Department of Health and Human Services

**DEPARTMENTAL APPEALS BOARD**

Civil Remedies Division

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| In the Case of: | ) | |
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| Britthaven of Chapel Hill, (CCN: 34-5334) | ) | Date: April 24, 2009 |
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| Petitioner, | ) | |
| | ) | |
| - v. - | ) | Docket No. C-08-327 |
| | ) | Decision No. CR1942 |
| Centers for Medicare & Medicaid Services. | ) | |
| | ) | |

## DECISION

Petitioner, Britthaven of Chapel Hill (Petitioner or facility), is a long term care facility located in Chapel Hill, North Carolina, that participates in the Medicare program. One of its residents ended up in the hospital with unexplained fractures of both knees. During its investigation of the injuries, the facility learned that, two weeks earlier, a nurse aide ignored instructions that the resident be transferred only by means of a Viking Lift. Instead, he lifted her manually which, in the views of the facility investigators, likely caused her injuries.

The facility reported the injuries to the North Carolina Department of Health and Human Services (State Agency), and, following a complaint investigation and surveys completed October 19 and November 29, 2007, the Centers for Medicare & Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare requirements, and that its deficiencies posed immediate jeopardy to resident health and safety. Petitioner here challenges those determinations.

I conclude that, from September 30, 2007, through January 1, 2008, the facility was not in substantial compliance with Medicare requirements governing quality of care (42 C.F.R. § 483.25) and accident prevention (42 C.F.R. § 483.25(h)), and that, from September 30 through November 28, 2007, its deficiencies posed immediate jeopardy to resident health and safety. I also affirm as reasonable the civil money penalties (CMPs) imposed: $3550 per day for the 60-day period of immediate jeopardy ($213,000), and

$100 per day for the 34-day period of substantial noncompliance that was not immediate jeopardy ($3400).

## 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, section 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, section 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, section 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a), 499.308.

Here, following surveys completed October 19 and November 29, 2007, CMS determined that the facility was not in substantial compliance with Medicare participation requirements, specifically, 42 C.F.R. § 483.25 (Tag F309 – quality of care) and 42 C.F.R. § 483.25(h) (Tag F323 – accident prevention). CMS also determined that the facility's deficiencies posed immediate jeopardy to resident health and safety. CMS subsequently determined that the immediate jeopardy abated effective November 29, 2007, and that the facility returned to substantial compliance on January 2, 2008. CMS Exs. 1, 2.

CMS has imposed against the facility a CMP of $3550 per day for the period of immediate jeopardy (60 days X $3550 = $213,000) and $100 per day for the period of substantial noncompliance that was not immediate jeopardy (34 days X $100 = $3400).

The parties agree that this matter may be decided based on the written record, without an in-person hearing. Waiver of Oral Hearing (October 10, 2008); P. Cl. Br. at 2. I have admitted into evidence CMS Exhibits (Exs.) 1-19, Petitioner's Exhibits (P. Exs.) 1-11, P. Ex. 12, pages 64-71, and P. Exs. 14-16. CMS objected to the relevance of P. Ex. 13, the conclusions of the state's informal dispute resolution (IDR) panel, and to portions of P. Ex. 12, materials from the IDR proceedings. Petitioner conceded that, since my review is *de novo*, P. Ex. 13 would be irrelevant, and the parties agreed on which portion of P. Ex. 12 would be admitted. *See*, Pre-hearing Conference Order (October 1, 2008); 42 C.F.R. § 498.50(b) (parties have 10 days to file objections to the pre-hearing order).

Nevertheless, in its subsequent submissions, Petitioner appears to have changed its position. Without citing to any portion of the excluded documents, Petitioner argues that the IDR determination "is the final decision in this case." P. Reply at 5; s*ee*, Discussion, below.

The parties have filed initial briefs (CMS Br.; P. Br.),[1] closing briefs (CMS Cl. Br.; P. Cl. Br.),[2] and reply briefs (CMS Reply; P. Reply).[3]

## II. Issues

The issues before me are:

- Whether, from September 30, 2007, through January 1, 2008, the facility was in substantial compliance with Medicare participation requirements, specifically 42 C.F.R. § 483.25 and 42 C.F.R. § 483.25(h);

- If the facility was not in substantial compliance from September 30 through November 28, 2007, did its deficiencies then pose immediate jeopardy to resident health and safety?

and

- If Petitioner was not in substantial compliance, were the penalties imposed − $3550 per day for the period of immediate jeopardy and $100 per day for the period of substantial noncompliance that was not immediate jeopardy – reasonable?

