Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Ridgecrest Healthcare Center,
(CCN: 55-5248),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-11-323

Decision No. CR2561

Date: June 29, 2012

DECISION

Petitioner, Ridgecrest Healthcare Center (Petitioner or facility), is a long-term care facility located in Ridgecrest, California, that participates in the Medicare program. Following its annual survey, completed June 18, 2010, the Centers for Medicare and Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare program requirements and that, for one day, its deficiencies posed immediate jeopardy to resident health and safety. The facility did not challenge those findings.

A surveyor revisited the facility on September 30, 2010, and, based on his findings, CMS determined that the facility had not achieved substantial compliance, because it was not then in compliance with 42 C.F.R. § 483.25(h)) (Tag F323), which governs accident prevention. CMS ultimately found that the facility returned to substantial compliance on November 24, 2010. Claiming that it returned to substantial compliance on August 13, 2010, Petitioner challenges CMS's determination and the resulting civil money penalties

(CMPs): $1,000 per day from June 19 through September 29, 2010 and $150 per day from September 30 through November 23, 2010. [1]

For the reasons set forth below, I find that the facility did not achieve substantial compliance with program requirements until November 24, 2010, and the penalties imposed – $1,000 per day from June 19 through September 29, 2010 and $150 per day from September 30 through November 23, 2010 – are reasonable.

I. Background

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program, and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months, and more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308.

Here, following the facility's annual survey, completed June 18, 2010, CMS determined that the facility was not in substantial compliance with multiple program requirements:

- 42 C.F.R. §§ 483.13(b) and (c) (Tags F223, F224, F225 and F226 – resident behavior and facility practices: abuse/staff treatment of residents);

- 42 C.F.R. §§ 483.15(a) and (e) (Tag F241 – quality of life: dignity/accommodation of needs); 42 C.F.R. § 483.15(g) (Tag F250 – quality of life: social services);

- 42 C.F.R. § 483.15(h) (Tags F253, F257, and F258 – quality of life: environment);

- 42 C.F.R. §§ 483.20(d), 483.20(k)(1), and 483.20(k)(3)(i) (Tags F279 and F281 – resident assessment: comprehensive care plans/professional standards of quality);

[1] Petitioner also complains that CMS imposed a "denial of payment for new admissions." However, because I decide that CMS has a basis for imposing a remedy, I have no authority to review its determination to do so. 42 C.F.R. § 488.438(e)(2). Nor may I review CMS's choice of remedy. 42 C.F.R. § 488.408(g)(2).

- 42 C.F.R. § 483.25(h) (Tag F323 – quality of care: accident prevention);
- 42 C.F.R. § 483.25(l) (Tag F329 – quality of care: unnecessary drugs);
- 42 C.F.R. §§ 483.25(m)(1) and (2) (Tags F332 and F333 – quality of care: medication errors);
- 42 C.F.R. § 483.25(n) (Tag F334 – quality of care: influenza and pneumococcal immunizations);
- 42 C.F.R. § 483.35(g) (Tag F369 – dietary services: assistive devices);
- 42 C.F.R. § 483.55(a) (Tag F411 – dental services);
- 42 C.F.R. § 483.60(a) and (b) (Tag F425 – pharmacy services: procedures/service consultation); and
- 42 C.F.R. § 483.70(h) (Tag F465 – physical environment: environmental conditions).

CMS also determined that the deficiencies cited under section 483.13 posed immediate jeopardy to resident health and safety. P. Exs. 2, 3. CMS imposed CMPs of $10,000 per day for one day of immediate jeopardy and $1,000 per day starting June 18, 2010. P. Ex. 3 at 2.

Petitioner did not appeal CMS's findings or the penalties imposed, which are therefore final and binding. 42 C.F.R. § 498.20(b). The facility was therefore not in substantial compliance with program requirements at least through June 18, 2010.

Responding to the June survey findings, the facility submitted a plan of corrections (POC), dated August 13, 2010, indicating that it had corrected its deficiencies as of that date. P. Ex. 2. A surveyor revisited the facility and completed a follow-up survey on September 30, 2010. Based on the survey findings, CMS determined that the facility remained out of substantial compliance with Medicare requirements governing accident prevention, 42 C.F.R. § 483.25(h) (Tag F323). CMS Ex. 1.

