Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Woods Edge Pointe,	)	Date: November 27, 2007
(CCN: 36-6209),	)	
	)	
Petitioner,	)	Docket No. C-03-587
	)	Decision No. CR1699
- v. -	)	
	)	
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

I decide that Woods Edge Pointe (Petitioner or facility) was not in substantial compliance with Medicare participation requirements. Consequently, the Centers for Medicare & Medicaid Services (CMS) had the authority to impose a civil money penalty (CMP) of $250 per day from April 4, 2003 through May 3, 2003, for a total CMP of $7,500 for the 30 days of Petitioner's noncompliance. I also decide that the CMP imposed against Petitioner is reasonable.

I. Applicable law

Petitioner is considered a long-term care facility under the Social Security Act (Act) and regulations promulgated by the Secretary of Health and Human Services (Secretary). The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Act and at 42 C.F.R. Part 483.

Sections 1819 and 1919 of the Act invest the Secretary with authority to impose CMPs against a long-term care facility for failure to comply substantially with federal participation requirements.

Pursuant to the Act, the Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. Part 488 of 42 C.F.R. provides that facilities participating 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. The regulations contain special survey conditions for long-term care facilities. 42 C.F.R. §§ 488.300-488.335. The regulations at 42 C.F.R. Part 488 give CMS a number of different remedies that can be imposed if a facility is not in compliance with Medicare requirements.

The regulations specify that a CMP which is imposed against a facility can be either a per day CMP for each day the facility is not in substantial compliance, or a per instance CMP for each instance that a facility is not in substantial compliance. 42 C.F.R. § 488.430(a). A per day CMP imposed against a provider will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The lower range of CMPs, from $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(2). The upper range of CMPs, from $3,050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a provider's residents, and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1), 483.438(d)(2).

The regulations define "substantial compliance" as "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Act and regulations make a hearing before an administrative law judge (ALJ) available to a long-term health care facility against whom CMS has determined to impose a CMP. Act, section 1128A(c)(2); 42 C.F.R. §§ 488.408(g), 498.3(b)(12), (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).

When a penalty is imposed and appealed, CMS must make a *prima facie* case that the facility has failed to comply substantially with federal participation requirements. To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd*, *Hillman Rehabilitation Center v. U. S. Dept. of Health and Human Services, Health Care Financing Administration*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004). Under *Hillman* and *Batavia*, CMS bears the burden of coming forward with evidence sufficient to establish a *prima facie* case that Petitioner failed to comply with participation requirements. Once

CMS has established a *prima facie* case of noncompliance, Petitioner has the ultimate burden of persuasion, and, to prevail, Petitioner must prove by a preponderance of the evidence that it was in substantial compliance with each participation requirement at issue. *Hillman*, DAB No. 1611, at 3-8.

II. Background

Petitioner is a long-term care facility located in Cincinnati, Ohio. Petitioner is authorized to participate in the federal Medicare program as a skilled nursing facility (SNF) and in the Ohio State Medicaid program as a nursing facility (NF). A standard survey was completed by the Ohio Department of Health (state agency) on April 4, 2003. As a result of the survey, Petitioner was found not to be in substantial compliance with federal requirements for nursing homes participating in the Medicare and Medicaid programs. CMS Exhibit (Ex.) 1, at 1. Specifically, Petitioner was found not to be in substantial compliance with 17 participation requirements, the most serious deficiencies cited were at F Tags 223 (Abuse) and 309 (Quality of Care) at Level G. *Id.*; CMS Ex. 5; CMS Post-Hearing Brief at 1. CMS concurred with the state agency recommendations and, on June 2, 2003, notified Petitioner that CMS was imposing mandatory denial of payment for all new admissions (DPNA) effective July 4, 2003, and was imposing a per day CMP in the amount of $250 for each day of noncompliance, totalling $7,500. CMS Ex. 1, at 1. Petitioner was found to be in substantial compliance effective May 4, 2003.

On July 23, 2003, Petitioner timely submitted a request for hearing to challenge CMS's determination. The case was assigned to me for a hearing and decision.

A hearing was held before me on August 12-13, 2005 in Cincinnati, Ohio. Geoffrey E. Webster, Esq. appeared on behalf of Petitioner, and Marian C. Nealon, Esq. appeared on behalf of CMS. The proceedings are recorded in a transcript (Tr.) with pages numbered 1 through 540. CMS Exs. 1-40 were offered and admitted into evidence. Tr. at 9. P. Exs. 1-11 were offered and admitted into evidence. *Id.* Debbie Truett, R.N., team leader of the April 4th survey team (Tr. at 24-167); Tracy Cooley, R.N., a state surveyor (Tr. at 168-226); and Debra Bricker, R.N., a state surveyor (Tr. at 228-333), testified for CMS. Susie Squires, the facility's Activity Director (Tr. at 334-358); Courtney Siebering, L.P.N., the facility's MDS restorative nurse as of October 2001 (Tr. at 359-387); Debra Fiehrer, R.N., the facility's clinical advisor (Tr. at 389-438); Josh Abner, a treatment/ancillary nurse at the facility (Tr. at 440-474); Kristina Conroy, a charge nurse at the facility during the survey period (Tr. at 475-494); and Carol Bottinari Turni, the facility's Administrator in training (AIT) during the survey period (Tr. at 495-532); testified on behalf of Petitioner. Josh Abner was recalled by CMS as a rebuttal witness (Tr. at 533-534). The parties submitted post hearing briefs (CMS Br. and P. Br., respectively) and CMS submitted a reply brief (CMS Reply).

III. Issues

The issues in this case are:

1. Whether Petitioner was in substantial compliance with Medicare participation requirements at the time of the April 4, 2003 survey; and

2. Whether the CMP imposed is reasonable if Petitioner is found not to be in substantial compliance.

IV. Findings of fact and conclusions of law

The findings of fact and conclusions of law, identified here, are discussed in detail in section V below, the Discussion section.

1. There is no statutory or regulatory mandate which requires an ALJ to enter a decision as to each deficiency cited against Petitioner. Section A of Discussion below.

2. Petitioner was not in substantial compliance with Medicare participation requirements at the time of the April 4, 2003 survey. Section B of Discussion below.

3. Petitioner's challenge to the *Hillman* standard is without merit. Section C of Discussion below.

4. The amount of the CMP imposed by CMS was appropriate and reasonable. Section D of Discussion below.

V. Discussion

A. It is not necessary to address each individual deficiency cited in order to render a decision in this matter.

This matter arose from a survey which was completed on April 4, 2003. The survey at issue cited a total of 17 deficiencies. CMS Ex. 5. In support of my decision, I am not mandated to address each and every deficiency cited. Specifically, the Act and the regulations establish that a facility must meet all of the standards established by both statutory and regulatory provisions. Furthermore, noncompliance with even one participation requirement authorizes the imposition of CMPs by CMS. *See* Act, section 1819(d)(4)(A) ([a] skilled nursing facility must operate and provide services in compliance with all Federal, State, and local laws and regulations . . . and with accepted

professional standards and principles which apply to professionals providing services in such a facility. *Emphasis added.*); 42 C.F.R. § 488.430(a) (CMS . . . may impose a civil money penalty for . . . the number of days a facility is not in substantial compliance with one or more participation requirements . . . .).

This preliminary question has been addressed by an appellate panel of the Departmental Appeals Board (Board). The issue before the Board in *Beechwood Sanitarium*, DAB No. 1824 (2002), questioned whether an ALJ of the Civil Remedies Division (CRD) had the authority to base his decision upon certain deficiencies cited against the petitioner and make no determination as to the deficiencies cited in the survey, but not addressed in the decision. The Board in *Beechwood* concluded that:

> The possibility of reversal of the deficiency findings on review . . . does not persuade us that the ALJ should be required to make more findings than is necessary to support the remedies imposed. The ALJ exercised his judgment and chose to discuss several deficiencies that he determined to be persuasively established, . . .
>
> We conclude that this exercise of judicial economy is within the ALJ's discretion.

Beechwood, DAB No. 1824, at 22.

In addition**,** neither party presented evidence at the hearing which addressed every single deficiency cited. Therefore, in the exercise of judicial discretion, in the Discussion section which follows, I address only those deficiencies argued during the course of the hearing as they pertain to the April 4th survey. As to the remaining deficiencies, I make no determination – favorable or otherwise – as to either party.

B. Petitioner was not in substantial compliance with participation requirements at the time of the April 4, 2003 survey.

Petitioner was cited with 17 deficiencies as the result of the survey conducted on April 4, 2003. This discussion will focus on those deficiencies litigated at hearing which were: Abuse, 42 C.F.R. § 483.13(b) (F Tag 223); Quality of Care, 42 C.F.R. § 483.25 (F Tag 309) and 42 C.F.R. § 483.25(d)(2) (F Tag 316); Resident Assessment, 42 C.F.R. § 483.20(k)(3)(i) (F Tag 281); and Infection Control, 42 C.F.R. § 483.65(a)(1)-(3) (F Tag 441) and 42 C.F.R. § 483.65(b)(3) (F Tag 444).

The April 4, 2003 survey cited Petitioner with a violation of the subsection of the regulations concerning Abuse, 42 C.F.R. § 483.13(b), which requires that:

> The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

CMS Ex. 5, at 1.

In the same survey, Petitioner was also cited with two deficiencies, specifically with violating the subsections of the regulations concerning Quality of Care, 42 C.F.R. §§ 483.25 and 483.25(d)(2), which state:

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
>
> * * * *
>
> (d) *Urinary Incontinence.* Based on the resident's comprehensive assessment, the facility must ensure that –
>
> (2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

CMS Ex. 5, at 21, 28.