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[1] The parties titled these initial briefs "CMS's Prehearing Brief" (submitted July 14, 2008), and "Petitioner's Prehearing Brief" (submitted August 13, 2008).

[2] The parties titled these closing briefs "CMS's Brief in Support of CMS' Enforcement Action" (submitted November 21, 2008) and "Petitioner's Opening Brief" (submitted November 21, 2008).

[3] The parties titled these reply briefs "CMS's Reply Brief in Support of Enforcement Action" (submitted December 19, 2008) and "Petitioner's Response Brief" (submitted December 19, 2008).

## III. Discussion

### *A. The facility was not in substantial compliance with 42 C.F.R. §§ 483.25 and 483.25(h) because staff did not follow the resident care plan instructions for transfers, did not timely report an inappropriate transfer, did not adequately address Resident 12's (R12) increased pain, bruising, and abnormal blood test results, and delayed investigation of those changes in R12's condition.*

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 resident's comprehensive assessment and plan of care. Act, section 1819(b); 42 C.F.R. § 483.25. The regulation also requires that the facility "take reasonable steps to ensure that a resident receives the supervision and assistance devices designed to meet his assessed needs and to mitigate foreseeable risks of harm from accidents." *Guardian Health Care Center*, DAB No. 1943, at 18 (2004) (*citing* 42 C.F.R. § 483.25(h)(2)). The facility must anticipate what accidents might befall a resident and take steps to prevent them.

> A facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods must constitute an "adequate" level of supervision under all the circumstances.

*Windsor Health Care Center*, DAB No. 1902, at 5 (2003).

The deficiencies cited in this case center around R12.[4] At the time of the surveys, R12 was a 95-year-old woman suffering from alzheimers dementia, osteoarthritis, osteoporosis of the spine, and scoliosis. She had histories of compression fractures of her thoracic spine, and fractures of her right hip and upper left arm. CMS Ex. 4, at 1, 2; P. Ex. 10, at 1, 2. Because she was not ambulatory and had fallen in the past, she was identified as at risk for falls. To prevent falls, her care plan called for use of a Viking Lift for transfers. CMS Ex. 4, at 172, 178, 188, 192; P. Ex. 10 at 13, 19.[5] A "resident care guide" for R12 directed staff to transfer her by means of a Viking mechanical lift. P. Ex. 12, at 64.

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[4] R12 is referred to as Resident 15 in the October 19 survey documents.

[5] R12's care plan also called for use of the Viking Lift as an approach for preventing skin breakdown. CMS Ex. 4, at 170-171, 176; P. Ex. 10, at 11, 17-18.

Notwithstanding these straight forward instructions, on September 30, 2007, Certified Nurse Aide (CNA) Mack Jones manually lifted R12 from her chair, "picked her up under her arms and legs," and put her into bed. During the transfer, R12 screamed and scratched him. CNA Jones reported the scratches to an unidentified nurse, but he apparently did not report the inappropriate transfer. P. Ex. 11, at 11, 16, 17, 20, 29. In any event, facility managers did not learn about the incident until two weeks later, when they investigated R12's fractures of unknown origin.

When facility management eventually learned about the inappropriate transfer, its investigators concluded that the September 30 incident resulted in significant injuries to the resident – bilateral knee fractures – which went undetected and untreated for two weeks. P. Ex. 11, at 10-11, 32-33. Petitioner now challenges its own investigators' conclusions and claims that the improper transfer did not cause R12 any actual harm.

Whether the improper transfer caused R12's fractures may be debatable, but compelling evidence establishes that, at a minimum, CNA Jones' actions caused the resident significant bruising and increased pain.

