

**Department of Health and Human Services**

**DEPARTMENTAL APPEALS BOARD**

**Civil Remedies Division**

Upland Rehabilitation and Care Center,  
(CCN: 05-5374),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-270

Decision No. CR5024

Date: February 7, 2018

**DECISION**

Upland Rehabilitation and Care Center (Petitioner or “the facility”) is a skilled nursing facility (SNF) located in Upland, California that participates in the Medicare program. Following a recertification survey in October 2015, the Centers for Medicare & Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare program requirements and that two of its deficiencies posed immediate jeopardy to resident health and safety. CMS imposed two separate \$5,000 per-instance civil money penalties (CMPs) based on these deficiencies. CMS also provided notice that it would impose a denial of payment for new admissions and that Petitioner would be prohibited from conducting a Nurse Aide Training and Competency Evaluation Program (NATCEP).

The survey cited eight deficiencies. (CMS Exhibit (Ex.) 1). Petitioner contests only the deficiencies cited under 42 C.F.R. §§ 483.13(b), (c)(1)(i) (Tag F223, right of residents to be free from abuse) and 483.25(h) (Tag F323, requirements for accident prevention and adequate supervision). *See* Request for Hearing. Both deficiencies were cited under the

“J” level of scope and severity.<sup>1</sup> CMS Ex. 1. Petitioner challenges CMS’s determinations of substantial noncompliance with 42 C.F.R. §§ 483.13(b), (c)(1)(i) and 483.25(h). Petitioner also challenges CMS’s findings that the deficiencies posed immediate jeopardy to resident health or safety.

For the reasons set forth below, I do not sustain CMS’s determination that Petitioner was not in substantial compliance with the requirements for participation at 42 C.F.R. § 483.13(b), (c)(1)(i). Therefore, I find that there is no basis for the imposition of a \$5,000 per-instance CMP for this deficiency. However, I find that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h), CMS’s immediate jeopardy determination was not clearly erroneous, and the \$5,000 per-instance CMP for this deficiency is reasonable.

## **I. Background**

The Social Security Act (Act) sets requirements for SNF participation in the Medicare program. The Act authorizes the Secretary of the United States Department of Health and Human Services (Secretary) to promulgate regulations implementing those statutory provisions. Act § 1819 (42 U.S.C. § 1395i-3). The Secretary’s regulations are found at 42 C.F.R. part 483.<sup>2</sup>

A facility must maintain substantial compliance with program requirements in order to participate in the program. To be in substantial compliance, a facility’s deficiencies may pose no greater risk to resident health and safety than “the potential for causing minimal harm.” 42 C.F.R. § 488.301.

The Secretary contracts with state agencies to conduct periodic surveys to determine whether SNFs are in substantial compliance with the participation requirements. Act

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<sup>1</sup> Scope and severity levels are used by CMS and state survey agencies when selecting remedies. The scope and severity level is designated by letters A through L. Pub. 100-7, State Operations Manual, § 7400.5.1 (Factors That Must be Considered When Selecting Remedies), “Assessment Factors Used to Determine the Seriousness of Deficiencies Matrix” (table), <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c07.pdf> (last visited January 29, 2018); see 42 C.F.R. § 488.408. As relevant here, a scope and severity level of “J” indicates an isolated deficiency that poses immediate jeopardy to resident health or safety.

<sup>2</sup> Federal nursing home regulations substantially changed beginning on November 28, 2016. 81 Fed. Reg. 68,688 (Oct. 4, 2016). Based on the date of the survey, which preceded the regulatory revisions, I refer to the regulations that were in effect at the time of the survey.