Additionally, Petitioner was cited with a deficiency for violating the subsection of the regulations concerning Resident Assessment, 42 C.F.R. § 483.20(k)(3)(i), which states:

> (k) *Comprehensive care plans*.
>
> (3) The services provided or arranged by the facility must –
>
> (i) meet professional standards of quality . . .

CMS Ex. 5, at 16.

Petitioner was also cited with two deficiencies, specifically for violating the subsections of the regulations concerning Infection Control, 42 C.F.R. §§ 483.65(a)(1)-(3) and (b)(3), which state:

> (a) *Infection control program.* The facility must establish an infection control program under which it –
>
> (1) Investigates, controls, and prevents infections in the facility;
>
> (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
>
> (3) Maintains a record of incidents and corrective actions related to infections.

42 C.F.R. § 483.65(a)(1)-(3); CMS Ex. 5, at 43.

* * * *

> (b) *Preventing spread of infection.*
>
> (3) The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

42 C.F.R. § 483.65(b)(3); CMS Ex. 5, at 45.

1. F Tag 223[1]

In the April 2003 Statement of Deficiencies (SOD), the surveyor alleged that Petitioner:

[1] Although six examples were cited on the SOD under F Tag 223, CMS withdrew example number 2 at the hearing in that the resident/example requested that her identity not be disclosed. CMS Br. at 10 n.7; *citing* Tr. at 14.

> . . . failed to prevent verbal and physical abuse which resulted in harm to two (#23, #71) residents and affected at least five other residents in the facility (#44, #65, #67, and two residents who chose to remain anonymous). Six staff members (#3, #8, #36, #37, #84, and #87) were determined to be verbally or physically abusive to residents . . .

CMS Ex. 5, at 1.

Specifically, the SOD cited six examples whereby Petitioner was in violation of this regulatory requirement, with scope and severity at a "G" level.

CMS alleges that Petitioner failed to take adequate measures to sufficiently supervise its employees and protect the residents from staffing abuse. CMS Br. at 5. CMS cites five of the six examples of noncompliance to support this tag. *Id.* at 5-13.

a. Resident (R) 23

The first instance cited relates to the abusive treatment sustained by R23 from one of the facility's Certified Nurse Assistant (CNA) Mary Allen. CNA Allen is also alleged to have failed to provide the necessary care to the resident. Upon review of the facility's records, and interviews with R23 as well as facility staff, the surveyor found that:

- The CNA was verbally abusive to R23;
- The CNA refused to provide R23 with the necessary care;
- R23 reported one particular incident to facility administration on December 13, 2002; and
- facility administration was aware of the abuse inflicted against the resident.

CMS Ex. 5, at 2-3; CMS Ex. 13, at 5-7.

R23 was diagnosed with congestive heart failure, insulin-dependent diabetes mellitus, hypertension, chronic obstructive pulmonary disease, renal failure and depression. CMS Ex. 13, at 1, 4; CMS Br. at 5. The resident was assessed as being totally dependent on staff for all care, including bed mobility, toileting, and personal hygiene. CMS Ex. 5, at 1-2; CMS Ex. 13, at 3; Tr. at 32; CMS Br. at 5. R23 used a urinal for bladder continence, but frequently missed or spilled the urinal which caused wet linen under his buttocks. *Id.* At the time of the survey, R23 was being treated for open sores on his buttocks. CMS Ex. 5, at 2; Tr. at 32-33; CMS Br. at 5-6. R23 was assessed as being alert and oriented and generally had a good memory and recall. Tr. at 30.

On December 13, 2002, an Abuse or Neglect of Residents Report was filed relating to a complaint by R23 to facility administration. CMS Ex. 13, at 5-7. The report indicated that CNA Allen:

> . . . was nasty to him. She cussed him, saying that 'I am not going to answer your call light again' . . . 'And I am not going to empty your urinal, you piss all over yourself anyhow.'

CMS Ex. 13, at 5-6. In addition, the report confirmed the resident's feelings of fear of CNA Allen and stated that:

> 'he did not want her as his CNA again because he felt she was mean and scared of her.'

Id. at 7. CNA Allen was subsequently interviewed by facility administration and stated that she would never treat a resident in the manner alleged, and that the resident "must be confused." *Id.* As a result of the complaint, CNA Allen was suspended for three days and removed from R23's unit. CMS Ex. 13, at 7. The report stated that the CNA would be "re-educated" with regard to resident's rights and appropriate resident treatment, and a final written warning would be given as a disciplinary measure. The report concluded by stating that any further problems with regard to CNA Allen's inappropriate treatment of residents would result in her termination. *Id.*

At the time of the survey, Debbie Truett, a state surveyor, had several interviews with R23, who advised her that CNA Allen was always mean to him and every time she would enter his room she would curse him. CMS Ex. 13, at 13. R23 further informed Surveyor Truett that he was refused care and that, in one instance, he had gone through an entire night shift without receiving any care. *Id.* at 12.

The allegations were investigated by the facility, and interviews conducted with R23 and CNA Allen. CMS Ex. 13, at 5; Tr. at 35-38. AIT Carol Bottinari Turni conducted the investigation and wrote the report. Tr. at 514. The report noted that, although abuse was suspected by the administration, that fact could not be confirmed. CMS Ex. 13, at 6; Tr. at 41, 416. According to the facility's policy, staff accused of abuse must be terminated if incidents of abuse or neglect can be substantianted. CMS Ex. 26, at 2. As a result of the reporting of the incident, CNA Allen was suspended for a three-day period, moved to a different unit, provided in-service training, and given a final written warning. CMS Ex. 5, at 3; CMS Ex. 13, at 9; Tr. at 40.

CMS contends that this course of action taken by Petitioner was not sufficient to protect residents from abuse and neglect. CMS raises the argument that the facility's abuse policy requires that "offending staff be terminated if abuse or neglect is substantiated." CMS Br. at 6.

In an attempt to counter CMS's position, Petitioner attacked the credibility of R23, the resident who sustained the abuse. At hearing, Petitioner attempted to insinuate that R23 was known to make up stories (Tr. at 399, 480), and that his statements were not reliable (Tr. at 420).

I am not persuaded by Petitioner's arguments. Petitioner does not offer any rebuttal to CMS's *prima facie* case, other than to attack the credibility of R23. If the resident's mental state was so tenuous as to make any statements coming from him unreliable, why did Petitioner discipline CNA Allen at all? Apparently, the facility administration investigating the matter had confidence in the accuracy of R23's statements and took measures against its staff member. Petitioner's own records describe the resident as "alert and oriented without short or long-term memory impairment." CMS Ex. 13, at 7. As CMS notes, if R23 had a pattern of making false representations, it is reasonable to conclude that such information would be documented somewhere within the resident's records. I do not find Petitioner's arguments convincing that it was R23 who was making up stories.

b. R44 and R65

On April 4, 2003, pursuant to surveyor protocol, an interview of a group of residents was conducted by the state surveyor, Tracy Cooley. CMS Ex. 5, at 4; CMS Ex. 10, at 26-27, 32-35; Tr. at 173-174. The purpose of the group interview was to make specific inquiries as to the residents' lives within the facility. Tr. at 173. In accordance with the protocol, potential resident interviewees were selected based on the condition of the residents – primarily, the residents sought were to be "alert, oriented and appropriate." CMS Ex. 5, at 4; Tr. at 174. 11 residents were selected to participate in the interview by Petitioner's own staff. CMS Ex. 10, at 32; Tr. at 174.

During the group meeting, the residents were asked by Surveyor Cooley how they were treated by the facility staff. Tr. at 176. The surveyor was told by R44 of threats and verbal assaults by facility nurses and aides. *Id.* at 177. Specifically, R44 identified CNA Mary Allen as a staff member who cursed her. *Id.* R44 stated that "[w]hat hurts most is the indifference, the ignoring you like you're nothing." CMS Ex. 10, at 26; CMS Ex. 5, at 4; Tr. at 177. According to Surveyor Cooley, facility records showed that CNA Allen had previously been the subject of disciplinary action. Tr. at 178. An abuse report dated December 19, 2002 was filed regarding CNA Allen, which has been previously discussed relative to abuse of R23. CMS Ex. 13, at 5, 7; Tr. at 178.

Surveyor Cooley interviewed R65 during the group meeting. CMS Ex. 5, at 4; CMS Ex. 10, at 26; Tr. at 178. R65 stated that he was told by a male nursing assistant, identified as "Roosevelt" (E84), that "you mess with me, you [expletive], you'll end up in the graveyard." CMS Ex. 10, at 26; CMS Ex. 5, at 4; Tr. at 179. R65 further indicated his desire to leave the facility because of the way staff treated him. Tr. at 179.

CMS asserts that, on discovery of the abusive treatment of the residents by CNAs Allen and E84, measures should have been taken to increase the degree of monitoring and supervision of the CNAs to prevent the potential for future abuse, especially with regard to CNA Allen. CMS Reply at 24.