First, much evidence supports CMS's position that, prior to the September 30 incident, pain was not a significant problem for R12. Two isolated entries describe aggressive or angry behavior ─ a note dated September 21, 2007, and a September 27, 2007 entry (inexplicably separate from the nurses' and all other notes) indicating that R12 had a skin tear on her right forearm, that she has intermittently refused to eat, and that she became angry, and would grab and bite when agitated. But no one suggested that pain underlay these behaviors. She was not assessed for pain; no pain medications were ordered or administered. Instead, she was prescribed the anti-anxiety medication, Ativan, as needed. CMS Ex. 4, at 46, 49.

Further, R12's medical records consistently indicate that, notwithstanding her longstanding diagnoses of osteoporosis and osteoarthritis, she was not in any significant pain prior to the September 30 incident:

- Her most recent assessments (February 2007, May 2007, August 2007) indicate no pain. CMS Ex. 4, at 209, 215, 220; P. Ex. 10, at 6.

- Her care plan does not identify pain as a problem. *See*, CMS Ex. 4, at 169-200.

- Her medication orders for September 2007 do not include medications for pain; she was not even administered any Tylenol until October 1, and an order for Roxanol (morphine) "for pain" was not added until October 13. CMS Ex. 4, at 87-91, 92, 93.

- A physician's progress note, dated January 8, 2007, says "no complaints of pain," (CMS Ex. 4, at 18) and nothing in subsequent notes, dated January 17, April 17, April 20, and June 18, 2007, suggests that R12 was experiencing any pain. CMS Ex. 4, at 19-22.

- Until October, the nurses' notes do not mention any complaints of pain. In fact, the opposite is true. To the extent that the notes say anything about the issue, they repeatedly report that R12 displays no signs or symptoms of pain, discomfort, or distress. *See*, *e.g*. CMS Ex. 4, at 39, 40, 41, 44, 45 (nursing notes dated January 16, February 2, February 19, March 8, March 15, April 22, May 6, May 10, May 11, May 12, May 13, August 3, August 4, August 23, August 29, and August 30, 2007).

Immediately following the September 30 incident, however, R12's increased pain is well documented. CNA J. Alston regularly cared for R12 during the night shift. *See*, CMS Ex. 4, at 237-246. CNA Alston later told facility investigators that, when she worked the 11 p.m. to 7 a.m. shift on the night of September 29, the resident was fine. The following night, however (September 30), the resident cried when she attempted to provide care. CNA Alston notified the charge nurse of the change in the resident's condition. CMS Ex. 12.

Nurses' notes written at 8:55 a.m. on October 1 – the morning after the incident ─ describe R12 as "yelling," with three dark purple bruises on her right arm. CMS Ex. 4, at 46; P. Ex. 10, at 23. Notes written that same day by the physician's assistant (PA) describe skin bruising on R12's upper limb, left face and right neck, "etiology unknown." The PA ordered a complete blood count and liver function test, apparently to see if a hematological problem explained the bruising. The note also refers to a need for pain management, which the PA attributes to osteoarthritis. CMS Ex. 4, at 23; P. Ex. 10, at 26; *see*, CMS Ex. 18, at 10 (Levy Decl. ¶ 46). At 7:00 p.m., nearly 24 hours after she began showing symptoms of pain, staff administered Tylenol, and, on October 2, Tylenol "as needed for pain" was added to R12's standing drug orders. CMS Ex. 4, at 92, 93.

Nurses' notes from the early morning hours of October 2 again describe R12's yelling, and say that the yelling increases when the resident is turned in bed. CMS Ex. 4, at 47; P. Ex. 10, at 24. She was given Tylenol for pain. CMS Ex. 4, at 47. Later in the day, her physician ordered a Duragesic Transdermal patch for pain.[6] CMS Ex. 4, at 47. Licensed Practical Nurse (LPN) Denise Bass confirmed to the facility investigators that, on

[6] A Duragesic patch slowly delivers, through the skin, the opiod pain medication fentanyl. The patch is effective for up to three days (72 hours). CMS Ex. 18, at 7-8 (Levy Decl. ¶ 35).

October 2, R12 was in a great deal of pain. The PA evaluated her, and ordered a Duragesic patch "which was effective." CMS Ex. 13, at 1; P. Ex. 11, at 14.