§ 1864(a) (42 U.S.C. § 1395aa(a)); 42 C.F.R. §§ 488.10, 488.20. The Act and its implementing regulations require that facilities be surveyed on average every twelve months, and more often if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A) (42 U.S.C. § 1395i-3(g)(2)(A)); 42 C.F.R. §§ 488.20(a), 488.308. Among other enforcement remedies, CMS may impose a per-instance CMP for each instance of noncompliance. 42 C.F.R. § 488.430(a). At the time of the October 2015 survey, a per-instance CMP could range from \$1,000 to \$10,000.<sup>3</sup> 42 C.F.R. § 488.438(a)(2).

The California Department of Public Health (state agency) conducted a recertification survey of the facility from October 12 through 16, 2015, at which time it cited eight deficiencies. CMS Ex. 1. As relevant for purposes of this discussion, the state agency determined that Petitioner was not in substantial compliance with 42 C.F.R. §§ 483.13(b), (c)(1)(i) (Tag F223, right of residents to be free from abuse) and 483.25(h) (Tag F323, requirements for accident prevention and adequate supervision) at the scope and severity level of “J.” CMS Ex. 1 at 1, 8. By letter dated November 24, 2015, CMS expressed agreement with the state agency’s determination that Petitioner was not in substantial compliance with participation requirements, that immediate jeopardy<sup>4</sup> to resident health and safety was identified and later abated by corrective action, and that the facility provided substandard quality of care.<sup>5</sup> CMS Ex. 3 at 1. CMS imposed a per-instance CMP of \$5,000 for the deficiency cited under 42 C.F.R. § 483.13(b), (c)(1)(i) and a separate \$5,000 per-instance CMP for the deficiency cited under 42 C.F.R. § 483.25(h). CMS Ex. 3 at 2. CMS also imposed a DPNA, effective January 16, 2016, and notified Petitioner that its NATCEP approval had been withdrawn. CMS Ex. 3 at 2.

On January 22, 2016, Petitioner requested a hearing. Administrative Law Judge (ALJ) Joseph Grow<sup>6</sup> issued an Acknowledgment and Pre-Hearing Order (Pre-Hearing Order) on February 3, 2016. CMS filed a Pre-Hearing Brief (CMS Br.) and 21 exhibits (CMS Exs.

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<sup>3</sup> CMP amounts increased, effective February 3, 2017, for deficiencies occurring after November 2, 2015. *See* 82 Fed. Reg. 9,174 (February 3, 2017).

<sup>4</sup> Immediate jeopardy exists when “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.” *See* 42 C.F.R. § 488.301.

<sup>5</sup> Substandard quality of care, as applicable here, “means one or more deficiencies related to participation requirements under . . . § 483.13, Quality of life . . . which constitute . . . immediate jeopardy to resident health or safety . . . .” 42 C.F.R. § 488.301.

<sup>6</sup> The Civil Remedies Division reassigned this case to me on April 1, 2016 following Judge Grow’s departure from the Departmental Appeals Board.

1-21), and Petitioner submitted a Pre-Hearing Brief (P. Br.), along with eight exhibits (P. Exs. 1-8). In the absence of any objections, I admit all submitted exhibits into the evidentiary record.

Petitioner does not challenge the imposition of a DPNA, and the evidentiary record does not address whether the DPNA went into effect or the duration of any such DPNA. Petitioner has also not challenged the determination that it could no longer conduct a NATCEP. *See* Request for Hearing; P. Br. Therefore, I need not address these uncontested remedies, which are administratively final.

Judge Grow's Order explained that a hearing to cross-examine witnesses would be "necessary only if a party files admissible, written direct testimony, and the opposing party asks to cross-examine." Pre-Hearing Order, § 10 (emphasis omitted). Both parties have filed written direct testimony; however, neither party has requested the opportunity to cross-examine any witnesses at a live hearing. This matter is therefore ready for a decision on the merits. Pre-Hearing Order, § 13.

