Department of Health and Human Services

DEPARTM ENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Woods Edge Pointe	)	Date: January 22, 2008
(CCN: 36-6209),	)	
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-04-510
	)	Decision No. CR1726
Centers for Medicare & Medicaid	)	
Services.	)	
	)	

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose civil money penalties (CMP) against Petitioner, Woods Edge Pointe, in the amount of $400 per day, for a period that began on May 21, 2004 and which ended on June 30, 2004.

I. Background

Petitioner is a skilled nursing facility doing business in Cincinnati, Ohio. It participates in the Medicare and Medicaid programs. Petitioner was surveyed for compliance with Medicare participation requirements on May 21, 2004 (May survey) by surveyors employed by the Ohio Department of Health (Survey agency). The surveyors found that Petitioner was not complying substantially with 25 Medicare participation requirements. On June 30, 2004, the Survey agency conducted a revisit survey and found that Petitioner had resumed substantial compliance as of that date.

CMS concurred with the surveyors' findings of noncompliance and proposed to impose sanctions against Petitioner consisting of a CMP of $400 per day for the period of May 21 through to June 30, 2004, totaling $16,000, and the disqualification of Petitioner's nurse aide training program (NATCEP) for a period of two years. CMS notices dated June 25, 2004 and July 19, 2004.[1]

On August 23, 2004, Petitioner requested a hearing before an administrative law judge (ALJ). The case was assigned to me for a hearing and a decision. In its request for hearing, Petitioner challenged all 25 deficiencies noted during the May survey. A schedule was established for the parties to file written pre-hearing submissions including proposed exhibits and briefs.

An in-person hearing was held in this matter from May 24, 2005 through May 25, 2005, in Cincinnati, Ohio. The following exhibits were admitted into evidence: CMS exhibits (Exs.) 1-19,[2] and Petitioner's exhibits (P. Exs.) 1-10, 12-18.[3] Transcript (Tr.) at 14, 105-06. Also admitted into evidence as ALJ Ex. 1 was a demonstrative diagram offered by Petitioner during witness testimony. Tr. at 230-34.

At the commencement of the hearing, the parties waived presentation of evidence and testimony for nine life-safety code tags identified in the May Statement of Deficiencies (SOD). The parties agreed not to proceed on the life-safety code tags maintaining that they were not considered as a basis for CMS's imposition of a CMP or other remedy, and that they are not at issue in this matter. Tr. at 16-17. Based on the representations of the parties, the life-safety tags are not considered in my analysis of the evidence and decision in this case. Additionally, the parties agreed that CMS would present testimonial evidence on only the quality of care citations listed in the May SOD, specifically, F-tags

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[1] The June 25, 2004 notice additionally proposed a denial of payment for new admissions (DPNA) effective August 21, 2004, and termination of Petitioner's provider agreement as of November 21, 2004. As Petitioner achieved substantial compliance by June 30, 2004, the DPNA remedy and the provider agreement termination were not effectuated. CMS notices dated June 25, 2004 and July 19, 2004.

[2] Subsequent to the submission of the parties' proposed witness and exhibit lists, CMS moved to supplement its exhibit list with CMS Ex. 19. Petitioner objected. On June 8, 2005, I issued a ruling granting CMS's motion to supplement its exhibit list with CMS Ex. 19. Additionally, at the commencement of the hearing, Petitioner raised a concern that CMS's exhibits were not redacted and, therefore, contained resident identifying information. CMS agreed to amend its submission with a redacted version. Those exhibits were received on June 13, 2005, and have substituted CMS's prior set of exhibits. Tr. at 10-12. Also, as requested by Petitioner at the hearing, I take judicial notice that although CMS's list of exhibits are identified as "Facility Records," the exhibits themselves include surveyor notes and are not exclusively facility records. Tr. at 11-12.

[3] At the hearing, P. Ex. 11 was stricken from the record per the agreement of the parties as counsel for Petitioner was unable to locate the document which corresponded with proposed P. Ex. 11. Counsel surmised that the exhibit may not have been proffered. Tr. at 105.

309, 312, 314, 316, 318, 324, 328, 332. Tr. at 16. CMS chose to present testimonial evidence at the hearing on eight of the 16 quality of care deficiency tags identified in the May SOD. CMS also chose to submit the May SOD as evidence of the allegations for the non-quality of care citations without providing testimonial evidence as to the tags.

Three surveyors testified for CMS at the hearing: Debbie Truett, Registered Nurse (R.N.), Bernie Poole, R.N., and Patricia Butjckowski, Licensed Social Worker (LSW). Petitioner presented the testimony of two witnesses: Kristina Convoy, Licensed Practical Nurse (LPN) and Clinical Advisor, and Brenda Nelson, Director of Nursing (DON).

Subsequent to the hearing, the parties were provided with a copy of the certified transcript of the hearing and opportunity to note any prejudicial errors - none were noted. CMS filed an initial post-hearing brief (CMS Br.) Petitioner filed a post-hearing response brief (P. Br.) and its findings of fact and conclusions of law. CMS filed a reply brief (Reply) and its proposed findings of facts and conclusions of law.

This decision is based on the complete record which includes the parties' arguments, written submissions, all exhibits admitted into the record, and the witness testimony adduced during the hearing.

II. Issues

The issues in this case are whether a sufficient basis existed for CMS to impose its remedies for the May survey and, if so, are they reasonable.

III. Applicable Law

Long-term care providers, such as Petitioner, participate in the Medicare program by entering into provider agreements with the Department of Health and Human Services (HHS). Requirements of participation are imposed by statute and regulation. Social Security Act (Act) §§ 1819, 1919; 42 C.F.R. Parts 483, 488, and 489. In order to continue participation in the Medicare program, providers must remain in substantial compliance with program requirements. 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.

If a facility is not in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, which includes imposing a CMP. Act, § 1819(h). CMS may impose a CMP for the number of days that the facility is not in substantial compliance with one or more program requirements, or for each instance that a facility is not in substantial compliance.

42 C.F.R. §§ 488.430(a); 488.440. The presence of a single deficiency cited at the D-level or above is sufficient to establish a facility's noncompliance with applicable regulations and authorize the imposition of remedies. *Beechwood Sanitarium,* DAB No. 1824 (2002).

The regulations specify that a CMP imposed against a provider will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408; 488.438. As applicable in the matter before me, the lower range of CMPs, 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).