On November 24, 2010, surveyors revisited the facility a second time. Based on their findings, CMS determined that the facility returned to substantial compliance as of November 24. P. Ex. 8.

CMS has imposed CMPs of $10,000 per day for one day of immediate jeopardy (June 17, 2010) and $1,000 per day for 104 days of substantial noncompliance that was not immediate jeopardy (June 18 through September 29), subsequently reduced to $150 per day for an additional 55 days (September 30 through November 23, 2010). P. Ex. 8 at 5.

In this appeal, Petitioner concedes that it remained out of compliance through August 12, 2010, but claims that it returned to substantial compliance on August 13. P. Br. at 1-5.

On November 7, 2011, I convened a video hearing from the offices of the Departmental Appeals Board in Washington, D.C. Counsel and witnesses convened in Bakersfield, California. Mr. Michael Propst appeared on behalf of CMS. Mr. Thomas Collins appeared on behalf of Petitioner. Transcript (Tr.) 5. I have admitted into evidence CMS Exhibits (Exs.) 1-7 and Petitioner's (P.) Exs. 1-4, 6-14, and 16-22. Tr. 7.

The parties filed pre-hearing briefs (CMS Br.; P. Br.) and post-hearing briefs (CMS. Post-hrg. Br.; P. Post-hrg. Br.). CMS filed a reply brief.

II. Issues

The issues before me are:

1. Did the facility correct its deficiencies and achieve substantial compliance prior to November 24, 2010, and, if so, when?

   and

2. If the facility's noncompliance continued beyond June 18, were the penalties imposed – $1,000 per day from June 19 through September 29 and $150 per day from September 30 through November 23, 2010 – reasonable?

III. Discussion

A. The facility did not establish that it corrected the deficiencies cited under 42 C.F.R. § 483.25(h) prior to November 24, 2010.[2]

Once a facility has been found to be out of substantial compliance (as the facility was here), it remains so until it affirmatively demonstrates that it has achieved substantial compliance once again. *Premier Living & Rehab Ctr.*, DAB No. 2146 at 23 (2008); *Lake City Extended Care*, DAB 1658 at 12-15 (1998). The burden is on the facility to prove that it has resumed complying with program requirements, not on CMS to prove that

[2] My findings of fact/conclusions of law are set forth, in italics and bold, in the discussion captions of this decision.

deficiencies continued to exist after they were discovered. *Asbury Ctr. at Johnson City*, DAB No. 1815 at 19-20 (2002). A facility's return to substantial compliance usually must be established through a resurvey. 42 C.F.R. § 488.454(a). To be found in substantial compliance earlier than the date of the resurvey, the facility must supply documentation "acceptable to CMS" showing that it "was in substantial compliance and *was capable of remaining in substantial compliance*" on an earlier date. (emphasis added). 42 C.F.R. § 488.454(e); *Hermina Traeye Mem'l Nursing Home*, DAB No. 1810 at 12 (*citing* 42 C.F.R. § 488.454(a) and (e); *Cross Creek Care Ctr.*, DAB No. 1665 (1998).

Further, if CMS accepts a deficient facility's POC, the facility must then timely implement all of the steps that it identified in the POC as necessary to correct the cited problems. *Cal Turner Extended Care Pavilion*, DAB No. 2030 at 19 (2006); s*ee also Meridian Nursing Ctr.*, DAB No. 2265 (2009); *Lake Mary Health Care*, DAB No. 2081 at 29 (2007).