## **II. Issues**

The issues are:

1. Was Petitioner in substantial compliance with 42 C.F.R. §§ 483.13(b), (c)(1)(i) (Tag F223);
2. Was Petitioner in substantial compliance with 42 C.F.R. § 483.25(h) (Tag F323);
3. If the facility was not in substantial compliance with 42 C.F.R. §§ 483.13(b), (c)(1)(i) and/or 483.25(h), did the noncompliance pose immediate jeopardy to resident health and safety; and
4. If the facility was not in substantial compliance, are the two \$5,000 per-incident CMPs imposed reasonable?

### III. Discussion<sup>7</sup>

#### A. *Petitioner was in substantial compliance with 42 C.F.R. § 483.13(b), (c)(1)(i) at the time surveyors observed an encounter between a resident and a facility employee.*

##### i. **Factual background, relevant law and facility policies**

An admission record documents that the facility admitted Resident # 20, a 76-year old female, on September 30, 2015, as a transfer from an acute care hospital, and her admission diagnoses included urinary tract infection, abnormal posture, and generalized muscle weakness.<sup>8</sup> CMS Ex. 11 at 1. Resident # 20's preceding acute care hospitalization had been "secondary to progressive weakness and pain and [altered level of consciousness]," and she had been diagnosed with septic shock due to urinary tract infection. CMS Ex. 11 at 13. The facility documented that it expected that Resident # 20 would be admitted for a short-term stay and that her family planned to take her home as soon as her strength improved. P. Ex. 5 at 102. Resident # 20's physician directed, through admission orders, that Resident # 20 receive both occupational therapy and physical therapy for five days per week for 30 days. CMS Ex. 11 at 32. Goals of therapy included improvements in dynamic balance, functional activity tolerance, sitting tolerance, postural control, and strengthening. CMS Ex. 11 at 8, 15. A physical therapy assessment by Petitioner reports that a treatment goal was "[f]or resident to get better and go home with family." CMS Ex. 11 at 6. A physical therapy evaluation and plan of treatment reports that Resident # 20 exhibited new onset paralysis and paresis, and that she had decreased dynamic balance, static balance, and activities of daily living participation. CMS Ex. 11 at 7. The assessment further noted that Resident # 20 had an increased need for assistance from others and decreases in strength, functional mobility, range of motion, and coordination. CMS Ex. 11 at 7. An occupational therapy plan of treatment reported that a goal was for Resident # 20 "to go home," and that she "demonstrates good rehab[ilitation] potential" and had "strong family support." CMS Ex. 11 at 12. The plan of treatment stated that Resident # 20's discharge plan was "to return to living with family." CMS Ex. 11 at 13.

Mr. K. Darnell, a physical therapy assistant (PTA) who has been employed by Petitioner since March 2011, provided physical therapy services to Resident # 20. P. Ex. 7 at 1. Mr. Darnell provided written direct testimony that Resident # 20's family had informed

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<sup>7</sup> Findings of fact and conclusions of law are in bold and italics.

<sup>8</sup> Facility records document that Petitioner had previously admitted Resident # 20 on August 28, 2015 following another hospital discharge, at which time her admitting diagnoses included status post hemicolectomy and ileocelectomy due to colon cancer, status post radical nephrectomy, and myocardial infarction. P. Ex. 5 at 102.

him that she could be “difficult in her interactions with others” and had a “history of resistive behavior and failure to engage in therapy services,” and that “[t]he Resident, her family and the therapy team agreed that it would be most beneficial and to the Resident’s benefit [if] a firm but fair approach was taken” and that Mr. Darnell not allow himself to be “intimidated . . . offended or deterred if she became verbally combative.” P. Ex. 7 at 2.

