Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Pinewood Care Center	)	Date: July 17, 2007
(CCN: 13-5052),	)	
	)	
Petitioner,	)	Docket No. C-07-240
	)	Decision No. CR1621
v.	)	
	)	
Centers for Medicare & Medicaid Services.	)	

DECISION

Petitioner, Pinewood Care Center, was out of substantial compliance with program participation requirements from August 1, 2006 through January 4, 2007. The remedies imposed by the Centers for Medicare & Medicaid Services (CMS), including a civil money penalty (CMP) of $500 per day (from August 1, 2006 through January 4, 2007) and a denial of payment for new admissions (DPNA) (from August 31, 2006 through January 4, 2007), are reasonable. Termination of Petitioner's provider agreement is not required by 42 C.F.R. § 488.412(d).

I. Background

Petitioner is a long-term care facility located in Coeur d'Alene, Idaho, and authorized to participate in the federal Medicare program as a skilled nursing facility (SNF) and the Idaho Medicaid program as a nursing facility (NF). The Idaho Department of Health and Welfare, Bureau of Facility Standards (the state agency) performed an annual recertification survey and complaint investigation of Petitioner's facility that was completed on August 1, 2006; a follow-up survey and complaint investigation that was completed on October 20, 2006; and a follow-up survey and complaint investigation that was completed on January 25, 2007. The state agency found that Petitioner was not in substantial compliance with program participation requirements based on each survey.

CMS notified Petitioner by letter dated August 16, 2006, that the surveyors found that Petitioner was not in substantial compliance with the following regulatory requirements: 42 C.F.R. §§ 483.10, 483.13, 483.15, 483.20, 483.25, 483.30, 483.35, 483.45, 483.65, and 483.75. CMS Exhibit (CMS Ex.) 15, at 1.[1] The CMS notice advised Petitioner that CMS was imposing an optional or discretionary DPNA to be effective for admissions on and after August 31, 2006. CMS Ex. 15, at 1-2. The notice further advised that Petitioner's provider agreement would be terminated effective February 1, 2007, if Petitioner remained out of substantial compliance. The notice advised Petitioner that it could request a hearing by an administrative law judge (ALJ) no more than 60 days from receipt of the notice. CMS Ex. 15, at 2. The notice also stated:

> Because of the nature of these findings, it is also our intention to seek a civil monetary penalty against Pinewood Care Center of $500.00 per day, effective August 1, 2006 until the facility is back in compliance.

The notice went on to advise Petitioner that before CMS could make a final decision on the amount of the CMP, pursuant to 42 C.F.R. § 488.438(f), CMS had to consider the facility's financial condition. CMS solicited submission of financial information by August 31, 2006. There is no dispute that Petitioner received this notice on August 18, 2006. CMS Ex. 15, at 6.

The state agency sent Petitioner a letter dated November 7, 2006, which enclosed the SOD from the October 20, 2006 survey. The letter indicates that the state agency found Petitioner not in compliance with the following regulations: 42 C.F.R. §§ 483.10, 483.13, 483.15, 483.20, 483.25, 483.35, 483.70, and 483.75. The letter advised Petitioner regarding submission of a plan of correction; that the state agency had previously recommended that CMS impose a DPNA and termination; and that the state agency recommended that CMS continue a CMP of $500 per day effective August 1, 2006. The state agency specifically stated in its letter that the letter did not constitute "formal notice of imposition of alternative remedies or termination" but that such formal notice would be

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[1] CMS Ex. 4 is a copy of an August 15, 2006 notice to Petitioner's Administrator from the state agency. The letter enclosed the statement of deficiencies (SOD); advised Petitioner that it could submit a plan of correction and what must be included in the plan; advised that the state agency was recommending that CMS impose alternative remedies and termination; advised of certain state actions; and advised of the availability of informal dispute resolution. The state agency letter did not advise Petitioner of the right to challenge remedies recommended for imposition by CMS and specifically provided that the letter did not constitute "formal notice of imposition of alternative remedies or termination" but that such formal notice would be given by CMS. CMS Ex. 4, at 2.

given by CMS. CMS Ex. 6, at 1-3. The letter did not include any notice that Petitioner could request a hearing by an ALJ.[2] Petitioner asserted as a correction date following the October 20, 2006 survey that it was in substantial compliance as of January 5, 2007. P. Brief at 5; Transcript (Tr.) 459-62; P. Ex. 2.

CMS sent Petitioner a letter dated January 12, 2007, advising that the Secretary of Health and Human Services intended to terminate Petitioner's provider agreement effective February 1, 2007, and advising of the procedure that would be followed. The letter referred to the surveys of August 1 and October 20, 2006, and stated that, based upon Petitioner's plan of correction, the state agency would make an unannounced final visit to the facility to determine if Petitioner was in compliance with participation requirements. The letter further advised that, as stated in the CMS letter dated August 16, 2006, a DPNA was effective August 31, 2006, and that it would continue until substantial compliance was achieved or termination on February 1, 2007, whichever came first. The letter also stated that "we also advised you in our August 16, 2006 letter," that a $500 per day CMP was assessed based upon the August 1, 2006 survey finding of a violation of 42 C.F.R. § 483.25 "posing actual harm to the health and safety of residents." CMS Ex. 13, at 3. The letter advised Petitioner of the right to request a hearing by an ALJ. CMS Ex. 13, at 3. A certified mail receipt shows that Petitioner received the January 12, 2007 CMS letter on January 16, 2007. CMS Ex. 13, at 8.

CMS sent Petitioner a letter dated January 31, 2007, which advised Petitioner that a complaint and second revisit survey was completed at Petitioner's facility on January 25, 2007. The state agency found that Petitioner was not in compliance with 42 C.F.R. § 483.25. CMS asserts in this letter that, based upon the August 1, 2006 survey, it had imposed a DPNA effective August 31, 2006, and a $500 per day CMP effective August 1, 2006 through the date of termination or the date on which substantial compliance was achieved. The letter went on to state under the heading "Remedies" that the DPNA was effective for admissions after August 31, 2006, and that the $500 per day CMP was for the period August 1, 2006 through January 31, 2007, and totaled $92,000. The letter advised Petitioner that if Petitioner waived the right to a hearing, the CMP would be reduced by 35 percent. The letter further advised that "[i]f you disagree with this determination, as previously stated in our letter, dated January 12, 2007, you or your legal representative may request a hearing" before an ALJ and that the request for hearing must be filed within 60 days of the date of receipt of "this letter." CMS Ex. 3.

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[2] The state agency letter did advise Petitioner of certain state actions and that Petitioner could request administrative review by the state and informal dispute resolution. CMS Ex. 6, at 4-5.

Petitioner requested a hearing by an ALJ on February 2, 2007, by a pleading styled as "Petition Appealing Imposition of Remedies Including Termination and Request for Emergency Hearing." The case was assigned to me for hearing and decision on February 7, 2007, and a Notice of Case Assignment and Prehearing Case Development Order (Prehearing Order) was issued at my direction on that date. On February 14, 2007, I held a telephonic prehearing conference in this case. Petitioner's motion for an emergency or expedited hearing was granted. On February 15, 2007, the Prehearing Order was amended and the parties were given notice of the dates for hearing.

On February 21, 2007, CMS moved to dismiss Petitioner's request for hearing pursuant to 42 C.F.R. § 498.70(c). Petitioner filed its response in opposition to the CMS motion on February 26, 2007. On February 28, 2007, I issued an order granting in part and denying in part the CMS motion to dismiss. I concluded as follows:

> Petitioner did not timely file a request for hearing to challenge the imposition of a DPNA based upon deficiencies cited by the survey completed at Petitioner's facility on August 1, 2006, and the CMS motion to dismiss was granted to this extent.
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> Petitioner's request for a hearing by an ALJ dated February 2, 2007, was filed within 60-days of receipt of the CMS notices of January 12 and 31, 2007.
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> The CMS notice of January 12, 2007, was the first legally sufficient notice of imposition of a CMP based upon the alleged violation of 42 C.F.R. § 483.25 found by the survey completed on August 1, 2006.
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> Petitioner's request for hearing was timely as to the alleged violation of 42 C.F.R. § 483.25 found by the survey of August 1, 2006 to have caused actual harm and the CMP based thereon, and Petitioner's right to hearing is preserved as to the alleged violation and the CMP. The alleged violations for which the right to a hearing is preserved are the alleged violations of 42 C.F.R. §§ 483.25(c) (Tag F314, scope and severity G) (CMS Ex. 1, at 61-66), 483.25(h)(2) (Tag F324, scope and severity H) (CMS Ex. 1, at 72-112), and 483.25(i)(1) (Tag F325, scope and severity G) (CMS Ex. 1, at 113-21). The CMS motion to dismiss was denied as to these deficiencies as a basis for imposition of a CMP.

> CMS provided no notice to Petitioner related to the findings of the October 20, 2006 survey or the continuation of the DPNA and the CMP based thereon prior to the January 12, 2007 notice. Accordingly, Petitioner's request for hearing was timely as to all the deficiencies alleged by that survey that were cited as being sufficiently severe to support a finding that Petitioner was not substantially compliant with program participation requirements or to be the basis for continuation of the DPNA or CMP. Any suggestion that the state agency notice was sufficient to trigger the running of the 60-day period for requesting a hearing was without merit given the plain language of the letter that indicates it was not formal notice of remedies and that formal notice would be given by CMS. The CMS motion to dismiss was denied to this extent.
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> Petitioner's February 2, 2007 request for hearing was also timely as to the CMS notice of January 31, 2007. The January 31, 2007 notice advised Petitioner that it was found not in substantial compliance based upon an alleged violation of 42 C.F.R. § 483.25 and that CMS was proceeding with the remedies of termination and continuation of the DPNA and the CMP based upon that finding. The CMS motion to dismiss was denied to this extent.

Another telephonic prehearing conference was conducted on March 8, 2007, to discuss the location for hearing and the availability of witnesses.

A hearing was held in Coeur d'Alene, Idaho, on March 13, 14, and 15, 2007. The following CMS exhibits (CMS Ex.) were offered and admitted: CMS Exs. 1, 2 (except pages 55, 56), 3-16, 19-25, 27-28, 30-32, 36-39, 40 (pages 2, 4 only), 41- 43, 46, 49-53, 56, 60-63. No CMS exhibits numbered 17 and 18 were offered. Ruling was deferred on CMS Exs. 64, 65, and 66 subject to those exhibits being offered later in the hearing, but they were not offered again. CMS exhibits not admitted: CMS Exs. 26, 29, 33-35, 44, 45, 47, 48, 54, 55, 57-59, 67. The following Petitioner's exhibits (P. Ex.) were admitted: P. Exs. 1-19, and P. Ex. 20, pages 6-9 and 24-28. CMS called the following witnesses: Surveyor Kari Head, Surveyor Marcia Key, Surveyor Kimberly Heuman, Surveyor Nicole Martin, and Surveyor Lorna Bouse. I called as a witness Captain Jerilyn McClain, Public Health Service. Petitioner elicited testimony from Thelma Reece, Audrey Siegel, Sarah Lorion, M.D., Demetria Haffenreffer, Karen Robbins, and Bonnie Neyman.