Program requirements. Under the statute and the "quality-of-care" regulation, each resident must receive, and the facility must provide, the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the his/her comprehensive assessment and plan of care. To this end, the regulation mandates that the facility "ensure" that each resident's environment remains as free of accident hazards as possible. 42 C.F.R. § 483.25(h)(1). It must eliminate or reduce a known or foreseeable risk of accident "to the greatest degree practicable." *Del Rosa Villa*, DAB No. 2458 at 7 (2012) (*quoting Clermont Nursing & Convalescent Ctr.*, DAB No. 1923 at 9-10 (2004), *aff'd*, *Clermont Nursing & Convalescent Ctr.*, 142 F. App'x 900 (6th Cir. 2005); 42 C.F.R. § 483.25(h)(2); *see also Briarwood Nursing Ctr.*, DAB No. 2115, at 5 (2007); *Guardian Health Care Ctr.*, DAB No. 1943, at 18 (2004) (*citing* 42 C.F.R. § 483.25(h)(2)) (mandating that the facility "take reasonable steps to ensure that a resident receives supervision and assistance devices designed to meet his assessed needs and to mitigate foreseeable risks of harm from accidents."); *see Burton Health Care Ctr.*, DAB No. 2051 at 9 (2006) (holding that determining whether supervision/assistive devices are adequate for a particular resident "depends on the resident's ability to protect himself from harm.").

June survey findings and POC. Resident 6 (R6) suffered from severe osteoporosis. She had a history of falls and had fractured her pelvis, facial bones, and the base of her skull. In June 2010, she was recovering from hip and arm fractures. P. Ex. 2 at 46; Tr. 99.

R6's wheelchair was "not new"; in fact, the facility admitted that it was "old" and had been repaired multiple times. CMS Ex. 1 at 2; Tr. 92. During the June survey, the surveyors saw R6 attempt to lock her wheelchair tires so that she could get into bed, but her wheelchair brake was broken. P. Ex. 2 at 46. The facility's Director of Nursing

(DON), Sharon Aleo, promised to repair it "right away." P. Ex. 2 at 46-47; P. Ex. 16 at 2 (Aleo Decl. ¶¶ 5, 6); Tr. 91. CMS cited a deficiency under 42 C.F.R. § 483.25(h), finding that the facility failed to maintain R6's wheelchair in proper working order, which put the resident at risk for falls. P. Ex. 2 at 46.

In its POC, the facility said that the maintenance supervisor had inspected "all other wheelchairs" to ensure that their brakes were functioning properly. On August 11, 2010, according to the POC, the administrator "in-serviced" the maintenance supervisor and facility staff "regarding monitoring of all wheelchair breaks[sic] to ensure they are in good condition." The facility also promised that staff would report to the maintenance supervisor "for immediate repair" any malfunctioning wheelchair brake, and the maintenance supervisor would "monitor all wheelchairs during daily routine rounds to ensure they are in good repair." P. Ex. 2 at 46.

September survey findings. During the September revisit, Surveyor Todd Elkins made a point of examining R6's wheelchair to make sure that the promised repairs had been made.[3] Tr. 63. He found the chair in the resident's room and noted that the two front brakes "did not secure the wheelchair when engaged," so the chair moved forward easily when lightly pushed. CMS Ex. 7 at 3 (Elkins Decl. ¶ 12); Tr. 75.[4] Surveyor Elkins spoke to Licensed Vocational Nurse (LVN) Letticia Zubia, who confirmed that the brakes did not work properly. CMS Ex. 7 at 3-4 (Elkins Decl. ¶ 12); P. Ex. 18 at 1 (Zubia Decl.
¶ 3); Tr. 60.

The parties argue about whether Surveyor Elkins observed and discussed broken front brakes, broken back brakes, or both. I find this dispute of little consequence. Surveyor Elkins testified, credibly, that the wheelchair moved even when the brakes were engaged. Petitioner has not refuted this testimony. Whatever the underlying cause, the evidence establishes that R6's wheelchair brakes did not prevent the chair from moving, which, everyone agrees, endangers any resident who uses the broken chair. *See, e.g.*, Tr. 99.

Surveyor Elkins subsequently spoke to James Kapp, the facility's maintenance supervisor, who told him that not all of the wheelchairs had been inspected and repaired. Maintenance Supervisor Kapp characterized the effort as a "work in progress" and estimated that fifteen chairs had been evaluated and repaired. CMS Ex. 7 at 4 (Elkins Decl. ¶ 13); Tr. 66, 69.

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[3] R6 is referred to as R12 in the September survey documents.

