Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Crawford Healthcare and Rehabilitation,
(CCN: 04-5326),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-1565

Decision No. CR4466

Date: November 25, 2015

DECISION

Petitioner, Crawford Healthcare and Rehabilitation (Petitioner or facility), is a long-term care facility that participates in the Medicare program. Based on a survey that was completed on May 2, 2014, the Centers for Medicare & Medicaid Services (CMS) determined that Petitioner was not in substantial compliance with multiple Medicare participation requirements. CMS imposed against Petitioner a civil money penalty (CMP) of $6,050.00 per day, effective March 20 through April 7, 2014, for a total of $114,950.00, and a CMP of $600.00 per day, effective April 8 through June 3, 2014, for a total of $34,200.00.

Petitioner contests only the deficiency cited under 42 C.F.R. § 483.25(h) (Tag F323, relating to accident prevention and adequate supervision), CMS's determination that this deficiency posed immediate jeopardy, and the amount of the CMP imposed for the deficiency.

For the reasons set forth below, I sustain CMS's determinations. I find that Petitioner was not in substantial compliance with the requirements for participation at 42 C.F.R.

§ 483.25(h), that CMS's immediate jeopardy determination was not clearly erroneous, and that the penalty imposed is reasonable.

I. Background

The Social Security Act (Act) sets requirements for skilled nursing facility (SNF) participation in the Medicare program. The Act authorizes the Secretary of the U.S. Department of Health & 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.

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 § 1864(a) (42 U.S.C. § 1395aa(a)); 42 C.F.R. §§ 488.10, 488.20. The Act and 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.

Petitioner is an SNF that operates in Van Buren, Arkansas. Surveyors from the Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care (state agency) conducted a survey of Petitioner that concluded on May 2, 2014. The state agency found that the facility was not in substantial compliance and the conditions constituted immediate jeopardy.[1] Petitioner Exhibit (P. Ex.) 12 at 1. Based on the survey findings, CMS determined that, among other deficiencies, the facility was not in substantial compliance with the participation requirement at 42 C.F.R. § 483.25(h) (Tag F323), concerning accident prevention and adequate supervision, and that the noncompliance constituted immediate jeopardy and substandard quality of care to residents' health and safety from March 20 through April 7, 2014.[2] Based on all the cited

[1] A separate survey and CMS Form 2567, dated April 29, 2014, addresses the Life Safety Code deficiencies. CMS Exhibit (Ex.) 5.

[2] Petitioner does not dispute the remaining deficiencies and related CMPs, which include findings that it was not in substantial compliance with the following nine other standards at a scope and severity level of either "E" (pattern - no actual harm with potential for more than minimal harm that is not immediate jeopardy) or "F" (widespread - no actual harm with potential for more than minimal harm that is not immediate jeopardy): 42 C.F.R. § 483.25(a)(3) (Tag F312, relating to activities of daily living care provided for

deficiencies, by letter dated July 21, 2014, CMS imposed a CMP in the amount of $6,050.00 per day effective March 20 through April 7, 2014, and a CMP in the amount of $600.00 per day effective April 8 through June 3, 2014. CMS Exhibit (Ex.) 3 at 1.

On July 14, 2014, Petitioner requested a hearing. On August 1, 2014, Administrative Law Judge (ALJ) Carolyn Cozad Hughes issued an acknowledgment and initial prehearing order establishing a briefing schedule. In accordance with the schedule, CMS and Petitioner filed prehearing exchanges, including prehearing briefs (CMS Br. and P. Br., respectively), exhibit and witness lists, and proposed exhibits.[3] CMS moved for summary judgment, and Petitioner objected. CMS submitted CMS Exs. 1 to 41, and Petitioner submitted P. Exs. 1 to 17. As neither party has objected to any of the proposed exhibits, I admit all of them into the record.[4]

II. Issues

The issues are:

1) Whether summary judgment is appropriate;

2) Whether Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h) (Tag F323, relating to accident prevention and adequate supervision);

3) If Petitioner was not substantially compliant with 42 C.F.R. § 483.25(h), then whether CMS's immediate jeopardy determination was clearly erroneous; and

4) Whether the CMP that CMS imposed is reasonable.

III. Findings of Fact and Conclusions of Law

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dependent residents); 42 C.F.R. § 483.25(m)(l) (Tag F332, relating to a facility being free of medication error rates of 5 percent or more); 42 C.F.R. § 483.25(m)(2) (Tag F333, relating to residents being free of significant medication errors); 42 C.F.R. § 483.35(c) (Tag F363, relating to menus meeting resident needs); 42 C.F.R. §§ 483.35(d)(1) and (2) (Tag F364, relating to nutritional value, appearance, palatability, and temperature of food); 42 C.F.R. § 483.70(a) (relating to four Life Safety Code standards under Tags K038, K052, K067, and K069). Petitioner's Brief (P. Br.) at 1 n.1.

[3] The case was reassigned to me on October 21, 2015.

[4] Several exhibits submitted by CMS and Petitioner contain identical documents. In some instances, when referring to these documents, I have identified the document by only CMS's or Petitioner's exhibit number, and not by both exhibit numbers.