IV. Burden of Proof

When a penalty is imposed and appealed, CMS must established a prima facie case that the facility was not in substantial compliance with federal participation requirements. To prevail, the facility must overcome CMS's showing by a preponderance of evidence.[4] *Emerald Oaks*, DAB No. 1800, at 4 (2001); *Cross Creek Health Care Center*, DAB No. 1665 (1998), applying *Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd Hillman Rehabilitation Center v. HHS*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999). I adopt the burden as set forth in the Board's decision in the *Hillman* case, and as stated and discussed in detail in the *Batavia Nursing and Convalescent Center* and *Batavia Nursing and Convalescent Inn* cases. *See Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004); and *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004).

V. Findings of fact, conclusions of law and discussion.

I make findings of fact and conclusions of law (Findings) to support my decision in this case. However, I do not make a Finding on every deficiency in controversy during these proceedings. The Board has previously sustained an ALJ's discretion to exercise judicial economy and not discuss each and every alleged deficiency. *Beechwood Sanitarium*, DAB No. 1824 (2002), at 22; *Beechwood Sanitarium*, DAB No. 1906 (2004). I discuss only those deficiency citations which I have determined support the noncompliance and the remedies imposed.

[4] Throughout these proceedings, Petitioner has voiced its objection to my use of the *Hillman* standard in determining the parties' burden of proof. As noted in section IV above, the application of this standard has been sufficiently outlined in prior ALJ and Board decisions and, therefore, I need not further address this issue. However, I note that Petitioner has properly preserved its argument for appeal. Tr. at 6.

A. Petitioner failed to comply substantially with Medicare participation requirements during the May survey.

The May SOD sets forth one deficiency at the G-level of scope and severity in which "actual harm" not at the immediate jeopardy level was alleged (F-tag 314); and 15 deficiencies constituting a "potential for harm" including 13 deficiency citations at the D-level (F-tags 157, 221, 248, 250, 272, 278, 281, 309, 312, 316, 318, 328, and 332) and two deficiency citations at the E-level (F-tags: 253, 324). CMS Ex. 1.

I first address the G-level deficiency, F-tag 314, where CMS alleges that Petitioner caused "actual harm" to a resident due to alleged inadequate care of the resident's skin which CMS maintains caused the develop of an avoidable pressure sores.

1. CMS has established that, as of the May survey, Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(c) - F-tag 314(G) - Pressure Sores.

The regulation that is at issue governs the prevention and treatment of pressure sores. The regulation provides that a resident who enters a facility does not develop pressure sores unless his or her clinical condition makes the development unavoidable. 42 C.F.R. § 483.25(c)(1). Therefore, a facility has a duty to take all reasonable measures to ensure that a resident does not develop a pressure sore. Although not a strict liability regulation, it does presume that pressure sores are avoidable. To establish its prima facie case that a facility was deficient under this tag, CMS must show that a resident developed a pressure sore after admission. Where a resident develops a pressure sore, the burden thus falls on the facility to show that the pressure sore was clinically unavoidable. *Koester Pavillion*, DAB No. 1750, at 34 (2000).

Petitioner was cited for noncompliance with this requirement because it failed to provide care and services necessary to prevent pressure sores from developing and subsequently worsening for resident R55.[5] Specifically, CMS alleges that R55, who was identified as at risk for the development of pressure sores, developed an avoidable pressure sore while at Petitioner's facility. CMS Br. at 23-26; CMS Exs. 1, at 22-24; 7, at 8-15

[5] Although the May SOD lists, in Example Two of tag F-314, allegations related to a second resident, at hearing I dismissed Example Two of tag 314. Example Two deals with surveyor observations of R30, however, at hearing CMS's witness relied on notes during her testimony which were not made available to Petitioner. My ruling striking testimony related to R30, Example Two, is available in the transcript at page 130. I also strike from the record in this case portions of pages 25-26 in CMS's post-hearing brief which pertain to example two and R30 under the F-314 citation.

CMS maintains that R55's diagnoses placed her at risk for the development of pressure sores. CMS Br. at 23; CMS Ex. 19, at 1. On May 5, 2004, R55 was assessed to have developed recent pressure sores. CMS Br. at 23; CMS Ex. 19, at 3. CMS maintains that R55's plan of care, dated February 6, 2004, required staff to bi-hourly turn and reposition R55; apply a fleece pad in her chair; check her for incontinence every two hours; and provide appropriate incontinence care as needed. CMS Br. at 23; CMS Ex. 19, at 3.

Surveyor Debbie Truett, RN., testified that on May 19, 2004, beginning at 12:23 p.m. and for over a period in excess of four hours, she observed as R55 sat in her wheelchair in the dinning room. Tr. at 28. During this period of time she noted that facility staff failed to check R55 for incontinence and failed to reposition her. Tr. at 28, 30. According to Ms. Truett, at 2:30 p.m. that afternoon she noticed R55's pants were wet. Tr. at 77. She testified as to having approached staff approximately three times to change R55, but to no avail. Tr. at 81.

It was not until 4:10 p.m. that same day that R55 received incontinence care. Tr. at 81. When two aides transferred R55 from her wheelchair to her bed, Ms. Truett noticed a puddle of urine on the R55's wheelchair. Tr. at 77. Ms. Truett reported that R55's "clothing and the incontinent brief were so soiled that she was wet from her back, the middle of her back, to her knees . . . when they took her brief off, there was urine and feces just all over her." Tr. at 29. Ms. Truett noted that during the incontinence care of R55, an open bloody pressure sore was found to the left of R55's sacral bone. Tr. at 29. The wound measured 1.2 by .5 by .2 centimeters in size and was determined to be a stage II pressure sore. CMS Br. at 24. When Ms. Truett checked R55's clinical record she could not find documentation of the noted pressure sore. Tr. at 29.

The following day, Ms. Truett interviewed the DON. Ms. Truett testified that the DON acknowledged that the pressure ulcer had been discovered on May 18, 2004, but the treating nurse had not documented it. The DON also admitted that R55's physician had not been notified of the pressure sore, and R55 had not received any treatment for the wound. Tr. at 32-33. The DON then stated to Ms. Truett that the treating nurse who provided care to R55 would be discharged. Tr. at 33.

Petitioner maintains that "[t]o the extent any pressure areas/sores were proven, such were clinically unavoidable and/or properly treated and any failure to deliver timely care was singularly aberrational." P. Br. at 4. Petitioner further asserts that the fleece pad was unwarranted, had no pressure relieving value, and R55 was seated in a pressure relieving seating system in a special wheelchair, with BAZA cream applied properly. P. Br. at 4 citing to Tr. 219-22. Petitioner maintains that the observations in the May SOD are "unverifiable and/or not reliable," and that Ms. Truett's "testimony is not credible." P. Br. at 5.