[4] In error, CMS cites the Elkins declaration as CMS Ex. 6. CMS Post-hrg. Br. at 5. CMS Exhibit 6 is, in fact, a resident roster. The Elkins declaration is CMS Ex. 7. *See* CMS List of Proposed Exhibits (July 6, 2011).

The surveyor findings present insurmountable problems for the facility: 1) contrary to the assurances in the POC, the brakes on R6's wheelchair did not function properly; 2) contrary to the assurances in the POC, the facility had not inspected and repaired all of its wheelchairs; and 3) notwithstanding Maintenance Supervisor Kapp's best efforts, the facility had not implemented effective procedures for ensuring that broken wheelchairs were promptly identified, reported to maintenance, and repaired. The absence of effective procedures was especially problematic, because most of the facility's wheelchairs were old and had required multiple repairs. Tr. 168.

Petitioner concedes that the brakes to R6's wheelchair were broken at the time of the September 30 survey but maintains that, consistent with the assurance of its POC, it had fixed them immediately after the June survey. P. Ex. 16 at 2 (Aleo Decl. ¶ 6); P. Ex. 17 at 3 (Kapp Decl. ¶ 13); Tr. 167-168. CMS questions this claim, pointing out that no one told Surveyor Elkins that the chair had been repaired earlier. Tr. 76-77.

Maintenance Supervisor Kapp testified that he repaired R6's wheelchair brakes during the June survey, on the same day they were brought to his attention, and I found this testimony credible. P. Ex. 17 at 3 (Kapp Decl. ¶ 13); Tr. 167-168, 177. He also testified that he kept logs indicating when a wheelchair was repaired. Tr. 178. The facility produced portions of a "maintenance log" that seems to indicate that the wheelchair was repaired on June 29, 2010. P. Ex. 13 at 2; Tr. 178.

That the brakes were temporarily repaired does not bring the facility into substantial compliance, however. Correcting a cited deficiency, by itself, does not mean that the facility has achieved substantial compliance; facilities must *remain* in substantial compliance. The "regulations emphasize the need for continued compliance, rather than cyclical compliance." The facility must not only remedy deficient practices, but "also ensure that correction is permanent." P. Ex. 2 at 3; 42 C.F.R. § 488.454(e); *Hermina Traeye Mem'l Nursing Home*, DAB No. 1810 at 12 (*citing* 42 C.F.R. § 488.454(a) and (e); *Cross Creek Care Ctr.*, DAB No. 1665 (1998). Thus, even though the facility temporarily repaired R6's wheelchair, it did not keep the chair in good and safe working order. The facility was therefore not in substantial compliance with 42 C.F.R. § 483.25(h).

Petitioner has not explained when, following the June repair, R6's wheelchair brakes broke again. In his written declaration, Maintenance Supervisor Kapp says that some time after he repaired R6's wheelchair brakes in June, he "received another notice that the same resident's wheelchair needed to be repaired." P. Ex. 17 at 3 (Kapp Decl. ¶ 14). But his written declaration is conspicuously silent as to when and how he received that notice. During his cross-examination, he was specifically asked when he received the notice that the resident's wheelchair needed to be repaired, and he said eventually that this occurred "after" the September survey. Tr. 172-73.

Maintenance log entries show that R6's wheelchair, identified as chair #8 (P. Ex. 13 at 2), needed brake repairs on June 29 and November 3, 2010. The chair and R6's room number are listed in an entry dated November 3, 2010, with the adjacent "status" box indicating problems with the brakes (and possibly other aspects of the wheelchair). Outside the status box is written "good," but that entry is not dated. P. Ex. 13 at 3. Neither Maintenance Supervisor Kapp nor Petitioner has explained the significance of these entries, but I can reasonably infer that something was again wrong with the wheelchair brakes on November 3. Petitioner produces no maintenance log entry indicating that that anyone reported or repaired malfunctioning brakes on this wheelchair between June 29 and November 3.