A. Summary judgment is appropriate.

Summary judgment is appropriate if there is "no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law." *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459, at 5 (2012) (citations omitted). In order to prevail on a motion for summary judgment, the moving party must show that there is no genuine dispute of material fact requiring an evidentiary hearing and that it is entitled to judgment as a matter of law. *Id.* If the moving party meets this initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial . . . .'" *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986). "To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact — a fact that, if proven, would affect the outcome of the case under governing law." *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010). In moving for summary judgment, CMS must present evidence sufficient to show, if uncontradicted, that it is entitled to judgment as a matter of law and that there are no genuine issues of material fact in dispute. *Chicago Ridge Nursing Ctr., DAB No. 2151 at 5.* If CMS makes this demonstration, the SNF can avoid an adverse summary judgment by: 1.) proffering evidence that there is a genuine dispute regarding facts that are material to CMS's basis for claiming judgment in its favor, or 2.) proffering evidence from which a trier of fact could conclude—if accepted as true—that the facility could carry the ultimate burden of persuasion (i.e., prove that the facility was in substantial compliance). *Id.* In evaluating an SNF's response to CMS's motion for summary judgment, the ALJ is to view the evidence in the light most favorable to the facility and is to draw all reasonable inferences therefrom in the facility's favor. *Id.*

The role of the ALJ in deciding a motion for summary judgment differs from the role of an ALJ in resolving a case after a hearing: The ALJ does not address credibility or evaluate the weight of conflicting evidence in evaluating a motion for summary judgment. *Holy Cross Village at Notre Dame, Inc.,* DAB No. 2291, at 5 (2009). Rather, in examining the evidence to determine the appropriateness of summary judgment, the ALJ must draw all reasonable inferences in the light most favorable to the non-moving party. *See Brightview Care Ctr.*, DAB No. 2132, at 10 (2007) (upholding summary judgment where inferences and views of non-moving party are not reasonable). "[A]t the summary judgment stage the judge's function is not . . . to weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial." *Anderson v. Liberty Lobby, Inc*., 477 U.S. 242, 255 (1986). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cedar Lake Nursing Home,* DAB No. 2344, at 7 (2010).

Here, there is no genuine dispute of material fact. The documents in the record, the majority of which were created and maintained by Petitioner itself, establish the following undisputed material facts:

Resident # 14: Resident # 14, a 91-year-old woman, spilled coffee on herself on March 1 and 27, 2014. (P. Ex. 7 at 6, 22; CMS Ex. 18 at 19, 21). A January 14, 2014 care plan conference summary report indicates, in pertinent part, that she has psychosis and that she "feeds [her]self." P. Ex. 7 at 20. In a subsequent evaluation on January 19, 2014 for a Minimum Data Set (MDS) dated January 20, 2014, an evaluator determined that she required a "[o]ne person physical assist" when eating. P. Ex. 7 at 14, 19. The MDS also reported that Resident # 14 had highly impaired vision, a Brief Interview for Mental Status (BIMS) score of 5,[5] communication ability limited to making concrete requests, was totally dependent on staff for bed mobility, transfers, and locomotion, and that she was always incontinent. P. Ex. 7 at 12-14. At the time of the hot liquid spill on March 1, 2014, Resident # 14 was drinking coffee in her bed. P. Ex. 7 at 22; CMS Ex. 18 at 19. The Incident and Accident Report (incident report) does not indicate that, at the time of the hot liquid spill, Resident 14 was receiving any assistance from a staff member while she was drinking the coffee, that she was wearing lap or shirt protectors, or that the coffee cup had a lid. *Id.* Petitioner does not deny that at the time of the spill Resident # 14 was not receiving any staff assistance, not wearing any protectors, or that the coffee cup did not have a lid. Staff was alerted when Resident # 14 began "hollering" for staff to help her, at which time staff discovered she had spilled coffee and a "reddened area" was immediately visible between her breasts. *Id*. Per telephonic orders by her doctor, the area was treated with triple antibiotic ointment twice daily through March 8, 2014. *Id.*; P. Ex. 7 at 2-4; CMS Ex. 18 at 45-47. A March 12, 2014 treatment record provides a diagnosis, of *inter alia*, end-stage dementia. (P. Ex. 7 at 24).

Resident # 14 spilled hot liquid on her chest again on March 27, 2014, at which time she was drinking coffee in her bed without assistance while wearing a clothes protector. The incident report does not document that a lid was on the coffee, and Petitioner does not assert that the coffee cup had a lid. CMS Ex. 18 at 21. The area on which the coffee spilled initially had redness following the spill, but upon examination one hour later there was no redness or sign of injury. *Id.* A new MDS was completed on April 18, 2014, at which time Petitioner's staff again assessed Resident # 14 as requiring a "[o]ne person physical assist" when eating. CMS Ex. 18 at 7, 11. Regarding both thermal injuries, the

[5] A BIMS score below 7 indicates severely impaired cognitive ability. *See* CMS RAI Version 3.0 Manual, *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-RAI-Manual-V113.pdf*, at C-14 (last visited November 12, 2015).

terms first, second, or third degree burn are not used in the nursing notes or incident reports.[6]

Resident # 3: Resident # 3, a 92-year-old woman, sustained second degree burns of the upper inner thighs when she spilled coffee on herself in the dining room on March 20, 2014. CMS Ex. 17 at 16, 22, 23; P. Ex. 6 at 17, 32. A November 15, 2013 social services note reports that she "feeds self" and that she had recently lost her dentures and that her family did not plan to replace them. P. Ex. 6 at 36. A February 18, 2014 setup care plan conference summary reported that she was on a mechanical soft diet and that she could feed herself. P. Ex. 6 at 9. A subsequent MDS completed shortly thereafter, on February 20, 2014, assessed that Resident # 3 required only set-up assistance when eating, along with "supervision" in the form of "oversight, encouragement, or cueing" when eating. P. Ex. 6 at 4, 8. The MDS also reported that Resident # 3 was frequently incontinent, required a one-person physical assist to walk, had communication ability limited to only concrete requests, and had a BIMS score of 3. P. Ex. 6 at 2-4. A February 21, 2014 social services note reported that she had diagnoses of Alzheimer's disease and depressive disorder and lived in the "secure unit." P. Ex. 6 at 36.