Petitioner presents neither documentary evidence, nor testimony or defense to contradict CMS's assertions as to these allegations.

c. R67 and R71

After the conclusion of the residents' group meeting, Surveyor Cooley was approached by R67 who requested to meet in private. Tr. at 180. R67 is described as being a "high functioning resident [who] lived on the behavior unit, but who came off the unit to do jobs at the facility in general population." Tr. at 180-181. R67 performed such jobs as cleaning off tables and other housekeeping-type of jobs. *Id.* at 181. R67 was on psychotropic medication, however the medication did not impair his thinking. The resident was depicted as being alert and oriented. *Id.* On April 3, 2003, Surveyor Cooley met with R67 regarding an incident involving R71 and a CNA identified as "Suzie" (Susie Beamon). According to R67, approximately two months prior to the instant interview, R71 and CNA Beamon had a verbal exchange which resulted in CNA Beamon slapping R71 in the face. CMS Ex. 5, at 5; CMS Ex. 10, at 26; Tr. at 181. The incident was witnessed by a second-shift CNA identified as "Charlene." *Id.* Surveyor Cooley verified the statements of R67 by reviewing the abuse report filed in connection with the incident. An abuse report filed relative to the incident indicated it, in fact, occurred on December 10, 2002. CMS Ex. 22, at 1. At that time, R71 (a wheel chair-dependent resident) was asked by CNA Beamon to go into the smoking lounge to smoke his cigarette. R71 became angry at the request, began to verbally assault the CNA, and attempted to bump the CNA with his wheelchair. CMS Ex. 22, at 1-2. R71 was able to get close enough to CNA Beamon to swing at her. CNA Beamon blocked the swing and ultimately hit R71 in the face. *Id.* As a result of CNA Beamon's actions, she was terminated from her position for resident abuse. CMS Ex. 22, at 12; Tr. at 185.

In addition, during the private meeting with Surveyor Cooley, R67 advised of his mistreatment by another CNA identified as "Antonio." Tr. at 185. R67 stated that "Antonio" cursed him and called him by derogatory names. *Id.* R67 said that such base treatment by the facility staff made him feel "depressed, degraded and helpless." *Id.* at 186; CMS Ex. 10, at 27. R67 indicated that the subject of resident abuse by the facility staff was brought up in the monthly counsel meetings, but to no avail. Tr. at 186; CMS Ex. 10, at 27.

CMS argues that Petitioner found merit with the abuse allegations as they related to R67 and R71, in that CNA Beamon's employment at the facility was terminated in response to the allegations. CMS Br. at 12. CMS contends that Petitioner cannot now attempt to disassociate itself from the actions of its employee in the ordinary course of her duties. CMS Reply at 25.

Petitioner asserts that the facility followed all of the procedures and policies established for the investigation of abuse complaints. P. Br. at 39.

d. Unidentified resident

On September 9, 2002, an abuse report was filed which alleged that, on September 3, 2002, a resident reported that CNA Chanel Hines was verbally abusive toward her. CMS Ex. 25, at 1; CMS Ex. 5, at 5-6. The unidentified resident complained that she, and residents in the women's behavior unit, were routinely verbally abused by CNA Hines. CMS Ex. 25, at 1, 3, 4; CMS Ex. 5, at 5-6. The allegations were substantiated by three other residents interviewed by Petitioner's AIT, Carol Bottinari, during an abuse investigation conducted on September 3-5, 2002. CMS Ex. 25, at 3, 5. It was determined that, although no staff personnel were found to support the abuse allegation, it was in the best interest of the residents to remove CNA Hines from the women's behavioral unit, suspend her, and ultimately return her to work in a different unit after completion of one-on-one counseling. CMS Ex. 25, at 7. It was further determined that the CNA did not have an intent to deliberately abuse the residents – that, due to her aggressive and forceful demeanor, some of the residents felt intimidated and apprehensive. CMS Ex. 25, at 7.

CMS contends that intentional infliction of the questioned harm is irrelevant. CMS Br. at 13. According to CMS, what matters is whether CNA Hines wilfully interacted with the residents in a manner that would "reasonably be perceived as offensive." *Id.*, *citing Dawson Manor Nursing Home*, DAB CR1224, at 6 (2004). CMS argues that the facility had reason to believe a problem may have existed with regard to CNA Hines' treatment of the residents. Petitioner did not take reasonable measures to protect the residents from harm. CMS Reply at 26.

Petitioner did not present any evidence to contest the allegations made by CMS. Instead, Petitioner maintains that the resident in this instance "was not identified and was not a resident of the facility at the time of the survey." P. Br. at 5, *citing* Tr. at 53. Aside from drawing attention to this piece of testimony, Petitioner does not address the purpose for or relevance of raising this issue.

I found the evidence and the testimony advanced by CMS to be persuasive. I found the witnesses and testimony presented by CMS at the hearing to be both credible and unbiased. Petitioner failed to present any relevant evidence to disprove the allegations made by CMS.

Petitioner was cited for failing to preserve the residents' right "to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." 42 C.F.R. § 483.13(b) (F Tag 223). The arguments presented by Petitioner more directly address citations that would fall under section 483.13(c), which was not cited in the April 2003 SOD, and is presently not an issue before me. However, in order to address Petitioner's arguments, some attention must be given to the provisions of section 483.13(c). 42 C.F.R. § 483.13(c) (F Tag 225) states that a facility must "develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents . . . ." Petitioner asserts in its Posthearing Brief that it complied with "the sparse regulatory requirements for abuse investigation . . . ." P. Br. at 67 (emphasis added). In support of this assertion, Petitioner relies on the ALJ determination in *Westview Manor*, DAB CR1308 (2005). In *Westview*, the petitioner was cited for allegedly failing to properly investigate a resident's abuse allegation. Upon discovery of the abuse, a facility nurse immediately reported the discovery to the house supervisor, on-call administrator, and the on-call physician, the staff member suspected of being the perpetrator was removed to another wing pending investigation, and, ultimately, that incident was reported to the police and the state agency by the facility administrator. In that case, CMS argued that the facility administrator did nothing more than report the incident to the police and the state agency, and that the actions taken at the time by the petitioner were insufficient to meet the requirements under section 483.13(c). The ALJ determined that the petitioner followed all of the steps in such instances by which ALJs in previous CRD cases have found substantial compliance. Further, the ALJ in *Westview* noted that CMS cited no authority nor presented any evidence to support the petitioner's substantial noncompliance based on some higher standard of care. *Id.* at 12. Clearly the situation in *Westview* is inapposite to the matter presently before me, and Petitioner's reliance on this particular case is misguided. The SOD did not allege that Petitioner failed to formulate and implement in-house policy and procedures relating to the prevention of abuse as required by 483.13(c). Petitioner was cited for failing to prevent verbal and physical abuse to the facility's residents. In determining if a facility is in violation of section 483.13(b), I must examine whether Petitioner deliberately or negligently failed to protect a resident from abuse. *Beverly Health and Rehabilitation*

Center - Williamsburg, DAB No. 1748, at 6 (2000). An instance of abuse "creates a presumption of noncompliance with the requirements . . . which a facility is obliged to rebut." *Oakwood Manor Nursing Center*, DAB CR818 (2001). Further, a facility is deemed to be noncompliant under section 483.13(b) if it knows or should have known of the potential for abusive behavior and does not take reasonably necessary steps to prevent the abuse from happening. *Id.* at 7; *Cedar View Good Samaritan*, DAB CR818, at 24, *aff'd in part*, DAB No. 1897 (2003).

In this case, I find that Petitioner did, in fact, fail to prevent abuse to the residents. The documents and testimony more than substantiate Petitioner's noncompliance. As early as September 2002, Petitioner was on notice of abuse allegations against certain staff members, in particular CNA Hines. Further notice was acquired in December 2002 when additional allegations of abuse surfaced with the occurrence of the incident involving R23 and CNA Allen. It is more than evident that, in each instance cited, the residents involved were abused, either physically or mentally, by the specific facility staff members. I need not find that CMS has proven its case in each instance cited. Previous ALJ and Board decisions have made it clear that even one isolated instance of noncompliance having a potential for more than minimal harm may be the basis for a finding of Petitioner's substantial noncompliance with the applicable participation requirement. *See Ridge Terrace*, DAB No. 1834, at 6 (2002); *Batavia Nursing and Convalescent Center*, DAB No. 1904, at 59 (2004); *Darby Square Nursing Home*, DAB CR979, at 9 (2002). At any time as far back as September 2002, but certainly by December 2002, Petitioner could have taken measures to monitor and more adequately supervise the CNAs' interactions with the residents under their care, in particular CNAs Allen and Hines, in that complaints had been filed against each. However, according to hearing testimony, at no time prior to the April 2003 survey did Petitioner increase supervision of the CNAs, or conduct performance evaluations of the CNAs as a method of monitoring their behavior with the residents. Tr. at 55-56. Under such circumstances, Petitioner cannot remove itself from the actions of its employees. If an employee, while in the pursuit of his/her official duty, is a party to adverse or abusive behavior, a facility cannot disassociate itself from the employee's adverse behavior. Section 1819(h)(2)(B)(ii) of the Act, which gives the Secretary the authority to impose CMPs, incorporates the provisions of section 1128(A)(a) of the Act, which states at subpart (1):

> A principal is liable for penalties . . . for the actions of the principal's agent acting within the scope of the agency.

In each instance of alleged abuse, the CNA involved was acting in the scope of his/her employment by providing care to the residents when the incidents at issue occurred.

Based on the foregoing facts and discussion, I conclude that Petitioner was not in substantial compliance with 42 C.F.R. § 483.13(b) (F Tag 223) with regard to R23, R44, R65, R67, and two unidentified residents, as Petitioner failed to prevent verbal and physical abuse. Petitioner's failure to take measures to prevent such abuse caused actual harm to two of the residents and presented the risk for more than minimal harm to the others.

2. F Tag 281[2]

In the April 2003 SOD, it was alleged that Petitioner failed to:

> . . . ensure residents were provided with services in accordance with professional standards of quality. This affected a total of five residents: one resident during medication administration (#26), one resident (#7) with routine blood sugar checks and insulin administration, and one resident (#23) with physician orders for preventative skin treatment, and one resident with a respiratory therapy treatment (#32), and one resident with gastrostomy feeding tube (#29).

CMS Ex. 5, at 17.