A note dated October 2, 2007, says that a nurse "evaluated" R12 for pain in her legs, although the note records only temperature, pulse and respiration, providing no information about any pain assessment. The note indicates that the physician was not notified about R12's complaints of pain. CMS Ex. 4, at 6. On the same day, a nurse told R12's daughter about R12's "interaction [with] CNA on 9/30/07." Presumably, the note means that staff told her about R12's scratching CNA Jones, but not CNA Jones' mishandling of the resident (which apparently had not been reported at this point). According to the note, R12's daughter opined that her mother's recent agitation could have been a response to pain from her history of osteoporosis. Of course, when she expressed this opinion, R12's daughter did not know that her mother had been mishandled. CMS Ex. 4, at 49.

Staff drew R12's blood on October 2, and the testing lab delivered the results on the following day. R12's previously normal hemoglobin and hematocrit levels were low, at 9.2 (normal range is 11.5-15.0) and 27.7 (normal range is 34.0-44.0) respectively. CMS Ex. 4, at 13; *see also*, CMS Ex. 4, at 10.[7] CMS's witness, Roger N. Levy, M.D., is a Board-Certified orthopedic surgeon who is a Professor of Orthopedics at Mount Sinai School of Medicine and Chief of Arthritis Surgery at Mount Sinai Hospital in New York. CMS Ex. 18, at 1 (Levy Decl. ¶¶ 2, 3, 4); CMS Ex. 19, at 2. Dr. Levy points out that these blood levels are consistent with acute blood loss; femur fractures can cause acute blood loss. But nothing suggests that anyone followed up on this lab report or otherwise used it to assess "what was going on with Resident 12." *See*, CMS Ex. 18, at 10 (Levy Decl. ¶¶ 46, 47).

Nurses notes dated October 4 again describe R12 as "screaming while changing position." She was "medicated for pain," apparently given Tylenol 650 mg. (in addition to the Duragesic patch), which her medication administration record (MAR) indicates was "ineffective." CMS Ex. 4, at 33, 47-48, 94; P. Ex. 10, at 24. LPN Bass later told facility investigators that, at this time, R12 had bruises on both arms. CMS Ex. 13, at 1; P. Ex. 11, at 14.

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[7] Hemoglobin is the protein molecule in red blood cells. A low hemoglobin level (anemia) may be caused by blood loss (e.g., from traumatic injury, bleeding colon, or stomach ulcer), nutritional deficiency, suppression by drugs, or certain illnesses. Hematocrit measures how much space in the blood is occupied by red blood cells. Low hematocrit levels may indicate, (among other conditions) excessive bleeding, liver disease, or cancerous bone marrow. *Dorland's Medical Dictionary*, 804 (27th ed. 1988).

Remarkably, aside from a short note dated October 11, the nurses' notes skip from October 4 to October 13. However, during that time, R12's Duragesic patch was in place, and was replaced every three days (October 2, October 5, October 8, and October 11). In addition, staff administered Tylenol 650 mg. on October 5 and October 11. CMS Ex. 4, at 93-94.[8]

The 11:00 a.m. October 11 nurses' note describes the resident as "quiet," says that she refused her morning medications, ate half of her breakfast and was out of bed in a gerichair. CMS Ex. 4, at 48. However, LPN Bass later told the facility investigators that, on October 11, R12 had dark bruising on both legs. CMS Ex. 13, at 1-2; P. Ex. 11, at 14-15.

CNA Wilhelmina Thompson told the facility investigators that, when she went in to help R12 with her morning care on October 13, she noticed bruises on her legs and swelling around her knees. She asked the charge nurse, Sheila Paul, about it, who said that she was aware of the problems and suggested they were caused by arthritis. Nurse Paul also described R12 as "very combative with swinging and kicking." P. Ex. 11, at 25, 26. The nurses notes for October 13, 2007 describe R12 as "crying at times" and complaining of pain while changing positions. The nurse also "noticed both knees swollen," and notified the PA, who ordered bilateral knee x-rays and bilateral venous doplar studies. CMS Ex. 4, at 7, 48; *see also*, CMS Ex. 4, at 24. X-rays taken that day showed acute fractures of both knees. CMS Ex. 4, at 3, 4, 5.

