Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Ussery Roan Texas State Veterans Home
(CCN: 67-6157),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-09-576

Decision No. CR2251

Date: September 28, 2010

DECISION

In this appeal Petitioner, Ussery Roan Texas State Veterans Home, contests a determination by the Centers for Medicare and Medicaid Services (CMS) that it was not in substantial compliance with the requirements for participation in the Medicare and Medicaid programs. Below, I sustain CMS's determination that Petitioner was not in substantial compliance with participation requirements. I sustain also the remedies imposed by CMS: a civil money penalty (CMP) of $6,050 per day for the period of immediate jeopardy (April 24 through 27, 2009) and a CMP of $600 per day for the period of non-immediate jeopardy (April 28 through May 28, 2009).

I. Background

Petitioner, located in Amarillo, Texas, is authorized to participate in the Medicare program as a skilled nursing facility and in the Texas Medicaid program as a nursing facility. Petitioner was surveyed on April 27, 2009, by the Texas Department of Aging and Disability Services (state agency). Surveyors found Petitioner out of substantial compliance with the following participation requirements: 42 C.F.R. §§ 483.10(f)(2) (F

Tag 166, at a scope and severity (ss) level E[1]); 483.13(c) (F Tags 224/226, ss K); 483.13(c) (F Tag 225, ss K); 483.15(a) (F Tag 241, ss E); 483.20(k)(1) (F Tag 279, ss E); 483.25(h) (F Tag 323, ss K); 483.25(l) (F Tag 329, ss E); 483.25(m)(1) (F Tag 332, ss E); 483.35(i)(2) (F Tag 371, ss F); 483.60(b), (d), (e) (F Tag 431, ss D); 483.65(b)(3) (F Tag 444, ss D); 483.75 (F Tag 490, ss K); 483.75(f) (F Tag 498, ss D); and 483.75(o) (F Tag 520, ss K).[2] By letter dated June 16, 2009, CMS notified Petitioner of the remedies imposed: termination of Petitioner's provider agreement if Petitioner did not achieve substantial compliance by September 5, 2009; a per-day CMP of $6,050 per day for the period of immediate jeopardy from April 24 through 27, 2009 and $600 per day beginning April 28, 2009; and a denial of payment for new admissions (DPNA) effective June 3, 2008. CMS Exhibit (Ex.) 3, at 1-3. Petitioner also lost its authority to conduct a nurse aide training and competency evaluation program (NATCEP).[3] CMS Ex. 3, at 2. By letter dated August 21, 2009, CMS notified Petitioner that it had been found in substantial compliance as of May 29, 2009, that the termination and DPNA remedies had been rescinded, and that the CMP owed for the period of noncompliance totaled $42,800 based on the $6,050 per day CMP for the period of immediate jeopardy and the $600 per day CMP for the period of non-immediate jeopardy noncompliance from April 28 through May 28, 2009. CMS Ex. 3, at 4-5.

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[1] An F Tag designation refers to the part of the State Operations Manual (SOM) that pertains to the specific regulatory provision allegedly violated, as set out in the statement of deficiencies (SOD). CMS and the state agency use scope and severity levels (ss) when selecting remedies. The ss level is designated by an alpha character, A through L, which CMS or the state agency selects from the ss matrix published in the SOM, section 7400E. *See* 42 C.F.R. § 488.408. An ss level of A, B, or C indicates a deficiency that presents no actual harm but has the potential for minimal harm. Facilities with deficiencies of a level no greater than C remain in substantial compliance. An ss level of D, E, or F indicates a deficiency that presents no actual harm but has the potential for more than minimal harm that does not amount to immediate jeopardy. An ss level of G, H, or I indicates a deficiency that involves actual harm that does not amount to immediate jeopardy. SS levels J, K, and L are deficiencies that constitute immediate jeopardy to resident health or safety. This matrix, which is based on 42 C.F.R. § 488.408, specifies which remedies are required and optional at each level based upon the frequency of the deficiency, i.e., whether a deficiency is isolated, part of a pattern, or widespread. 42 C.F.R. § 488.301.

[2] Petitioner was also found out of substantial compliance with a life safety code requirement, 42 C.F.R. § 483.70(a) (K Tag 0066, ss D). I do not consider it here.

[3] Petitioner has challenged imposition of the NATCEP. However, the NATCEP imposed is mandatory both because the CMP imposed and sustained is more than $5,000 and because of a finding of substandard quality of care. Act, sections 1819(f)(2)(B), 1919(f)(2)(B).