F Tag 281 was also cited at a "G" scope and severity level.

a. R26

R26 had diagnoses of myelodysplasia syndrome, schizophrenia, Parkinson's, senile dementia, anxiety state, anemia, cataracts, depression, epilepsy, diabetes, and glaucoma. CMS Ex. 5, at 17. At approximately 8:05 a.m. on April 2, 2003, R26 was observed during the administration of medication. During preparation of the medication dosages, the CNA used pliers to crush the medication. *Id.* While the CNA crushed the medications in their individual containers, some of the containers spilled onto the

[2] Although five examples were cited under F Tag 281, CMS determined not to discuss the example which relates to R32. However, CMS has indicated that it relies on the evidence in the SOD pertaining to R32 (CMS Ex. 5, at 19-20). *See* CMS Br. at 50 n.30.

medication cart. *Id.* After the CNA completed medication preparation, some pills were observed on the medication cart. *Id.*; Tr. at 99. The resident did not receive the complete dosage of medication ordered by the attending physician in that some of the medication remained on the cart. The CNA did not acknowledge the spilled medication. *Id.*

CMS contends that Petitioner failed to provide services which met a professional standard of quality in that pliers, instead of a pill crusher, were used to mash the resident's medication and, in that some of R26's medication was observed on the medicine cart, Petitioner did not provide the resident with a complete dosage of medication as prescribed by her physician. CMS Br. at 46.

Petitioner does not challenge the use of pliers by the CNA to crush the resident's medication, nor the fact that spilled medications were observed on the medication cart at a time when R26 was being administered her medication. What Petitioner does argue is that the deficiency should not have been cited in that a resident has a right to refuse doses of his/her medication without any harm resulting to the resident. P. Br. at 41, *citing* Tr. at 409. Petitioner asserts that, even though R26 was not harmed, the resident did not receive a complete dose of her medication.

Petitioner's arguments are without merit. First and foremost, Petitioner has not presented any evidence which supports the assertion of the resident's refusal to receive a complete dose of her medication. I agree with CMS's contention that even if a resident has the right to refuse to take all of his/her medication, that refusal does not negate the facility's responsibility to provide the resident with the complete dosage.

Additionally, Petitioner's argument regarding whether there was actual harm to the resident is baseless. In order to find substantial noncompliance with the regulations, CMS need only show that Petitioner's failure to provide R26 with a complete dosage presented the possibility of more than minimal harm. 42 C.F.R. § 488.301. CMS has presented evidence to support this contention. The medications being distributed to R26 during the April survey period were neurontin (an anti-convulsant), and glipizide and metformin (medications for diabetes). Although the lack of a full dosage to the resident, in this instance, did not cause any actual harm to her, there was the definite potential of risk in that the resident could have experienced elevated blood sugar levels or even the onset of diabetic seizures. Tr. at 101-102. At the hearing, Petitioner's witness, former facility treatment nurse Josh Abner, testified that he had no reason to suspect that an occurrence such as failure to provide complete medication dosages was commonplace. Tr. at 443-444. However, there is no evidence in the record to indicate whether or not the CNA had a history of providing incomplete/inaccurate medicine doses to the residents. The Board has previously held that a facility staff's failure to carry out a physician's

order constitutes failure to meet professional standards of care under 42 C.F.R. § 483.20(k)(3)(i). *See Georgian Court Nursing Center*, DAB No. 1866, at 8 (2003); *Emerald Oaks*, DAB No. 1800, at 37 (2001). Therefore, the CNA's failure to follow the physician's order by providing full medication doses to the resident constitutes a *prima facie* showing of a failure to provide services that meet professional standards of quality.

In light of the foregoing, I conclude that Petitioner's failure to provide a full medication dosage, as prescribed by the resident's physician, constitutes a failure to comply substantially with the requirement in section 483.20(k)(3)(i). This failure presented the possibility of more than minimal harm to R26 from her developing medical problems the medication was intended to prevent during the period at issue.

b. R7

R7 was a female resident, in her late 20's, diagnosed with schizo-affective disorder, depressed mood, mild mental retardation, and insulin-dependent diabetes. CMS Ex. 5, at 17; CMS Ex. 8, at 16. R7 attended a daily workshop offsite. CMS Ex. 8, at 16. The resident's care plan, dated December 20, 2002, required that R7 be allowed to administer her own insulin and finger stick blood sugar tests (FSBS), under the supervision of facility staff. CMS Ex. 8, at 16. At 11:40 a.m., on April 1, 2003, R7 was observed during medication rounds. *Id*. At this time, R7 advised the nurse administering meds that she was supposed to initiate her own blood sugar test. CMS Ex. 5, at 18; Tr. at 66. The nurse checked the MAR for April 2003 and told the resident that the test was not scheduled until later in the day. CMS Ex. 5, at 18; Tr. at 67. The MAR did not include the current physician's order dated March 5, 2003, which ordered the FSBS tests before each meal and sliding scale insulin administration after the finger stick. CMS Ex. 5, at 18; CMS Ex. 8, at 15. The surveyor reviewed R7's physician orders and located the March 5th order and brought it to the attention of the CNA. CMS Ex. 5, at 18; Tr. at 77. When the facility nurse administered the FSBS test, it was discovered that R7's blood sugar was elevated and required six units of regular insulin per the sliding scale referenced in the physician's order. CMS Ex. 5, at 18; CMS Ex. 8, at 3; Tr. at 72.

CMS argues that Petitioner failed to provide services that met professional standards of care to R7 when the facility nurse failed to follow the physician's order for an FSBS test to be administered to the resident before each meal. CMS Br. at 48.

Petitioner does not dispute the facts as presented. Instead, Petitioner accuses the surveyor of "inference stacking" with regard to the potential for adverse reaction in the absence of the administration of the proper dosage, and suggests that an adverse reaction would only occur in the event of a continued increase in the resident's blood sugar level. P. Br. at 7.

I am persuaded by CMS's arguments. Petitioner has not successfully demonstrated that it was in compliance with this particular deficiency. At the hearing, Surveyor Truett testified that, without receiving the proper dosage of insulin when there is evidence of an increase in blood sugar, the resident runs the risk of hypo and hyperglycemic reactions. Tr. at 77. Ms. Truett went on to state that the result of elevated blood sugar could be that the resident goes into a diabetic coma. *Id.* at 78. Further demonstration of Petitioner's failure to comply with the regulations in this matter is that, on April 22, 2003, the facility disciplined the nurse for her failure to check for the existence of a current physician's order and not following R7's care plan for self-administration of the FSBS test and insulin. P. Ex. 5, at 2.

c. R23

R23 was diagnosed with congestive heart failure, diabetes, cerebral vascular accident, arthritis, renal failure, and coccyx and buttocks decubiti. CMS Ex. 5, at 19. R23 was assessed as completely dependent on staff for all care, non-ambulatory with frequent bowel incontinence and resistant to care daily. *Id.* The resident was also assessed at risk for pressure sores due to noncompliance with turning schedule and diagnoses. *Id.* On January 3, 2003, a physician ordered the application of a medicated Granuflex spray to both heels in order to prevent skin breakdown. *Id.* This treatment was documented as administered through January 30, 2003. *Id.* After January 30th, there is no record or notation of the Granuflex being administered in accordance with the physician's order. *Id.* On April 2, 2003, a new order for the administration of the Granuflex was issued, to be applied to the resident's bilateral heels twice a day. *Id.* During the survey interview, charge nurse Kristina Conroy confirmed that she was not aware of a physician's order which terminated the application of the Granuflex to the resident's bilateral heels, and that application should not have been terminated without an authorization order from the resident's attending physician. Tr. at 489.

CMS asserts that Petitioner's failure to adhere to the physician's order for the application of the Granuflex to R23's bilateral heels placed the resident at risk of development of pressure sores on the resident's heels. CMS Br. at 50.

Petitioner's single argument is that R23 did not have any pressure areas on his heels, therefore there was no need to follow an order for the application of heel treatment medication. P. Br. at 51-52.

CMS has met its burden of showing Petitioner's substantial noncompliance with participation requirements as to this resident. Petitioner does not present any credible evidence to prove the contrary. At the hearing, Petitioner's own witness, Kristina Conroy, testified that a physician's order is needed to terminate a resident's treatment. Tr. at 488. Ms. Conroy further testified that a verbal order to discontinue may have been

received but not transcribed into the resident's record. *Id.* at 489. CMS makes a valid point when it suggests that even if this was the case, failure to transcribe an oral physician's order in itself constitutes the failure to comply with professional standards of quality. CMS Br. at 50. The Board has previously held that compliance with a physician's order "is a part of meeting professional standards." *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004); *see also*, *Emerald Oaks*, DAB No. 1800, at 37 (2001) ("[t]he professional standard implicated was the basic requirement that nurses must follow physician orders.").

d. R29

Facility clinical records for R29 indicate that the resident was admitted to the facility on October 23, 2002. On admission, R29 was diagnosed with dementia with delusions, glaucoma, dysphagia, hypothyroidism, psychosis, anemia, arteriosclerotic heart disease, arthritis to multiple sites, and a past history of a fracture to the left tibia and fibula. CMS Ex. 5, at 1, 22. R29 was completely dependent on facility staff for daily living activities, had severely impaired cognitive skills for decision-making, and was almost completely unable to understand others. *Id.* at 45, 46. R29 continuously received feeding through a gastrostomy tube. *Id.* at 22, 37. At 2:00 p.m. on March 31, 2003, a CNA was observed disconnecting R29's gastrostomy tubing, which provided the resident liquid nutrition. CMS Ex. 5, at 20. Upon removal, the CNA placed the tubing over the feeding pump beside the resident's bed and proceeded to provide care. *Id.*; CMS Ex. 9, at 30. On April 2, 2003, the CNA was again observed removing R29's gastrostomy tubing prior to providing care. *Id.* When questioned by the surveyor about this process, the CNA stated that she was permitted to disconnect the gastrostomy tubing but not permitted to reconnect it. *Id.* When the CNA's statement was passed on to the facility's management staff, the surveyor was advised that CNAs were not permitted to connect or disconnect gastrostomy tubing. *Id.*

CMS contends that Petitioner failed to meet professional standards of quality when the CNA disconnected R29's gastrostomy tube prior to administering care to the resident. CMS Br. at 50; CMS Reply at 49.

