Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Buena Vista Care Center,
(CCN: 55-5394),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-10-918

Decision No. CR2518

Date: March 22, 2012

DECISION

Petitioner Buena Vista Care Center challenges the determination of the Centers for Medicare & Medicaid Services (CMS) that it was not in substantial compliance with program participation requirements. Petitioner also challenges CMS's imposition of a per instance civil money penalty (PICMP) of $7,100. For the reasons discussed below, I sustain CMS's determination and imposition of the $7,100 PICMP.

I. Background

Petitioner is a long-term care facility located in Santa Barbara, California. Petitioner participates in the Medicare and Medicaid programs. The California Department of Public Health (state agency) conducted a recertification survey of the facility on May 20, 2010, and a revisit survey on July 13, 2010. Based on the findings of the May 20, 2010 survey, Petitioner was found out of substantial compliance with 19 participation requirements. The July 13, 2010 revisit found Petitioner back in substantial compliance. By letters dated June18 and August 2, 2010, CMS notified Petitioner that it was imposing the remedies of a denial of payment for new admissions (DPNA) effective July 3 through 13, 2010, and a $7,100 PICMP for a violation of 42 C.F.R. § 483.25(h), found on the

May 20, 2010 recertification survey statement of deficiencies (SOD) at Tag F-323, at a scope and severity level of K.[1] CMS also notified Petitioner of a two-year prohibition on Petitioner conducting a nurse aide training and competency evaluation program (NATCEP) (imposed both because of the imposition of the DPNA and because of the amount of the PICMP).[2] February 10, 2010 Joint Stipulations (Joint Stips.) 1-4;[3] Centers for Medicare & Medicaid Services Exhibits (CMS Exs.) 1, 3.

By letter dated August 16, 2010, Petitioner requested a hearing.

In the parties' joint stipulations (Jt. Stips.) of February 10, 2011, Petitioner agreed not to contest CMS's findings of substantial noncompliance with regard to 18 of the 19 deficiencies cited at the May 20, 2010 recertification survey. It agreed to contest only the findings for the deficiency cited at Tag F-323. CMS agreed to accept June 28, 2010, as the date Petitioner came back into substantial compliance with participation requirements (the date Petitioner's plan of correction indicated as the date it would achieve substantial compliance). CMS rescinded imposition of the DPNA, which had been effective July 3 through 13, 2010. The parties agreed that the issues remaining in dispute are whether there was a basis for CMS to impose a PICMP for the deficiency cited at Tag F-323 from the May 20, 2010 survey and, if so, whether the $7,100 PICMP is reasonable in light of the factors specified at 42 C.F.R. § 488.438(f). Jt. Stips. 5-7.

I held a hearing in this case in San Francisco, California, from June 20 through 22, 2011. A 575-page transcript (Tr.) was prepared. Testifying were: Susan Coombs, R.N. (Surveyor Coombs), at the time of the survey a health facilities evaluator nurse with the state agency and the team leader for the May survey of Petitioner's facility; Captain Mary Gessay (Captain Gessay), a federal surveyor in the Division of Survey and Certification, Region IX, CMS; Simon Chereme, R.N. (Surveyor Chereme), a health facilities evaluator nurse with the state agency; Leila Antonio, R.N. (DON Antonio), Petitioner's Director of Nursing (DON); Emar Bermudes, R.N. (RN Bermudes), the Regional Director of Clinical Operations for Covenant Care, an entity of which Petitioner is a part; and Celine Schweitzer, R.N. (RN Schweitzer), a nursing supervisor at the facility. I admitted CMS Exs. 1-10, 12-21, 32, 34, 36, 38, 40, 42, 43, 45, 46, 48, and 49. I admitted Petitioner's exhibits (P. Exs.) 1-32. Tr. at 559. Both parties filed post-hearing briefs (CMS and P. Br.) and post-hearing answer briefs (CMS and P. Ans. Br.).

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[1] A scope and severity level of K denotes a pattern of deficiencies that constitute immediate jeopardy to resident health and safety. State Operations Manual (SOM), § 7400E; 42 C.F.R. §§ 488.301, 488.404, 488.408.

[2] Petitioner did not contest the loss of NATCEP. However, even if it was contested, the PICMP I uphold ($7,100) demands the two-year NATCEP bar.

[3] Page 3 of the joint stipulation shows the date the stipulation was signed to be February 10, 2010, but that is an obvious typographical error.

II. Issues

The issues before me are:

> 1. Whether Petitioner was in substantial compliance with participation requirements in the Medicare and Medicaid programs; and
>
> 2. Whether the remedies imposed are reasonable.

III. Controlling Law

Sections 1819 and 1919 of the Social Security Act (Act) and the regulations at 42 C.F.R. Part 483 govern Petitioner's participation in Medicare and Medicaid. Sections 1819 and 1919 of the Act provide the Secretary of Health and Human Services (Secretary) with authority to impose remedies, including CMPs, against long-term care facilities for failure to comply with participation requirements.

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.

The Secretary has delegated to CMS and the states the authority to impose remedies against long-term care facilities not complying substantially with federal participation requirements. The applicable regulations at 42 C.F.R. Part 488 provide that state survey agencies, on behalf of CMS, may survey facilities participating in Medicare and Medicaid to ascertain whether the facilities are complying 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 if a state survey agency ascertains that the facility is not complying substantially with participation requirements. 42 C.F.R. §§ 4 88.406, 488.408, and 488.430. The CMP may begin to accrue as early as the date that the facility was first substantially out of compliance and may continue to accrue until the date the facility achieves substantial compliance, or until CMS terminates the facility's provider agreement. 42 C.F.R. § 488.440.

The regulations specify that if a CMP is imposed against a facility based on an instance of noncompliance, the CMP will be in the range of $1000 to $10,000 per instance. 42 C.F.R. § 488.438(a)(2). When a CMP is imposed against a facility on a per day basis, it must fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The

upper range of CMP, from $3,050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. § 488.438(a)(1)(i), (d)(2). The lower range of CMP, from $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). "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.

Sections 1819(f)(2)(B) and 1919 (f)(2)(B) of the Act prohibit approval of a NATCEP if within the last two years the facility has been subject to, among other things, an extended or partial extended survey; imposition of a CMP of not less than $5,000; or imposition or a denial of payment for new admissions.