On March 20, 2014, while eating in the dining room, Resident # 3 sustained burns on her right and left thighs when she spilled coffee on her lap. CMS Ex. 17 at 22, 125, 126. Petitioner's staff notified the nurse on duty, changed Resident #3's clothing, and contacted her doctor, who prescribed silvadene skin cream for the burns. CMS Ex. 17, at 104, 123-25. On March 24, the Resident was treated at a wound care center, where she was diagnosed with second-degree burns on her left and right thighs. CMS Ex. 17 at 129. The incident report from March 20 documents that a nursing assistant "reported she heard resident yell & went to [illegible] & resident said she spilled coffee on her legs." There is no indication that Resident # 3 was supervised while eating her meal, that she was wearing garment protectors, or that the coffee cup had a lid. CMS Ex. 17 at 22; P. Ex. 6 at 32. The report documents that the type of intervention that the facility initiated to prevent further injury was: "If she request[s] coffee make sure it[']s in a cup [with a] lid." *Id*. An April 16, 2014 care plan showed that Resident # 3 had the "[p]otential for injuries related to hot liquid spills due to poor safety awareness related to cognitive impairment / diagnosis of Alzheimer's." CMS Ex. 17 at 31; P. Ex. 6 at 46. The plan indicated that she should use a cup with handles as needed, wear clothing protectors when eating and drinking hot liquids, receive a lidded drinking cup, and have the temperature of hot

[6] CMS, in its brief, makes nine separate references to Resident # 14 sustaining a second degree burn. However, CMS points to no specific evidence in support of this assertion, and I found no evidence in the record that Resident # 14 sustained a second degree burn on either March 1 or 27, 2014. I also observe that on no less than ten occasions, CMS failed to include a citation in support of an evidentiary assertion (i.e., citing to "CMS Ex. __") or cited to wholly nonexistent evidence (i.e., citing to "CMS Ex. 52" and "CMS Ex. 19 at 88").

liquids monitored. *Id.* Treatment records through the date of the survey, approximately two months after the hot liquid spill, document continuing wound care for the burns and a "complicated course" that involved wound infections requiring antibiotic treatment. CMS Ex. 17 at 23-24, 38-74, 129-30; P. Ex. 6 at 37-38. Treatment for the burns included debridement on March 24, 2014. CMS Ex. 17 at 130. On March 31, 2014, the left thigh wound was assessed as .7 x 3.2 x. 2 centimeters in size, and the right thigh wound was 2.6 x 11.5 x .2 centimeters in size. CMS Ex. 17 at 49. Both wounds had a large amount of necrosis. *Id.*

Hot liquids assessments and training:

March 10, 2014: Following Resident # 14's hot liquid spill on March 1, 2014, Petitioner conducted in-service training on March 10, 2014 that covered numerous topics, including the prevention of accidents and the spillage of hot liquids. P. Ex. 9 at 1-4; CMS Ex. 33 at 14-16.

March 24, 2014: Following Resident # 3's hot liquid spill on March 20, 2014, Petitioner conducted another in-service training session on March 24, 2014, which included numerous topics. P. Ex. 9 at 5-9. One of the topics listed in the training agenda included: "Coffee cups & lids on carts – all hot liquids going down the hall and in the dining rooms." P. Ex. 9 at 5-9.

March 25, 2014: A small group of staff was given in-service training regarding care requirements for Resident # 3 on March 25, 2014. The topic was "prevention of burns" and staff was instructed as follows: "1. Hot liquids in cup [with] lid every time; 2. Put shirt protector on and one in lap for protection there; 3. Cool down her hot liquids." CMS Ex. 17 at 36; P. Ex. 9 at 10.

April 7, 2014: A "QA" form, dated April 3, 2014, references the problem of "spillage of hot liquids." The four identified solutions were:

1. In-service of nursing staff by Director of Nursing;
2. Reduce temperature of coffee from kitchen to 160 [degrees];
3. Monitor coffee temperature by dietary department;
4. Nursing monitor meal service 3x/week for lids on cups, cooling down coffee, etc. by [Director of Nursing].

P. Ex. 9 at 11. Shortly thereafter, on April 7, 2014, in-service training was given on at least four topics that included "survey preparedness" and "prevention of spillage of hot liquids." P. Ex. 9 at 12-16. Petitioner's plan of correction indicates that, on April 7, 2014, "[d]ietary and nursing staff were in-serviced . . . to place lids on hot liquids, use clothing protectors when available, use ice/cool water to cool liquids above 140° before serving them to residents." CMS Ex. 12 at 4.

April 16, 2014: In-service training was provided to a group of staff members regarding hot liquids precautions on April 16, 2014. The following instructions were given to the participants: "Temperature of coffee coming from kitchen is [160 degrees]; serve hot liquids [with] lids on cup; let dietary manager and nurse managers [know] of residents [who are] noncompliant with lids; make sure hot coffee is cooled by adding ice; residents to wear clothing protector/lap protector; residents are to be assisted with all hot liquids; read policy and procedures on classifications of burns." P. Ex. 9 at 17.