Petitioner reasons that a deficiency should not have been cited in this instance in that it cannot be shown that the resident did, in fact, suffer any harm whether from interruption or termination of the feeding process. P. Br. at 46, *citing* Tr. at 447.

Again, it is not necessary for CMS to show that there was actual harm. CMS need only prove the potential for more than minimal harm. CMS has clearly overcome this hurdle. First and foremost, CNAs are not permitted to connect or disconnect a resident's feeding tube; charge nurses are to be advised by CNAs when a feeding tube needs to be connected or disconnected. P. Ex. 5, at 5. Petitioner conceded that it was improper for the CNA to

disconnect the feeding tube when disciplinary action was taken against the CNA on April 22, 2003. *Id.* In addition, R29 received continuous tube feeding of 48 cc's per hour. CMS Ex. 15, at 22, 37. It is reasonable to conclude that, when the feeding tube was disconnected, the resident's feeding was disrupted, which put the resident at risk of not receiving the required hourly nourishment ordered by the resident's physician.

I am persuaded by CMS's arguments with regard to F Tag 281, and conclude that Petitioner was not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(i) as to Residents 26, 7, 23 and 29.

3. F Tag 309

Also in the April 2003 SOD, it was alleged that Petitioner failed to:

> . . . provide one of 17 sampled residents (#29) appropriate pain management allowing unnecessary and ongoing pain. In addition, two residents (#34 and #7) did not receive the necessary care and treatment in accordance with their assessed needs for oral care and the management of diabetes.

CMS Ex. 5, at 21.

a. R29

When admitted to the facility on October 23, 2002, R29 was diagnosed with, among other things, arthritis to multiple sites, and a past history of a fracture to the left tibia and fibula. CMS Ex. 5, at 22. The resident's Minimum Data Sets (MDS) for November 18, 2002 and February 9, 2003 noted daily moderate joint pain experienced by R29. CMS Ex. 5, at 22; CMS Ex. 9, at 2; Tr. at 235. R29's care plan called for, among other things, administering pain medication as ordered by the physician, monitoring for increased or decreased signs of pain, and contacting the physician as needed with information regarding changes in the resident's condition. CMS Ex. 5, at 22; CMS Ex. 15, at 4; Tr. at 238. According to the physician's orders, the resident was to be given 650 mg. of Tylenol every four hours as needed for pain. CMS Ex. 15, at 30-32; Tr. at 237-238. On the surveyor's review of R29's medication administration record (MAR) for March 30, 2003, it was noted that no pain medication had been administered to the resident for the months of December 2002, and January and February of 2003. Tr. at 238-239; CMS Ex. 15, at 30-32; CMS Ex. 5, at 22. Also during the survey period (on March 31, 2003), a surveyor observed R29 cry out in pain in a couple of instances when facility staff attempted to perform maintenance care. In one instance, a CNA was attempting to apply splints in accordance with the rotating splint schedule in response to the resident's arthritis and chronic contractures of extremities. CMS Ex. 5, at 22; CMS Ex. 9, at 2; Tr.

at 243. During the process, R29 was heard to cry out "I hurt, I hurt." The CNA advised the surveyor that the resident always cried out when care was given or when the splints were applied. CMS Ex. 5, at 22; CMS Ex. 9, at 2; Tr. at 244. The CNA further stated that such outcries subside when the care is completed. *Id.* However, on March 30, 2003, R29 was observed to experience increased "agitation and anxiety," rapid breathing, "ringing" her hands tightly and saying "I hurt, I hurt." Tr. at 243; CMS Ex. 15, at 24. In response to the resident's actions, a nurse administered the ordered Tylenol and contacted the resident's physician. Tr. at 242; CMS Ex. 15, at 25. The nurse was ordered to send the resident to the hospital emergency room. However, 30 minutes after administering the as-needed medication, the resident was seen to be sleeping calmly, and the order to send her to the hospital was rescinded. Tr. at 242; CMS Ex. 15, at 25.

CMS argues that Petitioner's failure to provide R29 with the ordered pain medication prior to the nurse's administration of the Tylenol on March 30th constituted a violation of 42 C.F.R. § 483.25. CMS Br. at 26. CMS further asserts that, since the resident's physician ordered the pain medication to be administered on an "as-needed" basis, the issue becomes not whether the physician's orders were or were not followed; the issue becomes whether the resident needed the medication. *Id*. at 27. CMS indicates that it is not asserting that Petitioner did not properly monitor the resident's pain or investigate alternative treatments for maximum pain relief.

Petitioner, on the other hand, avers that R29's declarations of being in pain were not attributed to actually being in pain, but were related to the resident's behavioral acting out. P. Br. at 47.

Petitioner's assertion is without merit and not substantiated by the record. The record clearly indicates that R29 was in daily pain and that the resident's physician ordered pain medication to be administered as needed for pain by the resident. Petitioner's own records support the existence of the resident's chronic joint and back pain (CMS Ex. 15, at 19), the need for medication was noted in the resident's medical records (CMS Ex. 15, at 23, 47), and ordered by the resident's physician (CMS Ex. 15, at 30, 31). Further, CMS correctly points out that Petitioner's "behavioral" assertion is not supported by its own records – specifically, the facility's weekly chronic mood/behavior summary sheets for the period of December 18, 2002 through April 2, 2003. The summary sheets for this period make no note of any resident "behavior" problems. CMS Ex. 15, at 5-11; Tr. at 252. Petitioner's Pain Assessment/RAP Module also notes that R29 routinely showed signs of pain by moaning and yelling out. CMS Ex. 15, at 19. Furthermore, when the pain medication was actually administered to the resident, clear signs of alleviation of the discomfort were evident. CMS Ex. 15, at 24. Based on the evidence presented, Petitioner's arguments are clearly not supported by the record.

b. R34

R34 was diagnosed with schizophrenia, dementia, major depression, hypertension, arthritis, urinary tract infection, and a history of right hip fracture. CMS Ex. 5, at 24; CMS Ex. 8, at 28. R34 had also been assessed with short and long-term memory impairment, severely impaired decision making ability, and required extensive physical assistance with all activities of daily living including oral care. *Id.* R34's dental comprehensive assessment noted that the resident had missing/lost natural teeth and no dentures. CMS Ex. 5, at 24; CMS Ex. 8, at 28. The resident's care plan for activities of daily living (ADL), dated July 2, 2002, noted that the resident was to receive dental visits pursuant to facility policy, and that R34 should receive assistance from staff every shift with oral hygiene, and as needed. CMS Ex. 8, at 29. An oral assessment completed on September 19, 2002 noted that R34 had broken teeth and would be referred to a dentist per facility policy. CMS Ex. 5, at 24; CMS Ex. 8, at 29. In a nursing note dated February 4, 2003, R34 was noted to have a foul breath odor. Subsequently, a physician's order was obtained for the administering of a medicated mouth swish and rinse. CMS Ex. 8, at 29. On review of the clinical record, there is no indication of follow-up by the nursing staff or referral for dental services. CMS Ex. 5, at 24; CMS Ex. 8, at 28-29. The resident was seen by her attending physician on February 21, 2003, however there is no note in the record as to whether or not an oral exam was conducted. CMS Ex. 5, at 25. The physician did state that the staff did not report any new problems or concerns. *Id.*; Tr. at 59. On March 11, 2003, the resident's diet was revised to a mechanical soft diet to ease chewing. CMS Ex. 5, at 25; CMS Ex. 8, at 28. The dietary note also indicated that R34 had varied acceptance of the change in diet and, in some instances, her intake was poor. *Id.* As of the date of the survey period, there is no clinical notation of an oral examination of R34 or evaluation of the effectiveness of the medicated oral mouth rinse. *Id.*

CMS argues that the nursing staff should have evaluated the effectiveness of the oral rinse being administered to R34 prior to the April survey period and sought to obtain a dental referral or some other alternative treatment from the resident's attending physician. CMS Br. at 33-34. I concur with CMS's assertion.

Petitioner acknowledges that R34 received an oral assessment, following which a dental referral was written on September 19, 2002. P. Br. at 6. Petitioner further acknowledges the fact that the surveyor was unable to find a dental referral for the resident within the records. *Id.* However, Petitioner does not present any argument or evidence to counter the arguments presented by CMS. Instead, Petitioner asserts that the Periodox mouth rinse ordered for administration to the resident is known to stain the teeth of the user and, therefore, the brown substance R34 was seen to spit out after use of the rinse was nothing more than "a natural reaction to the use of Periodox." P. Br. at 47, *citing* Tr. at 448, 449. Petitioner's contentions are unpersuasive as to the question of whether the facility provided R 34 with the necessary oral care and treatment as assessed.