The Act and regulations make a hearing before an Administrative Law Judge (ALJ) available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act, section 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *The Residence at Salem Woods*, DAB No. 2052 (2006); *Cal Turner Extended Care*, DAB No. 2030 (2006); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Anesthesiologists Affiliated*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991). A facility has the right to appeal a certification of noncompliance leading to an enforcement remedy. 42 C.F.R. § 488.408(g)(1); 42 C.F.R. §§ 488.430(e), 498.3. However, the choice of remedies, or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may challenge the scope and severity that CMS cites only if a successful challenge would affect the range of CMP amounts that CMS imposed or would affect the facility's NATCEP. 42 C.F.R. § 498.3(b)(14), (d)(10)(i). CMS's determination as to the scope and severity of non-compliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9 (2000), *aff'd, Woodstock Care Center v. U.S. Department of Health and Human Services*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (Board) has long held that the net effect of these regulations is that a provider has no right to challenge the scope and severity assigned to a noncompliance finding except in the situation where that finding is the basis for an immediate jeopardy determination.

See, e.g., Ridge Terrace, DAB No. 1834 (2002); *Koester Pavilion,* DAB No. 1750 (2000). ALJ review of a CMP is subject to 42 C.F.R. § 488.438(e).[4]

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

IV. Discussion

I make numbered findings of fact and conclusions of law (Findings) to support my decision. I set them forth below as separate headings, in bold and italic type, and discuss each in detail.[5]

At the outset, I note that Petitioner moved at hearing to dismiss one of the deficiency citations under Tag F-323 (regarding unsafe side rails), as well as the $7,100 PICMP. In its answer brief, Petitioner asserts that the motion should be granted because CMS did not

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[4] Although recognizing that the "prevailing interpretation of the regulations" precludes its challenging the immediate jeopardy determination where only a PICMP has been imposed, Petitioner argues forcefully that it should be permitted to challenge the immediate jeopardy finding and thus the scope and severity assigned to the deficiency. P. Br. at 26-29. Insofar as Petitioner asserts that it has a constitutional due process right to do so, I am without the authority to hear those arguments. However, its due process argument is preserved for appeal. Where Petitioner argues that it should be allowed to address the immediate jeopardy determination in challenging the reasonableness of the PICMP, as noted above, my review of the CMP is governed by 42 C.F.R. § 488.438(e) and it is under that standard that I evaluate the reasonableness of the PICMP.

[5] I have reviewed the entire record, including all the exhibits and testimony. Because the Federal Rules of Evidence do not control the admission of evidence in proceedings of this kind (*see* 42 C.F.R. § 498.61), I may admit evidence and determine later, upon a review of the record as a whole, what weight, if any, I should accord that evidence or testimony. To the extent that any contention, evidence, or testimony is not explicitly addressed or mentioned, it is not because I have not considered the contentions. Rather, it is because I find that the contentions are not supported by the weight of the evidence or by credible evidence or testimony.

specifically reference the motion in its post-hearing briefing. P. Ans. Br. at 2, citing Tr. at 509-10. I deny the motion. The entire thrust of CMS's post-hearing brief references why I should sustain the deficiency findings and the PICMP.

CMS noted at hearing that facts common to the F-Tag at issue here, Tag F-323, are also common to two of the deficiencies which were stipulated to be not at issue in this case. Specifically, Petitioner agreed,

> . . . to accept CMS's finding of substantial noncompliance and agrees not to challenge eighteen of the nineteen deficiencies cited at the May 20, 2010 recertification survey. Buena Vista contests the findings for the deficiency cited at F-323 (K) from the recertification survey conducted on May 20, 2010.

Jt. Stips. 5. Based on this stipulation, CMS moved for a ruling that the facts underlying these two deficiencies be found not to be in dispute and administratively final. Tr. at 35-36. Petitioner responds that the purpose of the joint stipulation was to narrow the issues for appeal. Petitioner asserts it reserved the right to contest the deficiency at Tag F-323 and that CMS's reading of the joint stipulation is incorrect. P. Br. at 26; P. Ans. Br. at 2 (which states that since CMS's brief did not address this motion CMS had thus conceded Petitioner's position). I deny CMS's motion. The language of the stipulation does not support CMS's argument that the facts underlying the deficiency citations are not contested where Petitioner specifically reserved contesting the findings underlying the deficiency cited at Tag F-323.

> ***1. Petitioner failed to comply substantially with the participation requirement at 42 C.F.R. § 483.25(h) (Tag F-323).***

42 C.F.R. § 483.25 requires that:

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

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

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

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

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

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

The Board stated in *Briarwood Nursing Home*, DAB No. 2115, that:

> [T]he "mere fact that an accident occurred does not, in itself, prove that the supervision or devices provided must have been inadequate to prevent it." Josephine Sunset Home, DAB No. 1908, at 13 (2004). On the other hand, it is not a prerequisite to finding noncompliance under section 483.25(h)(2) that any actual accident have occurred or be caused by the inadequate supervision to find noncompliance. Woodstock at 17. The occurrence of an accident is relevant to the extent the surrounding circumstances shed light on the nature of the supervision being provided and its adequacy for the resident's condition. St. Catherine's Care Center of Findlay, Inc., DAB No. 1964, at 12 (2005) (accident circumstances may support an inference that the facility's supervision of a resident was inadequate). The focus is on whether the facility took all reasonable steps to ensure that a resident receives supervision and assistance devices that met his or her assessed needs and mitigate foreseeable risk of harm from accidents. Woodstock Care Center v. Thompson, 363 F.3d at 590 (facility must take "all reasonable precautions against residents' accidents").
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> > The regulation speaks in terms of ensuring that what is "practicable" and "possible" to do is done. What is thus required of facilities is not prescience but reason and professional judgment in assessing what can be done to make residents (given their special needs) safe, through removing

> accident hazards, providing appropriate devices, and ensuring adequate supervision.
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> Josephine Sunset Home, at 14-15.

Briarwood Nursing Center, DAB No. 2115, at 11-12.

The Board has also held that the regulations permit facilities some degree of flexibility in choosing the methods they use to prevent accidents, so long as the chosen methods constitute an adequate level of supervision. *Windsor Health Care Center,* DAB No. 1902 (2003), *aff'd Windsor Health Center v. Leavitt*, 2005 WL 858069 (6th Cir. April 13, 2005). A facility must anticipate what accidents might befall a resident and take steps – increased supervision or the use of assistance devices – to prevent them. *Aase Haugen Homes,* DAB No. 2013 (2006).