On April 20 and 23, 2007, Petitioner moved to add four new exhibits, P. Exs 21, 22, 23, and 24. P. Ex. 21 consists of five letters all dated April 5, 2007, from the state agency to Petitioner's administrator, regarding the results of the January 25, 2007 complaint investigation. P. Ex. 22 is the final order in *Pinewood Healthcare, LLC, dba Pinewood Care Center*, Case No. CV07-0059-N-EJL (D. Idaho, March 16, 2007), dismissing Petitioner's motion for a preliminary injunction against CMS to prevent the termination of Petitioner's provider agreement. P. Ex. 23 is Petitioner's notice of appeal to the United States Court of Appeals for the Ninth Circuit of the final order in *Pinewood Healthcare, LLC, dba Pinewood Care Center*. P. Ex. 24 is a letter dated April 10, 2007, to Petitioner from CMS, amending CMS's January 31, 2007 Notice of Termination, changing the date of termination of Petitioner's provider agreement from February 1, 2007 to March 17, 2007. On April 25, 2007, CMS filed its opposition to the post-hearing admission of P. Exs. 21 and 24. On April 25, 2007, Petitioner filed a response to the CMS opposition. CMS objects to the admission of P. Exs. 21 and 24 on grounds that they were untimely offered and, as to P. Ex. 24, that it is not relevant. With regard to P. Ex. 21, Petitioner states that the letters were dated April 5, 2007, and not received until after that date, which I note is after the date of hearing. I find the letters are related to the January 25, 2007 complaint investigation, they are relevant, and I admit them. I also admit P. Ex. 24, as it shows that CMS modified the effective date of termination, which is also relevant. CMS's argument that the documents were not timely offered is unfounded, as CMS and the state agency produced these documents post-hearing and it was clearly not possible for Petitioner to offer them at the time of hearing. P. Exs. 22 and 23 are admitted without objection by CMS.

The parties submitted post-hearing briefs (CMS or P. Brief, respectively) and post-hearing reply briefs (CMS or P. Reply, respectively). On April 30, 2007, Petitioner moved to strike the CMS post-hearing brief on grounds that it was not timely filed, prejudicing Petitioner's ability to effectively respond via its reply brief. Post-hearing briefs were due April 26, 2007, but CMS did not file its brief until April 27, 2007. Petitioner asserts that it did not actually receive the CMS brief until April 30, 2007, rather than the anticipated date of April 27, 2007. The letter setting the post-hearing briefing schedule, issued at my direction on April 2, 2007, provided that reply briefs were due 15 days from receipt of the opposing party's brief. Thus, Petitioner's reply was due on May 15, 2007, rather than May 14, 2007, as it would have been had Petitioner received the CMS brief on April 27, 2007.[3] Given the fact that Petitioner's post-hearing reply was due 15 days after receipt of the CMS brief, I cannot determine that Petitioner was deprived of days in which to prepare its reply brief or that it was prejudiced by receiving the CMS

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[3] The fifteenth day after April 27, 2007, was actually May 12, 2007, a Saturday. Thus, Petitioner's brief needed to be post-marked not later than midnight the next working day, Monday, May 14, 2007, in order to be considered timely filed.

brief three days later than Petitioner anticipated. Petitioner also argues that CMS had an unfair advantage because CMS received Petitioner's post-hearing brief before filing its own brief. In fact, in its post-hearing brief, CMS refers to Petitioner's brief several times. However, my purpose for ordering simultaneous briefing is to ensure that counsel focus upon the merits of their own case in their post-hearing brief and then respond to the opposing party's post-hearing brief in their reply brief. In this instance, counsel for CMS used some of the limited pages for CMS's post-hearing brief to respond to Petitioner's post-hearing brief rather than addressing the merits of CMS's case, and the disadvantage enured to CMS, not Petitioner. Accordingly, Petitioner's motion to strike the CMS post-hearing brief is denied.

II. Discussion

A. Findings of Fact

The following findings of fact are based upon the exhibits admitted. Citations to exhibit numbers related to each finding of fact may be found in the analysis section of this decision if not indicated here.

1. The state agency conducted three surveys of Petitioner's facility: an annual recertification survey and complaint investigation completed on August 1, 2006 (August Survey); a follow-up survey and complaint investigation completed on October 20, 2006 (October Survey); and a follow-up survey and complaint investigation completed on January 25, 2007 (January Survey).

2. Petitioner does not contest the deficiency citations found during the August Survey or that the violation of 42 C.F.R. § 483.25 found during the August Survey caused actual harm, nor does it contest the DPNA imposed based on the August Survey.

3. Petitioner does contest the deficiency citations found during the October and January Surveys and the remedies imposed based on those surveys.

October Survey

4. Facts related to 42 C.F.R. §§ 483.10(d)(3) and 483.20(k)(2) (Tag F280) and 483.25(c) (Tag F314) regarding Resident 32.

a. Upon admission to Petitioner's facility, Resident 32 had two pressure sores or ulcers in the area of her lower back and buttocks, near the coccyx or sacral area. P. Ex. 9, at 56, 66.

b. Petitioner had a care plan to address Resident 32's skin integrity and ulcer issues. P. Ex. 9, at 15-19.

c. The care plan instructed staff to encourage mobility and remind Resident 32 to change position frequently. P. Ex. 9, at 15, 17.

d. Nurse's notes show Resident 32 was noncompliant with staff instructions to lie down and/or turn from September 22, 2006 through October 18, 2006, i.e., Resident 32 refused to get out of her wheelchair and lie on her bed to take pressure off her buttocks and refused to change position in bed to relieve pressure on her coccyx and sacral area. P. Ex. 9, at 27, 31, 32, 33, 35, 36, 37, 50, 53, 54, 56, 57.

e. Pressure relieving mattresses were not an effective intervention for Resident 32's refusal to leave her wheelchair to lie down. P. Ex. 9, at 17, 35.

f. Petitioner's multi-disciplinary care team did not consider how best to get the resident out of her wheelchair and into bed or how to minimize the impact of her sitting on her coccyx and sacral areas, either in her wheelchair or with the head of her bed elevated, as simple reminders were not effective to deal with her noncompliance. P. Ex. 9.

g. The order for health shakes was not in Resident 32's care plan. P. Ex. 9, at 4, 15-19, 56.

h. Resident 32 developed a third pressure sore at Petitioner's facility. P. Ex. 9, at 66-67, 73.

i. The development of the third pressure sore is actual harm to Resident 32 and was not unavoidable.

5. Facts related to 42 C.F.R. § 483.25 (Tag F309) regarding Resident 38.

a. Nurse's notes dated October 6, 2006, state the resident had "pinkish/red blood in her stool, possibly from Hemorrhoids, fax sent to MD." CMS Ex. 53, at 36.

b. Resident 38's care plan, under behavior management, notes on October 5, 2006, that the resident had a behavior of repeatedly asking to be put to bed when she was to stay up to avoid vomiting after meals. CMS Ex. 53, at 26.

c. On October 17, 2006, Resident 38's physician switched her medication from Zantac to Prilosec to address her vomiting after meals. P. Ex. 5, at 4, 13; CMS Ex. 53, at 36.

d. On October 17, 2006, Resident 38's physician prescribed the antibiotic Keflex, and an October 19, 2006 nurse's note states that the resident had no "noted adverse effects from" the antibiotic. P. Ex. 5, at 13; CMS Ex. 53, at 36.

e. Nausea and vomiting are possible side-effects of the use of Prilosec or Keflex. CMS Ex. 2, at 32.

f. Resident 38 was observed by a surveyor on October 19, 2006, at 1:25 p.m., in the hall next door to her room; she had had an emesis and was covered from her chest to her lap with reddish colored vomitus; and an aide found her in that condition after approximately ten minutes of surveyor observation. CMS Ex. 2, at 31.

g. Resident 38 was observed by a surveyor again on October 19, 2006, at 4:45 p.m.; she had had an emesis and was covered in vomitus from her neck to her lap, and it was all over her bed. CMS Ex. 2, at 31-32.

h. There were no nurse's notes or other documentation after October 6, 2006, regarding monitoring the resident for blood in her stool or showing whether the resident's physician had given staff new orders for tests or monitoring. CMS Ex. 2, at 32.

i. There was no documentation on October 19, 2006, that Resident 38 was assessed to determine what might have caused either emesis. CMS Ex. 2, at 32.

j. There was no documentation that a temperature or other vital signs were taken after either emesis. CMS Ex. 2, at 32.

6. Facts related to 42 C.F.R. § 483.25(h)(2) (Tag F324) regarding Resident 33.

a. Resident 33 was admitted to Petitioner's facility on August 1, 2006, and his diagnoses included chronic stomach ulcer, hearing loss, difficulty in walking, general muscle weakness, pulmonary collapse, congestive heart failure (CHF), shortness of breath, and peripheral vascular disease. CMS Ex. 50, at 24, 70, 92.

b. Resident 33's Minimum Data Set (MDS) from August 8, 2006, documented that the resident required limited assistance of one for bed mobility, transfers, and toilet use, and that he had no history of falls in the preceding 180 days. CMS Ex. 50, at 4, 5, 7.

c. A significant change MDS from August 29, 2006, shows that the resident required extensive assistance of one for bed mobility and extensive assistance with transfers; limited assistance of one for walking in the room or corridor; extensive assistance of one for locomotion on and off the unit, toilet use, and bathing; and that he had fallen within the past 30 days. CMS Ex. 50, at 15-20.

d. The change of condition Resident Assessment Protocol (RAP) triggered by the MDS, dated August 30, 2006, noted the resident had difficulty with balance and a decline in range of motion, and had fallen in the past 30 days; risk factors for falls included the use of a walker, cardiac dysrhythmias, a decline in functional status, chronic/acute conditions, and an unsteady gait; safety awareness was poor; and he had had multiple medication adjustments in the past six months. CMS Ex. 50, at 22-23.

e. Petitioner was readmitted to Petitioner's facility on October 14, 2006, at around 6:00 p.m., after a four day hospital stay for treatment for CHF. CMS Ex. 50, at 32, 73-82, 86; P. Ex. 4, at 11; P. Ex. 10, at 4.

f. An initial care plan dated October 14, 2006, had as a goal to minimize the risk of a fall/injury. CMS Ex. 50, at 12; P. Ex. 10, at 2.