May 1, 2014: Petitioner performed hot liquid assessments on all residents on May 1, 2014 and reported that all residents who were identified as receiving "2 or more marks will receive appropriate interventions when consuming hot liquids." CMS Ex. 12 at 4. While copies of the hot liquids evaluations have not been submitted by either party as evidence, the Statement of Deficiencies (SOD) dated May 2, 2014, documents that 68 residents were identified as being at risk from hot liquid injuries. CMS Ex. 12 at 12. Petitioner has not disputed this figure in its brief.[7]

Petitioner has not come forward with any evidence that raises a dispute of material fact. While Petitioner's brief includes a list of assertions titled "Statement of Facts About Which There Is A Material Dispute," I conclude that none of the items listed establishes a genuine factual dispute. P. Br. at 7-8. Among other things, Petitioner states that it disputes the state agency's assessment of the deficiency cited under section 483.25(h) as posing a pattern of immediate jeopardy to facility residents' health or safety. P. Br. at 7. Petitioner also states that it disputes the "immediate jeopardy finding because . . . it took reasonable steps to ensure its residents received supervision and assistance devices that met their assessed needs and mitigated foreseeable risks of harm." *Id.* at 8. Whether the state agency erred in assessing the scope and severity of the deficiency, and whether the facility took reasonable steps to ensure its residents received the requisite supervision and assistance are legal issues, however, and not issues of fact. Petitioner's assertions represent legal allegations that are based on non-factual disagreements with the state agency and CMS's ultimate legal conclusions.

Petitioner also asserts that there are several material factual disputes relating to Resident # 3's and Resident # 14's assessed physical conditions and functional statuses. For example, Petitioner says that "Resident 3 had no skin issues at the time of the coffee spill," contrary to CMS's allegations. P. Br. at 7. To support its statement, Petitioner points to a March 19, 2014 assessment by Resident # 3's doctor documenting Resident #3 had "[n]o skin issues" prior to the hot coffee spill. P. Ex. 6 at 34. CMS, however, has

[7] Although CMS asserts that Petitioner served "extremely hot coffee" and Petitioner counters that the coffee was not too hot, the precise temperature of the facility's coffee is not a material fact. The undisputed evidence shows that the coffee was served hot enough to cause second degree burns to Resident # 3.

not disputed that assessment. Rather, CMS asserts that *at the time of the survey*, which was several weeks *after* the resident sustained burns from the spill, Resident # 3 had a propensity for issues related to skin integrity. CMS Br. at 6. While Resident's # 3's physical condition apparently deteriorated between February and April 2014, after the spill, this change does not signal a factual dispute. Petitioner also claims that contrary to CMS's characterization, Resident # 3 was able to eat without assistance and required help from staff with meals only for "setup." P. Br. at 7, citing P. Ex. 6 at 4. The February 20, 2014 MDS states, however, that Resident # 3 needed "Supervision - oversight, encouragement, or cueing," along with "[s]etup help only" when eating. P. Ex. 6 at 4. Thus, viewed in the light most favorable to Petitioner, the evidence shows that the facility itself had determined that Resident # 3 required staff supervision when eating, even though she could feed herself.

With respect to Resident # 14, Petitioner challenges CMS's assertion that Resident # 14 "require[ed] limited assistance of one person for eating." P. Br. at 8; CMS Br. at 8. In disputing this factual assertion, Petitioner contends that Resident # 14 had a January 19, 2014 care plan that was "approved by her physician" that indicated "she was able to feed herself." P. Br. at 8. The document cited by Petitioner (P. Ex. 7 at 20) is a January 14, 2014 "Care Plan Conference Summary" that indicates that Resident # 14 "feeds self," but also remarks that she requires "extensive" two-person assistance and needs assistance with activities of daily living. P. Ex. 7 at 20. In addition, the January 20, 2014 MDS assessed Resident # 14 as requiring a *one-person physical assist* with eating. P. Ex. 7 at 14, 19.

Moreover, whether Resident # 3 had diagnosed skin integrity problems prior to sustaining burns from the coffee spill or whether both Residents # 3 and # 14 were able to feed themselves prior to the hot coffee spills are issues that are not material to the outcome of this case. As explained more fully below, even accepting Petitioner's factual assertions as true, the facility did not ensure that conditions at the facility were "as free of accident hazards as is possible" in light of its residents' compromised cognitive status, limited mobility and communication deficits, as well as the facility's failure to conduct hot liquids assessments and take precautionary measures to protect its residents from severe burns in the event they spilled hot liquids on themselves.

Finally, Petitioner disputes CMS's assertion that "[o]n May 2, 2014, the Facility lowered the brewing temperature of the coffee machine, which at the time brewed at 192 [degrees Fahrenheit]." P. Br. 8; CMS Br. at 10. In disputing this assertion, Petitioner contends that it "began requesting that its vendor lower the brewing temperature of its coffee machine on April 17" and "began monitoring the temperature of individual residents' coffee following the inservice training on March 10." P. Br. at 8. The written declaration of Petitioner's witness Richard A. Scott, however, reports that the temperature that coffee is served was lowered to below 140 degrees in *May* 2014 and that "[c]offee is usually brewed at a higher temperature than it is served, usually at 190 to 200 degrees

Fahrenheit." P. Ex. 2. Regardless, the temperature at which coffee was *brewed* in the facility's kitchen is not a *material* fact to this case; rather, whether the *service* of hot coffee to residents caused or was likely to cause serious injury, harm, impairment, or death to a resident is relevant to the questions at issue in this case. 42 C.F.R. § 488.301.

For the reasons explained above, I conclude that Petitioner has not come forward with any evidence that raises a dispute of any material fact. Accordingly, summary judgment is appropriate.

B. Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h) because it did not address foreseeable risks of harm from accidents involving hot liquids spills.

Program requirements. Subsection 483.25(h) is part of the quality of care regulation at 42 C.F.R. § 483.25, which states that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." Subsection 483.25(h) imposes specific obligations upon a facility related to accident hazards and accidents, as follows: 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.

