenge all the deficiencies cited in the September 28, 2007 SOD; specifically, Petitioner did not appeal six of the nine deficiency tags (Tags F280, F315, F431, F498, F502, and F520) which were cited at a scope and severity level of "D" and "E." As previously noted, those findings and remedies remain uncontested and are, therefore, final and binding against Petitioner. 42 C.F.R. § 498.20(b). CMS has established a finding of noncompliance which provides a basis for its imposition of remedies at the lower range of $50 - $3000 per day for deficiencies that do not constitute immediate jeopardy, but either caused actual harm or caused no actual harm, but have the potential for more than minimal harm. 42 C.F.R. § 488.438(a)(ii).

The State survey agency determined Petitioner returned to substantial compliance effective October 12, 2007. CMS Ex. 18. Based on this, CMS imposed against Petitioner a $800 CMP for each day of noncompliance from May 30, 2007 through October 11, 2007, for a total CMP of $108,000.

CMS has not presented evidence as to Petitioner's history of compliance. However, for the reasons already discussed in this decision, I find that the CMP of $800 per day is not unreasonable based on the seriousness of the deficiencies cited, Petitioner's culpability, its noncompliance with the unchallenged deficiency tags (F280, F315, F431, F498, F502, and F520), and the fact that Petitioner has not raised the issue of its financial condition.

Petitioner asks that I reexamine the period of noncompliance in assessing the CMP. P. Br. at 20-21. As for the duration, CMS states that the CMP date is based on the facility's failure to investigate and document the adequacy of the safety devices that were still in place at the time that Resident 9 fell on May 30, 2007, when the surveyors determined the facility was first out of compliance. CMS Br. at 21. Petitioner states that it was September 25 when the surveyor noted that Resident 9's bed was not in the low position and the alarm was present but not working. P. Br. at 21. Petitioner contends that it was also on September 25 that the surveyor noted Resident 11's bed alarm was not present. *Id.* at 23. As I have already found that Petitioner did complete an assessment of Resident 9's fall on May 30, but was not in substantial compliance with the regulatory provisions of 42 C.F.R. § 483.10(b)(11) (Tag F157) as of June 5, 2007, I find that the length of the violation established by CMS to be unreasonable. I find substantial evidence in the record to determine that Petitioner's noncompliance started June 5, 2007, and not May 30, 2007. 42 C.F.R. § 498.20(b).

VII. CONCLUSION

I conclude that CMS correctly determined that Petitioner was not complying with federal requirements governing participation of long-term care facilities in Medicare and State Medicaid programs, and that the imposition of a CMP of $800 per day from June 5, 2007 through October 11, 2007 is appropriate.

/s/
José A. Anglada
Administrative Law Judge