g. The initial care plan required that Resident 33 have the assistance of one staff for transfers, that an unspecified toileting routine be maintained, and that his call light and "frequently used" items be within easy reach. CMS Ex. 50, at 12; P. Ex. 10, at 2.

h. At 8:45 a.m. on October 15, 2006, Resident 33 fell; investigative reports and nurse's notes show that he told staff he decided to use the urinal and, when he stood, he fell backward; but there was no observed injury as a result of the fall. CMS Ex. 50, at 26-28, 32.

i. When Resident 33 returned from the hospital on October 14, 2006, he was on a higher dose of a diuretic, which can increase an individual's need to urinate. CMS Ex. 2, at 41; CMS Ex. 50, at 26.

j. The surveyor viewed the resident's room on October 20, 2006, and observed that the resident's urinal was on his bedside stand and not accessible to him. CMS Ex. 2, at 41.

k. A "Fall Risk Identification and Plan of Care" with an implementation date of October 15, 2006, notes that a "Star" symbol is to be applied to the resident's room; he is to be instructed to use a call light for assistance; he is to be instructed on fall risk; his room environment is to be maintained free of unnecessary furniture or clutter; he is to be reviewed for proper fitting shoes and slippers and clothing; frequently used items are to be in easy reach; he should have the assistance of one staff with toileting every two hours while awake and every four hours during the night; he should be instructed on proper use of his walker; and he should be provided assistance for unsteady gait and therapy as ordered. There is an undated entry to provide an alarm to his wheelchair. CMS Ex. 50, at 37.

l. An addendum to the plan of care dated October 16, 2006, shows a new intervention of a nonskid mat, which the resident refused, and the mat was removed on October 20, 2006. CMS Ex. 50, at 37.

m. A further amendment on October 20, 2006, was to check the resident's blood pressure for three days. CMS Ex. 50, at 37.

n. Inaccessibility of the resident's urinal is inconsistent with the care plan requirement to keep frequently used items accessible.

o. There was no intervention to teach the resident to use his urinal without standing.

p. There was no intervention for more frequent observations of the resident.

January Survey

7. The only deficiency cited as a result of the survey was 42 C.F.R. § 483.25(e)(2) (Tag F318), which requires a facility to ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

8. Petitioner does not deny that its restorative nursing program was in disarray after the nurse in charge of the program quit in December 2006, and one of two restorative aides abruptly quit in January 2007. P. Brief at 19.

9. The consultant Petitioner hired, at the state agency's behest, identified weakness with the documentation in the restorative program, but not care, and she reported to the state agency that the problems were being addressed and resolved before the final survey of Petitioner in January 2007. P. Brief at 19.

10. The SOD only cited specific allegations regarding this deficiency for Residents 36, 34, 52, 50, and 53. CMS Ex. 3, at 13-27.

11. Facts related to 42 C.F.R. § 483.25(e)(2) (Tag F318) regarding Resident 36.

a. Resident 36 had physician orders dated December 15, 2006, that discharged him from physical therapy with a referral to restorative nursing for exercise and gait. CMS Ex. 3, at 14.

b. A physical therapist document dated December 18, 2006, directed a restorative program three to five times per week with specific goals. CMS Ex. 3, at 14-15.

c. A restorative program plan and summary dated January 2, 2007, documented specific goals and interventions. CMS Ex. 3, at 15.

d. The surveyors found two "Restorative Care Flow Records" in Resident 36's record for January 2007, and neither showed that Resident 36 received any restorative services. CMS Ex. 3, at 15.

e. The record contained no documentation that restorative services were provided to Resident 36 in December 2006. CMS Ex. 3, at 16.

f. Resident 36 received sufficient restorative services to maintain or to increase his highest practicable level of functioning. Tr. 469-75.

g. There is no evidence of record that Resident 36's range of motion declined during the relevant period. Tr. 215.

12. Facts related to 42 C.F.R. § 483.25(e)(2) regarding Resident 34.

a. Resident 34's October 2006 MDS indicates a functional limitation in her range of motion and partial loss of voluntary movement of her arm on one side. CMS Ex. 3, at 17.

b. A physician's order dated December 5, 2006, directed occupational therapy be discontinued and a referral was made to restorative nursing for follow-up. CMS Ex. 3, at 17.

c. A "Rehab Instruction Record" dated December 2006 documents exercises for the resident three to five times a week. CMS Ex. 3, at 17.

d. A "Restorative Therapy Record" dated December 2006 included instructions for exercises three to five times per week. CMS Ex. 3, at 17-18.

e. Records reviewed by the surveyors only document Resident 34 receiving restorative care two times during the first week of December 2006 and no care the second week. CMS Ex. 3, at 18.

f. A "Restorative Program Plan and Summary" dated January 4, 2007, required exercises six times per week. CMS Ex. 3, at 18-19.

g. A "Restorative Therapy Record" for January 2007 required exercises six times per week. CMS Ex. 3, at 19.

h. Records from January 2007 show Resident 34 did not receive the restorative services six times a week in January. CMS Ex. 3, at 19-20.

i. Resident 34's left shoulder was immobilized and any decline in range of motion was unavoidable. Tr. 476.

j. Resident 34 was not at risk for any decline in range of motion. Tr. 215.

k. Resident 34 received all the restorative services necessary, because her condition improved to the degree she could be discharged to a lower level care facility. Tr. 476-77.

13. Facts related to 42 C.F.R. § 483.25(e)(2) regarding Resident 52.

a. Resident 52 suffered from a functional limitation in range of motion in both of his legs. CMS Ex. 3, at 20.

b. Documents dated December 26, 2006 and January 8, 2007, show a physical therapist directed Resident 52 to exercise his legs five times per week and his upper extremities three to five times per week with restorative nursing. CMS Ex. 3, at 21.

c. A "Restorative Program Plan and Summary" form dated January 4, 2007, indicated the resident was to increase to exercising six times per week. CMS Ex. 3, at 22.

d. Resident 52 was not started on the restorative exercise program until the second week in January and, during the second, third, and fourth weeks of January, he exercised less than six times per week. CMS Ex. 3, at 22.

e. Resident 52's restorative plan was discontinued on January 25, 2007. CMS Ex. 3, at 22-23.

f. Resident 52 had a limitation in range of motion in his hip due to an old, untreated fracture, and nothing could be done for that limitation. Tr. 432-33, 477-78.

g. It was appropriate to discontinue Resident 52 from restorative nursing. Tr. 477-78.

14. Facts related to 42 C.F.R. § 483.25(e)(2) regarding Resident 50.

a. Resident 50's admission MDS dated July 15, 2006, indicates that she had no functional limitation in range of motion. CMS Ex. 3, at 23.

b. A significant change MDS dated October 6, 2006, indicated Resident 50 had no functional limitation in range of motion. CMS Ex. 3, at 23.

c. A "Rehab Instruction Record" dated August 21, 2006, apparently signed by the physical therapist, specified an exercise program three times a week. CMS Ex. 3, at 24.

d. Resident 50's "Restorative Therapy Record" does not reflect that the

resident exercised with the frequency specified by the physical therapist. CMS Ex. 3, at 24.

e. On January 24, 2007, the physical therapist documented that Resident 50 had "[n]o decline in function." CMS Ex. 3, at 24.

f. On January 25, 2007, a "Restorative Program Plan and Summary" form for Resident 50 documented that the resident was not appropriate for restorative nursing services and discontinued the resident from the program because she was "at maximum functional ability." CMS Ex. 3, at 25.

15. Facts related to 42 C.F.R. § 483.25(e)(2) regarding Resident 53.

a. Resident 53's December 12, 2006 MDS identified the resident as having no limitation in range of motion. CMS Ex. 3, at 25.

b. In a "Rehab Instruction Record" dated October 27, 2006, the physical therapist documented that Resident 53 was to do exercises five times a week to maintain the ability to walk. CMS Ex. 3, at 25.

c. Documents reviewed by the surveyors show that the resident did not exercise as frequently as planned or ordered. CMS Ex. 3, at 26.

d. On January 24, 2007, the physical therapist documented that Resident 53 had "[n]o decline in function." CMS Ex. 3, at 26.

e. On January 25, 2007, a "Restorative Program Plan and Summary" form for Resident 53 documented that the resident was able to ambulate 200 feet without assistance and should be discontinued from restorative nursing and re-evaluated. CMS Ex. 23, at 26-27.

16. Petitioner was in substantial compliance with participation requirements as of January 5, 2007. P. Brief at 5; Tr. at 459-62; P. Ex. 2.

B. Conclusions of Law

1. Petitioner's request for hearing was timely and I have jurisdiction.

October Survey

2. The regulations at 42 C.F.R.§§ 483.10(d)(3) and 483.20(k)(2) require that a facility observe a resident's right to participate in care planning and treatment, or any changes in care planning or treatment, and require that the interdisciplinary team providing care and treatment for the resident be involved in determining the resident's needs and the best approaches to provide that care and treatment.

3. Petitioner was out of substantial compliance with 42 C.F.R. §§ 483.10(d)(3) and 483.20(k)(2) because Resident 32's comprehensive care plan did not include interventions to address the resident's noncompliance with turning and repositioning, and her need for liquid protein supplements (health shakes).

4. The regulation at 42 C.F.R. § 483.25(c) requires that a facility ensure that a resident who enters the facility without a pressure sore does not develop one unless clinically unavoidable, or that a resident with sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.

5. Petitioner was out of substantial compliance with 42 C.F.R. § 483.25(c) because Resident 32 developed a new pressure sore at Petitioner's facility that was not clinically unavoidable and which constituted actual harm to the resident.

6. The regulation at 42 C.F.R. § 483.25 requires that each resident receive and the participating facility provide the necessary care and services to attain or maintain a resident's highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care.

7. Petitioner was out of substantial compliance with 42 C.F.R. § 483.25 because Petitioner did not follow-up on a report of blood in Resident 38's stool, or assess Resident 38 after two episodes of vomiting on October 19, 2006.

8. The regulation at 42 C.F.R. § 483.25(h)(2) requires that each resident receive adequate supervision and assistance devices to prevent accidents.

9. Petitioner was out of substantial compliance with 42 C.F.R. § 483.25(h)(2) because Petitioner did not take all reasonable steps to ensure that Resident 33 received the supervision and assistance devices he needed to minimize the risk of injury due to falls.

10. Petitioner has not shown by a preponderance of the evidence that it was in substantial compliance with 42 C.F.R. §§ 483.10(d)(3) and 483.20(k)(2); 483.25; 483.25(c); and 483.25(h)(2), or that it had an affirmative defense for its noncompliance.