The Departmental Appeals Board (the Board) has held that subsection 483.25(h)(1) requires that a facility address foreseeable risks of harm from accidents "by identifying and removing hazards, where possible, or where the hazard is unavoidable because of other resident needs, managing the hazard by reducing the risk of accident to the extent possible." *Maine Veterans' Home - Scarborough*, DAB No. 1975, at 10 (2005) (explaining the inherent standard of care in section 483.25(h)(1)). The provisions of section 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). The Board has held that subsection 483.25(h)(2) requires that a facility take "all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents." *Briarwood Nursing Ctr.*, DAB No. 2115, at 11 (2007), *citing Woodstock Care Ctr. v. Thompson*, 363 F.3d 583, at 589 (6th Cir. 2003)(facility must take "all reasonable precautions against residents' accidents"), *affirming, Woodstock Care Ctr.*, DAB No. 1726 (2000). Facilities are given "the flexibility to choose the methods" they use to provide supervision or assistive devices to prevent accidents, so

long as the chosen methods constitute an adequate level of supervision for a particular resident's needs." *Windsor Health Care Ctr.*, DAB No 1902, at 5 (2003), *aff'd, Windsor Health Care Ctr. v. Leavitt,* 127 F. App'x 843 (6th Cir. 2005)(unpublished).

The State Operations Manual (SOM), which provides guidance on the Secretary's regulations, addresses burns from spills of hot liquids. P. Ex. 15 at 13-14.[8] The SOM states that "[m]any residents in long-term care facilities have conditions that may put them at increased risk for burns caused by scalding." P. Ex. 15 at 13. The SOM notes that these conditions include decreased agility (reduced reaction time), decreased cognition or dementia, decreased mobility, and decreased ability to communicate. *Id.* As discussed in the previous section, Residents # 3 and # 14 had cognitive, mobility, and communicative deficits. Thus, Residents # 3 and # 14 were at an increased risk for burns caused by scalding.

In the SOD dated May 2, 2014, CMS cited Petitioner for failing to ensure the environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents, in violation of 42 C.F.R. § 483.25(h). CMS Ex. 1 at 3. The SOD indicated that Resident # 14 had a first degree burn to the chest on March 1, 2014, and that Resident # 3 had a second degree burn to the right thigh on March 20, 2014, both of which were caused by spilled coffee. *Id.* at 4. While the first hot liquid injury occurred on March 1, 2014, the state agency did not find an immediate jeopardy situation until March 20, 2014, which is the time of the second hot liquid spill resulting in injury that month. P. Ex. 12.

CMS asserts that Petitioner's noncompliance began on March 20, 2014, when Resident # 3 sustained second degree burns to her thighs.[9] As previously discussed, at the time she spilled hot coffee on herself, Resident # 3 required supervision and set-up assistance during meals, and had a BIMS score of 3, which is indicative of severe cognitive impairment. P. Ex. 6 at 2-4. Surveyors cited this as an incident of noncompliance at the time of the May 2014 survey. CMS Ex. 1 at 3-8.

Petitioner now argues that it had no duty to provide hot liquids assessments of its residents because such assessments were incorporated in its residents' admission and MDS assessments, yet it fails to appreciate that had it followed Resident # 3 and # 14's

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[8] The SOM has been revised since Petitioner filed its brief, and the updated version (Revision 149, dated October 9, 2015) can be found at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf* (last visited November 12, 2015).

[9] CMS showed restraint in its determination that the noncompliance began on March 20, 2014. The evidence arguably demonstrates that noncompliance began at the time of Resident # 14's hot liquid spill on March 1, 2014.

assessments, these accidents may not have occurred in the first place. Thus, by not proving a hot liquids assessment, and not adhering to the supportive requirements set forth at the time of previous assessments of the residents' ability to consume meals, the facility did not make adequate efforts to protect these residents from hot liquid spills.

Specifically, Petitioner did not ensure that Resident # 14 received the adequate supervision and assistance devices necessary to prevent the spillage of coffee on March 1, 2014. According to her MDS, dated January 20, 2014, Resident # 14 had a severe cognitive impairment, and was totally dependent on staff for bed mobility, transfers, locomotion, toileting, and dressing. P. Ex. 7 at 12-14. The MDS also indicated that she required a one-person physical assist when eating. P. Ex. 7 at 14. However, on March 1, 2014, in contravention of the assessment, she was given a meal and hot coffee to consume while unsupervised in her bed. At that time, she sustained a hot liquid spill between her breasts. P. Ex. 7 at 22. The coffee was approximately 169 degrees Fahrenheit in temperature (CMS Ex. 23 at 2), and in addition to not being given the assistance she should have been afforded per her assessment, Resident # 14's coffee cup was not lidded and she was not wearing any clothing protectors. (P. Ex. 7 at 22). While Petitioner argues that a separate hot liquids assessment was wholly unnecessary because Resident # 14's assessment adequately assessed her safety needs, Petitioner fails to recognize that its utter disregard for the assistance requirements clearly listed in the January 2014 assessment resulted in an unassisted and unprotected cognitively and mobility-impaired resident spilling hot coffee on herself.