Despite Petitioner's assertions that Ms. Truett's testimony is not credible, Petitioner did not provide any support or documentary evidence to rebut Ms. Truett's testimony. Petitioner makes no reference to R55's clinical record to contradict the surveyor's observations. Additionally, Petitioner has failed to rebut the testimony that R55's plan of care required staff to bi-hourly turn and reposition R55; apply a fleece pad in her chair; check her for incontinence every two hours; and provide appropriate incontinence care as needed. Petitioner's assertions regarding Ms. Truett's credibility unsupported by evidence is not sufficient to rebut a prima facie case by a preponderance of the evidence.

Ms. Truett's testimony regarding her observations are documented in her surveyor notations and I accord her testimony and her notations the proper credit. *See Meadow Wood Nursing Home*, DAB No. 1841 (2002). I observed Ms. Truett's testimony, find it to be credible, and weigh it accordingly. Ms. Truett has been a state surveyor for twelve years performing long-term care surveys in nursing homes, residential care facilities and intermediate care facilities for the mentally retarded. Tr. at 25. Her testimony was not proffered as expert testimony on legal conclusions, but instead as the opinion of a state surveyor trained pursuant to federal requirements, with relevant education background and significant work experience, and direct and relevant knowledge of the instant survey process and deficiency findings.

The burden of persuasion throughout a provider enforcement case under *Hillman* and it's progeny is on the provider to show substantial compliance by the preponderance of the evidence once CMS has established its prima facie case of non-compliance. I find that Petitioner failed to prove the pressure sore which R55 developed while at its facility was unavoidable.

I also find that Petitioner has failed in its duty to take all reasonable measures to ensure that R55 did not develop a pressure sore. At a minimum, Petitioner's staff should have provided routine incontinence care, routine repositioning, and treatment to the pressure sore once it developed. Staff were aware of the pressure sore prior to the survey but failed to document it. As reported, the attending nurse had been informed by staff of the pressure sore the day before. Additionally, the surveyor directly observed an episode of incontinence that was not dealt with in a timely manner, leaving a resident who was at risk for pressure sores to sit for an extended period of time in her own urine and feces.

While it is not disputed that some appropriate care was provided to R55, such as the assessment and provision of a pressure relieving seating system in a special wheelchair, and the application of BAZA cream, Petitioner attempts to characterize the care as sufficient for me to conclude the pressure sore was unavoidable. I disagree.

A clinically unavoidable sore is one that occurs when all that reasonably can be done to prevent the sore is done. All that reasonably can be done does include, at a minimum, a facility adhering to its own plan of care for a resident. Here, Petitioner's staff failed to exercise their responsibility to provide the necessary interventions in order to minimize the adverse effects toward R55 of the development of a pressure sore. What was observed by Ms. Truett was failure to provide minimal routine care. I find that Petitioner's staff also failed to provide repositioning and routine incontinence care to R55. The record before me is absent of credible evidence that Petitioner's staff repositioned R55, provided proper incontinence care, or made efforts to keep R55 dry.

The weight of the evidence is that R55 developed a pressure sore while residing at Petitioner's facility. Petitioner has not advanced evidence to show that the development of R55's pressure sore was unavoidable. Therefore, I find that Petitioner failed to provide all necessary care and services to prevent the development of pressure sores to R55 and conclude that CMS has established a prima facie case that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(c)(1), and Petitioner has failed to rebut the evidence presented.

2. CMS has established that, as of the May survey, Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25 - F-tag 309(D) - Resident Assessment.

This regulation requires a facility to provide necessary care and services to residents in the interest of attaining their highest practicable physical, mental and psychosocial well-being consistent with their comprehensive assessment and plan of care. CMS alleges that Petitioner did not meet the requirements of this regulation when it failed to maintain padded bed rails in an upright position while R70 was in bed, as required by his plan of care and physician's order. CMS Br. at 20; CMS Exs. 1, at 20; 5, at 9, 33; Tr. at 146-48.

Surveyor Patricia Buczkowski, LSW, testified at the hearing that on two separate occasions during the survey (May 15 at 3:43 p.m. and May 19 at 8:38 a.m.) she observed R70 in his bed without the bed-rails in the required position. She also observed that the bed-rails did not have the required padding. Tr. at 146-47.

Petitioner does not deny that R70's bed-rails were not in the required position, nor does Petitioner challenge Ms. Buczkowski's observations on May 15 and May 19 that the bed-rails were not padded. In response to the allegations, Petitioner states that R70 was not at risk for harm and, at most, if R70 did have a seizure, he "would collide with some unspecified force with an unpadded side rail." P. Br. at 3. Unfortunately for Petitioner, this argument - standing alone- does not provide any support for its assertion that R70 was not at risk for harm.

Due to a seizure disorder, R70 had been identified by his physician to be in need of padded bed rails. Both his plan of care and his Minimum Date Set assessment (MDS) identify the need for the padded bed-rails. CMS Ex. 5, at 33. Petitioner does not dispute that on May 15 and 19, R70 was not provided with the care that had been ordered for him by his physician and as observed by Ms. Buczkowski.

Petitioner's witness, Kristina Convoy, LPN and Clinical Advisor to the facility, testified that there were times during the provision of care to R70 where the bed-rails and paddings were removed. Tr. at 217. However, Nurse Convoy's testimony does not rebut the fact that when the surveyor observed R70, his bed rails were down. Even if care had been provided to R70 right before the surveyor entered the room, it still does not explain why staff would have left the room without replacing the bed rail padding and lifting the bed rail after they had completed R70's care.

I find Ms. Buczkowski's account of her observations of R70 on May 15 and May 19 to be credible. Petitioner's staff placed R70 at risk for more than minimal harm by not ensuring R70's bed-rails were properly placed and padded in accordance with R70's assessed needs as identified both by his physician and his clinical record. Petitioner has failed to successfully rebut CMS's prima facie showing as to this citation. I conclude that Petitioner was not in compliance during the May survey with participation requirements as outlined in the regulations at 42 C.F.R. § 483.25.

3. CMS has established that as of the May survey, Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(a)(3) - F-tag 312(D) - Resident Assessment.