January Survey

11. The regulation at 42 C.F.R. § 483.25(e)(2) requires that a facility ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

12. Petitioner was in compliance with this regulation during the January Survey with respect to Residents 36, 34, 52, 50, and 53.

13. CMS did not make a prima facie case of deficiency with respect to Residents 50 and 53.

14. Petitioner rebutted CMS's prima facie showing with respect to Residents 36, 34, and 52.

Remedies

15. Petitioner did not contest the August Survey and remedies imposed.

16. There is a basis to impose a DPNA and a CMP based on the August and October Surveys.

17. A CMP of $500 per day from August 1, 2006 through January 4, 2007, and a DPNA from August 31, 2006 through January 4, 2007, are reasonable remedies for Petitioner's noncompliance.

18. Termination of Petitioner's provider agreement pursuant to 42 C.F.R. § 488.412(d) is not required.

C. Issues

In its post-hearing brief, Petitioner stated that it no longer disputes the deficiency citations and remedies from the survey concluded August 1, 2006. Petitioner only challenges the deficiency findings from the October 20, 2006 and January 25, 2007 surveys, and agrees that the only issues to be resolved are whether it was in substantial compliance as of

October 20, 2006, or at any time between that date and February 1, 2007; whether there is a basis for imposition of a CMP or DPNA based on any deficiencies found during the October 2006 or January 2007 surveys; and whether the amount of the CMP is reasonable. P. Brief at 2; P. Reply at 1.

The issues in this case are, thus:

> Whether Petitioner returned to substantial compliance prior to February 1, 2007;
>
> Whether there is a basis for the imposition of an enforcement remedy after October 20, 2006; and,
>
> Whether the remedies imposed are reasonable.

D. Applicable Law

Petitioner is a long-term care facility participating in the federal Medicare program as a SNF and in the state Medicaid program as a NF. The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Social Security Act (Act) and at 42 C.F.R. Part 483. Sections 1819 and 1919 of the Act vest the Secretary with authority to impose CMPs against a long-term care facility for failure to comply substantially with federal participation requirements.

Facilities that participate in Medicare may be surveyed on behalf of CMS by state survey agencies in order to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-488.28, 488.300-488.335. Pursuant to 42 C.F.R. Part 488, CMS may impose a per instance CMP (PICMP) or per day CMP against a long-term care facility when a state survey agency concludes that the facility is not complying substantially with federal participation requirements. 42 C.F.R. §§ 488.406; 488.408; 488.430. The regulations in 42 C.F.R. Part 488 also give CMS a number of other remedies that can be imposed if a facility is not in compliance with Medicare requirements. *Id.*

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, of from $3050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). The lower range of CMP, from $50 per day to $3000 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). There is only a single range of $1000 to $10,000 for a PICMP that applies whether or not immediate jeopardy is present. 42 C.F.R. §§ 488.408(d)(1)(iv); 488.438(a)(2).

The Act and regulations make a hearing before an ALJ available to a long-term care facility against which CMS has determined to impose a CMP. Act, § 1128A(c)(2); 42 C.F.R. §§ 488.408(g); 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et al*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Cal Turner Extended Care Pavilion*, DAB No. 2030 (2006); *The Residence at Salem Woods*, DAB No. 2052 (2006). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e) and 498.3. However, the choice of remedies by CMS or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge would affect the amount of the CMP that could be collected by CMS or impact upon the facility's nurse aide training program. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i). CMS's determination as to the level of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9, 39 (2000), *aff'd, Woodstock Care Center v. U.S. Dept. of Health and Human Services*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g., Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Review of a CMP by an ALJ is governed by 42 C.F.R. § 488.438(e).

The Board has addressed the allocation of the burden of persuasion and the burden of production or going forward with the evidence in past cases, in the absence of specific statutory or regulatory provisions. Application of the Board's analysis and approach is not disputed in this case and is appropriate. When a penalty is proposed and appealed, CMS must make a prima facie case that the facility has failed to comply substantially with federal participation requirements. "Prima facie" means generally that the evidence is "[s]ufficient to establish a fact or raise a presumption unless disproved or rebutted. *Black's Law Dictionary* 1228 (8th ed. 2004). In *Hillman Rehabilitation Center*, DAB No. 1611, at 8 (1997), *aff'd, Hillman Rehabilitation Center v. HHS*, No. 98-3789 (GEB) (D. N.J. May 13, 1999), the Board described the elements of the CMS prima facie case in general terms as follows:

> HCFA [now known as CMS] must identify the legal criteria to which it seeks to hold a provider. Moreover, to the extent that a provider challenges HCFA's findings, HCFA must come forward with evidence of the basis for its determination, including the factual findings on which HCFA is relying and, if HCFA has determined that a condition of participation was not met, HCFA's evaluation that the deficiencies found meet the regulatory standard for a condition-level deficiency.

DAB No. 1611, at 8. Thus, CMS has the initial burden of coming forward with sufficient evidence to show that its decision to terminate is legally sufficient under the statute and regulations. To make a prima facie case that its decision was legally sufficient, CMS must: (1) identify the statute, regulation or other legal criteria to which it seeks to hold the provider; (2) come forward with evidence upon which it relies for its factual conclusions that are disputed by the provider; and (3) show how the deficiencies it found amount to noncompliance that warrants an enforcement remedy.

In *Evergreene Nursing Care Center*, DAB No. 2069 (2007), the Board explained as follows:

> CMS has the burden of coming forward with evidence related to disputed findings that is sufficient (together with any undisputed findings and relevant legal authority) to establish a prima facie case of noncompliance with a regulatory requirement. If CMS makes this prima facie showing, then the SNF must carry its ultimate burden of persuasion by showing, by a preponderance of the evidence, on the record as a whole, that it was in substantial compliance during the relevant period. *See Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd*, *Hillman Rehabilitation Ctr. v. HHS*, No. 98-3789 (GEB) (D. N.J. May 13, 1999); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004), *aff'd*, *Batavia Nursing and Convalesent Center v. Thompson*, No. 04-3687 (6th Cir. 2005); *Guardian Health Care Center*, DAB No. 1943 (2004); *Fairfax Nursing Home, Inc.*, DAB No. 1794 (2001), *aff'd*, *Fairfax Nursing Home v. Dep't of Health & Human Srvcs.*, 300 F.3d 835 (7th Cir. 2002), *cert. denied*, 2003 WL 98478 (Jan. 13, 2003).

> CMS makes a prima facie showing of noncompliance if the evidence CMS relies on is sufficient to support a decision in its favor absent an effective rebuttal. *Hillman Rehabilitation Center*, DAB No. 1663, at 8 (1998), *aff'd*, *Hillman Rehabilitation Ctr. v. HHS*, No. 98-3789 (GEB) (D. N.J. May 13, 1999); *see also Guardian Health Care Center*. A facility can overcome CMS's prima facie case either by rebutting the evidence upon which that case rests, or by proving facts that affirmatively show substantial compliance. *Tri-County Extended Care Center*, DAB No. 1936 (2004). "An effective rebuttal of CMS's prima facie case would mean that at the close of the evidence the provider had shown that the facts on which its case depended (that is, for which it had the burden of proof) were supported by a preponderance of the evidence." *Id.* at 4 (quoting *Western Care Management Corp.*, DAB No. 1921 (2004)).

DAB No. 2069, at 7-8.

E. Analysis

The state agency completed a survey of Petitioner's facility on August 1, 2006. The SOD from that survey includes 35 alleged regulatory violations. All but two of the alleged deficiencies listed in the August SOD are alleged to be at a scope and severity level[4] indicating that they posed the potential for more than minimal harm to Petitioner's residents. CMS Ex. 1, at 172a. The state agency findings that some deficiencies presented the potential for more than minimal harm to Petitioner's residents compel the conclusion that Petitioner was not in "substantial compliance" or was in "noncompliance" with program participation requirements. 42 C.F.R. § 488.301. The conclusion that

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[4] According to the scope and severity matrix published in the State Operations Manual (SOM), section 7400E, a scope and severity level of A, B, or C indicates that a deficiency has the potential for no actual harm and has the potential for no more than minimal harm. A scope and severity level of D, E, or F indicates a deficiency that presents no actual harm but has the potential for more than minimal harm that does not amount to immediate jeopardy. A scope and severity level of G, H, or I indicates a deficiency that involves actual harm that does not amount to immediate jeopardy. A scope and severity level of J, K, or L indicates that a deficiency poses immediate jeopardy to resident health or safety. The matrix, which is based on 42 C.F.R. § 488.408, specifies which remedies are required and optional at each level based upon the frequency of the deficiency. *See* SOM, section 7400E.

Petitioner was in noncompliance required the state agency to certify to CMS that Petitioner was in a state of noncompliance. A certification of noncompliance by the state agency requires the imposition of some enforcement action against Petitioner -- termination, an alternative remedy listed in 42 C.F.R. § 488.406, or both. 42 C.F.R. § 488.330. Additionally, 42 C.F.R. § 488.412(a) provides that where a facility is not in substantial compliance but the deficiencies do not pose immediate jeopardy, and none did in this case,

> . . . CMS or the State may terminate the facility's provider agreement or may allow the facility to continue to participate for no longer than 6 months from the last day of the survey if–
>
> (1) The State survey agency finds that it is more appropriate to impose alternative remedies than to terminate the facility's provider agreement;
> (2) The State has submitted a plan and timetable for corrective action approved by CMS; and
> (3) The facility . . . agrees to repay to the Federal government payments received after the last day of the survey that first identified the deficiencies if corrective action is not taken in accordance with the approved plan of correction.

The regulation requires that if a facility does not meet the criteria for continuation of payment under the foregoing subsection: (1) the facility's provider agreement must be terminated by CMS and the state (42 C.F.R. § 488.412(b)); (2) not more than three months after the last day of the survey, CMS must deny payment for all new admissions if the facility is not back in substantial compliance by that time (42 C.F.R. § 488.412(c)); and (3) CMS must terminate the provider agreement for SNFs, and stop federal financial participation (FFP) to a state for NFs, for a provider continued under subparagraph (a), if the provider is not in substantial compliance within six months of the last day of the survey (42 C.F.R. § 488.412(d)).

I have no direct evidence that all the conditions of 42 C.F.R. § 488.412(a) were satisfied in this case, but, since an issue has not been raised in that regard, I presume the conditions are met. The August 16, 2006 notice letter from CMS indicates that CMS was imposing the alternative remedy of a DPNA, that CMS was considering imposing a CMP, and that Petitioner's provider agreement would be terminated February 1, 2007, if Petitioner remained out of substantial compliance. CMS Ex. 15. Neither CMS nor the state agency (CMS Ex. 4) notified Petitioner of immediate termination; rather, CMS, the state agency, and Petitioner all proceeded as though Petitioner had six months from August 1, 2006, to return to substantial compliance.