Petitioner requested a hearing by letter dated July 6, 2009. I held a hearing in Dallas, Texas, from February 22 through 25, 2010. A 924-page transcript of the hearing (Tr.) was prepared. Testifying at the hearing were: Beverly Briggs, R.N., a surveyor for the state agency (Surveyor Briggs); Jackqualene Kay Smith, R.N., a surveyor for the state agency (Surveyor Smith); Leland G. Persefield, LSW, a department manager and surveyor for the state agency (Surveyor Persefield); Captain Daniel J. McElroy, R.N., a nurse consultant for CMS (Captain McElroy); Diana S. Balzer, R.N., currently Petitioner's Director of Nursing (DON Balzer); Rebecca Orta, R.N., currently Critical Coordinator for MDS for Touchstone Communities, the company that manages Petitioner's facility (RN Orta); and Cheryl Lynn Morgan, R.N., a consultant hired by Petitioner (RN Morgan). I admitted CMS Exs. 1-57[4] and Petitioner's Exhibits (P. Exs.) 1-39. Tr. at 15-16. Both parties submitted briefs (CMS and P. Br.) and response briefs (CMS and P. Response).

II. Issues

The issues before me in this appeal are:

1. Whether Petitioner was in substantial compliance with participation requirements in the Medicare and Medicaid programs; and

2. Whether the remedies imposed as a result of this alleged substantial noncompliance are reasonable.

III. Controlling Statutes and Regulations

Petitioner's participation in Medicare and Medicaid is governed by sections 1819 and 1919 of the Social Security Act (Act) and the regulations at 42 C.F.R. Part 483. Sections 1819 and 1919 of the Act invest the Secretary with authority to impose remedies, including CMPs, against long-term care facilities for failure to comply substantially with participation requirements.

The regulations define the term "substantial compliance" to mean:

> [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.

[4] With its response brief CMS attached a 20-page document regarding prescription information for the drug Spiriva. The document is marked as CMS Ex. 58. While I do not accept this document in evidence, it remains in the record as an attachment to the response brief.

42 C.F.R. § 488.301.

The Secretary has delegated to CMS and the states the authority to impose remedies against long-term care facilities not complying substantially with federal participation requirements. The applicable regulations at 42 C.F.R. Part 488 provide that facilities participating in Medicare and Medicaid may be surveyed on behalf of CMS by state survey agencies in order to ascertain whether the facilities are complying with 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. Under Part 488, a state or CMS may impose a CMP against a long-term care facility if a state survey agency ascertains that the facility is not complying substantially with participation requirements. 42 C.F.R. §§ 488.406, 488.408, and 488.430. The CMP may begin to accrue as early as the date that the facility was first substantially out of compliance, and may continue to accrue until the date the facility achieves substantial compliance, or until CMS terminates the facility's provider agreement. 42 C.F.R. § 488.440.

The regulations specify that if a CMP is imposed against a facility on a per-day basis it must fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, from $3,050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and, in some circumstances, for repeated deficiencies. 42 C.F.R. § 488.438(a)(1)(i), (d)(2). The lower range of CMP, from $50 per day to $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)(1)(ii).

"Immediate jeopardy" is defined as:

> [A] situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

42 C.F.R. § 488.301.

A facility may challenge the scope and severity cited by CMS only if a successful challenge would affect the range of CMP amounts imposed by CMS or would affect the facility's nurse aide training program. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i). CMS's determination as to the scope and severity of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9 (2000), *aff'd, Woodstock Care Center v. U.S. Dept. of Health and Human Services*, 363. F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (Board) has long held that the net effect of these regulations is that a provider has no right to challenge the scope and severity assigned to

a noncompliance finding except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g., Ridge Terrace,* DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Since the scope and severity of Petitioner's alleged noncompliance is cited and sanctioned at a level of immediate jeopardy between April 24 through 27, 2009, the scope and severity of that alleged noncompliance is properly before me.

When a penalty is imposed and appealed, CMS has the burden of coming forward with evidence related to disputed findings that is sufficient, together with undisputed findings and relevant legal authority, to establish a *prima facie* case of noncompliance with a regulatory requirement. If CMS makes this *prima facie* showing, then a petitioner must carry its ultimate burden of persuasion by showing, by a preponderance of the evidence on the record as a whole, that it was in substantial compliance during the relevant period. CMS makes its *prima facie* showing if the evidence it relies on is sufficient to support a decision in its favor absent an effective rebuttal. A petitioner can overcome this by rebutting the evidence upon which that case rests or by proving facts that affirmatively show substantial compliance. An effective rebuttal of CMS's *prima facie* case would mean that the petitioner had shown that the facts on which its case depended (for which it had the burden of proof) were supported by a preponderance of the evidence. *Evergreene Nursing Care Center*, DAB No. 2069, at 7 (2007); *see* P. Response at 1.

IV. Discussion

An administrative law judge has the discretion, as an exercise of judicial economy, to determine whether to address findings that are not material to the outcome of a case. *Grace Healthcare of Benton*, DAB No. 2189, at 5 (2008); *Western Care Management Corp. D/B/A Rehab Specialties*, DAB No. 1921, at 19 (2004). The immediate jeopardy level deficiencies in this case all involve the same set of facts. CMS alleges those facts violate several participation requirements, set out in the Statement of Deficiencies (SOD) dated April 27, 2009, at F Tags 224, 225, 226, 323, 490, and 520. As an exercise of judicial economy, I address only the deficiency at Tag F 323, 42 C.F.R. § 483.25(h). That one deficiency is sufficient for me to decide this case. I would not find differently with regard to the CMP if I addressed the other immediate jeopardy level deficiencies because the CMP imposed is reasonable based on the violation of 42 C.F.R. § 483.25(h) alone. I do not address the non-immediate jeopardy level deficiencies, as I find Petitioner out of compliance with 42 C.F.R. § 483.25(h) for the relevant period.