Under cross-examination, Maintenance Supervisor Kapp seemed to surprise everyone by claiming, for the first time, that the wheelchair Surveyor Elkins examined in R6's room during the September survey was not the same wheelchair that other surveyors examined during the June survey. Tr. 173-74.[5] Maintenance Supervisor Kapp testified that R6's roommate's chair was "donated" to R6. Tr. 173. He was then unable to explain why, according to the facility's maintenance log, R6 (in room 103A) had the same chair with the same serial number in June and November. P. Ex. 13 at 2, 3; Tr. 174-75. In its closing brief, Petitioner claims, also for the first time, that the chairs were different but, again, does not explain why, if R6 changed chairs, the facility's maintenance log shows that she had the same one in June and in November. P. Post-hrg. Br. at 8.

I find it ultimately irrelevant whether the broken wheelchair Surveyor Elkins examined in September was the same one that the surveyors inspected in June. Replacing R6's broken wheelchair with another broken wheelchair would not have corrected the deficiency.

While acknowledging that R6 had broken wheelchair brakes at the time of the September survey, the facility suggests that this presented no problem because R6 had been admitted to the hospital the day before the survey began, so she would not have been using the wheelchair. Tr. 58, 59, 95. But the facility has not established how long those brakes had been broken prior to R6's hospital admission. Tr. 60. We know that R6 had been using the wheelchair up until the time she went to the hospital, and no one had reported the broken brakes to maintenance. Tr. 96. In the meantime, the wheelchair was left in her room with no indication that it was broken and no plan for its repair. Tr. 76, 97-98.

DON Aleo maintains that the chair "was on the maintenance schedule to be fixed" at the time of the September survey. P. Ex. 16 at 2, 3 (Aleo Decl. ¶¶ 7, 11). In this regard, I found her testimony singularly unconvincing. She said, "[T]he chair was scheduled to be

[5] In its pre-hearing brief, Petitioner acknowledged that, in September, Surveyor Elkins observed R6's wheelchair in her room and discussed its malfunctioning brakes with various staff. P. Br. at 2-3. It did not suggest that R6 had been given another chair.

fixed that day, to my understanding . . . [f]rom maintenance." Tr. 98. When asked if Maintenance Supervisor Kapp told her that the chair was scheduled to be fixed that day, her response was equivocal: "I believe that's my recollection." Tr. 98. Even though DON Aleo claimed that staff reported such problems, in writing, on a "maintenance log" and on a "communication log," the facility produced no log entries showing that the broken brakes were reported anytime between June and September. Tr. 96, 97, 111-12.

Moreover, Maintenance Supervisor Kapp's testimony totally undermines DON Aleo's claim. His description of events establishes that the broken wheelchair brakes were reported to him *after* Surveyor Elkins discovered them:

> When I was told that a wheelchair needed to be replaced, I was like, all right. So I grab my tools, I went to the chair and noticed the resident wasn't in her room.
>
> And I asked where the resident was. They said that she was over at the hospital. Well, I found out that the chair wasn't, like a quick fix, like I thought it would be, you know, tighten up the brake or something like that.
>
> No, it needed a little bit more. So *I took it back to my office*. I made sure that it had a note on the back of the chair that said what room number it was and, you know, that it needed repair.
>
> That way, so I knew that the chair was for that resident and that it was to be repaired. And I was in the process of working on something else, so since she wasn't using it at that point in time, I didn't repair [it] right then and there.

Tr. 187 (emphasis added). Thus, when he learned that the chair was broken, Maintenance Supervisor Kapp removed the chair from R6's room, which establishes that he first learned about the broken chair *after* Surveyor Elkins found it in the resident's room.

The facility claims to have implemented procedures to ensure that broken wheelchair brakes were promptly identified, reported to maintenance, and repaired. P. Ex. 2 at 46. In fact, as shown by the circumstances surrounding R6's broken brakes, it plainly had no such system in place. It seems that Maintenance Supervisor Kapp, on his own, was attempting to develop a system, which he referred to as an "inventory/log" as a means of identifying the facility's wheelchairs, their location and repair history. But he conceded that the system was "in the process of developing" and was never completed. Tr. 183-85, 189. In any event, he had no authority to enforce such a system. While he encouraged staff to write down their requests for repairs, no facility policy mandated that they do so. It was something that Maintenance Supervisor Kapp "politely tried to have everybody do." Tr. 191.