A facility's obligations with respect to quality of care (activities of daily living) are set forth, in relevant part, at 42 C.F.R. § 483.25(a)(3), which provides that based on the comprehensive assessment of a resident, the facility must ensure that . . . [a] resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. CMS alleges that Petitioner failed to comply with the requirements of this regulation because, on two observations during the May survey, Petitioner's staff failed to provide two residents with required oral care - R33 and R34. Both residents were identified by Petitioner's staff as needing oral care, and each was identified as being dependant and unable to carry out their own oral hygiene needs.

a. R33

A review of R33's June 26, 2003 plan of care indicates that staff are to "[p]rovide oral hygiene q day and PRN." CMS Ex. 14, at 2. During facility observations on May 19, 2004, Surveyor Bernie Poole, R.N., observed that during R33's morning care, she was not furnished with oral care as required in her MDS. Tr. at 112. According to Ms. Poole, facility staff conceded that they had failed to provide the resident with the required daily oral care. Tr. at 113. Ms. Poole avers that the lack of daily oral hygiene for an individual who is fed by a gastronomy tube can lead to halitosis, saliva buildup, and eventually dental cavities. Ms. Poole maintained that there was a potential for more than minimal harm with regard to Petitioner's omission of oral care of R33, as the buildup of saliva, in itself, can cause dental cavities. Tr. at 114.

Petitioner maintains that Ms. Poole made a half-hour observation of R33 and concluded that a failure to provide oral care to the resident during this time placed her at risk for more than minimal harm. P. Br. at 3. Petitioner states that R33 was not being fed anything by mouth and, therefore, could not develop cavities as claimed by Ms. Poole. *Id.* at 3-4. However, Petitioner provides no documentary evidence to dispute R33's plan of care which provides that staff are to provide oral care to R33 daily and as needed. Nor does Petitioner refute Ms. Poole's testimony that on the day following her observation she discussed her concerns about R33 not receiving oral care at a meeting at which staff confirmed to her that oral care should have been provided to R33 during her morning routine care. Tr. at 113.

Petitioner claims that if the allegations are proven, no actual harm occurred and therefore a CMP assessment is not warranted. P. Br. at 6-7. To support this assertion, Petitioner provided the testimony of its witness, Krystina Conroy, LPN and Clinical Advisor, who stated that oral care was not tracked specifically as oral care but rather as morning care by the facility. Ms. Conroy stated that since R33 was not taking anything in by mouth there could not be harm to the resident by not having oral care provided the day of the surveyor's observation. Tr. at 217-18.

First, with a D-level deficiency citation, actual harm does not have to be established. Rather, the potential for more than minimal harm must be shown. Second, R33's plan of care called for staff to provide her with oral care each day as determined by her interdisciplinary team. Just because R33 was not taking food orally does not eliminate her susceptibility to cavities, dry mouth and other oral problems.

Petitioner has introduced nothing that would suggest that, when Ms. Poole made her observations, R33 had been given oral care as prescribed by the plan of care. Consequently, I conclude that R33 was not provided the necessary services to maintain oral hygiene as required by 42 C.F.R. § 483.25(a)(3).

b. R34

R34's physician's order required staff to provide oral care to her three times per day after meals. Tr. at 113. CMS claims that R34 was assessed to need the oral care order following the diagnosis of an abscessed tooth. CMS Br. at 22. Ms. Poole observed R34 on May 19, 2004, at 7:30 a.m., in her room. She noted that R34 was dressed and waiting for breakfast. On May 20, 2005, Ms. Poole interviewed the nurse aide regarding R34's oral care. Ms. Poole reported that the nurse aide informed her that staff on the night shift assisted R34 in getting out of bed the morning of May 19. The nurse aide then stated that she had swabbed R34's mouth out prior to breakfast but did not provide any oral care after breakfast. The nurse assistant also informed Ms. Poole that she did not perform any oral care for R34 after her lunch on May 19, 2004. Tr. at 113.

During the hearing, Ms. Conroy, Petitioner's facility clinical advisor, did not dispute that R34 did not receive oral care after breakfast the morning of May 19. Tr. at 218. Ms. Conroy confirmed that several months prior to the survey, R34 had an abscessed tooth which resulted in the order for oral care after each meal. According to Ms. Conroy, however, the abscessed tooth had been resolved and the physician's order was "an order that did not get discontinued." Tr. at 218.

CMS has established that there was a current physician's order for R34 to receive oral care after each meal, and Petitioner does not dispute this. Petitioner also does not dispute that oral care as required by the physician's order was not provided to R34 after her breakfast on May 19. In its defense, Petitioner presented three exhibits which contained portions of R34's clinical records (P. Exs. 8-10). However, Petitioner does not direct me to any documentary evidence establishing that R34's physician did, in fact, discontinue the oral care order, thus establishing that there was no longer a need to continue the oral care. I have carefully reviewed P. Exs. 8-10, and do not find such documentation. Consequently, I find that the evidence before me does not support Petitioner's assertions that the abscessed tooth had been resolved and the physician's order was just not discontinued.

CMS has established that R34 had an abscessed tooth which necessitated a physician's order for oral care, and that order was still current at the time of the survey. Petitioner does not dispute that oral care was not provided to R34 as noted by Ms. Poole. At the

hearing, Ms. Poole testified that the lack of oral care created a potential of more than minimal harm to R34. I agree and, therefore, find that Petitioner's omission of necessary oral care for R34, in accordance with her physician orders, placed R34 at risk for more than minimal harm.

Petitioner failed in its rebuttal to prove that it was in substantial compliance with the oral hygiene requirements for R33 and R34 and, based on the evidence presented, I conclude that Petitioner was not in substantial compliance with requirements of 42 C.F.R. § 483.25(a)(3) during the May survey.

4. CMS has established that, as of the May survey, Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(d)(2) - F-tag 316(D) - Incontinence Care.

The regulation under 42 C.F.R. § 483.25(d)(2) requires that a resident who is incontinent of bladder receive appropriate treatment and services in order to prevent urinary tract infections and to restore as much normal bladder function as possible.

During observation of incontinence care to three residents, R33, R46, R54, surveyors observed a facility nurse aide use an improper technique to clean the residents' perineal area.

On May 19, 2004, Ms. Poole observed a nurse aide provide R33 with incontinence care by applying a washcloth repeatedly, in an up-and-down motion to the resident's perineal area while the resident was lying on her back. CMS Ex. 1, at 25; Tr. at 116. The nurse aid then turned the resident on her side and used the same soiled washcloth to clean R33's perineal and coccygeal area in repeated back and forth motions. CMS Ex. 1, at 25. CMS avers that this technique was improper as it could spread bacteria normally found in stool and around the coccygela area into the urinary tract, thus exposing R33 to the risk of urinary tract infections. CMS Br. at 27; CMS Ex. 1, at 25-26; Tr. at 116.