I make numbered findings of fact and conclusions of law (Findings) to support my decision. I set them forth below as separate headings in bold and italic type and discuss each in detail.

1. Petitioner failed to comply substantially with the participation requirement at 42 C.F.R. § 483.25(h).

42 C.F.R. § 483.25 regards a facility's quality of care. It requires that:

> 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.

The subsection at 42 C.F.R. § 483.25(h) references accidents and requires that:

> (h) *Accidents.* The facility must ensure that –
>
> (1) The resident environment remains as free of accident hazards as is possible; and
>
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

In the case of *Meridian Nursing Center*, DAB No. 2265, at 3 (2009), the Board stated,

> Section 483.25(h)(1) requires that a facility address foreseeable risks of harm from accidents "by identifying and removing hazards, where possible, or where the hazard is unavoidable because of other resident needs, managing the hazard by reducing the risk of accident to the extent possible." Maine Veterans' Home – Scarborough, DAB No. 1975, at 10 (2005). Section 483.25(h)(2) requires that a facility take "all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents." Briarwood Nursing Center, DAB No. 2115, at 11 (2007), citing Woodstock Care Ctr. v. Thompson, DAB No. 1726 (2000) (facility must take "all reasonable precautions against residents' accidents"), aff'd, Woodstock Care Ctr. v. Thompson, 363 F.3rd 583 (6th Cir. 2003).

The Board also relied on the State Operations Manual (SOM)[5] in defining an accident as,

[5] "Although the SOM does not have the force and effect of law, the provisions of the Act and regulations interpreted clearly do have such force and effect. *Northwest Tissue Ctr. v. Shalala*, 1 F.3d 522 (7th Cir. 1993); *Ind. Dep't of Pub Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991). Thus, while the Secretary may not seek to enforce the provisions of the SOM, she may seek to enforce the provisions of the Act or regulations as the SOM interprets." *Woodbine Healthcare and Rehabilitation Center*, DAB CR2140 (2010).

> "an unexpected, unintended event that can cause a resident bodily injury," excluding "adverse outcomes associated as a direct consequence of treatment or care (e.g., drug side effects or reactions.)" SOM Appendix PP, Guidance to Surveyors, Part 2, SOP 483.25 Quality of Care (Rev. 274, June 1995) (SOM Guidance).

Woodstock Care Center, DAB No. 1726, at 4 (2000).[6]

It is undisputed that 120 armed-service veterans and their spouses reside at Petitioner's facility. It is also undisputed that coffee is popular at meals and sipped all day long in the dining room, coffee bars and kitchenettes. It is also undisputed that Petitioner's residents are heavy coffee drinkers. P. Br. at 4. While the case specifically involves four residents who sustained hot coffee burns, the issue is broader than whether four individuals were burned. The issue is whether Petitioner was properly supervising the residents and providing an environment as free of accident hazards as possible.

The relevant SOD from April 27, 2009, asserts that Petitioner contravened this participation requirement as follows:

> Based on observations, interviews and record reviews, it was determined the facility –
> 1) Failed to supervise 4 of 4 residents, who had sustained hot coffee burns, and
> 2) Failed to maintain an accident free environment for the 4 of 4 residents as well as all 89 residents residing in the general population (Halls 400, 500 and 800) who consume hot liquids.
>
> On 9/16/08, Resident #26 received a 2nd degree burn on his thigh.
> On 1/14/09, Resident #27 received a 1st to 2nd degree burn on his abdomen . . . .
> On 3/4/09, Resident #28 sustained a 2nd to 3rd degree burn on her thigh due to hot coffee.
> On 4/5/09, Resident #14 sustained a 2nd degree burn on his abdomen due to hot coffee.

CMS Ex. 5, at 71.

Below is a brief description of the condition of each of the four residents at the time their burns occurred, and of the accidents, based on contemporaneous facility records.

Resident 26: Facility records compiled at the relevant times reflect that Resident 26, a 62-year-old man, was admitted to Petitioner's facility on June 20, 2007, and readmitted

[6] Petitioner submitted a copy of the SOM (Rev. 36, 08-01-08) as P. Ex. 39. When I refer to the SOM in this decision I will refer to P. Ex. 39.

on October 18, 2008. CMS Ex. 18, at 1, 14.[7] Facility records compiled at the relevant time show that Resident 26 had diagnoses including deep vein thrombosis, hypertension, arthritis, dementia other than Alzheimer's disease, paraplegia, Parkinson's disease, depression, emphysema/COPD, glaucoma, allergies, peripheral neuropathy, constipation, hyperlipidemia, and venous insufficiency. *Id.* at 1, 8. In a minimum data set (MDS) for a Medicare five day assessment, dated September 3, 2010, Petitioner assessed Resident 26, among other things, as independent in his daily decision making, without socially inappropriate or disruptive behavioral symptoms, using a wheelchair as his primary means of locomotion, having limited range of motion in his hands and feet, and requiring setup help when eating. *Id.* at 6, 7, 8.