Mr. Darnell testified that on October 13, 2015, a certified nurse aide informed him that Resident # 20 had requested that she be allowed to go back to bed. P. Ex. 7 at 3; *see* CMS Ex. 1 (statement of deficiencies documenting an encounter between Resident # 20 and Mr. Darnell that began at 12:12 pm); CMS Ex. 9 at 2-3 (written testimony of N. Paalam, a surveyor); CMS Ex. 12 at 3 (written testimony of A. Badeau, a surveyor). Mr. Darnell reported that, per Resident # 20’s treatment plan, he felt that she should “remain up a bit longer . . .” P. Ex. 7 at 3. Mr. Darnell testified that he kneeled when speaking for a few minutes to Resident # 20, who was in a wheelchair, and verbally encouraged her, at which time she used profanity and “continued with a level of resistance.”<sup>9</sup> P. Ex. 7 at 3. Two surveyors were positioned outside of Resident # 20’s room at the time of this encounter. *See* CMS Ex. 1 at 4 (statement of deficiencies notation that surveyors were “standing outside of Resident 20’s room . . .”). Mr. Palaam testified that Resident # 20 reported she was tired and in pain. CMS Ex. 9 at 3. The other surveyor, Ms. Badeau, reported that Resident # 20 stated she was nauseous and in pain, and that Mr. Darnell was standing over her and speaking in a “very loud voice.” CMS Ex. 12 at 3. Both surveyors, along with Mr. Darnell, seemingly agree that Mr. Darnell left the room after he made the following remark to Resident # 20: “I am not a pushover and I am not going to put up with this.” P. Ex. 7 at 3 (Mr. Darnell’s testimony that he left the room after he “indicated [he] would give her a few minutes to consider [his] request and if, after that time, she felt she still wanted to go to bed, [he] would assist her in doing so.”); CMS Exs. 9 at 3; 12 at 3. After Mr. Darnell’s departure, the surveyors immediately entered Resident # 20’s room at 12:15 pm (CMS Ex. 1 at 4), and Ms. Badeau testified that Resident # 20 “looked upset and she was shaking.” CMS Ex. 12 at 6. Resident # 20 informed Ms. Badeau, in a “loud, shaky voice,” that Mr. Darnell “talks down,” is “pushy,” and “is the boss,” and Resident # 20 expressed her preference for “Travis,” who is Mr. Darnell’s partner. CMS Exs. 1 at 4; 12 at 3.

Mr. Darnell returned to Resident # 20’s room during the course of the surveyor’s interview of Resident # 20. P. Ex. 7 at 3. Mr. Darnell ultimately assisted Resident # 20 to her bed after the surveyors exited her room. P. Ex. 7 at 3.

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<sup>9</sup> Mr. Darnell’s statement appears to be consistent with other evidence of record. *See* P. Ex. 5 at 102 (report of a discussion with Resident # 20’s son in which Resident # 20’s son acknowledged that Resident # 20 had behavioral issues that has made it difficult to care for her, and that she has been agitated and combative during care).

A surveyor subsequently interviewed Petitioner’s Rehabilitation Director, D. Lambert, at 12:20 pm. CMS Exs. 1 at 5; 12 at 4. The surveyor testified that, in response to a hypothetical question, Ms. Lambert stated that a therapist telling a resident “I am not a pushover and I am not going to put up with this” was not “encouraging.” CMS Ex. 12 at 4; *but see* P. Ex. 8 at 2 (testimony of Ms. Lambert that when she provided that answer, she “was not given any context for this statement” and that if she understood the context for “the basis of this question, [her] answer would have been different”). The surveyor further testified that Ms. Lambert stated that Mr. Darnell was “abrasive” toward Resident # 20 during the aforementioned encounter on October 13, 2015. CMS Ex. 12 at 5; *but see* P. Ex. 8 at 2 (Ms. Lambert’s testimony that she did not refer to Mr. Darnell as being “abrasive.”).

Fewer than 20 minutes after the encounter between Mr. Darnell and Resident # 20, Petitioner held a weekly meeting of its rehabilitation staff from 12:30 until 1:30 pm. CMS Exs. 1 at 5; 15 at 1. At the weekly staff meeting, Ms. Lambert conducted in-service training on several topics, to include appropriate communication with patients. CMS Ex. 15. At 3:46 pm on October 13, 2015, the surveyors called immediate jeopardy based on Mr. Darnell being “verbally abrasive” and Resident # 20 “experienc[ing] emotional distress due to derogatory comments made by [Mr. Darnell].” CMS Ex. 1 at 3-4. Immediate jeopardy was abated at 5:08 pm that same day. CMS Ex. 1 at 6.