At her daughter's request, R12 was sent to the emergency room for evaluation and treatment. CMS Ex. 4, at 48. Emergency Department notes describe her level of pain as "severe . . . worsened by movement" and "not relieved by anything." CMS Ex. 5, at 16. She was admitted to the hospital. Blood levels were taken, and her hemoglobin level was down to 8.3; her hematocrit level was 26. Hospital staff administered two pints of blood and those blood levels increased to normal, where they remained. Her physicians opined "an acute rather than chronic blood loss." CMS Ex. 5, at 11-12.

R12's fractures were treated conservatively with bilateral immobilizing braces, to be worn full time; her pain was treated aggressively. CMS Ex. 5, at 12-13.

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[8] Inasmuch as the facility produced virtually *no* nursing notes during this period, I find disingenuous, the statement from Bronda Burton Walker, R.N., Director of Regulatory Affairs and Policy Implementation for the facility's corporate offices, that "[n]ursing notes for October 5, 2007 through October 12, 2007 do not indicate that the Resident demonstrated any signs or symptoms indicative of fractures of the knees." P. Ex. 14, at 3 (Walker Decl. ¶ 10).

Regarding the cause of her injuries, the hospital discharge summary notes that: "Per daughter, she has had bilateral leg pain for several weeks [without] definitive [diagnosis]. She had been treated as agitated . . . . Family is uncertain how [fractures] occurred, there is concern for her having been dropped." CMS Ex. 5, at 11. The summary also mentions her history of osteoporosis, and suggests that it "may have contributed." CMS Ex. 5, at 12. She was discharged to a different facility on October 17.

Following R12's hospitalization, the facility reported her injuries to the State Agency. Facility administrator David Krizmanich also reported that he, the facility's director of nursing (DON), Pam Bondan, and the facility's Quality Assurance Nurse, Pam Caswell, conducted an investigation, which they completed October 18 (CMS Ex. 6, at 3) or October 19 (CMS Ex. 6, at 5). Allegation reports, dated October 18 and 19, 2007, signed by Administrator Krizmanich, say that the resident "was transferred from chair to bed using inappropriate technique resulting in injuries to the resident. Resident has bilateral knee fractures." Administrator Krizmanich also reported that CNA Jones was disciplined. He and other nursing assistants were retrained on transfers during an inservice training. CMS Ex. 6, at 2, 3; P. Ex. 11, at 32-33; *see also*, P. Ex. 11, at 10-11. In a puzzling inconsistency, Administrator Krizmanich writes that "resident was sent to hospital for immediate treatment." CMS Ex. 6, at 5. But he identifies the time of the incident as 8:00 p.m. on September 30. CMS Ex. 6, at 2, 4. R12 was sent to the hospital (at her daughter's insistence) on October 14. CMS Ex. 5.

Without regard to whether R12 sustained her fractures on September 30, these largely undisputed facts establish that the facility was not in substantial compliance with the Medicare requirements governing quality of care and prevention of accidents. The facility understood that safely transferring R12 required an assistive device – the Viking mechanical lift ─ and it planned accordingly. Staff unfortunately did not follow the care plan's instructions, which put the resident at risk of injury.[9] The CNA then failed to report his error, and any investigation of the incident was delayed by two weeks. Failure to report and investigate an incident shows that the facility is not taking reasonable steps to mitigate foreseeable risks of harm from accidents. Moreover, a facility's failure to document, report, or investigate an incident undercuts reliance on facility records as proof that such incidents have not recurred. *Century Care of Crystal Coast*, DAB No. 2076 (2007), ***aff'd, Century Care of Crystal Coast v. Leavitt***, No. 07-1491 (4th Cir., May 13, 2008).

In the meantime, as of October 1 (and likely the night of September 30), R12 showed new symptoms: increasing pain, particularly when she was turned in bed, and bruising on her upper arm, face, and neck. But the facility made virtually no effort to investigate the causes of these symptoms. R12's PA appropriately ordered a blood test, but then no

[9] I discuss below how such disregard of R12's care plan was "likely to cause" serious injury.

one followed up on the abnormal results. Finally, the facility was slow in addressing R12's symptoms of significant pain, waiting to administer any pain relief until almost a full day after the onset of symptoms.