On September 16, 2008, nurse's notes reflect that:

> Resident on call light and c/o of a blister/burn to his [left] thigh. Assessed resident and noted a fluid filled area to his [left] upper thigh 0.5 x 0.5 cm and an open area 1.5 x 1 cm. Asked resident what happened and he stated "I spilled coffee on myself this morning." Area cleaned and Dr. called. N.O. received to apply Silvadene until healed. Called and notified … wife and RN supervisor. Area cleaned and Silvadene applied. Denies any pain or discomfort at this time.

Id. at 45-46.

An accident/incident and investigation report, completed on April 16, 2008 at 19:30, noted that Resident 26 was "eating breakfast this am and spilt coffee on his [left] leg." Resident 26 received a "[b]urn to [left] thigh." The description and location of the incident stated "Res was eating breakfast and spilt coffee on his [L] leg while in bed. Burn noted to [left] thigh." The action taken was "Dr. called and area cleaned and Silvadene applied [with] a [dressing]. The disposition was "[l]inen changed and area to [left] thigh cleaned." The corrective action was "[m]opped up coffee off floor." The final resolution after 24 hours noted "[b]urn to [left] thigh is 6 cm long and 21/2 cm wide. Area cleaned [with] wound cleaner, covered . . . secured [with] . . . tape. Does have redness that measured about an inch around the blister and extends down lateral thigh." P. Ex. 10.

On September 17, 2008, at 9:00 a.m., nurse's notes reflect that:

> Resident does have a large Blister to [left] thigh. It measures 6 cm long and is 21/2 cm wide. (An inch wide.) I cleaned the area [with] wound cleaner and

[7] Where the parties have submitted duplicate copies of exhibits or pages contained in exhibits, I generally refer to CMS's exhibit. I refer to Petitioner's exhibit when I am citing Petitioner's briefing and Petitioner has cited its own exhibit in that briefing.

> covered . . . and secured [with] . . . tape. He has redness around the blister that extends . . . down [left] thigh (outer). No c/o pain/discomfort noted.

CMS Ex. 18, at 47-48. A nurse's note from September 26, 2008 noted that the "[b]urn to [left] thigh looks much better. Is healing, and is open to air at this time." *Id.* at 56.

Resident 27: Resident 27 was an 80-year-old man admitted to Petitioner's facility on December 4, 2008. CMS Ex. 19, at 7-8. His admission information notes that he had diagnoses including dementia with behaviors, pelvic fracture, arrhythmia, depression, GERD and hypercholesterothemia, used a wheelchair and an air mattress, and was an elopement risk. *Id.* at 33. His admission MDS reflects that he had diagnoses of cardiac dysrhythmias, hypertension, dementia other than Alzheimer's disease, anxiety disorder, depression, hyperlipidemia, dementia with "[behavior] dist," and psychosis. *Id.* at 11. Resident 27 also had long and short-term memory problems, moderately impaired decision making skills, and used a wheelchair as his primary means of locomotion. He needed setup help and supervision with eating. He could make himself understood, had clear speech, and was able to understand others. *Id.* at 8-13. A RAP narrative report regarding assessments done on December 17, 2008, reflects that Resident 27 had dementia and was only oriented to self, needed assistance with activities of daily living (ADLs) in order to complete tasks, and took psychotropic medications which increased his risk of unwanted side effects. His poor balance also increased these risks. *Id.* at 18-19.

An accident/incident and investigation report dated January 14, 2009 reflects that Resident 27 "lost handle on coffee cup." He received a "2nd degree burn (blister)." The description of the incident is that "Resident had coffee cup in hand with hot coffee in it when dropped it spilled over abdominal area." The facility "applied cold compress on to abdomen" and assessed the injury with "redness and blistering." His physician ordered silver sulfadiazine cream with a dressing to treat the burn. *Id.* at 5. As a corrective action the facility determined that "Resident is to be given no hot beverages at any time." A follow up observation noted "continued redness & blisters (multiple) to right side of abdomen, sulfa diazine applied and will continue to monitor. *Id.* at 30. A physician progress note dated January 15, 2009 notes that Resident 27 was "[b]urned [with] hot coffee yet otherwise doing ok." *Id.* at 1. A care plan update dated February 2, 2009 noted that Resident 27 was at risk for burns. Approaches to deal with that risk included discussion of the treatment and condition of the wound and that "hot liquid will be cooled with ice, cold H2O, etc. . . . before serving. Nurses were also to "remind [Resident 27] of safety when requesting hot liquids." P. Ex. 26. A care plan conference summary dated March 11, 2009, did not reflect any discussion of Resident 27's burn. CMS Ex. 19, at 34.