The regulations define abuse as “the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.” 42 C.F.R. § 488.301. Medicare regulations include requirements for the prevention of abuse of SNF residents. As relevant here, 42 C.F.R. § 483.13 provides, in part:

(b) *Abuse*. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

(c) *Staff treatment of residents*. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

(1) The facility must—

(i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion[.]

The State Operations Manual (SOM) provides interpretive guidance regarding the definition of abuse. *Kindred Transitional Care and Rehab - Greenfield*, DAB No. 2792 at 16 (2017). The SOM notes that abuse “includes the deprivation by an individual,

including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.” Pub. 100-07, SOM, Apx. PP, § 483.13(b) (Rev. 127, effective Nov. 26, 2014). The SOM further defines mental abuse to include “humiliation, harassment, threat of punishment or deprivation.” *Id.* Finally the SOM defines verbal abuse as:

The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.

*Id.* Consistent with the Secretary’s regulations, the facility has a policy that directs that its residents have a right to be free from abuse. CMS Ex. 19 at 5.

## ii. Analysis

CMS contends that Petitioner was not in substantial compliance with 42 C.F.R. §§ 483.13(b), (c)(1)(i) because Mr. Darnell spoke to Resident # 20 in a “loud voice,” was verbally abrasive and intimidating, and “deprived her of the services she need to go to bed when she was feeling nauseated and in pain.”<sup>10</sup> CMS Br. at 13. CMS further contends that Mr. Darnell used his position of authority, posture, and tone in an attempt “to intimidate Resident 20.” CMS Br. at 13.

CMS emphasizes that Mr. Darnell had an “abrasive” demeanor with Resident # 20. CMS Br. at 2, 13; *see* CMS Ex. 12 at 5-6 (surveyor’s testimony that Mr. Darnell was verbally abrasive with Resident # 20, and that Ms. Lambert stated Mr. Darnell was abrasive). The term “abrasive” has been defined as “[s]howing little concern for the feelings of others; harsh,” or as simply “causing irritation.” Oxford Dictionary (online edition) <https://en.oxforddictionaries.com/definition/us/abrasive> (last visited January 29, 2018); Merriam-Webster Dictionary (online edition) <https://www.merriam-webster.com/dictionary/abrasive> (last visited January 29, 2018).

Even assuming as true, for purposes of this discussion, the disputed allegation that Mr. Darnell had an “abrasive” demeanor, CMS has not demonstrated that an abrasive

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<sup>10</sup> CMS has not presented any probative evidence that the facility deprived Resident # 20 of a needed service, and I will not further address this unsupported argument. Further, to the extent that CMS infers that Petitioner did not respect Resident # 20’s right to refuse treatment, such a deficiency was not cited in the statement of deficiencies or otherwise raised by CMS in connection with the instant case. The matter before me is limited to whether Resident # 20 was free from verbal, sexual, physical, or mental abuse; corporal punishment; and involuntary seclusion. 42 C.F.R. §§ 483.13(b), (c)(1)(i).



demeanor that is “irritating” or “thoughtless” under these circumstances amounts to abuse, as being abrasive does not necessarily connote any intent to inflict pain or mental anguish. 42 C.F.R. § 488.301. CMS has not established that, even if Mr. Darnell had an abrasive demeanor, this should be considered to be abuse within the meaning of section 483.13(b).