At the hearing, Surveyor Debbie Truett testified that as of April 2, 2003, R34's mouth odor was "very foul," "almost rotten." Tr. at 62. Logic would dictate that, for mouth odor to be that horrendous, it would not develop overnight. The physician's order for the oral mouth rinse was issued on February 5, 2003 and, therefore, should have been administered to the resident for approximately a two-month period. The nursing staff had to be aware, prior to the April 2nd survey, of the ineffectiveness of the oral wash. The matter should have been brought to the attention of the resident's attending physician in order to obtain an order for alternative treatment or a dental referral.

c. R7

During the medication rotation on April 1, 2003, R7 advised the nurse administering medication that she was supposed to initiate her own blood sugar test. CMS Ex. 5, at 18; Tr. at 66. The nurse checked the MAR and told the resident that the test was not scheduled until later in the day. *Id.*; Tr. at 67. At 12:15 p.m., the nurse conducted the blood sugar test, at which time R7 repeatedly informed the nurse that she was allowed to do the test and requested to do it herself. CMS Ex. 5, at 26; Tr. at 67. On review of the resident's physician orders, an order dated March 5, 2003, authorizing the testing of blood sugars before each meal and sliding scale insulin administration afterwards, was discovered. CMS Ex. 5, at 26; CMS Ex. 8, at 15; Tr. at 67-68. However, the order was not recorded on the MAR for April 2003. Tr. at 69. When the order was brought to the attention of the nurse administering the medication, the nurse admitted the error to the resident and prepared to administer the blood sugar test. At that time, R7 told the nurse that she usually tested herself. CMS Ex. 5, at 26; CMS Ex. 8, at 3; Tr. at 71. Without checking the resident's care plan, which stated that the resident was able to self-test for blood sugars and self-administer her own insulin, the nurse refused to allow her to self-test and conducted the test herself. CMS Ex. 5, at 26; CMS Ex. 8, at 16. After completion of the testing process, the nurse determined that insulin needed to be administered to the resident, at which time R7 told the nurse that she is usually allowed to administer the insulin. CMS Ex. 5, at 26; CMS Ex. 8, at 3. The nurse, again, refused R7's request and administered the insulin. *Id.*

CMS contends that Petitioner's failure to comply with R7's care plan violated the regulatory requirement to "provide necessary care and services to attain or maintain the resident's highest practicable mental and psychosocial well-being." CMS Br. at 36. CMS asserts that Petitioner's disregard of R7's care plan to self-administer the blood sugar test and slide scale insulin could jeopardize the resident's mental well-being by diminishing her self-confidence and independence. *Id.* at 35-36.

Petitioner does not dispute the facts as described above. Instead, Petitioner asserts that the surveyor Debbie Truett only witnessed one incident when R7 was not permitted to administer the FSBS or administer her own insulin. P. Br. at 12. Petitioner seems to suggest that the end result, *i.e.*, that the nurse performed the FSBS test and administered the insulin correctly, is all that matters. *Id.*

I am not swayed by Petitioner's arguments. CMS is correct in its reading of the Board's determination in *Ridge Terrace*, DAB No. 1834 (2002). In *Ridge Terrace,* the Board concluded that:

> . . . even one isolated instance of non-compliance having a potential for more than minimal harm may be the basis for a finding that the petitioner is not substantially complying with the applicable participation requirement. See, e.g., Lake City Extended Care Center, DAB No. 1658 (1998).

Ridge Terrace, DAB No. 1834, at 6. Petitioner's contention is not supported by the case law. CMS does not have to prove a pattern of Petitioner's failure to follow R7's care plan. One incident is enough to support the deficiency citation in this instance.

Based on the evidence, I find that Petitioner was not in substantial compliance with the regulation at 42 C.F.R. § 483.25 with respect to R29, R34, and R7, and that Petitioner's noncompliance presented the potential for more than minimal harm.

4. F Tag 316

The April 2003 survey also resulted in Petitioner's citation for its failure to:

> . . . ensure residents who were incontinent of bladder received the toileting and incontinence care to prevent the development of urinary tract infections and restore as much normal bladder function as possible. The citation found that three of 17 sampled residents (#5, #29, and #31) were affected by this cited failure.

CMS Ex. 5, at 29.

a. R5

R5 was diagnosed with, among other things, MELAS syndrome, cardiomyopathy, seizure disorder, deafness, poor vision, dementia, manic depression, and bipolar disorder. CMS Ex. 5, at 29; CMS Ex. 11, at 8. As of December 17, 2002[3], R5 was assessed with short and long-term memory impairment, and severely impaired decision-making ability. R5 required limited physical assistance with transfers and ambulation, extensive physical assistance with toileting and personal hygiene, occasional bladder incontinence, and required a scheduled toileting plan. CMS Ex. 5, at 29; CMS Ex. 11, at 6, 7. R5 was identified, in the comprehensive assessment, as a candidate for bladder retraining. CMS Ex. 5, at 29; CMS Ex. 11, at 3. The resident's care plan provided for toileting every two hours, and checking and providing incontinence care every two hours. *Id.*; CMS Ex. 11, at 3.

Between 2:30 p.m. and 6:00 p.m. on April 1, 2003, R5 was observed by the surveyor being physically restrained in a wheelchair in the television room. CMS Ex. 5, at 29; Tr. at 85. During this period, R5 was not provided toileting or checked for incontinence. CMS Ex. 5, at 29; Tr. at 88. The resident had been given her meal tray, and spoon-fed by a nurse's aide. At approximately 6:00 p.m., the resident was pushed into the hallway outside of her room by a nurse. CMS Ex. 5, at 29-30; Tr. at 87. Subsequently, a nurse's aide returned the resident to the television room and helped her out of the wheelchair. CMS Ex. 5, at 30; Tr. at 87. The nurse aide then proceeded to walk R5 up and down the hall, ultimately returning her to the wheelchair and reaffixing the restraints. *Id.* It was during this time that the surveyor asked the nurse aide when R5 would be checked for incontinence and/or toileted. CMS Ex. 5, at 30; Tr. at 87-88. In response to the surveyor's inquiry, the nurse aide returned the resident to her room and proceeded to check for incontinence and toileting. When the resident's incontinence brief was removed, the brief was urine saturated, had a foul odor, and the urine in the saturated brief was a dark brown color. CMS Ex. 5, at 30; Tr. at 88. Subsequently, R5 was put to toilet for a brief period and then returned to her bed for perineal care. CMS Ex. 5, at 30.

Petitioner does not present any specific argument to dispute the evidence as presented. Instead, Petitioner makes a vain attempt to attack the credibility of CMS's primary witness to these facts - Surveyor Truett. For example, Petitioner asserts that Surveyor Truett testified as to the lack of a standard nursing practice for a toilet in advance of need program (Tr. at 84), and that Ms. Truett also made an inaccurate statement when she testified of having "consistently" observed R5 during the relevant period, which would have been impossible in that she was also observing the medicine administration of

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[3] The SOD incorrectly notes the assessment date as "12/17/**03.**" The correct assessment date is 12/17/02.

another resident. P. Br. at 8. Petitioner's assertions are baseless and the witness' testimony misconstrued. Ms. Truett did not claim that there was no standard nursing practice for a toilet in advance of need program. What she did state was:

> The standard is, it's dependent upon the facility policy, and also it's individualized for each individual. Hers specifically was toileting every two hours and as needed.

Tr. at 84-85.

R5's toileting program was incorporated into her care plan. The Board in *Coquina Center*, DAB No. 1860 (2002), noted that it had previously upheld deficiencies pursuant to 42 C.F.R. § 483.25 grounded on a facility's failure to follow a resident's established care plan, stating:

> [a] care plan is based on a facility's assessment of a resident's needs and represents an interdisciplinary team's best judgment of the services required for the resident, including services required under section 483.25.

Coquina Center, DAB No. 1860, at 21, *citing Cherrywood Nursing and Living Center*, DAB. No 1845, at 8 (2002); *Crestview Parke Care Center*, DAB No. 1836 (2002); *Asbury Center at Johnson City*, DAB No. 1815 (2002). The Board stated that establishing and following a resident's care plan is required by the regulations and, as such, a showing of a facility's failure to follow a particular standard of care is not required.

Likewise, Petitioner's representation of Surveyor Truett's testimony regarding her "consistent" observation of R5 during the relevant period is equally misleading. Petitioner argues that Surveyor Truett could not have consistently observed R5 on April 1st between 2:30 p.m. and 6:00 p.m. if she was also observing the medication administration of another resident. P. Br. at 8-9. When presented with this line of questioning at the hearing, Surveyor Truett initially stated that she did observe the medication administration on April 1, 2003. However, she immediately corrected her statement by indicating that the medication administration occurred on April 2, 2003, not April 1st. Tr. at 95. Ms. Truett's corrected testimony is supported by her surveyor notes (CMS Ex. 8, at 5-6) and the SOD (CMS Ex. 5, at 17).

b. R29

Details of R29's admission diagnosis were discussed above at Discussion B.2.d. R29's MDS, dated February 9, 2003, indicates that she was assessed as being incontinent of bowel and bladder, and dependent on staff to provide all hygienic needs. *Id.* A report in R29's record, dated January 27, 2003, noted an abnormal urinalysis, which is indicative of a urinary tract infection. *Id.*; CMS Ex. 15, at 33.