Despite the fact that the facility disregarded Resident # 14's assessment and she sustained a burn between her breasts, the surveyors did not cite the facility for noncompliance until another resident was burned 19 days later, on March 20, 2014. Although the facility was on notice that an unsupervised, cognitively-impaired resident could sustain a burn injury when consuming hot coffee, the evidence does not show that the facility changed its practices with respect to hot liquids service for anyone other than for Resident # 14.[10] At the time Resident # 3 was burned on her upper and inner thighs on March 20, 2014, the facility once again allowed a resident with severe cognitive impairment and who required supervision while eating, to drink coffee unsupervised and without any protection, in the form of a lidded cup or clothing protectors. In this instance, the coffee was served at approximately 165 degrees Fahrenheit, there was no lid on the coffee, and the resident

[10] The facility conducted in-service training on March 10, 2014. Petitioner claims that the DON "discussed the issue of hot liquids and addressed ways to avoid hot-liquid spills." P. Br. at 17. However, the exact content of the training is not included in exhibits submitted by the parties. P. Ex. 9 at 1; CMS Ex. 33 at 14-16. The plan of correction submitted by Petitioner indicates that the Director of Nursing "inserviced staff [on] 3/10/14 on the prevention of accidents and spillage of hot liquids" but gave no further elaboration. CMS Ex. 12 at 4.

was not wearing any clothes protectors. P. Ex. 17; CMS Ex. 17 at 22; CMS Ex. 23 at 2. Unfortunately for Resident # 3, she sustained second degree burns to her upper thighs. Of particular significance is that the wound on her right thigh took approximately two months to heal after a complicated course involving open blisters, debridement, and infection. CMS Ex. 1 at 5-6,7; CMS Ex. 17 at 23-24, 38-74,118-23; P. Ex. 6 at 16-31, 37-38.

Following Resident # 3's second degree burn injury, Resident # 14 spilled coffee on herself for a second time on March 27, 2014, while drinking coffee in her bed. CMS Ex. 18 at 21. Fortunately, the injury was much less significant than the previous injuries associated with hot liquid spills in the facility that month, in that the redness on Resident # 14's chest subsided within an hour. *Id.* While the incident report indicates that Resident # 14 was wearing a clothing protector while she was drinking her coffee, it does not indicate that there was a lid on the coffee cup[11] or that she was receiving a one-person physical assist as was stated to be required in her MDS.[12]

Petitioner argues that a hot liquids assessment was unnecessary because the facility conducts a "Resident Admission Nursing Assessment" and an MDS assessment, which both involve "the gathering of information that would put [Petitioner's] staff on notice if a resident needed assistance on hot liquids." P. Br. at 13. Petitioner further stated that "[s]imply the absence of a separate form called a 'hot liquids assessment' form does not mean that [Petitioner] was not doing its job in assessing in [sic] residents in general, and in particular with regard to Resident # 3." *Id*. Petitioner essentially contends that drinking hot liquids is a subcomponent of eating, and that its residents' assessments include the capability for consuming hot liquids that can be served at a temperature of 165 degrees or higher in an open and non-spillproof container. Even if this assertion is true, neither Resident # 3 nor Resident # 14 was given the level of assistance for eating that was specified in their existing assessments.

As shown by the fact that the facility did not adhere to the assessments previously in place for its residents, in that Resident # 14 should have had a one-person assist and Resident # 3 should have had supervision while eating, there is no indication that the facility would have followed a plan required based on a separate hot liquids assessment if such an assessment had been provided to each resident. After a severely cognitively-impaired resident in the facility experienced a hot liquids spill on March 1, 2014, the

[11] The March 1, 2014 incident report documented that the initiated interventions were lap and shirt protectors and the use of a "spill proof lid." CMS Ex. 18 at 19.

[12] The incident report documents that Resident # 14 was "yelling for help" and that the "aide checked on her," which demonstrates that Resident # 14 was drinking her coffee without assistance. CMS Ex. 18 at 21.

facility made no systemic changes to prevent a significant burn affecting another severely cognitively-impaired resident on March 20, 2014. And even after the second resident was burned on March 20, 2014, a third incident occurred on March 27, 2014 involving a resident who had already spilled hot liquid on herself earlier that month. At that time, this resident, who required a one-person physical when eating, was injured yet again when drinking her coffee alone and unassisted. It is noteworthy that this resident was to have a lid on her cup and lap and shirt protectors, yet she was drinking coffee served at approximately 164 degrees Fahrenheit without any supervision and potentially without a lid on the cup.[13] This series of hot liquid spills in the same month on elderly and cognitively-impaired residents evidences a pattern of substantial noncompliance in avoiding accident hazards for Petitioner's residents.

Based on the March 1, 2014 incident, Petitioner was on specific notice of a foreseeable risk of harm from hot liquid spills starting that date, yet it failed to take steps to protect residents from the serious, foreseeable harm posed by that risk.

B. CMS's determination of immediate jeopardy is not clearly erroneous.

CMS asserts that Petitioner's deficiency constituted immediate jeopardy (at the "K" scope and severity level) to resident health and safety from March 20 through April 7, 2014. Petitioner argues that if I were to find noncompliance, that such noncompliance does not constitute immediate jeopardy.

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. The regulation does not require that a resident *actually* be harmed. *Lakeport Skilled Nursing Ctr.*, DAB No. 2435, at 8 (2012). I must uphold CMS's determination as to the level of a facility's substantial noncompliance (which includes an immediate jeopardy finding) unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board directs 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." *See, e.g., Barbourville Nursing Home*, DAB No. 1962, at 11 (2005)(*citing Florence Park Care Ctr.*, DAB No. 1931, at 27-28 (2004)).

Here, CMS's finding of immediate jeopardy is not "clearly erroneous." Resident # 14 spilled hot liquid on herself twice, and Resident # 3 sustained second-degree burns from spilling hot liquid on herself. The evidence shows that not only were these residents' individual MDS assessments and care plans not followed as prescribed, but also, the

[13] The incident report documents that a clothes protector was worn but does not document that a lid was on the cup. Petitioner has not asserted that the coffee cup had a lid. CMS Ex. 18 at 21.

facility did not endeavor to timely assess if other residents were at risk for hot liquid spill injuries. CMS Ex. 12 at 4. Although the facility determined, on April 3, 2014, that it would reduce the temperature of coffee from the kitchen to 160 degrees Fahrenheit (P. Ex. 9 at 11), coffee was routinely served at above that temperature for the remainder of April 2014. CMS Ex. 23 at 1. It was not until April 7, 2014 that the facility began to provide lids on coffee cups. CMS Ex. 12 at 4; CMS Ex. 21 at 1. It is noteworthy that, following the universal administration of hot liquids assessments on May 1, 2014, 68 residents were ultimately deemed to be at risk for hot liquid injuries. CMS Ex. 12 at 4.