Resident 28: Resident 28 was an 83-year-old female admitted to Petitioner's facility on March 18, 2008. Her primary diagnosis was dementia, but other diagnoses included hypertension, peripheral neuropathy, osteoporosis, hypothyroidism, urinary incontinence,

depression, insomnia, CVA, depressive disorder, and conjunctivitis. CMS Ex. 20, at 7, 19. Resident 27's annual MDS notes that Resident 28 had memory problems, moderately impaired cognitive skills, her mental function varied over the day, she had difficulty finding words or finishing thoughts, a wheelchair was her primary means of locomotion, and she had limited range of motion in one arm. *Id.* at 23-33.

Nurse's notes from March 4, 2009 at 3:00 p.m., reflect that:

> Res stated she spilled coffee in her lap yesterday or day before, but didn't think it had burned her but that her leg was now hurting. Upon examination, a 4.0 x 3.0 red area [with] a 2.0 x 1.0 open blister to the middle was found on the left leg, upper thigh. Also a 2.0 x 1.0 blister, intact, to the right upper thigh. Dr. & family notified. Burn to be treated per protocol.

CMS Ex. 20, at 21.

An accident/incident and investigation report dated March 4, 2009 reflects that Resident 28 "spilled hot coffee on [her] lap." *Id.* at 36. The injury was assessed as a "burn [with] blister 4.0 x 3.0 c [with] 2.0 open blist." The spill occurred in the dining room. Nurses assessed and cleaned the wound. Her physician ordered "Clean [with] wound cleaner, Silvidine, cover non-adhesive pad." Resident 27 was left in her wheelchair and "counseled res. to put ice cubes in coffee to cool it down before drinking." *Id.* at 7, 36, A care plan conference summary on March 18, 2009 did not reference the burn. *Id.* at 20.

On March 6, 2009, nurse's notes report "wound looks good." *Id*. A care plan conference on March 18, 2009 did not reflect any discussion of Resident 28's burn. *Id* at 20.

Resident 28's March 24, 2009 MDS stated she had sustained second or third degree burns within the past seven days. *Id. at* 27.

Resident 14: Resident 14 was an 84-year-old man admitted to Petitioner's facility on October 9, 2008. CMS Ex. 17, at 5, 6. Resident 14's quarterly MDS, dated January 20, 2009 recorded that he had diagnoses, among other things, of hypothyroidism, hypertension, peripheral vascular disease, dementia other than Alzheimer's disease, depression, asthma, ingrowing nail, chronic kidney disease, renal artery atherosclerosis, and venous insufficiency. *Id.* at 19. Resident 14 was assessed as having short and long term memory problems, including the inability to recall the current season, location of his room, staff names or faces and the basic fact of his being in a nursing home. *Id.* at 17. He had moderately impaired cognitive skills. *Id*. His mental function varied over the course of the day. *Id.* He sometimes understood others, he usually made himself understood although he had difficulty finding words or finishing thoughts, he had unclear speech, speaking with slurred or mumbled words and he sometimes understood others, responding adequately to simple, direct communication. *Id*. His primary mode of

locomotion was a wheelchair and he could wheel himself. *Id.* at 19. He needed supervision when eating and setup help. *Id.* at 18.

Nurse's notes reflect that on:

> 4/5/09 2300 Burn . . . to abdomen above nipple measuring 6 x 2 inches noted during brief change, resident stated that he spilled coffee on himself today during breakfast . . . wound bed is reddened [with] skin flap folded along the edges, wound secured [with] dressing to prevent resident from rubbing on area.
> 2320 Placed call to Dr. . . ., awaiting call back.
>
> 4/6/09 1100 . . . Resident has a large burn to [lower] mid abdomen just above his naval. The skin on most of the burn has been rolled up but there is still a small blister intact on the left far side. The entire burned area measures 17 cm long x 5 cm wide. [No] depth noted. No redness or irritation to skin surrounding the burn. No infection noted. Spoke with Dr. . . . via telephone and he ordered silvadine ointment to burn bid [with] cleaning area with wound cleaner, pat dry. Apply silvadine bid, cover [with] dry 4 x 4's and secure [with] . . . tape. Will change bid until healed. Resident's sister . . . was notified of the burn. Will cont to monitor condition.
>
> 4/9/09 6P Burn to abdomen . . . naval measures 23 cm x 7 cm. Wound bed is white in color, there is another wound on his [left] thigh measuring 0.5 cm in diameter and a little red with surrounding skin, silvadine cream applied as ordered, covered [with] 4x4 and secured with . . . tape, will continue to monitor. . . .
>
> 4-13 1100 Notified physician on evaluating wound on abdominal area for debridement. . . .
>
> 4/20/09 (2200) Removed dsg from abd. Cleaned area [with] wound cleaner. Applied Silvadene oint/applied 4 x 4's/ secured [with] . . . tape. . . .
>
> 4/21/09 1100= Burn to abdomen measures 14 cm long x 3.3 cm wide with about .1 cm depth. A large amount of the wound bed seen have thick yellow slough present. The edges have beefy red granulation. Tx done as ordered. . . .
> 4/21/09 1400= Spoke to Dr. . . . concerning the burn to residents abdomen. He stated that he looked at it when he was here on the 14th and he will look at it again when he comes out next time (within the next few days). He also said he did not want to debride that at this stage, but to continue the current treatment. The area is looking better than it did. Will cont to monitor.