R46's clinical record indicates that she has a history of urinary tract infections and her plan of care requires incontinence checks every two hours. Tr. at 43; CMS Ex. 19, at 9; P. Ex. 15, at 2. Ms. Truett observed incontinence care of R46 on May 19, 2005. Ms. Truett found R46 was in her wheelchair all afternoon in the dining/activities area without having been checked for incontinence. Tr. at 44. R46 told Ms. Truett that she had not received incontinence care since "she had gotton up in the morning." Tr. at 44. The information R46 reported to Ms. Truett was confirmed by the nurse aide responsible for R46's care. Tr. at 45. Ms. Truett also noted that a review of R46's clinical record disclosed that R46 had a recent history of urinary tract infection that was E-coli. Tr. at 44. At 3:30 p.m. on May 19, Ms Truett observed a nurse aid transport R46 to her room where she was checked for incontinence. R46's brief was filled with urine and feces. Ms. Truett noted dried feces surrounded the outer areas of R46's buttocks. Ms. Truett then

observed the nurse aid use a soiled washcloth to clean the befouled areas. Tr. at 45-46; CMS Exs. 1, at 27; 19, at 42. Ms. Truett concluded that this technique placed R46 at risk of contamination of her perineal area and her outer urinary tract area. Tr. at 45.

Ms. Truett observed incontinence care of R54 on May 20, 2004, and also reported the use of a soiled washcloth to clean the incontinent resident. Ms. Truett reported that the nurse aide wiped both the perineal area and the catheter site of R54 with a visibly noticeable feces-soiled cloth. Tr. at 47; CMS Ex. 1, at 27. The nurse aide then proceeded to clean R54's in-dwelling catheter as well with the same feces-soiled cloth. Tr. at 47.

Petitioner challenged whether Ms. Truett made "consistent observations" during the time period she alleges; specifically, Petitioner challenges the length of time that passed before the onset of incontinence services. Petitioner questions why both surveyors did not themselves intervene when they saw incontinence care being performed incorrectly. P. Br. at 6. Petitioner also questions the hearsay statement from the nurse aide confirming that R46 had not received incontinence care and further maintains that Ms. Poole's survey notes do not support her claim about talking to staff. *Id*. at 6-7. Petitioner concludes its argument by stating that "[n]o actual harm occurred," and the facility was in substantial compliance by June 4, 2004. *Id*. at 7.

Petitioner presented the testimony of Ms. Conroy who testified that nurse aides attend a training program prior to commencement of work at the facility. Ms. Conroy also testified that a quality assurance program is provided three times a week where a nurse observes the certified nurse aides. Tr. at 223, 225. Ms. Conroy was queried on direct examination as follows:

> Q Do you know whether residents 33, 46 or 54 had a UTI within - - urinary tract infection, within say the month after the survey?
> A No, I do not.
> Q Are there any other reasons you can identify for the tribunal as to your disagreement with the citation of the facility under this tag?
> A No.
> Q Did you actually speak to any of the nurse aides that were alleged to have performed the incontinence care at issue under tag F-316?
> A No, I did not.

Tr. at 224. I find it surprising that Ms. Conroy, as the clinical advisor to the facility, did not seek out the nurse aides who were on duty during the surveyors' observations. She could have easily have looked at the staff schedule to determine which nurse aides were working with R33, R46, and R54. She also could have examined the clinical records for these residents in order to ascertain whether they had been diagnosed with any urinary tract infections. But, she did not.

Even if none of the residents at issue under this tag had developed urinary tract infections subsequent to the survey, that does not show that they were not at risk for harm. It is a long settled principle that CMS is not required to demonstrate that residents have suffered actual harm in order to establish a prima facie case of a violation. *See Beechwood Sanitarium*, DAB No. 1906 (2004). An appellate panel of the Board noted that "implicit in Congress' requirement that a facility [substantially comply with each regulation] is a finding that a failure to do so poses a threat of more than minimal harm." *See Beverly Health & Rehabilitation-Springhill*, DAB CR 553 (1998), *aff'd* DAB No 1696 (1999).

As for Petitioner's challenge to Ms. Truett's "consistent observations" during the time period she alleges. I am not persuaded that Ms. Truett's pattern of making observations shows the observations themselves to be unreliable. Petitioner provides no bases upon which I can find Ms. Truett's observations to be unreliable other than to argue that Ms. Truett made more than one observation relatively close in time as the survey progressed. Petitioner has introduced neither evidence to attack the reliability of Ms. Truett's personal observations nor evidence that CMS was mistaken in its conclusion that incontinence care offered to R33, R46 and R54 on the dates in question was inadequate.

Petitioner also questions why both surveyors did not themselves intervene when they saw incontinence care being performed incorrectly. I note that it is not the role of the surveyor to intervene and assist the facility staff in their responsibility to provide the appropriate care and services to the residents. The surveyors are at the facility on behalf of CMS as observers of care, not to intervene and assist staff.

Petitioner also questions Ms. Poole's hearsay assertion that the nurse aid providing care to R46 confirmed that R46 had not received incontinence care, stating that Ms. Poole's survey notes do not support her claim about talking to staff. Petitioner seems to suggest that Ms. Poole's testimony based on hearsay should be discounted, although Petitioner must know that hearsay is admissible in these proceedings.

I find Ms. Truett and Ms. Poole's account of what they observed on May 19 and 20, 2004 to be credible. I also find that Petitioner has not provided either documentary or testimonial evidence to rebut CMS's prima facie case that R33, R46, and R54 were not provided with proper incontinence care to prevent urinary tract infections. CMS has established that the actions of Petitioner's staff when they used improper techniques in cleaning the residents perineal areas placed R33, R34, and R56 at risk. I find that the improper practices by Petitioner's staff placed these residents at risk for more than minimal harm as bacteria from feces can contaminate the residents' urinary tract resulting in urinary tract infections. Based on this finding, I conclude that based on the evidence before me, CMS has established that as of the May survey, Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(d)(2).

5. CMS has established that, as of the May survey, Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(e)(2) - F-tag 318(D) - Range of Motion.

The regulation at issue requires a facility to ensure that a resident with a limited range of motion receives appropriate treatment and services to increase the resident's range of motion and/or to prevent further decrease in their range of motion.