In finding Petitioner in violation of this participation requirement, the state agency determined that Petitioner failed to: (1) identify and replace unsafe side rails for 17 of 44 sampled residents where the rails were utilized for bed mobility;[6] (2) implement a bed alarm for Resident 20 after identifying that a tab alarm was ineffective in alerting staff to unassisted transfers; (3) provide a post-fall rehabilitation assessment and install wheelchair anti-tip bars for Resident 3; (4) pad Resident 14's headboard and side rails per facility policy and develop and implement seizure precautions as part of an individualized plan of care; (5) promptly answer call lights for Residents 45 and 46; and (6) turn on the bed alarm to alert staff when Resident 19 was attempting to get out of bed to use the bathroom. CMS Ex. 1, at 27-45. Below, I address all but one of these alleged violations. In its post-hearing briefing, CMS did not address whether Petitioner promptly answered call lights for Residents 45 and 46 and I do not address the issue below because it is not necessary for me to do so to support the PICMP imposed. *Community Skilled Nursing Centre*, DAB No. 1987 (2005); *Batavia Nursing and Convalescent Center,* DAB No. 1904, at 21-22 (2004), *aff'd, Batavia Nursing and Convalescent Center v. Thompson,* DAB No. 04-3325 (6th Cir. April 15, 2005).

A. Petitioner failed to develop an effective system to identify and replace unsafe side rails.

For 17 residents, Petitioner utilized full metal side rails for bed mobility. These side rails, which bordered the sides of the mattress,

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[6] Petitioner's plan of correction to eliminate full-length bed side rails and/or maximize safety with those rails noted that as of May 11, 2010, Petitioner had 24 beds with full-length side rails of which 20 were occupied. CMS Ex. 7, at 3. Other references in the record are to 17 occupied beds with side rails. Whether the count is 17 or 20 is not relevant to my decision.

> were designed to have a metal spacer in the middle of the top and bottom side rail frame, which allowed the side rail to lengthen when lowered and shorten when raised. This metal spacer connected the full metal side rail together in the middle . . . .

CMS Ex. 1, at 28; CMS Ex. 7, at 14; CMS Ex. 13; P. Ex. 3. CMS asserts that the mere fact that Petitioner used these side rails is not at issue. What is at issue, as CMS argues its case, is an "overarching safety issue" with regard to the condition of the rails and the revelation by maintenance staff that weekly repairs to the rails were necessary. CMS Br. at 7.

The SOD relates that the metal spacers provided stability for the side rails. However, the SOD asserts, and CMS agrees, that Petitioner failed to ensure these metal spacers were maintained to prevent separation, causing exposed sharp metal edges, instability, and collapse of the side rail without warning. CMS Ex. 1, at 28. During the May survey, the surveyors allegedly identified five side rails that were either disconnected at the upper or lower railing or were observed to have a gap in the middle of the side rail caused by a missing metal spacer. CMS Ex. 1, at 30-33; CMS Ex. 7, at 22-23. Specifically, Surveyors Coombs and Chereme, and Captain Gessay, testified variously that they observed the full length side rails being used and that the five rails were in a state of disrepair sufficient to present an accident hazard to Residents 36, 37, 38, 42, and 44. The side rails were found to have gaps in the middle of the bars caused by missing metal spacers. And according to the surveyors and CMS, Resident 42's side rail had splits in the top bar creating a sharp surface. CMS Exs. 1, at 30-33; CMS Ex. 7, at 17, 22-23; CMS Ex. 13; Tr. at 48, 51, 59, 70-72, 270, 342-44.

CMS alleges that the disconnected side rails exposed Petitioner's residents to sharp metal edges at the gap that could have caused serious injury to elderly residents' fragile skin. Tr. 207; CMS Ex. 13, at 2. CMS notes that DON Antonio and RN Schweitzer both testified that elderly residents' fragile skin leaves them more prone to skin tears. Tr. at 442, 550. CMS asserts that Resident 44, who was capable of being interviewed, reported to Surveyor Coombs and Captain Gessay that the edges of her disconnected side rail felt sharp to the touch and that she used her side rails to assist with movement in the bed. CMS Ex. 1, at 30; Tr. at 51, 150-51, 271-72; CMS Ex. 7, at 17. Surveyor Coombs testified that she also touched the exposed edges of the side rail and found it sharp. Tr. at 51. Surveyor Coombs testified that when the side rail was lowered it was flush with the mattress. It was Surveyor Coombs' opinion that if an elderly resident slid off the edge of the bed to get to a wheelchair, the gap in the side rail could catch the resident's leg. Tr. at 55.

CMS also alleges that the disconnected side rails were unstable, wobbly, and leaned out - away from the bed when a resident grabbed the rail and applied pressure. Surveyor

Coombs and Captain Gessay testified specifically that they both observed that the rails were unstable, wobbly and leaned out during a medication pass when Resident 44 reached for her side rail near the gap and pulled on it as she attempted to move in bed. Tr. at 50-51, 277-80. Surveyor Coombs testified that this was an accident hazard because a resident could fall out of bed and "possibly . . . even be impaled by the side rail if it collapsed." Tr. at 86-87.

CMS alleges that the possibility of side rail collapse and consequent resident injury is not merely theoretical or speculative, but very real in these circumstances. CMS Br. at 9-10. Surveyor Chereme testified that he was in Resident 38's room with two members of Petitioner's maintenance staff, the maintenance supervisor (Mr. Zeimkiewicz) and his assistant (Mr. Sausedo).[7] Mr. Sausedo informed Surveyor Chereme that the metal spacer had slipped into one part of the disconnected rails. Mr. Sausedo tried to pull the spacer out with his fingers, could not, and obtained a tool to pry it loose. When he attempted to align the lower disconnected side rail, the top rail became disconnected, causing the entire rail to collapse. Surveyor Chereme testified Mr. Sausedo was not handling the side rail in a rough manner or using the tool to "bang on" the rail, "jerk on" it, or "shake" it when it collapsed. Tr. at 342-48.