Contrary to Petitioner's arguments, the risk of harm from hot liquid spills at the facility was significant, affecting a potential population of 68 residents by the facility's own assessment. CMS Ex. 1 at 4. While Petitioner, in arguing against summary judgment, contends that the two residents who were injured had previously been assessed as being capable of eating and drinking with little or no assistance, Petitioner also acknowledged that a different screening measure showed that 68 of its residents required protective measures when drinking hot liquids, such as the use of a lid or clothing protectors. CMS Ex. 12 at 4. While the hot liquid spills involving Residents #3 and # 14 were the impetus for the state agency to find deficiencies resulting in a finding of immediate jeopardy, the incidents involving these two residents showed a pattern of accident hazards and a lack of supervision and adequate assistance devices to prevent accidents.

Petitioner argues that the "imposition of penalties based on Immediate Jeopardy should be particularly troubling in this matter, because they were based on false evidence submitted by" the surveyor to her supervisor. P. Br. at 9. Petitioner contends that the state agency "included factual information in its worksheets and reports that simply was not true, and effectively violated the standards in the State Operations Manual that provide guidelines for Immediate Jeopardy determinations." *Id*. Petitioner focuses on an "Immediate Jeopardy Worksheet" in which the state surveyor made a notation that "Resident 8" had sustained a third degree burn. P. Br. at 15, citing CMS Ex. 33 at 4. Petitioner also takes issue with a survey worksheet notation that Resident # 3 had third degree burns to her right thigh. P. Br. at 15, citing CMS Ex. 33 at 6. I could not locate any references to third degree burns involving either Resident # 3 or # 8; however, these references were made in worksheets, and ultimately not listed in the deficiencies included in the SOD. By not being included in the CMS Form 2567, these statements were not the basis for, nor were they necessary to support, the findings of substantial noncompliance and immediate jeopardy.

Furthermore, Petitioner attempts to minimize the injuries sustained by the two residents, aged 91 and 92, whose safety was entrusted to its facility and its staff. In doing so, Petitioner contends "Resident 14 had minor redness never diagnosed at any burn level, and Resident 3 had second-degree burns covering a few inches on her thighs." P. Br. at 15.

Petitioner disputes that Resident # 14 was ever burned, stating: "The only notation of any injury resulting from Resident 14's March 1 coffee spill was in the nurse's notes, which reflected a reddened area on her chest that quickly went away following the coffee spill." P. Br. at 16. Petitioner highlights that a skin assessment two days after the spill found no evidence of any injury. P. Br. at 16, citing P. Ex. 7 at 30. However, I observe that an assessment two days later, on March 3, 2014, indicated "[r]edness noted [at] breast." CMS Ex. 18 at 46. I also observe that the resident "hollered" and said "help me" when the coffee spilled between her breasts, and that she had redness lasting for two days, which certainly evidences an injury. CMS Ex. 18 at 19. I do not see the term "first degree burn" as a diagnosis for Resident # 14's injury. However, the medical evidence plainly shows that redness lasted at the site of the thermal injury for approximately two days, and that treatment continued for a full week. CMS Ex. 18 at 46-47. I therefore reject the allegation that the surveyors mischaracterized the injury as a "first-degree burn."[14]

With respect to Resident # 3, Petitioner contends that her burns "were diagnosed as second-degree burns, but they were not on a large surface area of her skin, resulting in blisters that covered *only* a few inches in diameter on her thighs." P. Br. at 15 (emphasis added). While I did not observe any reference in the record to Resident # 3 having sustained third-degree burns, I note that wound care specialists reported that Resident # 3 had "complicated" wounds. CMS Ex. 17 at 69, 72. Furthermore, her wounds required debridement, and she developed infections of the wounds on both thighs that required a 10-day course of antibiotic treatment. CMS Ex. 17 at 38-74. Resident # 3 also required topical treatment and weekly wound care treatment. *Id.* The wounds were clearly painful, as nursing notes reflect that Resident # 3 would "barely let [the nurse] look" at her wounds and she "tried hitting this nurse while [ointment] was applied." P. Ex. 6 at 17. The nursing notes indicate that the wounds were at the "upper" and "inner" thighs and that they were painful to touch. *Id.* Resident # 3 continued to be treated by Sparks Wound Care Center until May 20, 2014, which is approximately two months after the injury. P. Ex. 6 at 25.

Petitioner argues that, per the SOM, Resident # 3's burns should not result in an immediate jeopardy situation, as they were not on a large surface area of her skin. P. Br. at 15, referencing P. Ex. 15 at 29 (SOM statement that immediate jeopardy "might include . . . a 2nd degree burn covering a large surface area.") Petitioner's argument is flawed; immediate jeopardy is defined as a "situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to

[14] *See http://www.cdc.gov/masstrauma/factsheets/public/burns.pdf* (last visited November 12, 2015) (noting that "First-degree burns involve the top layer of skin" and "Sunburn is a first-degree burn." The Centers for Disease Control and Prevention (CDC) reports that signs of a first degree burn include redness, pain on touch, and mild swelling.

cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. While there is no precise gauge as to whether Resident # 3 had burns over a "large surface area," it is clear that this 91-year-old's injury was "serious," in that it required approximately 8 weeks of wound care treatment, along with debridement, antibiotics, topical management, and a complicated course that involved wound infections.[15] Furthermore, *assuming arguendo* that Resident # 3's injuries were not "serious" within the meaning of the definition of immediate jeopardy, I note that the potential for serious injury, harm, or impairment to a resident was significant in light of the facility's pattern of not assessing residents' abilities to handle hot liquids in combination with its failure to adhere to assessments specifying assistance that was required during meals.