Id. at 29-30.

A skin condition record dated April 5, 2009 shows that Resident 14 had a burn on his abdomen "above nipple, 6 x 2 inches burn caused by coffee spill this morning. Skin flap folded along edge, wound bed red in color, no drainage noted at this time." On April 13, 2009, the wound still measured 6 x 2 inches, there was a thick yellow exudate and the wound bed was red. On April 20, 2009, the wound still measured 6 x 2 inches with a red wound bed. *Id.* at 35. On April 21, 2009, the wound was measured at 14 x 3.3 cm with a large amount of yellow slough in the wound bed, and pink/red beefy granulation at the wound edges. On April 23, 2009, the wound was still 14 x 3.3 cm., with a depth of .1 cm wide, with yellow slough in the wound bed, with pink at the wound edge. *Id.* at 36.

Physician's telephone orders, dated April 6, 2009, at 11:00 a.m., state "Silver sulfadiazine cream to burn on abdomen with dressing change bid. Clean burn to mid [lower] abd [with] wound cleaner pat dry. Apply silvadine to area and cover [with] dry 4x4s secure [with] . . . tape. [Check] Bid until healed." *Id.* at 26.

Surveyor notes dated April 21, 2009, reflect that the licensed vocational nurse (LVN) caring for Resident 14 stated she thought Resident 14 fell asleep with coffee in his hand. *Id.* at 4.

During the survey Residents 26, 27, 28 and 14 were assessed. Resident 14 was screened for handling hot liquids on April 25, 2009. He understood that he was holding coffee, that he drinks coffee out of a cup, that it's hot and that it could burn him. He was observed to demonstrate that he could bring the cup to his mouth and drink without difficulty. His safety recommendations were to have a hot drink served in a cup with a lid and at a temperature where there is no visible steam. *Id.* at 37. Resident 14's skin was also checked. The burn to his abdomen was noted to be 14 cm long x 3.3 cm wide x .1 cm deep, and there was another area on the top of his left upper thigh (2 cm diameter scabbed) dry. It noted that the physician and family were aware of both areas and no treatment to the area on the top left thigh was ordered. *Id.* at 38. A therapy referral form dated April 24, 2010, notes that Resident 14 "needs to be in dining room for monitoring during meals. Res is able to perform hand-mouth but is weak." *Id.* at 39.

Resident 26 was screened for handling hot liquids on April 25, 2009. He understood that he was holding and could drink from a coffee cup, and that coffee was hot and could burn him. He was able to bring the cup to his mouth to drink. His safety recommendation was to have his hot drink served in a cup with a lid. CMS Ex. 18, at 61. A therapy referral form dated April 24, 2009, indicated that he had the strength to perform hand-mouth but it would be "helpful to eat in dining room for safety." *Id.* at 63. An April 24, 2009 care plan noted he was at risk for burns and that motor weakness and dementia were contributing factors. Hot liquids were to be provided and served by staff in a cup with a lid on a stabilized surface as permitted by the resident. *Id.* at 24. His skin was assessed also on April 24, 2009. *Id.* at 62.

Resident 27's skin was assessed on April 24, 2009. CMS Ex. 19, at 36-37. The burn was noted as "[o]ld burn (pink discoloration 2 cm diameter) [with] a 1 cm Brown scab to the area" on Resident 27's right thigh. It noted that Resident 27's family and physician were aware of the burn, knew the area had healed and no further treatment was necessary. *Id.* at 36. The record does not contain a screen for Resident 27 handling hot liquids.

Resident 28 was screened for handling hot liquids on April 25, 2009. She understood she was holding a coffee cup and drank coffee from it, that coffee is served hot and could burn her. She was able to bring the cup to her mouth to drink. Safety recommendations included having a hot drink served in a cup with a lid and having it served at a temperature without visible steam. CMS Ex. 20, at 38. A therapy referral form dated April 24, 2009, recorded that the resident had "strength for hand-mouth" but that she should eat her meals in the dining room in order to be monitored. *Id.* at 39. Her skin was also assessed on April 24, 2009. *Id.* at 37.

CMS asserts that each of these residents was identified as having dementia and poor mobility and agility. CMS argues that Petitioner failed to identify the residents as at risk for hot liquid burns and, after each incident, failed to assess the resident who was burned for the risk of sustaining burns from handling hot liquids, and failed to care-plan for the resident to prevent future burns resulting from hot liquids. CMS argues that had the facility identified the potential after the first burn sustained by Resident 26, Petitioner could have assessed other residents with dementia and poor mobility in order to protect them from future burns resulting from handling hot liquids. CMS Br. at 11.