Both Surveyor Coombs and Captain Gessay testified that they were told by the maintenance staff that because of the problems with the metal spacers weekly repairs had to be made to the side rails. Tr. at 72, 272. Surveyor Coombs testified that Mr. Ziemkiewicz told her that nursing staff would inform maintenance that a spacer was missing, and, although there was a maintenance log at the nurse's station, repairs to the spacers were not routinely documented. Surveyor Coombs checked the maintenance log but did not identify any entries regarding spacer repair. Moreover, the facility administrator did not recall whether he had been made aware of the spacer problem. Tr. at 81-82. DON Antonio confirmed that Petitioner's practice is to report side rails needing repair to the maintenance staff and not to document that a repair needs to be done. Tr. at 429-30.

CMS notes also that despite daily rounds made by assigned staff or department heads where, among other things, the condition of the side rails was allegedly examined, DON Antonio could not explain why on May 10 and 11, 2010 (the first two days of the survey), Petitioner's personnel did not identify any of the five full-length side rails that were disconnected and had gaps in the middle until it was brought to their attention by the survey team. Tr. at 427. CMS notes too that even though Petitioner's administrator was a member of the safety committee, he denied knowing about weekly repairs being made to the full-length side rails or that Petitioner had a problem with spacers sliding into

[7] Petitioner submitted the statements of Mr. Ziemkiewicz and Mr. Sausedo in lieu of testimony. I can afford those statements but little weight as Mr. Ziemkiewicz and Mr. Sausedo were not made available for cross-examination.

bed rails leaving a gap in the middle. However, he informed Surveyor Coombs that Petitioner was replacing the beds with full-length side rails as funds became available. CMS Ex. 7, at 7, 13; Tr. at 160.

CMS argues that the "verbal system" in place was not effective in getting a message to the DON or administrator that the full-length side rails needed weekly maintenance and thus that their use should be evaluated. CMS asserts that no one was tracking the wear and tear of the rails, which Petitioner asserts had been in use for over 20 years. Moreover, Petitioner did not appreciate that disconnected, sharp, wobbly side rails presented an accident hazard. CMS argues that Petitioner failed to take all reasonable steps necessary to ensure the environment was free of accident hazards and that it should have reasonably foreseen that a dangerous condition existed. *Azalea Court*, DAB No. 2352 (2010); *Woodland Village Nursing Center*, DAB No. 2172, at 18 (2008).

Petitioner vigorously disputes Petitioner's contentions. Petitioner argues both that CMS failed to make a *prima facie* case of a deficiency with respect to the side rails and that the evidence it produced demonstrates that the side rails never posed more than minimal harm to its residents and that Petitioner had an effective system to keep the side rails (and all equipment in use at the facility) in good working order. Petitioner argues that CMS has conflated minor maintenance issues into immediate jeopardy to resident health and safety.

Petitioner argues specifically that in approximately 20 years of use at the facility, no resident, family member, or staff member ever noted a resident suffered harm from the side rails or believed they posed a threat for more than minimal harm. DON Antonio testified that in her five years of working at the facility no one got "close to being hurt" by the side rails. Moreover, she testified that she was not aware of an instance of side rail collapse, other than that identified by the surveyors. Tr. at 394, 397. Nurse Schweitzer testified that for the 20 years she worked at the facility no one has been hurt by the side rails. Tr. 538, 540.

Petitioner refers to testimony of its witnesses, DON Antonio and RNs Bermudes and Schweitzer, that the edges of the side rails were not sharp and that even when the spacer was correctly in place the allegedly-sharp edges of the side rail tubes were still exposed. Tr. at 392-93; 527-28, 532-33. Petitioner notes that the photographs of the side rails (CMS Ex. 13) do not show sharp edges and the totality of the evidence regarding their supposed sharpness is that Surveyor Coombs and Resident 44 touched the rails. Petitioner correctly points out that neither Surveyor Coombs nor Resident 44 suffered even minimal harm from the contact. Tr. at 142. The surveyors did not objectively test to determine how sharp the side rails were. Petitioner argues that whether residents of SNFs are frail and elderly, and thus more prone to skin tears, does not amount to or equate with credible evidence that the side rails in question were dangerously sharp.

Petitioner also refers to testimony of its witnesses that the rails were not wobbly to the point of presenting a safety issue. RN Schweitzer testified that she was not concerned and the rails were used many times over the years. Tr. at 537. DON Antonio testified that she had not observed a wobbly side rail and that the approximately one-inch space between the side rail and mattress meant there was no potential for resident entrapment. Tr. at 394. Petitioner argues that the surveyors never objectively tested, reviewed records for, or interviewed anyone regarding "wobbliness."

With regard to the side rail collapse witnessed by Surveyor Chereme, Petitioner argues that CMS jumped to an "illogical conclusion" that the rails were coming apart on a regular basis and presented the likelihood of serious injury. Petitioner asserts that a one-time occurrence is dissimilar to the way a resident usually employs the side rails, does not plainly demonstrate anything, and cannot support a citation of this sort based on the hazard of injury. It is Petitioner's position that there is no competent evidence in the record that points to a side rail collapse even potentially threatening a resident's safety.

Petitioner notes that it has been using the side rails for a long time and that for at least the previous five years of surveys neither the state agency nor CMS has even commented on the condition of its side rails. Petitioner argues that had the rails posed a safety risk surely some previous surveyor would have noted the risk.

Petitioner argues that that CMS is incorrect in asserting that Petitioner did not have a system for identifying and replacing unsafe side rails. Petitioner asserts it had a system that was 100% successful over a 20-year period. As Petitioner views the question, repair of side rails was a maintenance issue, not a resident safety issue. Tr. at 532-33. Petitioner argues that CMS is ignoring information regarding its safety system noting that Petitioner's administrator informed Surveyor Coombs that Petitioner had a safety committee that conducted room rounds and used a form to report issues. These room rounds were done on a daily basis. Tr. at 384. Equipment safety was checked, despite Ms. Coombs' testimony that she did not recall the administrator telling her that the safety of the side rails should be identified during the room rounds. Equipment was checked as staff was "looking @ items in room." Tr. 170-71; CMS Ex. 8, at 8-9. In addition to daily room rounds, Petitioner had a safety committee that made weekly room checks which included inspecting bed rails to make sure they were in good working order. CMS Ex. 8, at 10; Tr. at 166, 387. If the safety committee or employees conducting room rounds identified equipment issues, the issues were brought up at the standup meeting of department heads which took place every weekday morning. Tr. at 387-88. Moreover, anyone on staff could notice something that needed to be fixed and report the defective equipment to maintenance, a department head wasn't required to be the one reporting the defective equipment to maintenance. Tr. at 391. Petitioner also had spare side rails on the premises and would replace any side rail which could not be fixed. Tr. at 391, 536. As an additional safety program, Petitioner conducted walking rounds every 30 to 45 days that included each resident's interdisciplinary team. These were thorough reviews

at the resident's bedside where all equipment the resident used was inspected. Tr. at 515-16. Petitioner argues that CMS did not fully investigate what safety systems existed, or simply ignored evidence of the safety systems they claimed did not exist. Despite CMS's criticism, Petitioner asserts that the fact that no resident was ever harmed by side rails in disrepair demonstrates the effectiveness of Petitioner's safety systems (despite the missing spacer issue having occurred for over 20 years). Tr. at 532-33.