C. The CMP that CMS imposed is reasonable in amount and duration.

With regard to the amount of the CMP, I examine whether 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.

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408; 488.438. The upper range of a CMP, $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i); 488.438(d)(2). The lower range of CMP, $50 to $3,000 per day, is reserved for deficiencies that do not pose 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). In assessing the reasonableness of a CMP amount, an ALJ looks at the per-day amount, rather than the total accrued CMP. *See Kenton Healthcare, LLC*, DAB No. 2186, at 28 (2008). The regulations leave the decision regarding the choice of remedy to CMS, and the amount of the remedy to CMS and the ALJ, requiring only that the regulatory factors at 42 C.F.R. §§ 488.438(f) and 488.404 be considered when determining the amount of a CMP within a particular range. 42 C.F.R. §§ 488.408; 488.408(g)(2); 498.3(d)(11); *see also* 42 C.F.R. § 488.438(e)(2) and (3); *Alexandria Place*, DAB No. 2245, at 27 (2009); *Kenton Healthcare, LLC*, DAB No. 2186, at 28-29.

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[15] While not making a finding that this was a "major" second degree burn, I point out that the aforementioned NIH discussion regarding burns (FN 19) remarks that a "major" second degree burn is greater than 2-3 inches in diameter, as was this wound.

Unless a facility contends that a particular regulatory factor does not support the CMP amount that CMS imposed, the ALJ must sustain it. *Coquina Ctr.*, DAB No. 1860, at 32 (2002). CMS decided to impose a per-day CMP in this case, and I found that the immediate jeopardy level of noncompliance was not clearly erroneous in this case. Thus, the minimum CMP I am required to sustain is $3,050 per day. The $6,050 per day CMP CMS imposed is in the low-to-middle range for immediate jeopardy level noncompliance.

Neither party has addressed the regulatory factors listed above in its briefs. While Petitioner has contended that another ALJ's decision in *St. Joseph Villa Nursing Ctr.*, DAB No. 2210 (2010), is instructive with respect to the amount of CMPs that should be allowed, I disagree. P. Br. at 20. The *St. Joseph* case involved a per-instance CMP in which the range of allowable CMPs differed and the finding of immediate jeopardy was not subject to review.

I note that in evaluating the regulatory factors listed above, I conclude that Petitioner's history of noncompliance supports the CMP imposed, considering also that Petitioner was cited for nine other deficiencies in the same survey. CMS Ex. 2. It is not lost on me that the same resident, Resident # 3, was affected by two separate deficiencies that were cited at the time of the May 2014 survey; Resident # 3 sustained a second-degree hot liquids injury and was also kept in blood-stained clothing on April 29, 2014, in violation of the requirement that the facility maintain good grooming. CMS Ex. 1 at 1-4. In explaining the CMP, the stage agency discussed, in its May 15, 2014 letter, that the facility had deficiencies "at the harm level or above on the previous survey of June 6, 2013." P. Ex. 12 at 1; P. Ex. 13. Based on this regulatory factor alone, a CMP that is in the low end of the middle range of allowable CMPs is not unreasonable.

Petitioner has not asserted that its financial condition should be considered in mitigation of the CMP. Therefore, I do not consider this to be a mitigating factor.

The burden of persuasion regarding the duration of noncompliance is also Petitioner's. *Owensboro Place and Rehab. Ctr.*, DAB No. 2397 (2011). Petitioner has not made any arguments regarding the duration of the period of immediate jeopardy. I note that Petitioner was first put on notice of the potential for harm created by its failure to prevent residents from spilling hot liquids on themselves on March 1, 2014, when Resident # 14 spilled coffee on herself in bed. Although Petitioner did begin to address the problem,[16]

[16] As mentioned earlier, Petitioner conducted in-service training on various occasions prior to the removal of immediate jeopardy on April 7, 2014. However, it was not until April 7, 2014, based on the facility's plan of correction, that Petitioner instructed its staff to put lids on coffee cups. CMS Ex. 4 at 12. An April 16, 2014 record of in-service

the noncompliance continued. On March 20 and March 27, 2014, severely cognitively-impaired residents spilled hot liquids on themselves in situations that were in contravention of their established assessments. Not until Petitioner implemented its plan of correction by ensuring that lids were placed on coffee cups, residents were donned with clothes protectors, and coffee was served at a lower temperature did the facility effectively prevent the risk for burns. CMS Ex. 12 at 4. Petitioner has not met its burden to persuade me to find the facility returned to substantial compliance at any point earlier than the date determined by CMS.

IV. Conclusion

For the reasons set forth above, I sustain CMS's determinations. I find that Petitioner was not in substantial compliance with the participation requirement at 42 C.F.R. § 483.25(h) and that the CMP imposed, a $6,050.00 per day CMP effective March 20 through April 7, 2014, and a $600.00 per day CMP effective April 8, 2014 through June 3, 2014, is reasonable.

/s/
Leslie C. Rogall
Administrative Law Judge

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training indicates that a number of staff members were instructed to serve hot liquids with lids on the cups and to use clothing and lap protectors. P. Ex. 9 at 17.