CMS maintains that R33 had a physician's order for hand splints to be applied to both her hands between 9:00 a.m. and 3:00 p.m. daily. Tr. at 116; CMS Ex. 14, at 6. Ms. Poole reported that on May 19, 2004, the hand splints were not applied to R33's hands as required. Tr. at 116-17. Ms. Poole testified that she discussed this omission with Petitioner's staff and was told that R33 should have had the hand splints on. Tr. at 117; CMS Ex. 1, at 28.

R75 had a physician's order for splints/braces to be applied to both legs. CMS Ex. 18, at 38. On May 21, 2004, Ms. Buczkowski observed the velcro strap on R75's left leg brace was broken and did not fit securely on his leg. Tr. at 149. When she inquired about the broken strap, a staff nurse on the unit advised her that the strap had been broken for as long as six months. Tr. 149. CMS maintains that this created a potential risk for more than minimal harm in that R75's brace did not fit securely to his leg while he was receiving services to work with assistance in transferring.

In its post-hearing brief, Petitioner indicated that based on the evidence at hearing, it wished to waive argument on tag F-318. P. Br. at 7. Therefore, I find that Petitioner has not successfully rebutted CMS's showing that facility staff failed to apply R33's hand splints on May 19, 2004, nor has Petitioner provided evidence to refute that R75's leg brace was broken. The language of the regulation does not require that there be a showing of actual harm, only that treatment or services were not delivered.

CMS has established a prima facie case as to R33 and R75. Thus, Petitioner bears the burden of rebutting the prima facie case. I find that Petitioner has not successfully done so here. I therefore conclude that Petitioner was not in substantial compliance with the requirements of 42 C.F.R. § 483.25(e)(2) at the time of the May survey.

6. CMS has established that, as of the May survey, Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h)(2) - F-tag 324(D) - Supervision and Accidents.

The regulation at 42 C.F.R. § 483.25(h)(2) requires that each resident be provided with adequate supervision and assistance devices in order to prevent accidents. In interpreting and applying section 483.25, the Board has been consistent in the opinion that providers are not strictly liable as insurers or unconditional guarantors of good outcomes in the

delivery of services to facility residents. Rather, the quality of care provisions of section 483.25 impose an affirmative duty upon providers to deliver services designed to achieve the best possible outcomes to the highest practicable degree. *Woodstock Care Center*, DAB No. 1726, at 25 (2000), *aff'd*, *Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). This interpretation is based upon the legislative history of the Act and regulations which reflect that Congress and the Secretary chose to focus upon the desired ends or results of care, thus allowing facilities to meet the requirements for individual care in a variety of ways. *See* Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203 (Dec. 22, 1987); 54 Fed. Reg. 5316 (Feb. 2, 1989).

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

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

Based on the regulation and the cases addressing this provision, CMS will meet its burden in establishing a prima facie case if it shows that Petitioner failed to do what it could to supervise residents or provide assistance devices to minimize risks that could lead to accidents. If CMS establishes a prima facie case, the burden shifts to Petitioner and the record will then be considered in terms of where the preponderance of the evidence lay.

CMS contends that Petitioner failed to ensure that three residents (R30, R44, and R53) were provided with adequate supervision and assistance devices necessary to prevent an accident from occurring.

a. R30

CMS alleges that R30 did not receive adequate supervision because she was improperly transferred with less than total assistance. CMS Br. 32. R30 had a history of falls within the previous 31-180 days and her May 2, 2004 MDS assessment indicated that she required a two-person transfer. Tr. at 118.

On May 18, 2004, surveyor Buczkowski observed R30 being transferred from the wheelchair to the bed by only one staff member who used a gait belt and a stand-and-pivot transfer. When the transfer was first attempted, Ms. Buczkowski observed R30 holding the arm of the wheelchair not letting go. On the second transfer attempt, R30 did not let go of the wheelchair and was dragged by the staff from the chair to the bed in a pivoting motion. Tr. at 118-19.

Petitioner does not dispute the May 18, 2004 observations of Ms. Buczkowski, nor does Petitioner dispute that R30 was transferred with just one staff person, not two as oultined in her MDS. As a comment regarding the transfer of R30 observed by the surveyor, Petitioner stated "perhaps that was not advisable." P. Br. at 7. Petitioner maintains that at no time during the incident observed by the surveyor did R30 bear weight on any part of her body that placed her at risk. *Id.* Further, Petitioner questions CMS's assertion of possible harm to R30 stating that if R30 was strong enough to resist her transfer by grabbing onto her wheelchair, it is highly unlikely that she was at risk of a bone fracture. *Id*.

I find that CMS has met its burden. CMS has first established that on May 18, 2004, proper care and supervision was not provided by Petitioner's staff when R30 was transferred by one staff rather than the two staff required. The improper transfer placed R30 at risk of harm. Furthermore, CMS has shown that Petitioner's staff failed to do what they could do and what was required in R30's plan of care. Having established a prima facie case, the burden shifts to Petitioner and I find that Petitioner has not presented either documentary or testimonial evidence to rebut CMS's prima facie showing. Petitioner has denied this allegation only to the extent that it maintains that it was unlikely the R30 was at risk for harm. I therefore sustain the citation of noncompliance relative to this resident.

b. R44

CMS alleges that Petitioner's staff failed to use an alarm device intended to provide protection to R44 from accidents in accordance with his plan of care. CMS Br. at 31; CMS Ex. 19, at 19. R44's MDS assessment, dated February 12, 2004, noted that he

required physical assistance with transfers and ambulation. Tr. at 35; CMS Ex. 19, at 18. R44 fell on October 27, 2003, and was found on the facility floor. As the result of that fall R44 was assessed to need a pressure sensitive alarm in both his bed and wheelchair to minimize the risk of further falls. R44's plan of care identified his risk and the intervention included the use of the alarm. Tr. at 35, 37-39.

On February 16, 2004, R44 was found on the floor on his back. Tr. at 37; CMS Exs. 11, at 5;19, at 22. The record documenting this fall notes that the alarm device was planned but was not in place at the time of the fall. Tr. at 37; CMS Exs. 1, at 29-30; 11, at 1-2; 19, at 19.