Petitioner argues the reason that there were not maintenance log entries related to the spacer repairs is "self-evident: if the issue was significant enough to warrant tracking, maintenance would have kept records." P. Ans. Br. at 5. This supports a finding that the missing spacer was not a safety issue. There is no regulatory requirement of a need to document minor maintenance activity.

In sum, Petitioner asserts the "overwhelming" weight of the evidence demonstrates that the side rails posed no potential for more than minimal harm and that its three-layered safety system of: (1) daily rounds; (2) weekly rounds by the safety committee; and (3) interdisciplinary team walking rounds was a system that kept its residents safe and was 100% successful in preventing injuries caused by faulty side rails. Petitioner asserts it thus proactively ensured its side rails were not an accident hazard. Given the side rails' use for 20 years without incident, there was no basis on which Petitioner believes that it could have reasonably been expected to foresee that the side rails posed any danger. CMS's subjective and hastily formed opinion, without significant observation, interview, or record review, should not be substituted for Petitioners' 20 years' experience of using the side rails and dealing with minor spacer issues.

I find that CMS has shown, and Petitioner has not been able to rebut, that Petitioner failed to have an effective system to identify and reduce accident hazards at its facility and failed to provide adequate supervision and assistance devices (the side rails) to protect its residents from foreseeable risks. As noted in the Board's decision in *Meadow Wood Nursing Home*, DAB No. 1841, at 18 (2002), "poorly maintained equipment is precisely the sort of preventable accident hazard that a facility can practicably be expected to address." Petitioner relies on its record of 20 years without a side rail accident as evidence of its compliance with this participation requirement. However, it is not a prerequisite to my finding noncompliance that an actual accident have occurred. Nor is it a prerequisite to my finding noncompliance in this instance that Petitioner has never been cited by the state agency or CMS for prior side rails problems. It is possible that during other surveys the side rails appeared undamaged or that for some reason its three-layered safety system was just not working effectively in May 2010. Obviously, there are many other possibilities that could explain surveyors' non-citation of the side rails over two decades, but their number and nature are not important here: what does matter is that, once again, it is remembered that the absence of real evidence on the point does not amount to evidence that the side rails were affirmatively determined to be compliant with program requirements. Thus, the history of Petitioner's systems with regard to side rails

is not relevant in this instance of alleged noncompliance. Instead, I am obliged to determine whether, during this survey in May 2010 and based on the observations of the surveyors at that time, an accident hazard existed and whether Petitioner's residents were receiving the supervision and assistance devices contemplated by the regulations.

There is no dispute that during the survey the surveyors found five sets of full-length side rails in which certain rails were disconnected at either the upper or lower railing and were observed to have a gap in the middle of the side rail caused by a missing spacer. One of the rails was observed to have a split, or crack, in the top metal bar. These five side rails represent, at a minimum, one quarter of all the full-length side rails in use at the facility at that time. Petitioner has not explained how, despite Petitioner's system of daily and weekly rounds and monthly interdisciplinary team walking rounds, no one at the facility was aware, when in May 2010 the surveyors entered the facility, that fully one quarter of its full-length side rails had observable gaps in the middle of the railings caused by the missing spacers until the surveyors brought the problem to the facility's attention. Tr. at 427. Although Mr. Ziemkiewicz and Mr. Sausedo were apparently aware of a general problem with side rail spacers, there is no evidence of record as to exactly when or how many times side rails were repaired because there is no documentation regarding the problem. Even though the administrator served on a safety committee with maintenance staff, he did not know about the ongoing problem with spacers, although acknowledging his facility was replacing the full-length side rails.

I do not agree with Petitioner's argument that the spacer issue was only a minor maintenance issue. While I cannot determine from Surveyor Coombs' testimony and the photographs in CMS Ex. 13 precisely how sharp the ends of the rails might have been, I need not reference the exact sharpness of the tube ends or whether the rails were likely to collapse to find noncompliance. I need only credit the observations of the surveyors who testified at the hearing that the side rails were wobbly and leaned outwards, to agree with CMS that a wobbly and/or outwardly leaning side rail presents a hazard to a nursing home resident using the rails for purposes of bed mobility. Expert testimony is not necessary in this regard. Moreover, in reviewing the photographs at CMS Ex. 13, the photograph at CMS Ex. 13, at 3, depicts an obvious gap in the upper rail. It is evident that a resident exiting the bed could get caught in that gap when the rail is in a lowered position.

B. Petitioner failed to provide an adequate level of supervision to protect Resident 20, assessed as a fall risk, from unassisted transfers and potential falls.

Resident 20 was admitted to the facility on April 19, 2010. CMS Ex. 12, at 1. His admission assessment of that date revealed he was at high risk for falls due to intermittent confusion, gait problems, and a history of falls. His daughter informed the facility that he had previously fallen at night because of confusion and attempting to get out of bed

unassisted. CMS Ex. 1, at 35; CMS Ex. 12, at 28, 31, 36, 44. Petitioner's plan of care to address Resident 20's falls included the interventions of: a tab alarm (an alarm attached to a resident and the resident's bed that sounds if the resident attempts to get out of bed unassisted), a mattress on the floor, and keeping the floor free of spills and clutter. CMS Ex. 1, at 35-36; CMS Ex. 12, at 25. The SOD alleges that Petitioner did not implement a bed alarm[8] when a tab alarm was ineffective in alerting staff to an unassisted transfer. CMS Ex. 1, at 29.