CMS notes that the time and temperature gradations for sustaining third degree burns are: 155 degrees Fahrenheit (F) – one second of skin contact; 148 degrees F – two seconds; 140 degrees F – five seconds; and 133 degrees F – 15 seconds. CMS Br. at 12, citing http://www.americanburn.org. A resident spilling hot liquid on their skin at a temperature of 158 degrees F would thus sustain a third degree burn after one second of contact. *Id*. CMS also notes that the Lippincott Manual of Nursing Practice, Sixth Ed., identifies second degree burns as being deeper and, in addition to pain, redness and inflammation, the skin blisters. Third degree burns are deeper still, involving all layers of skin, effectively killing the area of skin that is burned. The damage to blood vessels and skin from a third degree burn appears white, leathery and tends to be relatively painless. Petitioner does not dispute this information. P. Br. at 21-22.

CMS measured coffee temperatures during the survey on April 24, 2010. Referring to surveyor notes compiled by a surveyor, Ms. Edwards, who did not testify, CMS asserts that coffee temperatures during the morning of the survey of April 24, 2009, measured: at 10:00 a.m., at the coffee bar, 162.6 degrees F; at 10:04 a.m., on the 400/500 hall, 130.9 degrees F; at 10:08 a.m., on Hall 800, 158.3 degrees F; and at 10:10 a.m., on Hall 600, 156.6 degrees F. CMS Ex. 13, at 1; *see* CMS Br. at 12. CMS also asserts that Petitioner's dietary manager informed Surveyor Briggs that coffee temperatures had been

lowered to 140 degrees F but, after complaints from residents, they were returned to normal temperatures. Petitioner raised coffee temperatures back up about two weeks prior to Resident 14 being burned. CMS Br. at 12; Tr. at 63-66; CMS Ex. 10, at 4.

CMS refers to Surveyor Briggs' testimony in arguing that Petitioner failed to implement other measures to prevent burns, such as using a "sippy" cup, which she recognized the facility had discussed but dismissed as a "dignity issue." Tr. at 54-55. No other assistive devices were tried to allow residents to have their coffee and still be safe. Tr. at 55. Surveyor Briggs specifically testified that Tag F 323 was cited because the survey team could not find evidence demonstrating that Petitioner had identified an accident hazard, developed a plan to address the hazard, or assessed the residents to determine who might be at risk and what precautions through supervision or assistive devices could be used to prevent future burns. Tr. at 69-70. CMS refers to Surveyor Persefield's testimony with regard to citing Tag F 323,

> . . . with having coffee accessible to the residents at all times, the facility had failed to assess individual residents based on their needs or services that needed to be provided. They failed to document the amount of supervision that residents are provided, and also failed to document the residents' need for assistive devices to prevent accidents from occurring.

Tr. at 273. Surveyor Persefield also testified that Petitioner failed to recognize the pattern of the accidents, investigate the causes of the accidents, and assess residents to discover who might be at risk. Tr. at 273-76. Surveyor Persefield testified,

> . . . in preventing the accidents, there is the failure on the facility's part to assess the actual physical environment, of the location, the accessibility of coffee to everyone, the residents' individual needs, assessing their needs and services; the failure to determine the amount of supervision, and also, any assistive devices that [they] may need to prevent further accidents from occurring.

Tr. at 275.

CMS asserts that when Petitioner finally recognized the risk the approaches it took were "inadequate" or "lacked follow-up for effectiveness." CMS Br. at 14. Surveyor Persefield testified that Petitioner's corrective action plan for Resident 28 was to put ice cubes in her coffee to cool it down before drinking. Tr. at 270; CMS Ex. 20, 36. Surveyor Persefield testified that instructing a resident with dementia to do this would not be appropriate or effective. Further, CMS asserts that there was no indication that Petitioner developed care plans or follow-ups to determine if residents were actually receiving lower temperature coffee or were placing ice cubes in their coffee as Resident 28 was instructed to do. Tr. at 271.

CMS asserts that Captain McElroy testified that anyone carrying a cup of coffee at 180 degrees F is at risk of burning themselves and, because the individuals in question are residents in a nursing facility, the nursing facility has "the responsibility to assess the residents and to fill out plans of care to deal with accident hazards in the environment." Tr. at 380.

CMS argues specifically that Petitioner's staff was unaware for hours or days that these residents had sustained burns requiring treatment. CMS argues that for Resident 14 the burn occurred during breakfast on April 5, 2009, but was not observed until 11:00 p.m. at night. Tr. at 35. Petitioner did not begin treating the burn until the following day when physician orders were obtained. Tr. at 35-37. Resident 28 stated on March 4, 2009, that she had suffered a burn one or two days before, which would have been March 2 or 3, 2009. Tr. at 269; CMS Br. at 11.