At hearing, surveyor Truett testified to the following direct observations:

> (1) At 2:25 p.m. on May 19, 2004, R44 was awake and lying in bed stating that he planned on getting up and out of bed. An alarm box was observed on the bed, but the alarm was turned off. Tr. at 36. Facility staff verified to Ms. Truett that the alarm was not functioning. The same staff shook the alarm a few times and the light began to flash. Tr. at 36-37.
>
> (2) At 7:55 a.m. on May 20, 2004, R44 was lying in bed on his back. The alarm box was on the bed, but the green light was not flashing. Ms. Truett testified that facility staff informed her that the alarm was not functioning and stated that the alarm box was actually turned off. Tr. at 37-38.

According to Ms. Truett, the alarm was available and on the bed, but it was not turned on or it was not functioning correctly. Tr. at 38.

Petitioner suggests that R44 could have deactivated the alarm himself. P. Br. at 8; Tr. at 227. Petitioner also maintains that the alarm was only one intervention used for R44 and staff were "readily nearby when both 'incidents' occurred." P. Br. at 8; Tr. at 226-28. Additionally, Petitioner states that R44's room is near the nursing station in the hallway which is staffed with six to seven staff members including Ms. Conroy, who was at the corner of the nursing station on the day the surveyor noted that R44's alarm was not functioning - May 20, 2004. P. Br at 8; Tr. at 226-27.

However, as Ms. Truett testified during cross examination, there was no assessment or other notation in R44's clinical record that identified R44 as deactivating his alarm himself. If there were such an assessment or notation, then staff should have not continued use of the device as it was then ineffective. Tr. at 83. Ms. Truett further testified that staff kept the pressure sensitive alarm as their primary device for fall prevention although they did have other interventions in place as well. Tr. at 83.

I find that staff should have been aware if R44 had, in fact, intentionally turned off the device as this would defeat the purpose of having the alarm. I also find that staff were not using the alarm intended to provide R44 protection from accidents in accordance with R44's plan of correction – the device simply was not functioning. That R44 did not have any recorded incidents of falls from February 16, 2004 through May 20, 2004 does not negate the need for a fall intervention to be effective. Given R44's history of falls, I find that there was risk of more than minimal harm that could result in injury to R44 in the event he fell. Additionally, Petitioner did not present any documentation that the physician who ordered the alarm device had ever been informed that R44 deactivated the alarm as Petitioner alleges. I find that there is no indication that the facility tried to safeguard R44 by at least documenting the alleged problem of R44 deactivating his alarm or informing his physician of this alleged practice. Documentation of R44's alleged practice of deactivating his alarm would have placed the physician and the interdisciplinary team on notice that other interventions should be utilized. Based on the evidence before me, I conclude that R44 was not provided with the necessary device and supervision as required by 42 C.F.R. § 483.25(h)(2).

c. R53

As to the allegations presented by CMS pertinent to R53, I conclude that CMS has not established a prima facie case in showing that R53 did not receive adequate supervision. R53 had been assessed as at high risk for falls, had an unsteady gait, impaired vision and vertigo. Tr. at 40; CMS Ex. 1, at 26. R53's plan of care identified the need for use of a call light to be kept within reach. Tr. at 41; CMS Ex. 1 at 31. During the survey, Ms. Truett observed that R53's call light was located out of R53's reach. Tr. at 41. She observed R53 sitting in his wheelchair and his call light was on the other side of the room. Ms. Truett maintained that R53 would not be able to get around the bed as there was not sufficient room to maneuver around the foot of the bed. Tr. at 85. R53 was in a two-person room and his roommate also had a call light. Tr. at 85.

Petitioner maintains that although CMS cited the facility for failure to place a call light within R53's reach, he was in a wheelchair in a two-person bedroom and could easily have wheeled himself over to the call light and that he was sufficiently mobile and vocal enough to either get help or call out for it. P. Br. at 8. Ms. Conroy testified and drew a floor plan of R53's room which was marked as ALJ Ex. 1 and admitted into the record. I have considered the parties' arguments related to R53, the testimony of both Ms. Truett and Ms. Conroy, and I have reviewed the diagram of R53's room. I find that given the dimensions of the room and objects located within the room that R53, as Ms. Conroy testified, had sufficient space to be able to get around his bed and maneuver to where his call light was placed. The parties agree that the access space to the call light is six feet. R53's wheelchair is approximately 46-48 inches as represented by Petitioner and not disputed by CMS. Tr. at 240. Even if R53 was seated in his wheelchair near the bathroom door when Ms. Truett walked into his room, it appears feasible that based on

the relative locations of objects in his room, R53 had sufficient room to propel his wheelchair to the location of the call light. ALJ Ex. 1, Tr. at 239-42. I rely on Ms. Conroy's personal familiarity with R53's room as well as her personal experience with R53's usage of his room. Ms. Conroy testified that R53 could not have been to the left of his bed when Ms. Truett entered his room as there is a refrigerator located in that area. Tr. 85, 229. Ms. Conroy further stated that while in his room, R53 frequents the space next to the bathroom door in order to sit and look out into the hallway. Tr. at 229. I find this very likely and given the location of the call light in the room and that there is six feet of access space for R53 to propel himself to the call light, I conclude that it is more likely than not that R53's call light was accessible to him.

However, while I find that CMS did not establish a prima facie case for the allegations related to R53 under F-tag 324, I previously determined that based on the evidence before me, Petitioner's staff failed to provide the necessary supervision to R30 and R44. Therefore, for the reasons previously outlined for R33 and R44, I conclude that, as of the May survey, Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h)(2).

7. CMS has established that, as of the May survey, Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25 (m)(1)- F-tag 332(D) - Medication Error.

The regulation requires that a facility not exceed a medication error rate of five percent. CMS maintains that during the May survey, Petitioner was determined to have a medication error rate of nine percent which included three omitted medications and one dosage error. CMS Br. at 35; CMS Ex. 1, at 34-36.

Petitioner does not dispute that the medication dosages were not administered. P. Br. at 9-10. Rather, Petitioner maintains that observation of eight medication passes is statistically insignificant for a facility with over 80 residents and thousands of medications passed each day. P. Br. at 9. Petitioner directs me to *Pacific Regency Arvin,* CR792 (2001) to support its assertion that there is an incongruity in the sampling methodology applied by the surveyors in this case. I have read the *Pacific Regency Arvin* case and the Board's review of that decision and find that Petitioner's reliance on this case is misplaced. I note, and as CMS has pointed out, Petitioner's argument has already been sufficiently addressed by the Board in *Pacific Regency Arvin.* The Board rejected the ALJ's approach in that case in that he required surveyors to document not just errors but also to demonstrate the statistical validity of its medication pass procedures in order to establish its prima facie case. The Board concluded that the regulation in no way imposes such a requirement by stating: "[t]here is no basis for the ALJ's imposing on CMS an additional requirement of a showing of statistical significance to establish a prima facie case that the medication error regulation was violated." *Pacific Regency Arvin,* DAB No. 1823, at 12 (2002).