The state agency completed a revisit survey of Petitioner's facility on October 20, 2006. The surveyors found that 21 of the alleged regulatory violations from the August 2006 survey had been corrected. CMS Ex. 2, at 1-2. However, the surveyors found that Petitioner remained in violation of 14 regulatory provisions,[5] all of which posed the potential for more than minimal harm to Petitioner's residents. CMS Ex. 2, at 3-56.

The state agency completed a second revisit survey on January 25, 2007. The surveyors found that all of the alleged regulatory violations from the October 2006 survey had been corrected as of January 5, 2007. CMS Ex. 3, at 11-12. However, the surveyors allege that Petitioner was in violation of another regulatory requirement, and that the violation posed more than minimal harm to Petitioner's residents. CMS Ex. 3, at 13-27. CMS notified Petitioner by letter dated January 31, 2007, that termination of Petitioner's provider agreement would occur on February 1, 2007, because Petitioner remained out of substantial compliance. CMS listed as alternative remedies the DPNA which was effective for Medicare and Medicaid admissions on and after August 31, 2006, and the $500 per day CMP for the period August 1, 2006 through January 31, 2007, which totaled $92,000. CMS Ex. 3, at 1-4.

Pursuant to regulations, CMS had the authority to terminate Petitioner's provider agreement at any time between August 1, 2006 and February 1, 2007, based on a finding that Petitioner was not in substantial compliance with program participation requirements. However, the foregoing history shows that CMS did not terminate Petitioner as a discretionary matter. Rather, CMS permitted Petitioner to attempt to regain substantial compliance for six months, the maximum period allowed by the regulations. Termination occurred in this case because the regulation mandated termination.

Petitioner's primary focus is upon avoiding the termination of its provider agreement. However, Petitioner also alleges that after October 20, 2006, there is no basis for the CMP, which was imposed initially based upon the alleged violations of 42 C.F.R. § 483.25 from the August 2006 survey (CMS Ex. 13, at 3) and continued based upon the October 2006 and January 2007 surveys (CMS Ex. 3, at 2-3). I ruled on the CMS motion to dismiss that Petitioner had waived the opportunity to contest the DPNA imposed based on the findings of the August 2006 survey. However, Petitioner is not precluded from challenging the findings of the October 2006 and January 2007 surveys, and the penalties based thereon, including the DPNA. Before me, Petitioner does not challenge the findings of the August 2006 survey or the CMP or DPNA based on those findings. Rather, Petitioner alleges that it returned to substantial compliance with program

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[5] All but one of the deficiencies cited during the October 2006 survey allege violations of regulations found violated during the August 2006 survey. CMS Ex. 1, at 172a; CMS Ex. 2, at 3.

participation requirements by October 20, 2006, and, thereafter, there is no basis for an enforcement remedy. More specifically, Petitioner asserts that it has been in substantial compliance since it corrected the deficiencies identified in the August 2006 survey, and that it was in substantial compliance on October 20, 2006, January 25, 2007, and February 1, 2007. P. Brief at 2, 5; *see* P. Reply at 1. Petitioner also asserted, as the correction date for the October survey, that it was in compliance with participation requirements as of January 5, 2007. P. Brief at 5; Tr. 459-62; P. Ex. 2. Thus, I consider the deficiencies identified in the October 2006 and January 2007 surveys.

1. Petitioner was not in substantial compliance with participation requirements as of October 20, 2006.

CMS has alleged, based on the SOD dated October 20, 2006, that Petitioner was out of compliance with 14 participation requirements. CMS Ex. 2. In its post-hearing brief, CMS only addresses the alleged violations of 42 C.F.R. §§ 483.13(c) (Tag F225) and 483.25(c) (Tag F314). CMS Brief at 10-12. In its post-hearing reply brief, CMS addresses the alleged violations of 42 C.F.R. §§ 483.10(f)(2) (Tag F166), 483.13(c) (Tag F225), 483.15(a) (Tag F241), 483.15(h)(1) (Tag F252), 483.20(k) (Tag F280), 483.25 (Tag F309), 483.25(a)(3) (Tag F312), 483.25(c) (Tag F314), 483.25(h)(2) (Tag F324), and 483.25(i)(1) (Tag F325). CMS Reply, at 4-14. The four alleged violations cited by the surveyors during the October 20, 2006 survey that are not specifically addressed by CMS in either of its post-hearing briefs, I treat as abandoned by CMS. Further, I do not have to address all the participation requirements found out of substantial compliance as reflected in the October 20, 2006 SOD to find Petitioner out of substantial compliance, and I discuss only those examples I find to be necessary to support the finding of noncompliance and the remedies imposed. *Community Skilled Nursing Centre,* DAB No. 1987 (2005); *Batavia Nursing and Convalescent Inn,* DAB No. 1911 (2004); *Beechwood Sanitarium,* DAB No. 1824, at 19-20 (2002).

a. Petitioner violated 42 C.F.R. §§ 483.10(d)(3) and 483.20(k)(2) (Tag F280), and 483.25(c) (Tag F314) with regard to Resident 32.

The SOM indicates that the intent of 42 C.F.R. §§ 483.10(d)(3) and 483.20(k)(2)[6] is to ensure that a facility observes the resident's right to participate in care planning and treatment, or any changes in planning or treatment, and to ensure that the interdisciplinary team providing care and treatment of the resident is involved in determining the resident's needs and the best approaches. SOM, App. PP, Tag F280. The surveyors allege in the SOD that for four of 11 residents reviewed, Petitioner did not ensure that care plans were revised to reflect the current status of the resident. CMS Ex. 2, at 20. For purposes of this decision, I focus only upon the example of Resident 32. The example of Resident 32 is significant because there is a relationship between two regulatory violations. The example of Resident 32 is also significant because, contrary to the state agency and CMS assessment of scope and severity, the two regulatory violations resulted in or contributed to the development of a new pressure ulcer, which constitutes actual harm to Resident 32.[7]

The surveyors allege that Petitioner failed to document in October 2006, the resident's response to staff's frequent reminders to turn. It has never been clarified what the surveyors intended by this allegation. The nurse's notes do not indicate that the resident failed to turn when reminded, and I thus infer that she probably did turn when instructed. The notes, however, clearly indicate that the resident did respond with repeated noncompliance, requiring repeated reminders to turn. The surveyors also allege that the

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[6] The SOD dated October 20, 2006, incorrectly lists the sections of the regulations allegedly violated as 42 C.F.R. §§ 483.20(d)(3) (non-existent) and 483.10(k)(2) (establishes the right to reasonable access to a telephone and has no subsection 2). The SOD, however, discusses the regulatory requirements for: a resident to have the right to participate in planning care and treatment or changes in care and treatment, and that requirement is established by 42 C.F.R. § 483.10(d)(3); and for a comprehensive care plan to be developed within seven days of completion of the comprehensive assessment, and that requirement is established by 42 C.F.R. § 483.20(k)(2). I conclude that the SOD provided Petitioner sufficient notice of the allegations despite the apparent clerical errors, and that Petitioner suffered no prejudice as a result of the errors.

[7] The SOD reflects a scope and severity for Tag F314 of D, which means there was no actual harm but the potential for more than minimal harm to one or more of Petitioner's residents. However, a scope and severity of D is inconsistent with the fact that Resident 32 developed a new stage III pressure ulcer, an open sore. Development of an open sore or wound is clearly actual harm.

resident's care plan was not revised to include alternatives for her noncompliance, and that it was not updated to reflect that she needed liquid protein supplements, also known as health shakes. CMS Ex. 2, at 24-25. These latter allegations have some merit.

Petitioner argues that Resident 32's care plan included the interventions to remind her to turn and reposition every two hours or at any nursing encounter; that nurse's notes show the resident was reminded to reposition and turn, and that she was educated about why it was necessary; that implementation of an alternating air pressure mattress also addressed the resident's noncompliance; and that nothing more was needed. Petitioner argues, regarding the requirement for liquid protein supplements, that they are in the record in the form of physician's orders that do not need to be specifically listed on a document called a care plan. P. Brief at 10.

Petitioner's records show that upon admission to the facility, Resident 32 had two pressure sores or ulcers in the area of her lower back and buttocks, characterized in some documents as on or near the coccyx and in others as being in the sacral area. P. Ex. 9, at 56, 66. There is no question that Petitioner had a care plan to address skin integrity and the ulcers. CMS Ex. 9, at 25; P. Ex. 9, at 15-19.

The nurse's notes presented for my consideration show that staff was regularly documenting instances of noncompliance by Resident 32 with instructions to lie down and/or turn from September 22, 2006 through October 18, 2006. The most frequent noncompliance was Resident 32's refusal to get out of her wheelchair and lie on her bed to take pressure off her buttocks. There were a few instances where the resident refused to change position in her bed. Petitioner is correct that staff frequently reminded the resident of the need to stay off her buttocks to allow for healing of her sores, but she continued with her noncompliance. P. Ex. 9, at 27, 31, 32, 33, 36, 37, 50, 53, 54, 56, 57. Because the most significant noncompliance that caused the nursing staff concern was the resident's refusal to leave her wheelchair to lie down, the pressure-relieving mattress (P. Ex. 9, at 17, 35) cited by Petitioner was not an effective intervention for that noncompliance, even though it was an appropriate intervention for dealing with the resident's noncompliance with turning in bed. Petitioner has offered no evidence that shows its multi-disciplinary care team actually considered, with or without the resident or her representative, how best to get the resident out of her wheelchair and into bed or how to minimize the negative impact of her sitting on her buttocks, either in her wheelchair or with the head of the bed elevated. Simple reminders were clearly not effective to address the behavior of noncompliance, and the impact upon the healing of Resident 32's pressure sore and the development of a new sore.

Petitioner is correct that there is evidence in the clinical records, including the nutrition assessment and physician orders, that show that Resident 32 was to receive liquid protein supplements to help her sores heal. P. Ex. 9, at 4, 55, 64. Petitioner argues this is sufficient. I disagree. The "comprehensive care plan" is the document that guides the delivery of care and services to a resident. 42 C.F.R. § 483.20(k). The doctor and nutritionist both specifically recognized that the resident's poor intake of nutrition could be contributing to the slow healing of her existing sores and could contribute to the development of more ulcers. P. Ex. 9, at 4, 56. The order for health shakes was an important intervention, and it should have been in the resident's comprehensive care plan but was not.

The absence of specific interventions in the comprehensive care plan to address the resident's noncompliance and her need for liquid protein supplements constitute a violation of the participation requirements of 42 C.F.R. §§ 483.10(d)(3) and 483.20(k)(2).