Likewise, Mr. Darnell’s statement that “I am not a pushover and I am not going to put up with this[,]” does not evidence that he abused Resident # 20. This statement, on its face, is neither derogatory nor disparaging, nor does it communicate any threat of potential harm to a resident. *See* CMS Ex. 12 at 3; *see also* 42 C.F.R. § 488.301; Pub. 100-07, SOM, Apx. PP, § 483.13(b); P. Br. at 8-9. Rather, while Resident # 20 may have been upset, based on the observations of the surveyor, she may simply have been upset because a conscientious employee was attempting to encourage her participation in an activity that she did not want to perform, but from which she would benefit. CMS Ex. 12 at 3 (testimony that Resident # 20 was upset after the encounter). Although Resident # 20 may not have appreciated Mr. Darnell’s unsuccessful effort to encourage her participation in the therapy that could enable her to regain her strength so she could be discharged from the facility and return home, and she may not have agreed with Mr. Darnell’s approach that she should not go back to bed in the middle of the day, such failed efforts at motivation are simply not abuse under these particular circumstances.<sup>11</sup> Further, CMS has not rebutted Mr. Darnell’s testimony that he had adopted a “firm and insistent” approach to overcome Resident # 20’s “history of resistive behavior and failure to engage in therapy services,” and that telling a resident he is not a “pushover” is not abusive under these circumstances. P. Ex. 7 at 2.

CMS also points out that Mr. Darnell was leaning over Resident # 20 while she was seated in her wheelchair during the encounter and that such a posture is intimidating. CMS Br. at 13. Regardless of whether Mr. Darnell was standing over Resident # 20 with his hands on the armrests of her wheelchair (CMS Ex. 12 at 2) or knelt to speak with her (P. Ex. 7 at 3), it appears that Mr. Darnell deliberately positioned himself at a height *lower* than his full and natural height in an effort to communicate with Resident # 20 at her eye level. CMS has not demonstrated that Mr. Darnell postured himself in this manner in order to intimidate Resident # 20, as contemplated by section 488.301.

Based on the foregoing, I do not find that Petitioner subjected Resident # 20 to abuse. Rather, Petitioner’s employee attempted to further a resident’s rehabilitation goals by encouraging her not to return to her bed during the middle of the day. CMS has not demonstrated that Petitioner was not substantially compliant with 42 C.F.R. §§ 483.13(b),

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<sup>11</sup> I reiterate that if CMS was concerned that Resident # 20 was wrongly denied her right to refuse treatment, it should have presented such a charge in the statement of deficiencies. Further, Mr. Darnell, within a few minutes, assisted Resident # 20 in going back to bed, and thereby, he respected her wishes.

(c)(1)(i). Therefore, I also do not sustain the associated remedy of a \$5,000 per-instance CMP.

***B. Petitioner did not substantially comply with 42 C.F.R. § 483.25(h) because it did not take all reasonable steps to protect Resident # 21 from the foreseeable risk of entrapment by the side rails of his bed.***

**i. Factual background, relevant law, and facility policies**

In citing a deficiency under 42 C.F.R. § 483.25(h), the state agency reported the following in the statement of deficiencies:

During a routine observation of another resident . . . on October 14, 2015 at 6:15 AM, Resident 21 was found with his head completely through the full side rail. His head was dangling, and his entire body was on the bed. The side rail was observed to have no padding to prevent Resident 21's head from going through the side rail when he wiggled in the bed. The side rail was observed to be a full side rail which had a latch at each end that was lifted up to let the side rail down. If the side rail were not completed [sic] locked into place, Resident 21 could wiggle and cause the rail to drop with his head between the slats, resulting in serious injury, suffocation or death. There was no facility staff in the room at that time, Resident 21 was still, eyes closed.

CMS Ex. 1 at 10-11.

Resident # 21 was initially admitted to the facility on May 12, 2015, and has a medical history that includes intellectual disability, quadriplegia, psychosis, and anxiety. CMS Ex. 6 at 12. Resident # 21 is non-ambulatory and has contractures to both hands (CMS Ex. 4 at 4), and a facility record reports that Resident # 21 experienced "repetitive physical movement." CMS Ex. 6 at 8.