Resident 20 fell twice within days of admission. His first fall was on April 21, 2010, at approximately 4:30 p.m., during which he sustained a skin tear to his left forearm and apparently a bump to his head. CMS Ex. 12, at 11, 12; P. Ex. 7, at 5. Facility notes reflect that Resident 20 stated that he was looking for a telephone, slid out of bed, and may have bumped his head. Petitioner's post-fall investigation revealed that his tab alarm did not activate. CMS Ex. 12, at 3, 11; P. Ex. 7, at 5. When Surveyor Chereme asked the DON why the tab alarm failed, she indicated it was not functioning properly. CMS Ex. 1, at 36; CMS Ex. 12, at 3, 11; P. Ex. 7, at 5; Tr. at 340.

In response to the fall, Petitioner's nursing staff conducted neurological checks (brief assessments of the nervous system to determine abnormalities in sensation, movement, and level of consciousness) which the neurological assessment flow sheet indicates were completed by 12:45 a.m. on April 22, 2010. CMS Ex. 1, at 36; CMS Ex. 12, at 7-8; P. Ex. 7, at 8. Petitioner also updated Resident 20's care plan, instructing staff to check the placement of his tab alarm before, during, and after each shift. CMS Ex. 12, at 9. CMS asserts that Petitioner did not, and should have, documented interventions to increase Resident 20's supervision after the neurological checks ended, such as moving Resident 20 closer to the nurse's station, utilizing a different type of alarm, or placing a telephone in a position more easily accessible to his bed. CMS Ex. 1, at 36.

Petitioner fell again on April 22, 2010, at about 3:00 a.m. P. Ex. 7, at 2-3. A CNA heard Resident 20 cry for help and found him on the floor, away from his mattress, with his tab alarm unattached to his clothing. CMS Ex. 12, at 3, 13, 49. When discovered, he was confused and stated he wanted to call his son and he had pain in his head and left hip. After being transferred to a hospital, an x-ray revealed he had a left hip fracture. CMS Ex. 12, at 13, 33. The SOD notes that recommendations for his care upon returning from the hospital included that the facility should utilize a bed alarm. CMS Ex. 1, at 37.

The SOD states that on May 20, 2010, at 10:00 a.m., a surveyor observed Resident 20 in a bed lowered to the floor with one side against a wall, a tab alarm attached to the back of his hospital gown, and a blue foam pad on the right side of the bed. The SOD alleges that

[8] A bed alarm is a type of safety alarm with a pressure-release pad that activates when a resident rises off a bed, as opposed to a tab alarm, which is attached to a resident and is activated when a resident attempts to get up. CMS Ex. 1, at 29.

Petitioner continued interventions which had proven to be ineffective, apparently referring to the tab alarm, and this placed him at risk for further falls. CMS Ex. 1, at 37.

CMS adopts Surveyor Chereme's testimony that in his professional opinion Petitioner failed to provide Resident 20 with adequate supervision and assistance devices after his first fall and continued ineffective interventions placing him at risk for further falls. Tr. at 341. CMS argues that aside from a brief period of increased supervision associated with the neurological checks, Petitioner failed to provide alternative and more effective interventions and Resident 20 suffered serious actual harm, sustaining a fracture during his second fall. Moreover, CMS asserts that Petitioner admitted that it had no documentation to prove that any increased visual checks were conducted on Resident 20 after the visual checks associated with the neurological checks stopped. P. Ex. 7, at 13. I note, however, that nurse's notes from April 22, 2010, at 2:45 a.m., reflect that Resident 20 was to be visually checked every thirty minutes and as needed. CMS. Ex. 12, at 43; Tr. at 412.

Petitioner argues that based on its experience with Resident 20, the use of the tab alarm was still a reasonable intervention after the first fall. Petitioner states it toileted Resident 20 and checked that his tab alarm was functioning and in place 20 minutes before he fell the second time on April 22, 2010. P. Ex. 7, at 2; Tr. at 412-14. Petitioner argues that the only reasonable conclusion to be drawn from the second fall is that Resident 20 removed the tab alarm himself. Tr. at 414-15. Finally, Petitioner notes that because he had not previously removed the tab alarm, Petitioner had no basis to believe he would do so. Petitioner asserts CMS acknowledges (Tr. at 355) that residents have the right to remove a tab alarm. Petitioner notes that it ultimately implemented a bed alarm for Resident 20, as well as other interventions such as a low bed, a bed against the wall, and a floor mattress. P. Ex. 7, at 14; Tr. at 415-16. Petitioner argues, however, that CMS ignored its other interventions when, during the survey, the surveyors decided that the facility continued an ineffective intervention (the tab alarm) because a surveyor saw a tab alarm on Resident 20.

Petitioner argues that the presence of the tab alarm during the survey did not increase the potential for Resident 20 to experience a fall. In fact, Resident 20 did not fall again after his readmission. Petitioner argues that, as with any new resident, it took time for the facility to determine what interventions constituted the most effective approach to deal with Resident 20's falls, but that it determined the best interventions within "a reasonably short period of time." P. Br. at 15. Petitioner notes (P. Ans. Br. at 8) that since CMS's briefing did not address the SOD's allegation that Petitioner was not in substantial compliance with this F-Tag due to Resident 20 having a tab alarm on during the survey, I should not consider the issue.

I do not find Resident 20's having a tab alarm on during the survey to be a deficiency given the other interventions in place which apparently included a bed alarm. Instead

what I examine here is whether the supervision and interventions that Petitioner was utilizing on April 22, 2010, after the first fall, provided an adequate level of supervision for Resident 20. Although the facility urges that it was most likely that the tab alarm did not sound for some apparently mechanical reason, Petitioner also notes that a resident has the right to remove a tab alarm. Given Resident 20's obvious propensity for falls, Petitioner should have re-evaluated its interventions and, as CMS notes, have considered other possibilities, including the use of a bed alarm. I find disturbing Petitioner's argument that it takes time to determine what interventions are the most effective approach to deal with a resident. Given that Petitioner knew the resident was a fall risk, Petitioner should, in the interim, have provided the most comprehensive interventions possible to assure that the resident was actually supervised, provided appropriate assistive devices, and protected from accidental falls.

C. Petitioner failed to provide an assistive anti-tip device as required by Resident 3's care plan.

The SOD indicates that Resident 3 was admitted with diagnoses including dementia, coronary artery disease, and depression. Resident 3 was assessed on September 13, 2009, to be confused, to have short and long term memory problems, and to require extensive assistance with walking, transfer, bed mobility and toilet use. Resident 3's fall risk assessment determined him to be at risk for falls, and his August 31, 2009 care plan identified interventions to counteract his risk for falls to include monitoring for unsteady gait and balance, side effects of medications, physical and occupational therapy post-fall evaluations and treatment as needed. CMS Ex. 1, at 38.