I further find and conclude that Petitioner violated 42 C.F.R. § 483.25(c) (Tag F314). The regulation requires: (1) that a facility ensure that a resident who enters the facility without a pressure sore not develop one unless clinically unavoidable; or (2) that a resident with sores receive necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. There is no dispute that in this case Resident 32 was admitted to Petitioner's facility with two pressure sores documented on July 18, 2006, and that she developed a new pressure sore documented on October 18, 2006. P. Ex. 9, at 66-67, 73. Thus, CMS has made a *prima facie* showing of a violation of 42 C.F.R. § 483.25(c). *Clermont Nursing and Convalescent Center*, DAB No. 1923, at 8-10 (2004).

Petitioner argues that the development of the third pressure sore while Resident 32 was in Petitioner's care was unavoidable, and that Petitioner took all reasonable measures to avoid the development of the sore. P. Brief at 12-14. I have already discussed my conclusion that Petitioner did not adequately document in the comprehensive care plan interventions for Resident 32's noncompliance with positioning in bed and her refusal to lie on the bed rather than sitting in her wheelchair or with the head of the bed elevated. I also note from the nurse's notes reviewed that not only did Petitioner fail to document interventions to address Resident 32's noncompliance, the nurse's notes reflect no interventions to deal with the noncompliance other than frequent reminders and requests which were routinely ignored. P. Ex. 9, at 27, 31, 32, 33, 36, 37, 50, 53, 54, 56, 57. I conclude that Petitioner did not, as it was obliged by the regulation to do, take all reasonable steps to prevent the development of the new pressure sore. *Clermont*, DAB No. 1923, at 8-10; *Ivy Woods Health Care and Rehabilitation Center*, DAB No. 1933 (2004). The development of this sore constitutes actual harm to Resident 32.

b. Petitioner violated 42 C.F.R. § 483.25 (Tag F309).

The general quality of care regulation requires that each resident receive, and the participating facility must provide, the necessary care and services to attain or maintain a resident's highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. 42 C.F.R. § 483.25. CMS alleges, based on the SOD, that Petitioner did not ensure that two residents (Resident 31 and Resident 38) were assessed for pain management, symptoms of illness, pressure sores, or were positioned to maintain good body alignment. I find that Petitioner violated the regulation by its care of Resident 38.

It is not disputed that Resident 38 had diagnoses of diabetes, a history of cerebrovascular accident (stroke), dementia, and bipolar disorder. The resident's quarterly MDS, dated September 30, 2006, documented the resident as: having modified cognition, short and long-term memory deficits, repetitive verbalizations and socially inappropriate and/or disruptive behaviors; requiring extensive assistance by one staff member for most activities of daily living (ADLs) that were observed during the assessment period; and being incontinent of bowel and bladder. CMS Ex. 2, at 31; CMS Ex. 53, at 3, 6, 7, 8, 9, 18. Her annual assessment, with a reference date of October 11, 2006, did not vary significantly from the quarterly assessment, except she required setup assistance only for eating, and she was totally dependent on staff for locomotion off the unit. P. Ex. 5, at 5-12. Nurse's notes documented that on October 6, 2006, the resident was noted to have blood in her stool, suspected hemorrhoids, and a facsimile was sent to her physician. An October 18, 2006 nurse's note shows that her physician ordered showers instead of baths, to discontinue Zantac and start Prilosec, to change the resident's diet to mechanical soft instead of pureed, to start the antibiotic Keflex, and records that she received the first dose of the antibiotic that evening. A note dated October 19, 2006, shows that the resident had no adverse effects from the antibiotic, she slept well, and that she had been noted to play with her food following the change from pureed to mechanical soft diet. A nurse's note from October 20, 2006, shows the resident slept well and had no emesis. The October 20 note also states that "nearly all" the resident's falls had been associated with her wanting to go to bed, but no further explanation is provided. CMS Ex. 53, at 36-37; P. Ex. 5, at 13.

The SOD records that the resident was observed by a surveyor on October 19, 2006, at 1:25 p.m., in the hall next to the door to her room. She had an emesis and was covered from her chest to her lap with reddish colored vomitus. An aide found her in this condition after 10 minutes of surveyor observation. She was again observed in her room on October 19, 2006, at 4:45 p.m. She had an emesis and was covered in vomitus from her neck to her lap, and it was all over her bed. A nurse was passing medication in the hall. The surveyor asked the nurse to get some help for the resident. The nurse indicated

that she did not know where the resident's aide was and that she would check on the resident as soon as she finished giving medications to another resident. She came to the room in approximately two minutes, and then the survey team left the area. CMS Ex. 2, at 31-32.

Petitioner was cited with violation of 42 C.F.R. § 483.25 because, as alleged in the SOD, Petitioner's documents do not show that Petitioner followed-up the report of blood in the stool, or the vomiting episodes, with further assessment, monitoring, or cares. The surveyors allege that vomiting is a possible side effect of use of the antibiotic Keflex and Prilosec. CMS Ex. 2, at 32. I note that a progress note dated October 17, 2006, shows that the resident was switched from Zantac to Prilosec specifically to address her problem with vomiting after meals. P. Ex. 5, at 4.

Petitioner argues that this resident had a noted behavioral issue of inducing vomiting when she wanted to go to bed and that staff were monitoring the condition. Petitioner refers to documentation that: on August 19, 2006, she was found sticking her fingers down her throat and then vomiting (CMS Ex. 53, at 40); on August 20, 2006, the PAR [Patient At Risk] Committee met to review the resident's behavior of inducing vomiting and staff were instructed to monitor the resident (CMS Ex. 53, at 40); on August 26, 2006, the resident told staff that she made herself vomit and then told staff "can you lay me down now, I vomited" (CMS Ex. 53, at 39); on October 5, 2006, Petitioner care planned for her repetitive behavior of demanding to be put to bed after meals, when she was supposed to remain up to avoid vomiting (CMS Ex. 53, at 26); and, finally, noting that on October 17, 2006, the resident's physician switched the resident from Zantac to Prilosec to address the resident's vomiting after meals. P. Ex. 5, at 4, 13; CMS Ex. 53, at 36. Petitioner did not address the allegations of blood in the resident's stool at all.

Petitioner directed me to nothing in the record regarding a follow-up or other orders to monitor for blood in the resident's stool. The absence of some record of follow-up and no orders for tests or further monitoring leads me to conclude that the facility was not providing care and services for this resident as required by 42 C.F.R. § 483.25. Further, while the resident had a history of vomiting, her recent change in medication to Prilosec, and administration of the antibiotic Keflex, should have caused the facility to assess whether the resident's vomiting on October 19, 2006, had an etiology other than her behavioral issues. I find the failure to follow-up and monitor for other potential causes to also be in violation of 42 C.F.R. § 483.25.

c. Petitioner violated 42 C.F.R. § 483.25(h)(2) (Tag F324) with regard to Resident 33.

A facility must ensure that "[e]ach resident receives adequate supervision and assistance devices to prevent accidents." 42 C.F.R. § 483.25(h)(2). The Board has explained the requirements of 42 C.F.R. § 483.25(h)(2) in numerous decisions. *Eastwood Convalescent Center,* DAB No. 2088 (2007); *Liberty Commons Nursing and Rehab - Alamance,* DAB No. 2070 (2007); *Golden Age Skilled Nursing & Rehabilitation Center*, DAB No. 2026 (2006); *Estes Nursing Facility Civic Center*, DAB No. 2000 (2005); *Northeastern Ohio Alzheimer's Research Center*, DAB No. 1935 (2004); *Woodstock Care Center*, DAB No. 1726, at 28 (2000), *aff'd*, *Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). Section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, but it does require 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. *Woodstock Care Center v. Thompson*, 363 F.3d at 589 (a SNF must take "all reasonable precautions against residents' accidents"). A facility is permitted the flexibility to choose the methods of supervision it uses to prevent accidents, but the chosen methods must be adequate under the circumstances. *Id.* Whether supervision is "adequate" depends in part upon the resident's ability to protect himself or herself from harm. *Id.* Based on the regulation and the cases in this area, CMS meets its burden to show a *prima facie* case if the evidence demonstrates that the facility failed to provide adequate supervision and assistance devices to prevent accidents, given what was reasonably foreseeable. *Alden Town Manor Rehabilitation & HCC*, DAB No. 2054 (2006), at 5-6, 7-12. An "accident" is "an unexpected, unintended event that can cause a resident bodily injury," excluding "adverse outcomes associated as a direct consequence of treatment or care (e.g., drug side effects or reactions)." SOM, App. PP, Tag F324; *Woodstock Care Center*, DAB No. 1726, at 4.

The SOD alleges, based on observation, resident/staff interview, record review, and a review of facility incident and accident reports, that Petitioner did not ensure that two residents were protected from falling. I address only the example of Resident 33, and the allegation that the resident did not have adequate supervision or assistance devices to prevent a fall after he was readmitted to Petitioner's facility from the hospital. CMS Ex. 2, at 37-42.

Resident 33 was admitted to Petitioner's facility on August 1, 2006. His diagnoses included chronic stomach ulcer, hearing loss, difficulty in walking, general muscle weakness, pulmonary collapse, CHF, shortness of breath, and peripheral vascular disease. CMS Ex. 50, at 24, 70, 92. Resident 33's MDS, with a reference date of August 8, 2006, documented the resident's cognitive skills as independent with no indication of mood or behavior problems and good psychological health; showed the resident required limited

assistance of one for bed mobility, transfers, and toilet use; and that he had no history of falls in the preceding 180 days. CMS Ex. 50, at 4, 5, 7. A significant change MDS, with a reference date of August 29, 2006, shows a change in mood; that the resident required extensive assistance of one for bed mobility and extensive assistance with transfers; limited assistance of one for walking in the room or corridor; extensive assistance of one for locomotion on and off the unit, toilet use, and bathing; and a deterioration in ADL performance since the last assessment. The significant change MDS also shows that he had fallen within the past 30 days. CMS Ex. 50, at 15-20. The significant change MDS triggered a change of condition RAP dated August 30, 2006. Petitioner documented that the "Resident has had a generalized decline in status. He has difficulty with balance and a decline in range of motion . . . has fallen in the past 30 days. External risk factors include use of walker . . . cardiac dysrhythmias, decline in functional status, chronic/acute condition, unsteady gait. His safety awareness is very poor. He has had multiple medication adjustments also in the past 6 months." CMS Ex. 50, at 22-23. Other than the reference in the significant change MDS, I find no evidence regarding a fall in August 2006, and I have no falls care plan prepared as a result of a fall in August 2006, the significant change MDS, or the RAP.