On October 15, 2015, the Assisting Director of Nursing (ADON) reported that Resident # 21 was found "by staff during rounds with his head between the bed side rails." CMS Ex. 6 at 8. The ADON further explained that after staff found Resident # 21 with his head between the side rails on October 14, 2015, "assistance was called to the room immediately and the resident's head was removed from the side rails." CMS Ex. 6 at 9 (capitalization omitted). A surveyor testified that the distance between the vertical bars on the side rails was eight inches, whereas Resident # 21's head has a width of six inches. CMS Ex. 9 at 5. The same surveyor testified that the investigation revealed that Resident # 21 "wiggled around in the bed" and that the facility was aware that Resident # 21 was unable to hold the side rails by himself. CMS Ex. 9 at 5.

Based on the determination of immediate jeopardy, the facility submitted a written corrective action plan that included the following: Removing Resident # 21’s head from the side rails; completing a “[l]icensed-nurse-restraint/[e]nabling [d]evice/[s]afety [d]evice [e]valuation”; and, convening the interdisciplinary team, which “determined that the appropriate plan for the resident is to be on a low bed with no side rails, with floor mats on both sides for precaution.” CMS Ex. 6 at 13.

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

(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.

42 C.F.R. § 483.25(h). The facility’s policy instructs that “[i]f a resident has involuntary movements that could result in rolling off a bed then side rails can be used to prevent rolling out of bed.” CMS Ex. 19 at 1. The facility’s policy further directs that “[w]hen a resident has involuntary movements that could result in rolling off a bed – padding may be added to prevent injury.” CMS Ex. 19 at 1.

## ii. Analysis

The Departmental Appeals Board (DAB) has explained that the stated goal of 42 C.F.R. § 483.25(h) is “to prevent ‘accidents’ that might harm a SNF resident.” *Crawford Healthcare & Rehab.*, DAB No. 2738 at 5 (2016). A facility must “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 Ctr.*, DAB No. 2115 at 5 (2007); *Guardian Health Care Ctr.*, DAB No. 1943 at 18 (2004). The facility must anticipate what accidents might befall a resident and take steps to prevent them. A facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods must constitute an “adequate” level of supervision under all the circumstances. *See Windsor Health Care Ctr.*, DAB No. 1902 at 5 (2003). A facility must 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) (explaining the inherent standard of care in § 483.25(h)(1)). The provisions of § 483.25(h) “come into play when there are conditions in a facility that pose a known or foreseeable risk of accidental harm.” *Meridian Nursing Ctr.*, DAB No. 2265 at 9 (2009), *aff’d*, *Fal-Meridian, Inc. v. U.S. Dep’t of Health & Human Servs.*, 604 F.3d 445 (7th Cir. 2010).

CMS argues that Petitioner’s side rails had a gap that was large enough to entrap Resident # 21’s head, and that the facility was aware that Resident # 21 would move in his bed. CMS Br. at 8, citing CMS Exs. 4 at 3; 9 at 5. CMS argues that Petitioner failed to prevent accidents involving side rails, even though “[t]he dangers of entrapment posed by side rails in long term care facilities have been widely known for 20 years,” to include being the subject of guidance from the U.S. Food and Drug Administration (FDA). CMS Br. at 6; *see* CMS Ex. 17 at 13, 24 (HHS/FDA guidance to reduce entrapment, to include a recommended gap in side rails of no more than 4 ¾ inches and that openings could be covered to reduce the risk of entrapment ); CMS Ex. 18 at 2 (FDA’s August 1995 Safety Alert concerning entrapment hazards associated with the use of hospital bed side rails, in which it reported that all deaths involving side rails “involved entrapment of the head, neck or thorax,” and advised that there should be “no gap wide enough to entrap a patient’s head or body.”).