Nurse's notes dated September 24, 2009, reflect that Resident 3 tipped backwards in his wheelchair, fell, and hit his head. Petitioner's post-fall care plan was to apply an anti-tip device[9] to his wheelchair to prevent future tipping and falling. However, on May 12, 2010, at 2:30 p.m., Resident 3 was observed by a surveyor propelling himself in his wheelchair, in the hallway, without the anti-tip device attached. The SOD states that during an interview, the assistant director of nursing (ADON) confirmed Petitioner failed to apply the anti-tip device to Resident 3's wheelchair. During an interview with a surveyor on May 12, 2010, at 12:00 p.m., a physical therapist and an occupational therapist both indicated that they did not reassess Resident 3 or his wheelchair after the fall for safety measures, nor was the anti-tip device added to Resident 3's wheelchair. CMS Ex. 1, at 39.

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[9] Surveyor Chereme testified that an anti-tip device consists of two metal pieces that attach to the bottom frame of a wheelchair. It extends out straight and the two tips point down to the ground. The purpose of an anti-tip device is to prevent a wheelchair from tipping backward. Tr. at 328.

Petitioner does not refute the SOD statements that Resident 3 fell or that he did not have an anti-tip device on his wheelchair during the May survey. Instead, Petitioner argues that it provided adequate assistance devices to prevent Resident 3 from experiencing falls. Petitioner asserts that it provided other measures, including a lap belt, that constituted adequate assistance devices to prevent accidents because the measures it provided were effective in preventing further falls. CMS Ex. 9, at 83. Petitioner argues that the fact Resident 3 experienced no further falls between his September 2009 fall and the May 10, 2010 survey shows by a preponderance of the evidence that Petitioner was in substantial compliance by providing reasonable and adequate assistance to Resident 3 to mitigate his fall risk. Tr. at 410.

When the facility investigated this incident it determined that Resident 3 fell backwards onto a cement floor when he tried to cross from the patio to the dining room. Tr. at 324. For this backwards fall, it determined that an anti-tip device should be applied to his wheelchair. The anti-tip device was added as an intervention to his post-fall care plans. CMS Ex. 9, at 3, 13, 14. Petitioner also modified his fall risk assessment to an 18, which indicates he was at high risk for falls. CMS Ex. 9, at 10; Tr. at 326. On May 12, 2010, Surveyor Chereme observed that Resident 3's wheelchair was not equipped with an anti-tip device and confirmed this with Petitioner's staff. CMS Ex. 9, at 4; Tr. at 329. Given that Resident 3 fell backwards, the anti-tip device was a reasonable accommodation to protect the resident that Petitioner appears to have either forgotten to make or discontinued at some time while apparently not modifying the resident's care plan. Tr. at 330-32; P. Ex. 4, at 3. Petitioner has not alleged that its interdisciplinary team discussed the device and decided not to apply it. CMS Ex. 9, at 83. The other interventions that Petitioner asserts it provided were not specific to preventing a backwards fall. That Resident 3 did not fall backwards again is providential, but it is not evidence that Petitioner was in compliance with participation requirements.

D. Petitioner failed to develop an individualized care plan to reduce Resident 14's risk of injury from seizures.

Resident 14 suffered a full body seizure on October 29, 2009. The resident was seen to drool and lost consciousness for about one and a half minutes. CMS Ex. 1, at 39; CMS Ex. 10, at 8. A care plan for seizures was placed in the resident's record (CMS Ex. 10, at 18) but the plan was a pre-printed plan giving boxes which could be checked against various approaches which could be used. None of the approaches on the plan were checked, and no other approaches for the individualized care of future seizures were written up. Thus, it is not clear what approaches were to be used if Resident 14 suffered another seizure. Surveyor Coombs testified that when a preprinted care plan is used it must be individualized to meet a resident's needs, and Resident 14's care plan was not so modified. Tr. at 92.

The facility does have a seizure policy. CMS Ex. 10, at 5-6. One of the purposes of the policy is to prevent resident injury. One of the approaches, under the "EQUIPMENT" heading, is to support and protect the resident from injury by padding a resident's side rails and the head of their bed.

The SOD alleges that Petitioner was not in substantial compliance with this participation requirement because it did not follow its written policies regarding seizure management by permanently padding Resident 14's side rails and headboard and by not identifying particularized care plan approaches to protect Resident 14 in the event she had a seizure. I find that CMS has not made a *prima facie* case that Petitioner should have permanently padded the resident's side rails and headboard. DON Antonio testified that Petitioner's seizure policy (CMS Ex. 10, at 6) applies only after a resident is actually having a seizure. Tr. at 452-53. A plain reading of the policy CMS relies on supports Petitioner's argument that the policy is for the care of a resident in an active seizure, not to protect the resident from future seizures. CMS Ex. 10, at 6. CMS has, however, proved that the care plan Petitioner devised for Resident 14 was not adequate to ensure that her environment remained as free of accident hazards as possible or that she received adequate supervision and assistance devices to prevent her accidentally injuring herself during future seizures. CMS Ex. 10, at 18; Tr. at 92. While Petitioner argues that the allegation does not state a violation of 42 C.F.R. § 483.25(h), but instead one of the other regulations in Part 483 that address care planning, the fact is that here Petitioner's failure to care plan for active seizures placed Resident 14 at risk of accident.

DON Antonio testified that Petitioner did not have a policy or procedure to prevent harm related to seizures that were not actually occurring. Moreover, she admitted that Petitioner did not have any individualized approaches identified in Resident 14's care plan to provide for Resident 14's safety in the event she suffered another seizure. Tr. at 423-25; P. Ex. 5, at 5. While Petitioner argues that it complied with the regulations by informing the attending physician of the seizure, following which laboratory tests were ordered and Resident 14 was referred to a neurologist who ordered medication (Petitioner asserting it was thus following a "physician-ordered, individualized seizure care plan" (P. Ans. Br. at 9, citing Tr. at 409)), these actions do not take the place of a facility care plan to ensure that the resident was adequately protected from risk of accident in the event of a future seizure.