The facility thus did not insure that R12 received necessary care and services to allow her to maintain her highest practicable physical, mental, and psychosocial well-being in accordance with her assessment and plan of care. Nor did it take reasonable steps to ensure that she received supervision and assistance devices designed to meet her assessed needs and to mitigate foreseeable risks of harm from accidents. The facility was therefore not in substantial compliance with 42 C.F.R. §§ 483.25 and 483.25(h)(2).

### *B. CMS's finding of immediate jeopardy is not clearly erroneous.*

I next consider whether CMS's immediate jeopardy finding is "clearly erroneous." Immediate jeopardy exists if the facility's noncompliance has caused or is likely to cause "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance ─ which includes an immediate jeopardy finding ─ must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c).

First, Petitioner makes much of the fact that, following the October complaint investigation, the State Agency characterized the scope and severity of the facility's deficiencies at level G (an isolated instance of actual harm), but, based on essentially the same findings, the State Agency subsequently changed its mind and recommended an immediate jeopardy finding. CMS then adopted the immediate jeopardy finding. In this *de novo* review, I am not so much concerned with the means by which CMS reached its determination as with whether that determination is in accordance with the Act and regulations. So long as the immediate jeopardy finding is not clearly erroneous, I must uphold it, without regard to the federal/state deliberations that led to that ultimate determination. *See* discussion *infra* ¶ D, (CMS findings of noncompliance take precedence.)

Next, Petitioner misapprehends the standard of review for an immediate jeopardy finding. Relying on the Administrative Law Judge (ALJ) decision in *Daughters of Miriam*, DAB CR1357 (2005), Petitioner argues that CMS failed to meet its burden of coming forward with evidence sufficient to establish that the facility's noncompliance posed immediate jeopardy to resident health and safety. P. Cl. Br. at 12-13. In fact, the Departmental Appeals Board reversed the ALJ decision in *Daughters of Miriam*, DAB No. 2067 (2007). The Board noted that the language of the regulation – CMS's determination as to the level of noncompliance must be upheld unless it is "clearly erroneous" – requires that the ALJ and the Board presume that CMS's determination is correct unless the facility demonstrates that the determination is clearly erroneous. To hold otherwise "would effectively eviscerate the review limitation in [42 C.F.R. §] 489.60(c)(2)." *Daughters of*

*Miriam*, DAB No. 2067, at 7; *see also Liberty Commons Nursing and Rehab Center – Johnston*, DAB No. 2031 (2006), *aff'd*, *Liberty Commons Nursing and Rehab Center – Johnston*, No. 07-1329, 2008 WL 2787675 (4th Cir. July 18, 2008). The facility is thus charged with rebutting the presumption "with evidence and argument showing that the harm or threatened harm did not meet any reasonable definition of 'serious.'" *Daughters of Miriam*, DAB No. 2067, at 9.

The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy. Determinations of immediate jeopardy are sustained if CMS presents evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1962, at 11 (2005) (*quoting Florence Park Care Center*, DAB No. 1931, at 27-28 (2004)); *Koester Pavilion*, DAB No. 1750 (2000).

Applying this wrong standard, Petitioner argues that "no conclusive proof" establishes that the inappropriate transfer of September 30 caused R12 any injury. P. Cl. Br. at 4; s*ee also* P. Ex. 14, at 3 (Walker Decl. ¶ 9) ("Review of documentation in the clinical record of [R12] and review of current literature indicates that the date, time, or cause of [R12's] fractures cannot be determined with concise certainty.") But if Petitioner is correct, it has only itself to blame. The difficulties determining the cause of R12's injuries are directly attributable to facility failures to report and investigate timely the September 30 incident. It should hardly benefit from its own failure to act appropriately.

Moreover, the reliable evidence and medical opinion suggest that it is more likely than not that CNA Jones' mishandling of the resident caused her injuries. Petitioner offers no actual medical evidence or opinion to show otherwise, but instead refers generally to the conclusions made by the State IDR panel, that the bruising process and absence of new bone growth suggested a more recent injury. P. Reply at 9-10. Petitioner also refers to "new onset of symptoms of pain on October 13, 2007," along with "the first indications of physical trauma, swollen knee and bruising as described on October 11, 2007." P. Reply at 10. But these claims ignore the significant evidence of pain and trauma described immediately after the September 30 incident, and discussed above.