On October 10, 2006, Resident 33 was hospitalized and treated for CHF. CMS 50, at 73-82, 86. Resident 33 returned to Petitioner's facility on October 14, 2006, around 6:00 p.m. CMS Ex. 50, at 32; P. Ex. 4, at 11; P. Ex. 10, at 4. At 8:45 a.m. on October 15, 2006, Resident 33 fell while attempting to self-toilet without assistance from staff. Resident 33 was not reported to have any physical injury as a result of the fall. CMS Ex. 50, at 26-28.

Petitioner argues that CMS presented no testimony at hearing regarding this alleged deficiency, and, therefore, CMS failed to make a *prima facie* case. However, both parties have presented documentary evidence, mostly Petitioner's clinical records for Resident 33, the reliability and credibility of which is not challenged by Petitioner. The evidence is sufficient to satisfy the requirement for a *prima facie* showing of a violation of 42 C.F.R. § 483.25(h)(2). The resident, who was at risk for falls, fell at Petitioner's facility. Thus, the burden is upon Petitioner to rebut the *prima facie* showing or to establish any affirmative defense by a preponderance of the evidence.

I have already observed that I have not been presented as evidence any care plan for the prevention of falls from August 2006. The significant change MDS from August 29, 2006, clearly shows that Resident 33 was assessed as at risk for falls. Whether or not Petitioner implemented any interventions in light of that fall risk has not been shown. I did receive as evidence an "Initial Care Plan" with four goals, including the goal to minimize the risk of a fall/injury, with a "date initiated of October 14, 2006." CMS Ex. 50, at 12; P. Ex. 10, at 2. Absent any evidence to the contrary, I conclude that the initial

care plan was the plan in place for Resident 33 upon his readmission from the hospital on October 14, 2006. The initial plan required that Resident 33 have the assistance of one staff for transfers, that a toileting routine be maintained (although there is no indication what that might be), that his call light and "frequently used" items were to be within easy reach. The initial care plan indicated that Resident 33 was unable to use his walker very far and that he used his wheel chair all the time when out of bed. I also received as evidence a document entitled "Fall Risk Identification and Plan of Care" with a date of implementation of October 15, 2006. CMS Ex. 50, at 37, 54, 66. The evidence I have received does not show whether or not this plan of care was implemented prior to the resident's fall at 8:45 a.m. on October 15 or after the fall. The care plan directs that a "Star" symbol be applied to Resident 33's room; that he be instructed to use the call light for assistance; that he be instructed on fall risk; that his room environment be maintained free of unnecessary furniture or clutter; that he be reviewed for proper fitting shoes/slippers and clothing; that frequently used items be within easy reach; that he have assistance of one staff with toileting every two hours while awake and every four hours during the night; that he be instructed on proper use of his walker; that he be provided assistance for unsteady gait and therapy as ordered. The plan also has an undated entry to provide an alarm to his wheelchair, and there is evidence this requirement was actually added after the October 15 fall, possibly as late as October 20 (CMS Ex. 50, at 26, 30). The plan was amended on October 16, 2006, with a new intervention to add a non-skid mat at bedside, but the mat was refused by the resident and it was removed on October 20, 2006. A further amendment on October 20, 2006, was to check the resident's orthostatic blood pressure for three days. CMS Ex. 50, at 37.

If the interventions of either the initial plan of care from October 14, or the interventions from the October 15 plan of care, or the interventions of both plans, were implemented before Resident 33's fall at 8:45 a.m. on October 15, the inference arises that the interventions were inadequate, or that they were ineffectively implemented because the resident fell. Petitioner has not presented evidence sufficient to show that it took all reasonable steps to ensure that Resident 33 received supervision and assistance devices that met his assessed need and mitigated foreseeable risks of harm from an accidental fall.

Furthermore, the investigative reports and nurse's notes show that Resident 33 told staff that he decided to use the urinal, and, when he stood, he fell backward. CMS Ex. 50, at 26-28, 32. When he returned from the hospital he was on a higher dose of diuretic, which can increase the need to urinate and is particularly problematic for an oriented resident who complained to the surveyor that, when he had the urge, he needed to go immediately. CMS Ex. 2, at 41; CMS Ex. 50, at 26. The surveyor reported that on viewing the resident's room, she observed that his urinal was actually on his bedside stand and not accessible to him. The inaccessibility of his urinal is inconsistent with the care plan requirement to keep frequently used items accessible. I also note that Petitioner identified

an obvious concern or risk of falls due to lightheadedness secondary to possible orthostatic hypotension, as the resident's blood pressure was noted to be 102/62 following the fall, though there were no observable or reported injuries. CMS Ex. 50, at 26. Petitioner even listed a care plan intervention to monitor Resident 33's blood pressure. However, no intervention to teach the resident to use his urinal without standing is listed on either care plan in evidence. Despite the fall on October 15, and continuing concern about possible hypotension, Petitioner adopted no intervention for more frequent observations of the resident, even for a short term.

Based on all the facts, I conclude that Petitioner has not proven that it took all reasonable steps to ensure that Resident 33 received the supervision and assistance devices he needed to minimize the risk of injury due to falls. Accordingly, Petitioner was in violation of 42 C.F.R. § 483.25(h)(2) with regard to Resident 33.

2. Petitioner was not in violation of 42 C.F.R. § 483.25(e)(2) (Tag F318) as of the January 25, 2007 survey, but returned to substantial compliance as of January 5, 2007.

The surveyors determined during the January 25, 2007 revisit survey of Petitioner's facility that all the deficiencies cited on the October 2006 survey were corrected as of January 5, 2007. CMS Ex. 3, at 11. However, the surveyors allege in the January 25, 2007 SOD that Petitioner was in violation of 42 C.F.R. § 483.25(e)(2) (Tag F318). Subsection 483.25(e)(2) of the Quality of Care regulation requires that a facility ensure that "[a] resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion." The SOD reflects that the state agency had received a complaint from the public that residents were not receiving restorative nursing services. The surveyors allege generally that based on the complaint, record review, and staff interview, it was determined that Petitioner did not ensure that 24 residents received restorative nursing services at the frequency care planned by the physical therapy department. The surveyors only made specific allegations regarding Residents 36, 34, 52, 50, and 53. CMS Ex. 3, at 13-27. The five residents for whom the SOD describes specific facts are the only residents for whom Petitioner received adequate notice of what deficiencies to defend. Accordingly, I only consider the examples cited related to Residents 36, 34, 52, 50, and 53. Tr. 27-28.

Resident 36 is alleged by the surveyors to have been admitted to Petitioner's facility on January 13, 2005, with multiple diagnoses including muscle disuse and difficulty walking. The surveyors allege that the resident's MDS from September and December 2006 show that the resident had limitation in range of motion and partial loss of voluntary movement of his arm and leg on one side and full loss of voluntary movement of both hands. The

surveyors allege that the resident had physician orders dated December 15, 2006, that required he be discharged from physical therapy with referral to restorative nursing for exercise and gait. The surveyors found a physical therapist document dated December 18, 2006, that directed a restorative program three to five times per week with specific goals. The surveyors also found in Resident 36's records a restorative program plan and summary dated January 2, 2007, with specific goals and interventions. The alleged deficiency is based on the fact that the surveyors found two "Restorative Care Flow Records" for January 2007, and neither showed that Resident 36 received any restorative services and the surveyors found no documentation that restorative services were provided in December 2006. According to the surveyors' allegations, the Director of Nursing (DON) and administrator conceded that Resident 36 received no restorative services in January 2007 or December 2006. CMS Ex. 3, at 14-16.

Resident 34 is alleged to have been admitted to Petitioner's facility on December 6, 2005, with multiple diagnoses including muscle disuse atrophy, rheumatoid arthritis, osteoporosis, and osteomalacia. The surveyors found an October 2006 MDS for the resident that indicates a functional limitation in range of motion and partial loss of voluntary movement of an arm on one side. A physician's order dated December 5, 2006, directed that occupational therapy be discontinued with referral to restorative nursing for follow-up. The surveyors located a document from the physical therapist dated December 4, 2006, that specified exercises for the resident three to five times per week. The surveyors also found a "Restorative Therapy Record" dated December 2006, that included the instructions from the physical therapist for exercises three to five times per week. The deficiency is alleged because the records reviewed by the surveyors only document that the resident received restorative care two days during the first week of December 2006 and no such care the second week of December. The surveyors also found a "Restorative Program Plan and Summary" and a "Restorative Therapy Record" for January 2007 that required exercises six times per week. However, the records reviewed showed that the resident only received planned restorative services one time during the first week of January 2007, three times during the second week, and only one time during the first three days of the third week rather than the planned six times per week. The surveyors allege that the DON agreed that Resident 36 did not receive the care planned restorative services. CMS Ex. 3, at 16-20.

Resident 52 was admitted to Petitioner's facility on October 20, 2006, with diagnoses including idiopathic scoliosis. The surveyors located an MDS from October 24, 2006, that indicated the resident suffered a functional limitation in range of motion in both legs. The surveyors located documents dated December 26, 2006 and January 8, 2007, by which the physical therapist directed that Resident 52 exercise legs five times per week, and upper extremities three to five times per week with restorative nursing. The surveyors also found a "Restorative Program Plan and Summary" form dated January 4,

2007, which indicated that the resident was to increase to exercising six times per week. The surveyors cited the deficiency because the documents showed that the resident was not started on the restorative exercise program until the second week in January, and, during the second, third, and fourth weeks of January, he exercised less than six times per week. The surveyors allege that on January 25, 2007, the resident's restorative plan was discontinued. CMS Ex. 3, at 20-23.

Resident 50 was admitted to Petitioner's facility on July 8, 2006, with multiple diagnoses and a history of a CVA. The surveyors located an admission MDS dated July 15, 2006, which showed she had no functional limitation in range of motion. Similarly, a significant change MDS dated October 6, 2006, showed she had no functional limitation in range of motion. However, the surveyors also found a "Rehab Instruction Record" dated August 21, 2006, and apparently signed by the physical therapist, that specified an exercise program five times per week to maintain gait ability and strength. A physical therapy note dated January 19, 2007, documented restorative care no more than three times a week or the resident would refuse. The deficiency was cited because the documents reviewed by the surveyors showed the resident did not exercise with the frequency specified by the physical therapist. The surveyors note that during the survey they received a document from the physical therapist dated January 24, 2007, that indicated the resident had no decline in function. The surveyors also indicate that they received a document from the DON dated January 25, 2007, that indicated that the resident was not appropriate for restorative nursing services and that she was discontinued from that program. CMS Ex. 3, at 23-25.