E. Resident 19's bed alarm did not alert staff when she tried to get out of bed without assistance.

The SOD alleges that Petitioner failed to turn on a bed alarm to alert staff when Resident 19 was attempting to get out of bed and needed assistance to use the bathroom. Resident 19 was a fall risk and needed assistance in ambulating, and who walked to the bathroom while incontinent of stool, and then went back to bed creating a great risk of injury. CMS Ex. 1, at 30.

Resident 19 was a cognitively impaired resident who was at high risk of falls and had, in fact, fallen at the facility on March 23, 2010, and again on April 10, 2010, while attempting to go to the bathroom. CMS Ex. 32, at 51, 54. She was assessed as requiring extensive assistance with bed mobility, transfer, toilet use, and personal hygiene. CMS Ex. 32, at 10; CMS Ex. 1, at 43. After the March 10 fall, the facility instituted interventions, noted in her care plan, of placing her bed against the wall in the lowest position, placing a mattress on the floor, and placing a bed alarm in the bed, which alarm the resident had previously not accepted. CMS Ex. 32, at 20, 53. After the April 10, 2010 fall, the facility determined that the bed alarm activated, the bed was in the correct position, and the mattress on the floor was in place. To prevent recurrence, Petitioner recommended that staff reinforce safe practices with Resident 19, such as calling and waiting for help before getting out of bed, and these interventions were placed in her care plan. CMS Ex. 32, at 20, 24, 54.

On May 16, 2010, Resident 19 was identified to have diarrhea. The interventions for toileting on her continence care plan are identified as a prompt toileting every two hours and to monitor her bowel and bladder status. CMS Ex. 32, at 21, 22; Tr. at 107-08. This does not appear to have been adjusted to take account of her diarrhea, however. On May 17, 2010, at 1:00 p.m., Surveyor Coombs testified that she observed Resident 19 in her bed with brown substance on her sock and a brief on the floor of the bathroom with what appeared to be stool on it. A brown substance was also smeared on the floor. Tr. at 101; CMS Ex. 32, at 86. Surveyor Coombs further testified that it appeared Resident 19 had transferred herself back to bed because otherwise the stool would not be on the floor and on the resident. Tr. at 102. Surveyor Coombs testified that she was concerned that Resident 19's bed alarm was not functioning properly because she would have expected it to go off when Resident 19 changed her weight and transferred off of the bed. Given the condition of the resident and the room, she would still have expected it to be sending an alarm. Tr. at 102-03. Surveyor Coombs testified that staff initially told her that Resident 19 could turn off the bed alarm, but Resident 19 was unable to identify to Surveyor Coombs how to turn off the bed alarm. Staff suggested to Surveyor Coombs that someone probably assisted Resident 19 to the bathroom earlier, turned off the alarm and then forgot to turn it back on. Tr. at 108. Surveyor Coombs testified that she was concerned for Resident 19 because she had previously fallen and her environment was a hazard with the brown substance on the floor in conjunction with her attempts to get to or leave the bathroom. Tr. at 109.

Petitioner argues that CMS's only evidence that Petitioner failed to activate Resident 19's bed alarm is the "pure speculation" of a staff member, which Petitioner asserts is not credible as it was only a guess. Thus, says Petitioner, CMS has not made a *prima facie* case of a deficiency. Moreover, Surveyor Coombs could only speculate as to whether the resident or someone else turned off the alarm. Petitioner argues that even if I determine CMS made a prima facie case, Resident 19's bed alarm was in working order because it

was checked daily weekdays during room rounds and weekly by the safety committee. Tr. at 410-11. Even if Resident 19 transferred herself without staff assistance, this happened despite Petitioner's practice of toileting her every two hours to address her incontinence. Tr. at 411; P. Ex. 6, at 3; CMS Ex. 32, at 22. Moreover, Petitioner suggests that it is more likely that Resident 19 turned the alarm off herself before transferring herself from the bed, as two staff members told Surveyor Coombs that she had done so on other occasions. CMS Ex. 34, at 85.

I find that a staff member turned off the alarm, given another staff member's suggestion to Surveyor Coombs that a staff member forgot to turn off the alarm in conjunction with Surveyor Coombs' observation that Resident 19 herself was not able to turn off the alarm. Moreover, despite Resident 19's having fallen twice while attempting to go to the bathroom, it did not occur to Petitioner to toilet the resident more often than every two hours when she had diarrhea. It was certainly foreseeable that in this instance the resident would be likely to get up and go to the bathroom, which I find she did given the presence of the soiled diaper in the bathroom. It was again simple providence that Resident 19 did not fall and injure herself.

2. The remedy imposed for the noncompliance, a PICMP of $7,100, is reasonable.

As noted above, I need not consider CMS's finding that the deficiency here constituted immediate jeopardy because the only remedy imposed is a PICMP. In determining whether the PICMP imposed here is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f), which include: (1) the facility's history of non-compliance; (2) the facility's financial condition; (3) the factors specified in 42 C.F.R. § 488.404; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort, or safety. The absence of culpability is not a mitigating factor. The factors at 42 C.F.R. § 488.404 include: (1) the scope and severity of the deficiency; (2) the relationship of the deficiency to other deficiencies resulting in non-compliance; and (3) the facility's prior history of non-compliance in general and specifically with reference to the cited deficiencies.

Petitioner has a history of noncompliance with the participation requirement at issue, having been issued a G-level citation based on a survey which took place in February 2007 (CMS Ex. 48, at 1). Petitioner has provided no evidence of its financial condition. Petitioner is culpable for its failure to develop an effective system to identify the hazards to which residents with full-length side rails were exposed, and failed to take all reasonable steps to eliminate foreseeable risks from these hazards. Additionally, Petitioner did not provide adequate supervision and assistive devices and reduce accident hazards for Residents 20, 3, 14, and 19. The failure to do so placed the residents at risk of more than minimal harm.

While a $7,100 PICMP is in the upper middle range of PICMP that CMS may impose for an instance of non-compliance, given that I have found several instances of a deficiency involving Tag F-323, involving different failures on Petitioner's part, the amount of PICMP imposed is reasonable and could even be considered de minimis.

V. Conclusion

For the reasons set forth above, CMS is authorized to impose a $7,100 PICMP for Petitioner's non-compliance with 42 C.F.R. § 483.25(h).

/s/
Richard J. Smith
Administrative Law Judge