Petitioner does not deny the medications errors occurred and, based on the record before me, I find that CMS has established a prima facie case that at the time of the May survey Petitioner's medication error rate was higher than five percent. I therefore conclude that Petitioner was not in substantial compliance with the requirements of 42 C.F.R. § 483.25(m)(1).

B. Remaining deficiencies cited during the May survey of Petitioner's facility.

As previously noted, Petitioner was cited for lack of substantial compliance with 25 Medicare participation requirements during the May survey of its facility. The parties waived presentation of evidence and testimony for nine life-safety code tags identified in the May SOD based on CMS's assertion that they were not considered as a basis for the imposition of a CMP or other remedy. In addition, the parties agreed that CMS would present testimonial evidence on only the quality of care citations listed in the May SOD, specifically, F-tags 309, 312, 314, 316, 318, 324, 328, 332. CMS chose to present testimonial evidence at the hearing on eight of the 16 quality of care deficiency tags identified in the May SOD and to submit the May SOD as evidence of the allegations for the non-quality of care citations without providing testimonial evidence as to the remaining tags.

I have addressed allegations in the SOD related to seven quality of care deficiency F-tags: 314 (42 C.F.R. § 483.25 (c)); 309 (42 C.F.R. § 483.25); 312 (42 C.F.R. § 483.25(a)(3)); 316 (42 C.F.R. § 483.25(d)(2)); 318 (42 C.F.R. § 483.25(e)(2)); 324 (42 C.F.R. § 483.25(h)(2)); and 332 (42 C.F.R. § 483.25). I do not find a need to continue to review any of the other alleged deficiencies identified by CMS and outlined in the May SOD because, as noted above, I discuss only those deficiency citations which I have determined support the noncompliance and the remedies imposed. Therefore, for purposes of judicial economy, I will not review the 200 series deficiencies which CMS alleged in the May SOD, nor do I analyze tag F-328 as I have determined that the deficiencies I have reviewed and sustained, as identified above, provide a sufficient basis for the CMP imposed in this case.

C. A CMP of $400 per day for each day of the May 21, 2004 through June 30, 2004 period is reasonable.

Having found a basis for imposing a CMP, I now consider whether the $400 per day CMP is reasonable. I apply the four factors listed at 42 C.F.R. § 488.438(f), which include: (1) the facility's history of noncompliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404; and (4) the facility's degree of culpability.

First, with regard to Petitioner's history of noncompliance, the deficiency in the previous survey is not at issue in this appeal except for the purpose of showing relevant survey history which is considered here for the limited purpose of evaluating the facts supporting the reasonableness of the CMP. CMS has established and Petitioner has not refuted that it was cited for a G-level deficiency at tag F314 in its previous standard survey which also involved a failure to provide adequate pressure sore treatment for residents.

Second, as to Petitioner's financial condition, Petitioner did not submit evidence that the financial viability of the facility was at risk by paying the CMP. While an ALJ may consider a facility's financial condition in determining whether the amount of a CMP is within a reasonable range, the facility must initially raise that issue as a basis for disputing the reasonableness of the amount of the CMP; otherwise, the ALJ can properly exercise his discretion in excluding it. *Community Nursing Home,* DAB No. 1807*,* at 21, 26 (2002). Where either party fails to take advantage of its opportunity to submit evidence of a facility's financial condition, that opportunity is waived. *Id.* at 15-16; *Emerald Oaks*, DAB No. 1800 (2001). In this case, the record is silent as to Petitioner's financial solvency, and Petitioner has not claimed that its financial condition makes the amount of the CMP unreasonable.

Third, I find that all of these deficiencies are serious failure on the part of this Petitioner. Specifically, Petitioner's staff's failure to provide care and services necessary to prevent pressure sores from developing on R55; failure to provide R70 with his bed rail padding and place the rails in the required position; failure to provide oral hygiene care to both R33 and R34; failure to use proper washing techniques when providing incontinence care to R33, R46, and R54; failure to apply R33's hand splints and ensure R75's leg brace was not broken; failure to provide adequate supervision to R30 and R44; and failure to maintain a medication error rate of less than five percent.

Fourth, Petitioner manifests a high degree of culpability for the deficiencies that were identified at the May survey of Petitioner's facility. The deficiencies are not simply isolated dereliction of care as Petitioner would have me conclude. Together, they show that Petitioner and its staff were not diligent in meeting the fundamental responsibility to residents to ensure that the residents be provided with the necessary care and services as required by regulation.

Where there is no immediate jeopardy alleged, a CMP may be imposed within a range from $50 – $3,000 per day for each day of continued noncompliance. 42 C.F.R. § 488.438(a)(1)(ii). As I mention above, it is well established that a single deficiency at a D-level or above is sufficient to authorize CMS to certify a finding of noncompliance. 42 C.F.R. §§ 488.301, 488.408(c)(2)(i); *see also Beechwood Sanitarium*, DAB No. 1824 (2002); *Wisteria Care Center*, DAB No. 1892 (2003).

I have weighed Petitioner's evidence relevant to the regulatory factors in order to contest the reasonableness of the amount of the CMP. Based on the testimony offered at the hearing, the documentary evidence, the arguments of the parties, and the applicable law and regulations I conclude that the CMP which CMS determined to impose here - $400 per day - which is at the lower end of the non-immediate jeopardy range, is reasonable. Petitioner has offered no evidence that would rebut or detract from the foregoing. I further conclude that as Petitioner was out of substantial compliance with several quality of care requirements, CMS is acting within its authority to disqualify Petitioner's NATCEP for a two-year period. A finding of substandard quality of care results in the loss of approval for the facility's NATCEP. 42 C.F.R. § 498.3(b)(14); *see Alden-Princeton Rehabilitation and Health Care Center*, DAB No. 1978 (2005).

VI. Conclusion

Based on my consideration of all of the evidence before me, I sustain the determination of CMS to impose a CMP against Petitioner in the amount of $400 per day, for a period that began on May 21, 2004 and which ended on June 30, 2004 and to disqualify Petitioner's NATCEP for two years.

/s/
Alfonso Montano
Administrative Law Judge