At 9:00 a.m. on March 31. 2003, a nurse aide was observed while providing perineal care to R29. Before entering the resident's room, the nurse aide failed to wash her hands. Tr. at 255. On entering R29's room, the nurse aide used her ungloved hand to confirm that the resident had urinated and saturated the disposable pad underneath her. CMS Ex. 5, at 30. The nurse aide then put on a pair of latex gloves to commence the care process, but realized she did not have a clean washcloth. She then took off the gloves, left the room without washing her hands, returned to R29's room, put on a new pair of latex gloves, all without washing her hands. CMS Ex. 5, at 31. The nurse aide then proceeded with the resident's incontinence care by commencing to wash the resident's front area. *Id.* The nurse aide took the peri-wash solution and sprayed it directed to the resident's frontal area, contrary to the manufacturer's instructions. Tr. at 256. Instead of spraying the solution on a warm washcloth and cleansing the area, the aide sprayed the solution directly on the resident's genital area and towel-dried the area. *Id.* The nurse aide then placed the soiled towel on the resident's bed and proceeded to cleanse R29's buttocks following the improper procedure previously used. Tr. at 256. The CNA dried the resident's rear section with the soiled towel used to clean the front peri-area. Tr. at 256. Using the same latex gloves, and without washing her hands, the nurse aide opened a jar of peri-ointment and applied it to the resident's perineal area and buttocks. The nurse aide removed the urine-saturated gown from R29 and placed it directly on top of the resident's splints which were on the night stand. CMS Ex. 5, at 31; CMS Ex. 9, at 1; Tr. at 256. The CNA, with the assistance of the charge nurse, pulled the resident up in bed. When she completed her task, the nurse aide removed the soiled gloves and threw them away. CMS Ex. 5, at 31; Tr. at 257. She then placed the soiled towel under her arm while searching for a plastic bag in which to put it. *Id.* The towel was placed in a plastic bag. The nurse aide then picked up the soiled gown with her bare hands and placed it in the plastic bag with the towel. Tr. at 257. The CNA left the room (without washing her hands), and went down the hall to a utility room where she did wash her hands. CMS Ex. 5, at 31; CMS Ex. 9, at 1; Tr. at 257.

CMS contends that R29 was susceptible to contracting urinary tract infections based on her immobility, past history of prior infection, and overall incontinence. CMS further asserts that, based on R29's prior history and potential susceptibility to infections, the nurse aide's failure to follow proper protocol for urinary infection control increased the risk of R29 contracting another urinary tract infection. CMS Br. at 58. CMS avers that R29 did not receive the requisite treatment and services to prevent urinary tract infections, as specified at 42 C.F.R. § 483.25(d)(2). *Id.* at 57-58.

Petitioner does not dispute the facts, nor has Petitioner raised an argument as to whether the actions taken by the nurse aide were appropriate and proper. Instead, Petitioner focuses its attention on the issue of the abnormal January 27, 2003 urinalysis and whether it was indicative of the presence of a urinary tract infection. P. Br. at 22.

I am persuaded by the evidence and testimony presented by CMS. At the hearing, CMS's witness, Surveyor Debra Bricker, credibly testified as to what she witnessed**.** (Tr. at 255-258) as discussed above. Surveyor Bricker further stated that the CNA's improper handling and cleansing of R29 was not appropriate care in which to prevent the risk of future urinary tract infections. *Id.* at 255.

c. R31

R31 was admitted into the facility on June 6, 2001 with a diagnosis which included renal failure, Alzheimer's dementia, osteoporosis, degenerative joint disease, and osteopenia. CMS Ex. 5, at 32. The resident's records also indicate that R31 was treated for a urinary tract infection on January 8, 2003. *Id.* On March 31, 2003, at approximately 1:50 p.m., a CNA was observed providing peri-care to the resident in the unit shower room. CMS Ex. 5, at 32. As the resident was assisted by the charge nurse into a standing position, the CNA (with gloves on) placed a washcloth into a public sink of running water. *Id.* After saturating the washcloth with water, the CNA sprayed the cloth with peri-wash cleaner and, using the same washcloth, proceeded to wash the resident's frontal and buttock areas. The CNA then dried R31 with a towel. *Id.* Still wearing the gloves, the CNA put the soiled linen in a plastic bag and then placed a disposable pad on the resident, ultimately repositioning the resident's clothes. *Id.* In completing R31's incontinence care, still wearing the soiled gloves, the CNA picked up R31's lap cushion, connected it to the resident's chair, then gave the resident her purse. *Id.*

CMS argues that Petitioner's failure to provide R31 with the proper incontinence care and implementation of proper infection control procedures increased the risk of the resident's contraction of another urinary tract infection, particularly in light of a prior history of urinary tract infections. CMS Br. at 58-59.

Petitioner does not address this particular example and has presented no testimony or documentary evidence to prove that it was in substantial compliance in this instance.

Therefore, I find that CMS has sufficiently proven that Petitioner was not in substantial compliance as to F Tag 316.

5. F Tag 441

The April 2003 survey also cited Petitioner for failure to:

> . . . ensure the infection control program was implemented in a manner to control and prevent the potential spread of infections in the facility.

CMS Ex. 5, at 43.

Specifically, the SOD cited two separate instances whereby Petitioner was in violation of this regulatory requirement.

a. R5

The facts relating to this resident and the April 1, 2003 incident were previously discussed as it pertains to F Tag 316. *See* Discussion B.4.a. CMS argues that Petitioner did not utilize an infection control process to prevent the spread of infection as it administered incontinence care to R5. CMS Br. at 78.

Petitioner does not present any evidence or testimony to support that it was in substantial compliance in this instance. Petitioner primarily attacks the testimony of Surveyor Debbie Truett with regard to R5. Petitioner makes a point of noting Ms. Truett's lack of knowledge with regard to the resident's regular pattern for urine elimination, and also argues that R5 was not suffering from a urinary tract infection at the time of the survey. P. Br. at 13.

The evidence and arguments advanced by Petitioner are insufficient to rebut the evidence presented and the testimony elicited by CMS at the hearing. First and foremost, on April 1, 2003, R5 was allowed to sit in a wheelchair watching television for approximately three and one-half hours before the CNA commenced incontinence care. That care was only provided after Surveyor Truett questioned the CNA about incontinent care for R5. Surveyor Truett testified at hearing that she observed the CNA providing incontinence care. She stated that upon removal of the resident's incontinence pad, the pad was saturated, brownish, with a foul odor. Tr. at 89. Surveyor Truett also stated that the CNA placed the resident's soiled materials in the sink and then on the back of the toilet. *Id.* at

92. The CNA was later observed putting fresh washclothes, to be used in cleansing R5, in the sink where the soiled brief had been placed previously and then placed on the resident's night stand. *Id.* When the CNA finished washing R5's legs and perineal areas, the used washclothes were placed back on the night stand. *Id.* Surveyor Truett stated that the CNA's actions would more than likely advance infection, in that any staff member providing services after the CNA would be unaware that the soiled materials had been placed in the sink or on the back of the toilet, and would not know that the instruments should be sanitized first. Ms. Truett testified that there is a likelihood of contamination of other resident materials (such as a toothbrush or a clean washcloth) if and when they would come into contact with the soiled sink or toilet back. *Id.* at 93-94. Surveyor Truett concluded that proper protocol would be for the CNA to place the soiled incontinence brief and washclothes in a plastic bag and deposit them in a dirty linen receptacle. *Id.* at 95.

b. R51

At the time of the April 2003 survey, R51 was in a vegetative state and had a tracheostomy (a surgical opening in the neck through to the trachea usually for the passage of air). CMS Ex. 5, at 44; CMS Ex. 20, at 1; *Merriam-Webster's Collegiate Dictionary* 1249 (10th ed. 1998). The resident's MDS assessment dated February 27, 2003 noted R51's complete incontinence of bladder and bowel, and that the resident was dependent on facility staff for daily living activities. CMS Ex. 5, at 44; CMS Ex. 20, at 3.

At 10:30 a.m., on March 31, 2003, a CNA (Laketa) was observed providing care to R51. R51 had a bowel movement which spilled onto the pillow underneath the resident's legs. CMS Ex. 5, at 44; CMS Ex. 10, at 4. The pillow was visibly soiled with fecal matter. *Id.* The CNA removed the soiled pillow from under the resident's legs and placed it next to R51's head. *Id.* On completion of the cleansing process, the CNA removed her gloves, took hold of the visibly soiled pillow with her bare hands, and proceeded to put the soiled pillow into a clean pillow case. *Id.* The resident was prevented by the surveyor from replacing the soiled pillow under the resident. *Id.*

CMS argues that Petitioner failed to provide care to R51 which would prevent the spread of infection. CMS Br. at 80; CMS Reply at 65. At the hearing, Surveyor Tracy Cooley testified that:

> . . . [the CNA] placed [the pillow] next to the resident's head, which bacteria from the stool could have gotten in her eyes, her nose, her mouth, or the tracheotomy tube, which is a direct pathway to her lungs.

Tr. at 199.

Ms. Cooley further testified:

> She was placing [the pillow] back in a pillowcase and was going to put it back under the resident. Which that stool could have come up through the pillowcase and could have introduced bacteria into the urinary tract, or it could have caused skin irritation, promoting skin breakdown.

Id. at 200.

Ms. Cooley concluded that had the CNA continued to handle the soiled pillow and not wash her hands afterwards, there was a likelihood of spreading contamination throughout the facility. *Id.*

Petitioner did not present any testimony to rebut the statements made by Ms. Cooley. Rather, Petitioner focuses on whether the witness was aware of any spread of infection within the facility, and the fact that R51 has never had a urinary tract infection, neither of which is relevant to the issue at hand. P. Br. at 20.

Petitioner bears the burden of overcoming CMS's proof by a preponderance of the evidence. Petitioner could have called the CNA to give testimony to support the argument that she did, in fact, follow proper infection control protocol, in rebuttal to the testimony given by Ms. Cooley. However, Petitioner chose not to do so. The regulations define "substantial compliance" as a level of compliance with participation requirements such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm. 42 C.F.R. § 488.301. On the other hand, a showing by CMS that the deficiency poses a potential for more than minimal harm, even in the absence of actual harm, is enough to establish noncompliance. Clearly, Petitioner's failure to follow infection control protocol placed R51 at risk for more than minimal harm, and threatened the spread of contamination and infection throughout the facility.

6. F Tag 444

In the April 2003 SOD, the surveyor alleged that Petitioner failed to:

> . . . assure handwashing was done when required during and after perineal care to prevent spread of infection.