CMS, on the other hand, points to the conclusions drawn by the facility's own investigators, none of whom offered any testimony retracting their conclusions. CMS also observes that R12's injuries undeniably occurred while the resident was under the facility's care, and that the facility has offered no other explanation for them. Dr. Levy observes that the fractures occurred at the same time, and that R12 would not have sustained them spontaneously, by moving around in her sleep, or through agitation.[10]

[10] Although referred to generally as knee fractures, Dr. Levy more precisely pinpoints the breaks as "bilateral distal ⅓ femur fractures." CMS Ex. 18, at 1 (Levy Decl. ¶ 6); *see also*, CMS Ex. 4, at 3, 4, 5 ("fracture involving right supracondylar femur").

CMS Ex. 18, at 1 (Levy Decl. ¶¶ 6, 7, 8, 9). He opines that, given her age, medical condition, poor bone quality, and the location of her fractures, "it would be unusual to see evidence of early bone healing response on an x-ray exam two weeks after her fractures occurred." CMS Ex. 18, at 3 (Levy Decl. ¶17). Further, when bones are fractured and internal bleeding occurs, it takes time for the blood to work its way to the surface, where it would look like bruising. "The fact that the staff first observed "bruising" on [R12]'s legs as late as October 13th is [in Dr. Levy's view] consistent with fractures which occurred two weeks prior." CMS Ex. 18, at 3 (Levy Decl. ¶ 16).

But I need not even resolve this issue in order to sustain the immediate jeopardy finding. Dr. Levy explains how manual transfer might have caused R12's fractures: CNA Jones might have placed his hands on her lower legs, and applied a straightening force to her contracted knees that would have been transmitted to her distal femurs; she might have slipped while in his arms, and, as her body weight dropped toward the bed, she acutely flexed her knees, with leverage force applied to the distal ⅓ of both femurs; she could have fallen or the CNA could have dropped her on her knees. CMS Ex. 18, at 2-3 (Levy Decl. ¶¶ 12, 13, 14).

Thus, Dr. Levy credibly explains the dangers inherent in attempting to transfer R12 without using the Viking Lift. I need not find that any of these scenarios actually caused R12's fractures, in order to conclude that the CNA's disregard of R12's care plan *was likely* to cause a serious injury. CMS's finding of immediate jeopardy is therefore not "clearly erroneous."

### *C. The penalties imposed are reasonable.*

I next consider whether the CMP is reasonable by applying the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) 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.

In reaching a decision on the reasonableness of the CMP, 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 kind of deficiencies found, and in light of the above 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 Center*, DAB No. 1848, at 21 (2002); *Community 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 has imposed a penalty of $3550 per day for the period of immediate jeopardy, which is at the low end of the penalty range ($3050-$10,000). For the remaining period of substantial noncompliance, CMS imposed a penalty of $100 per day, also at the low end of the penalty range ($50-$3000). 42 C.F.R. § 488.438(a)(1).

CMS does not contend that the facility has a history of noncompliance that justifies a higher CMP. Petitioner has not argued that its financial condition affects its ability to pay the penalty. With respect to the remaining factors, I find that the facility is culpable for its staff member disregarding his obligation to follow the resident's care plan. I also find deeply troubling the long delay in reporting and investigating the September 30 incident, which seriously jeopardized the facility's ability to conduct a meaningful investigation. Further, the facility's failure to follow up on R12's abnormal blood test results shows disregard for resident care, comfort, and safety. These factors alone are sufficient to justify penalties significantly higher than the regulatory minimums.[11]

### *D. Where CMS and the state disagree, CMS's findings of noncompliance take precedence.*

In addition to pursuing this appeal, Petitioner disputed the survey findings by means of the state's IDR process. 42 C.F.R. § 488.331. Apparently, the IDR panel eliminated altogether CMS's determination that the facility was not in substantial compliance with the quality of care regulation (42 C.F.R. § 483.25), and lowered the scope and severity of the accident prevention deficiency (42 C.F.R. § 483.25(h)) from immediate jeopardy to level D (an isolated incident that caused no actual harm with the potential for more than minimal harm). CMS obviously disagreed with the IDR determination, and, in letters dated July 2, 2008, and July 11, 2008, notified Petitioner that it rejected the IDR decision, and the state's revised statement of deficiencies, and determined that both deficiencies were properly cited at the immediate jeopardy level, and "for the sake of clarity" sent the facility an additional copy of the statement of deficiencies upon which CMS based its determination. CMS Ex. 11, 14; see, CMS Ex. 1.