In this regard I see virtually no evidence of any meaningful management involvement in ensuring that repairs were timely reported and made nor evidence that staff timely learned about malfunctioning equipment. The facility produced no written procedures, but apparently the responsibility for all of this rested with Maintenance Supervisor Kapp. Tr. 110-11. But Maintenance Supervisor Kapp had no assistance. "I was running the whole department, doing it all by myself." Tr. 194. In addition, the majority of wheelchairs in the facility were in need of repair, and Maintenance Supervisor Kapp typically spent two and a half hours per day repairing them. Tr. 168, 178. I have no doubt that Maintenance Supervisor Kapp was a hard-working employee, committed to keeping the facility's equipment in good repair. But the demands placed on him were unreasonable and virtually guaranteed that he would not be able to do all that he was charged with doing.

Thus, the facility did not implement all of the steps it identified as necessary for it to achieve substantial compliance. It did not maintain R6's wheelchair brakes in good working order and had no effective system in place to ensure that all other wheelchairs were kept in good repair. It was therefore not ensuring that each resident's environment remained as free of accident hazards as possible and was not in substantial compliance with 42 C.F.R. § 483.25(h).[6]

B. The penalties imposed are reasonable.

To determine whether a CMP is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating factor. The factors in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the

[6] Because I find that the facility's deficiencies regarding identification and repair of wheelchair brakes put it out of substantial compliance with 42 C.F.R. § 483.25(h) and justify the penalties imposed following the September survey, I need not address the deficiencies cited with respect to staff's placement of the Marissa sling. *See Senior Rehab & Skilled Nursing. Ctr.*, DAB No. 2300 at 6, n.5 (2010), *aff'd, Senior Rehab Skilled Nursing. Ctr.v. HHS*, No. 10-60241 (2011).

kind of deficiencies found, and in light of the section 488.438(f) factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848, at 21 (2002); *Comty Nursing Home*, DAB No. 1807, at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800, at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638, at 8 (1999).

CMS imposed a CMP of $1,000 per day, which it reduced to $150 per day following the September survey. One thousand dollars is at the lower end of the applicable penalty range and $150 is at the very low end of that range ($50 to $3,000). 42 C.F.R. §§ 488.408(d)(1)(iii); 488.438(a)(1)(ii).

CMS does not argue that the facility's history justifies a higher CMP. Petitioner has not claimed that its financial condition affects its ability to pay the penalty.

With respect to the other factors, it is important to remember that the $1,000 per day CMP was based on the findings of the June survey. The sheer number of deficiencies cited then justifies a significant penalty. Even after the immediate jeopardy was removed, its deficiencies caused actual harm to facility residents. Among other problems, the facility failed to assist residents who needed help with meals and did not provide essential dental services. P. E. 2 at 28-30, 35, 37-38. It failed to arrange ophthalmology services to multiple residents with failing eyesight, including one who suffered from glaucoma. P. Ex. 2 at 35-39. The facility was not properly heated, with temperatures as low as 60 degrees in one of the resident's rooms and 65 degrees in the dining room. P. Ex. 2 at 40. Surveyors observed an electric curling iron plugged-in and unattended. P. Ex. 2 at 45-47. The facility had an excessively-high medication error rate (16.7%). P. Ex. 2 at 50. In addition to wheelchair brakes, other necessary repairs had not been made (which is not surprising considering that one unassisted individual was responsible for repairs): torn and missing window screens, broken ice makers, broken bench, a water valve in need of repair, and dangerous holes in the residents' garden. P. Ex. 2 at 63-64. These significant deficiencies more than justify the relatively low $1,000 per day penalty.

Following the September survey, CMS determined that most of these deficiencies had been corrected and reduced the penalty to the low amount of $150 per day. Inasmuch as the remaining deficiency was serious, threatening resident health and safety, I find the amount reasonable.

IV. Conclusion

For the reasons discussed above, I find that the facility did not return to substantial compliance until November 24, 2010. I affirm as reasonable the penalties imposed – $1,000 per day from June 19 through September 29, 2010 and $150 per day from September 30 through November 23, 2010.

/s/
Carolyn Cozad Hughes
Administrative Law Judge