In its request for hearing, Petitioner challenged the citation of a deficiency under section 483.25(h), contending “[t]hat it properly ensured that the resident environment remained as free of accident hazards as is possible; and each resident . . . received adequate supervision and assistance devices to prevent accidents.” Request for Hearing at 2. Petitioner subsequently “elected not to dispute” this deficiency. P. Br. at 2. Therefore, Petitioner has not offered any evidence to rebut CMS’s *prima facie* showing that the entrapment of Resident # 21’s head in a side rail amounted to immediate jeopardy to resident health and safety. Consequently, I do not disturb the determination that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h).

***C. CMS’s determination that the deficiency cited under 42 C.F.R. § 483.25(h) posed immediate jeopardy to resident health and safety is not clearly erroneous.***

CMS asserts that Petitioner’s deficiency constituted immediate jeopardy at the “J” scope and severity level to resident health and safety. Immediate jeopardy exists if a facility’s noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. 42 C.F.R. § 488.301. CMS’s determination as to the level of a facility’s noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is “clearly erroneous.” 42 C.F.R. § 498.60(c). The DAB has observed repeatedly that the “clearly erroneous” standard imposes on facilities a “heavy burden” to show no immediate jeopardy and has sustained determinations of immediate jeopardy

where CMS presented evidence “from which ‘[o]ne could reasonably conclude’ that immediate jeopardy exists.” *Barbourville Nursing Home*, DAB No. 1962 at 11 (2005); *Florence Park Care Ctr.*, DAB No. 1931 at 27-28 (2004) (citing *Koester Pavilion*, DAB No. 1750 (2000); *Daughters of Miriam Ctr.*, DAB No. 2067 at 7, 9 (2007)).

It is widely known that using side rails on the hospital bed of a resident who moves involuntarily creates a risk of entrapment. Yet, the facility created a foreseeable risk of harm by using side rails with openings far wider than the width of Resident # 21’s head, and the width of the gap in the side rails far exceeded the 4 ¾ width recommended by the FDA. *See* CMS Ex. 17. Moreover the facility failed to take reasonable steps to mitigate the risk of harm, such as using padding. Further, Resident # 21 was *found* with his head entrapped in his side rails, and he is quite fortunate that he did not suffer grave injury or death as a result of his entrapment. Therefore, the facility created a risk of injury or death by leaving the side rails on Resident # 21’s hospital bed in such a manner that posed an entrapment risk. I find that CMS’s determination that an immediate jeopardy level condition existed is not clearly erroneous.

#### ***D. CMS imposed a reasonable penalty***

I examine whether the amount of a CMP is reasonable by applying the factors listed in 42 C.F.R. § 488.438(f): 1) the facility’s history of noncompliance; 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 listed in 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 noncompliance; and 3) the facility’s prior history of noncompliance in general and specifically with reference to the cited deficiencies.

Here, CMS imposed a per-instance CMP of \$5,000, which is in the middle of the spectrum for a per-instance CMP (\$1,000-\$10,000), and is modest considering the amount of CMP that CMS was authorized to impose. 42 C.F.R. § 488.408(e)(1)(iv); *see Plum City Care Ctr.*, DAB No. 2272 at 18-19 (2009) (observing that even a \$10,000 per-instance CMP can be “a modest penalty when compared to what CMS might have imposed”). Petitioner does not raise any specific objections to the amount of the CMP imposed. P. Br. Therefore, I conclude that the \$5,000 CMP that was imposed based on a deficiency involving the actual entrapment of a resident’s head in his bed’s side rails was entirely reasonable.

**IV. Conclusion**

For the reasons discussed above, I find that Petitioner was in substantial compliance with 42 C.F.R. §§ 483.13(b), (c)(1) (i). I otherwise sustain the remaining deficiencies and associated remedies.

\_\_\_\_\_/s/\_\_\_\_\_  
Leslie C. Rogall  
Administrative Law Judge