Resident 53 was admitted to Petitioner's facility on January 4, 2005, with diagnoses including difficulty walking. The surveyors found an MDS dated December 13, 2006, which indicated that she had no limitation in range of motion. The surveyors also found a "Rehab Instruction Record" dated October 27, 2006, in which the physical therapist directed exercises for the resident five times per week. The deficiency was cited because documents reviewed by the surveyors did not show the resident exercised as frequently as planned or ordered. The surveyors note that during the survey they received a document from the physical therapist that indicated the resident suffered no decline in function. The surveyors also received a document signed by the DON and dated January 25, 2007, which indicated the resident was not appropriate for restorative nursing and that she was discontinued from the program effective that date. CMS Ex. 3, at 25-27.

Petitioner does not deny that its restorative nursing program was in disarray after its nurse in charge of the program quit in December 2006, and one of two restorative aides abruptly quit in January 2007. According to Petitioner, the consultant hired at the behest of the state agency had already identified weakness with documentation in the restorative program, but not care, and she had reported to the state agency that the problems were

being addressed and resolved before the final survey of Petitioner in January 2007. P. Brief at 19.

The regulation that CMS alleges was violated requires:

> (e) *Range of motion.* Based on the comprehensive assessment of a resident, the facility must ensure that –
>
> * * * *
>
> (2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

42 C.F.R. § 483.25(e)(2).

The SOM provides that the intent of the "regulation is to ensure that the resident reaches and maintains his or her highest level of range of motion and to prevent avoidable decline of range of motion." SOM, App. PP, Tag F318. Range of motion is defined by the SOM as the "extent of movement of a joint." The SOM provides as an example of a clinical condition that may show that a reduction of range of motion is unavoidable, to be immobilization of limbs or digits due to injury or surgical procedures. *Id.*

Based upon the language of the regulation and the SOM explanation, the elements of a *prima facie* case are: (1) a resident with a limited range of motion or movement of a joint; (2) did not receive treatment and services (a) to increase range of motion or (b) to prevent further decrease in range of motion. The SOM recognizes as a defense to a *prima facie* case that a reduction in range of motion may be unavoidable. The language of the regulation does not require that there be a showing of no increase or a decline in range of motion, only that treatment and services were not delivered.

Review of the allegations of the SOD regarding Residents 50 and 53 shows that CMS cannot make a prima facie showing of a violation of the regulation. The SOD states in each case that there was no assessment of a limitation of range of motion for either resident. CMS Ex. 3, at 23, 25. Thus, the first element is missing in the case of each resident. Accordingly, the examples cited regarding Residents 50 and 53 do not amount to violations of 42 C.F.R. § 483.25(e)(2).

CMS did make a prima facie showing as to Residents 34, 36, and 52. In each case the resident's assessment reflected limitation of range of motion and, in each case, there is evidence that the resident did not receive some or all services specified in their care plan for increasing or maintaining range of motion. Thus, Petitioner bears the burden of rebutting the prima facie case or establishing that loss of range of motion was unavoidable.

Petitioner admits that Resident 36 was coded on his MDS as having a limitation in range of motion, but Petitioner argues the limitation was due to the fact that he was missing fingers on both hands and that he had some slight limitation in movement of his arm and leg. P. Brief at 22-23; P. Ex. 13, at 6, 20; Tr. 469-75. Regarding the missing fingers, there is no question that loss of range of motion is unavoidable. Regarding the arm and leg, Petitioner does not deny the survey allegation that interventions for the limitation of the resident's range of motion were not documented. Rather, Petitioner argues that Resident 36 received "informal restorative services" because he had a transfer pole in his room to permit self-transfers to and from bed and through walking with staff supervision. P. Ex. 13, at 22; Tr. 388, 469-70; P. Brief at 23. Petitioner's expert witness, Demetria Haffenreffer, R.N., who is also the consultant that Petitioner hired at the recommendation of the state agency following the October Survey, testified that she had reviewed Resident 36's records. She testified that she also personally assessed the resident. She testified that he received some services from the restorative aide and that he also received such services from the regular nursing staff. She opined that services he received for limitation of range of motion were sufficient to help him reach and maintain his highest practicable level of functioning. Tr. 469-75. I find R.N. Haffenreffer credible and her opinion weighty. The surveyor who reviewed Resident 36's records agreed that there was no evidence of a decline in his range of motion. Tr. 215. Thus, the question is were Petitioner's interventions sufficient to maintain or increase the resident's range of motion in arm and leg. The regulation and SOM do not require the preparation or maintenance of particular forms. While clear recordkeeping may avoid a citation of a deficiency or provide an easy defense in the case of a citation, the absence of documentation is not itself a violation of this particular regulation. I conclude that the testimony and documents Petitioner has presented are sufficient to rebut the CMS prima facie showing, which was based on an inference arising from an absence of documentation. The credible evidence is that Resident 36 received sufficient treatment and services to increase and/or maintain the range of motion in his leg and arm.

The example cited by the surveyors regarding Resident 34, and CMS's prima facie case, is also based on the absence of documentation that the resident received all care planned restorative services for limited range of motion in one arm. Petitioner argues that there is no evidence of limitation in range of motion; rather, she was care planned for services to maintain her strength. Petitioner further notes that the surveyor agreed that this resident

was not at risk for any decline in range of motion (Tr. 215). Petitioner asserts that the resident received informal services to increase her strength. P. Brief, at 23-24. Petitioner presented the testimony of Resident 34's former treating physician, Sarah Lorion, who testified that Resident 34 had no functional range of motion limitations. Tr. 432. The resident's MDS shows that she had limitation of functional range of motion on one side with partial loss of voluntary movement. P. Ex. 14, at 11, 17. Consistent with Petitioner's position, the resident's care plan, with dates from September and October 2006, reflects that the concern was maintaining strength of upper and lower extremities rather than avoiding or minimizing decline in range of motion of a joint. P. Ex. 14, at 2. R.N. Haffenreffer testified that Resident 34 did have a limitation in range of motion of her left shoulder, due to an old fracture, in addition to left hemiparesis or weakness possibly due to an old stroke. The resident's left shoulder was actually immobilized. Tr. 476. R.N. Haffenreffer's testimony is credible. To the extent that Resident 34's left shoulder was immobilized, Petitioner has shown that any decline in range of motion was unavoidable. To the extent that the resident's care plan called for strengthening rather than improving range of motion of a joint, 42 C.F.R. § 483.25(e)(2) is not applicable. Furthermore, R.N. Haffenreffer testified that, in her opinion, the resident received all the restorative services necessary, consistent with the fact her condition improved to the degree that she could be discharged to a lower level care facility. Tr. 476-77. Based upon the credible testimony, I conclude that Petitioner has rebutted the CMS prima facie showing of a violation of 42 C.F.R. § 483.25(e)(2) pertaining to the example of Resident 34.

Regarding Resident 52, the CMS prima facie case is based on the facts that Resident 52's care plan for a restorative exercise program, dated December 26, 2006, was not implemented until January 10, 2007, and that Petitioner's records do not reflect Resident 52 received services as frequently as planned. CMS Ex. 3, at 22. These facts are not disputed by Petitioner. Petitioner argues, rather, that Resident 52's limitation in range of motion was due to an old fusion of his hip secondary to an old hip injury. Petitioner's position is that Resident 52's range of motion limitation would not be affected by restorative services; thus, as acknowledged in the SOD (CMS Ex. 3, at 23), the restorative program was discontinued. P. Brief at 24. Dr. Lorion testified that Resident 52 is her patient, that he had a limitation in range of motion of his hip due to an old, untreated fracture, and that nothing could be done for the limitation. Tr. 432-33. Dr. Lorion is credible and her medical opinion is weighty. R.N. Haffenreffer testified that she is familiar with Resident 52's case, that he had limitation in range of motion due to an old hip injury, nothing could be done to affect the range of motion, and it was appropriate to discontinue him from the restorative program. Tr. 477-78. Based upon the credible testimony, I conclude that Petitioner has rebutted the CMS prima facie showing of a violation of 42 C.F.R. § 483.25(e)(2) pertaining to the example of Resident 52.

Based upon the foregoing, I conclude that:

- As found by the surveyors during the January 2007 survey, Petitioner corrected all deficiencies cited on the October 2006 survey not later than January 5, 2007.

- Petitioner was not in violation of 42 C.F.R. § 483.25(e)(2), the only deficiency cited by the January 2007 survey.

- Petitioner was in substantial compliance with program participation requirements as of the date of the January 2007 survey.

3. Termination is not required by operation of law, and CMS has not directed termination as a discretionary enforcement remedy.

There is no question that CMS has the discretionary authority to terminate a long-term care facility's provider agreement upon a finding that the facility is not in substantial compliance, even when the deficiencies do not pose immediate jeopardy to facility residents. 42 C.F.R. § 488.412. However, this case does not involve a discretionary termination by CMS. Rather, termination was based on the provisions of 42 C.F.R. § 488.412(d), which prohibits CMS from permitting a facility to continue participation for more than six months from the last day of the survey that first determined the facility was not in substantial compliance, unless the facility returns to substantial compliance within the six month period. Because Petitioner returned to substantial compliance not later than January 5, 2007 (the date Petitioner alleges it was in substantial compliance following the October Survey), the regulation does not compel termination in this case. CMS has also not given any notice in this case that it has revised its prior decision regarding remedies and terminated Petitioner as a matter within its discretion.

4. A DPNA from August 31, 2006 through January 4, 2007, and a CMP of $500 per day from August 1, 2006 through January 4, 2007, are reasonable enforcement remedies.

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, including a DPNA and a CMP. CMS may impose a CMP for the number of days that the facility is not in compliance or for each instance that a facility is not in substantial compliance. 42 C.F.R. § 488.430(a). There are two ranges for per day CMPs. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, of from $3050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§

488.438(a)(1)(i), (d)(2). The lower range of CMP, from $50 per day to $3000 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). The $500 per day CMP in this case is at the low end of the lower range.

In determining whether the amount of the CMP is reasonable, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of non-compliance, 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.

Petitioner did not contest the August 2006 survey and remedies; thus, the only issue is whether there is a basis for the imposition of a DPNA or CMP based on the October 2006 survey. The deficiencies from the October 2006 survey discussed herein are a sufficient basis to impose a DPNA and the $500 per day CMP, particularly as I find that the violation of Tag F314 amounts to actual harm (not, as CMS characterized, no actual harm but more than minimal harm). There is no evidence in the record that Petitioner cannot pay the CMP. There is no evidence in the record of prior noncompliance, except from this same survey cycle. Petitioner is culpable for its failure to recognize and remedy these obvious deficiencies.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner was out of substantial compliance with participation requirements from August 1, 2006 through January 4, 2007. I conclude further that the remedies of a CMP of $500 per day from August 1, 2006 through January 4, 2007, and a DPNA from August 31, 2006 through January 4, 2007, are reasonable. Termination of Petitioner's provider agreement pursuant to 42 C.F.R. § 488.412(d) is not required.

/s/

Keith W. Sickendick
Administrative Law Judge