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[11] Petitioner also complains that CMS rejected the State Agency's recommendation to impose a $5000 per instance CMP for each of the deficiencies cited. Again, I do not concern myself with the deliberative process, nor the disagreements between CMS and the State Agency (*see* discussion *infra* ¶ D). Moreover, the facility may not appeal the choice of remedy, including the factors considered by CMS or the State in selecting the remedy. 42 C.F.R. §§ 488.408(g)(2); 498.3(d)(14) (choice of remedy is not an initial determination and therefore not subject to review).

Petitioner now complains that CMS rejected the State Agency recommendations. Citing the ALJ decision in *Ridgely Care & Rehabilitation Center*, DAB CR1258 (2004), Petitioner claims that CMS cannot summarily reject the findings of the IDR panel. But the ALJ in *Ridgely* was reacting to CMS's total silence as to the IDR results. Only the litigation position espoused by counsel in that case suggested any disagreement with the IDR results. CMS presented no statement or other evidence establishing that it rejected the IDR result. Here, in contrast, CMS has twice explicitly rejected the IDR result. I find this more than sufficient to establish CMS's position, and wholly compatible with the *Ridgely Care* reasoning.

Moreover, governing law does not permit the State Agency's finding of compliance to override CMS's finding of noncompliance. As the Board spelled out in *Lake Mary Health Care*:

> Ultimate responsibility for the interpretation and enforcement of federal participation requirements lies with CMS, not with the state surveyors who conduct surveys under an agreement with CMS. Any greater familiarity that [the State Agency] may have with practices in [state] nursing homes cannot override the expertise of federal regulators in the nationally-applicable regulations involved in this matter. Federal law makes clear that, in a situation such as that presented here, CMS's finding of noncompliance and imposition of remedies for a determination of immediate jeopardy not only is legally permissible but must take precedence over the state's position. The statute and regulations contemplate the possibility that state and federal findings and choice of remedies may not always be in accord. Thus, section 1919(h)(6)(B) of the [Social Security] Act provides that, in the case where CMS finds noncompliance (but no immediate jeopardy) but the state makes no finding of noncompliance, CMS may nevertheless "impose any remedies specified in paragraph (3)(C)" which include civil money penalties up to $10,000 per day. [footnote omitted] See also, §§ 1819(h)(2)(A) and 1919(g)(3)(A) of the Act; 42 C.F.R. § 488.452(a)(2) (CMS findings of noncompliance take precedence over state findings of noncompliance); 59 Fed. Reg. 56,116, at 56,129 (November 10, 1994). Where either CMS or the state finds immediate jeopardy, section 1919(h)(5) of the Act provides that the entity finding immediate jeopardy shall notify the other and take "immediate action to remove the jeopardy and correct the deficiencies" by applying the legal remedies available in immediate jeopardy situations.

> We therefore find no merit to [the facility's] arguments that [the State Agency's] findings on noncompliance or scope and severity should have controlled here.

*Lake Mary Health Care*, DAB No. 2081, at 7 (2007).[12]

## IV. Conclusion

For the reasons discussed above, I find that, from September 30, 2007, through January 1, 2008, the facility was not in substantial compliance with Medicare requirements governing quality of care (42 C.F.R. § 483.25) and accident prevention (42 C.F.R. § 483.25(h)), and that, from September 30 through November 28, 2007, its deficiencies posed immediate jeopardy to resident health and safety.

I also affirm as reasonable the CMPs imposed: $3550 per day for the 60-day period of immediate jeopardy ($213,000), and $100 per day for the 34-day period of substantial noncompliance that was not immediate jeopardy ($3400).

/s/
Carolyn Cozad Hughes
Administrative Law Judge

[12] I note also that, to reach its conclusion, the IDR panel applied the wrong standard, holding "there was not concrete proof that the resident's bilateral femur fractures of 10/14/07 were the direct result of the deficient practice of 9/30/07." P. Reply at 6; s*ee* discussion, above.