CMS Ex. 5, at 45.

The survey report cited two instances whereby Petitioner failed to meet the statutory requirements. The two instances below were also cited as deficiencies under F Tag 316 and the facts were previously discussed in detail relative to that F Tag. *See* Discussion B.4.

a. R29

The facts of this finding are detailed at Discussion B.4.b. The CNA was observed to not wash her hands before beginning perineal care for R29. She then came into contact with the resident's incontinence pad, which was saturated with urine, without the benefit of gloves on her hands. The CNA then put fresh gloves on her unwashed hands, but removed them and exited the room when she discovered the lack of washclothes. When the CNA returned to R29's room, she put gloves on her unwashed hands and proceeded with the resident's peri-area care. CMS Ex. 5, at 45-46. After providing care to R29, and still wearing the soiled gloves, the CNA handled and placed the soiled items in a plastic bag, placed a disposable pad on the resident, replaced the lap cushion, and handed the resident her purse. CMS Ex. 5, at 46.

CMS asserts that the CNA violated the standards of handwashing when she did not wash them prior to beginning care of the resident, as well as when she was contaminated from coming into contact with the resident's soiled waste products, and did not wash her hands when incontinence care was completed. CMS Br. at 82.

Petitioner presents neither evidence nor testimony to refute CMS's assertions. Rather, Petitioner makes an issue of the fact that the surveyors did not question or examine the facility's records with regard to the nosocomial infection rate at the facility. P. Br. at 22 n.13. Petitioner argues that there were no infections present at the time of the survey or at any other time at the facility. *Id.* However, Petitioner presented no evidence to support this contention.

b. R31

The facts of this finding are detailed at Discussion B.4.c. On March 31, 2003, at 1:50 p.m., perineal care was provided to R31 in the unit's shower room, which houses a public toilet and sink. CMS Ex. 5, at 46. During the care process, the CNA cleaned the resident's peri-area and buttocks. *Id.* Without removing the contaminated gloves, the CNA touched the resident's person, her clothing, her lap buddy, and her purse. *Id.*

CMS asserts that the CNA's failure to remove the soiled gloves and wash her hands not only contaminated the resident, but also presented the risk of the spread of infection to other residents who may come in contact with R31 or her contaminated possessions. CMS Br. at 83.

Petitioner offers no evidence to show substantial compliance relative to this instance.

CMS has sufficiently demonstrated that Petitioner failed to meet participation requirements with regard to R31 under F Tag 444. Surveyor Bricker testified at hearing that the CNA violated the regulation with regard to this example in that, when she entered R31's room, she should have washed her hands, which she didn't do. Tr. at 259. Ms. Bricker additionally stated that the CNA put on gloves over her contaminated hands and proceeded to care for the resident. It's a "universal precaution" or standard to wash your hands after entering a resident's room and before leaving it to circumvent the spread of infection. *Id.* at 259-260.

Based on the evidence and testimony presented by CMS, I find that Petitioner was not in substantial compliance with 42 C.F.R. § 483.65(b)(3) and that there was a potential for more than minimal harm as to R29 and R31.

C. Petitioner's challenge to the Hillman burden of proof is without merit.

Petitioner contends that the standard of proof, applicable to all cases presented before this tribunal and as delineated in *Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd*, *Hillman Rehabilitation Center v. U.S. Department of Health and Human Services*, No. 98-3789 (GEB), slip op. At 25 (D.N.J. May 13, 1999) is an "improperly high burden of proof" to be met by Petitioner. P. Br. at 59. Petitioner argues that the *Hillman* standard is the "wrong standard." *Id.* Petitioner further asserts that, as the proponent in this case, the burden is on CMS to make its *prima facie* case by a preponderance of the evidence and that the *Hillman* standard is in direct conflict with section 7(c) of the federal Administrative Procedure Act (APA). *Id.* at 59, 60-61.

I do not have the authority to determine whether the *Hillman* standard is in direct conflict with section 7(c) of the Federal Administrative Procedure Act. It is noted that the issue raised by Petitioner is preserved for appeal to a Court that has the authority to address and decide the matter.

It must be noted in this case that Petitioner admits that CMS produced a *prima facie* case. *See* P. Br. at 65. However, Petitioner contends it produced evidence of an increased quality and quantity as to "bring this matter to equipoise," and in such instances, the trier of fact is bound to rule against the party having the burden of proof, here CMS." *Id.*

As established in a line of Board decisions, CMS bears the initial burden of coming forward with evidence which is sufficient to establish a *prima facie* case for each alleged cited deficiency. In order for a petitioner to prevail, it must prove that it was in substantial compliance with the applicable statutory and regulatory participation requirements. *Emerald Oaks*, DAB No. 1800 (2001); *Cross Creek Health Care Center*,

DAB No. 1665 (1998); *Hillman Rehabilitation Center*, DAB No. 1611. Even the United States Supreme Court has weighed in on the issue of defining "burden of proof." In *Department of Labor v. Maher Terminals, Inc.*, 512 U.S. 267 (1994), the Supreme Court determined that the phrase "burden of proof," when applied in cases subject to the Administrative Procedures Act, means "the burden of persuasion," as opposed to "the burden of production." *Department of Labor v. Maher Terminals, Inc.*, 512 U.S. at 272. The Court went further to conclude that the burden of persuasion is:

> . . . the notion that if the evidence is evenly balanced [in equipoise], the party that bears the burden of persuasion must lose.

Id.

However, in cases where the evidence is not in equipoise, it is settled case law that I need not decide this case (or any case) based on the *Hillman* standard burden of proof. *Fairfax Nursing Home, Inc. v. United States Department of Health and Human Services*, 300 F.3d 835, 840 n.4, *cert. denied*, 537 U.S. 1111 (2003); *Ivy Woods Health Care and Rehabilitation Center*, DAB CR1093 (2003).

As indicated in the above Discussion of each Tag addressed, I have determined that Petitioner did not overcome CMS's *prima facie* case - therefore, obviously, the evidence presented by both sides is not equally balanced, and *Hillman* is not applicable. Therefore, I need not entertain further Petitioner's arguments as they pertain to the standard set forth in *Hillman*.

D. The amount of the CMP imposed by CMS was appropriate and reasonable.

If a facility is found not to be in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies listed at 42 C.F.R. § 488.406, including 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 in not in substantial compliance. 42 C.F.R. § 488.430(a). The low range for a per day CMP is between $50 and $3,000 for non-immediate jeopardy deficiencies. In this case, CMS imposed a $250 per day CMP for 30 days beginning April 4, 2003 through May 3, 2003, which is at the low end of the CMP range. I must consider whether the proposed CMP is reasonable.

In determining whether the amount of the per day CMP is reasonable, the following factors specified at 42 C.F.R. § 488.438(f) must be considered:

> (1) the facility's history of noncompliance, including repeated deficiencies;
> (2) the facility's financial condition;
> (3) the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404; and
> (4) the facility's degree of culpability.

Petitioner has neither argued nor presented any evidence as to the reasonableness of the CMP. As noted, the CMP amount is at the low-end of the range. CMS has put forward sufficient evidence to show a pattern of Petitioner's past noncompliance. In a complaint survey completed on January 7, 2003, Petitioner was cited for an F Tag 324 deficiency at the immediate jeopardy level. CMS Ex. 2, at 1-2. Additionally, as a result of a standard survey completed on February 1, 2002, Petitioner was cited for 11 deficiencies, five of which were also found in the April 2003 survey and are at issue in the case presently before me. *Id.* at 5.

As to the second factor - Petitioner's financial condition - Petitioner has not brought forth any evidence or testimony of its inability to pay the CMP. Therefore, in the absence of any evidence to the contrary submitted by Petitioner, I can only conclude that the amount of the CMP, totalling $7,500, would not cause a substantial financial burden to Petitioner. *Crestview Parke Care Center v. Thompson*, 373 F.3d 743,756 (6th Cir. 2004).

As to the remaining factors, I note that the deficiencies cited were not inconsequential. Eight of the 17 deficiencies cited in the April 2003 SOD were at a "D" scope and severity level (isolated instances of no actual harm, but potential for more than minimal harm not immediate jeopardy); seven deficiencies were "E" level (a pattern of no actual harm with more than minimal harm that is not immediate jeopardy); and two "G" level deficiencies (isolated instance of actual harm that is not immediate jeopardy). SOM § 7400E. Case law has established that, in my discretion, I may find that the two G-level deficiencies alone support the CMP imposed by CMS without considering the other deficiencies cited in this case. *Batavia Nursing and Convalescent Center v. Thompson*, 129 Fed. Appx. 181 (6th Cir. 2005). With regard to F Tag 223, as discussed above, the residents involved were slapped, verbally abused, and threatened with physical violence by various facility CNAs in charge of their care. The actual harm suffered by these residents was both physical and mental/emotional in nature. It is not my intent to minimize the nature and effect of the other deficiencies cited in this case, but the actions relating to the G-level deficiencies are enough for me to find adequate support for the penalty imposed. Ultimately, Petitioner is responsible for the actions of its employees while they are functioning in the scope of their employment. Further, the facility's actions threatened resident comfort, health and safety, for which the facility is culpable. This conclusion, along with the facility's substandard history, justifies the relatively low CMP imposed. I find CMS's determination as to the CMP imposed in this case to be reasonable.

VI. Conclusion

Petitioner was not in substantial compliance with Medicare participation requirements at the time of the April 2003 survey. Therefore, CMS was authorized to impose the CMP against Petitioner. I further find that the CMP imposed was reasonable and in accordance with 42 C.F.R. § 488.438(f).

/s/
Alfonso J. Montano
Administrative Law Judge