In sum, according to CMS, Petitioner's failure to reduce coffee temperatures, to assess residents' needs for supervision when handling hot liquids, and failure to provide an environment free from the potential for hot liquid spills, resulted in the deficiency cited under 42 C.F.R. § 483.25(h).

Petitioner asserts that CMS has not established a *prima facie* case of a deficiency. Petitioner asserts that at issue here is whether the four coffee spills were isolated accidents or were caused by a failure to properly assess residents' ability to handle hot liquids. Petitioner asserts that the spills were typical accidents, "the result of being sloppy, bumping your mug, getting your chair knocked when you are taking a sip, or simply picking up the mug wrong and losing your grip. "CMS's assumptions that the spills were due to the fact that the individuals got around in wheelchairs and had some dementia were, quite simply, wrong." P. Br. at 2. Petitioner asserts that it thoroughly assessed its residents on an ongoing basis and knew their needs well. It provided coffee service with supervision and assistance to allow residents to enjoy coffee as they had done all their lives. It "strove to balance the equally important obligations of making the environment safe and respecting residents' rights to self determination and dignity." P. Br. at 3.

Petitioner asserts that just because it allowed its residents to exercise their right to drink coffee does not indicate a failure to identify four residents as at risk for coffee burns or a failure to implement interventions to reduce the risk of such burns. P. Br. at 8. Petitioner asserts that the special hot liquid safety assessments it performed as a result of the survey findings were not needed because Petitioner's ongoing assessments covered possible cognitive and physical issues that could affect residents' ability to safely handle hot liquids. These assessments included nurses' and CNAs' visual assessments, comprehensive assessments upon admission, quarterly and annually, assessments for changes of condition, functional ability, activity tolerance, falls, skin, diet, mental health, drug side effects, restraints, bowel and bladder needs, and smoking safety. Resident

status was also reviewed in quality of life committee meetings, during shift changes, and in 24-hour reports. P. Br. at 8-9; Tr. at 553-54, 711-13.

Petitioner asserts further that its residents were well supervised in the dining room (capacity 92) by 10 to 13 staff and that the dining room is where most of the coffee was consumed. P. Br. at 8; Tr. at 551, 706-08. Petitioner asserts that residents were provided varying levels of assistance as their conditions changed and that those needing more supervision or assistance dined at tables that could provide that assistance. P. Br. at 8; Tr. at 553-54.

Petitioner also asserts that the condition of the four residents at the time of their spills reflects that it was safe for them to handle coffee as provided to them. P. Br. at 9.[8] Petitioner asserts that Resident 26 moved about in an electric wheelchair without any trouble and that his Parkinson's disease did not cause tremors, only an occasional shaky hand. Petitioner asserts that the spill was not related to his Parkinson's disease and that he had experienced no lessening of his ability to hold a cup. Petitioner argues that Resident 26 had neuropathy in his lower extremities but not in his arms or hands; did not appear shaky at mealtime and ate and drank without assistance; had only short term memory deficits, but was normal in his decision making with no communication deficits or behavioral issues. Petitioner maintains that Resident 26 handled coffee well and had no previous spills. The second degree burn he received on September 16, 2008 covered an area about the size of a deck of cards. Petitioner asserts that Resident 26 experienced no discomfort, as the burn was in the area affected by his paralysis and there was no

[8] Petitioner argues that the surveyors listed a number of potential risk factors shared by the four residents, yet did not investigate to determine if they were factors in the accidents, including checking if there had been previous spills; assessing the residents for the extent of their cognitive difficulties, communication problems or mobility concerns; determining if they appreciated the risk posed by hot coffee; determining whether they could safely handle hot liquids; observing them with a hot liquid; determining whether staff provided assistance with hot liquids; determining the level of supervision; interviewing three of the four residents; failing to ensure they had the right resident; or failing to thoroughly review the residents' charts. P. Br. at 9-10. As noted by CMS, Petitioner mistakenly attempts to shift its burden to the surveyors or CMS. It is Petitioner's responsibility to conduct assessments and investigate its residents' ability to safely handle hot liquids. Surveyors do not need to witness accidents or conduct resident assessments to cite a deficiency. Based on facility records, observations, and interviews, the surveyors here identified that four residents were physically harmed by sustaining burns from a hot liquid, determined that this constituted a pattern, and that the incidents constituted immediate jeopardy to Petitioner's residents. It is Petitioner's burden to rebut CMS's case. Petitioner is in the best position to do so as it created the records that CMS relied upon and it actually cared for the residents.

change in his physical or mental status. P. Br. at 10-11; Tr. at 486-95, 508-10, 701; P. Exs. 10, 29, 30.

Petitioner asserts that Resident 27 did not pour his own coffee because he couldn't reach it in his wheelchair. It was brought to him at the table. He did not have a history of any spills or any spills after January 14, 2009. He fed himself at the time (although he was later moved to a feeding assistance table) and did not have any tremors or disease. Tr. at 520-33, 743. After the spill he was given cooled-down coffee. The directive to cool Resident 27's coffee was communicated at shift change and in the 24-hour report and written up in his next care plan, but implemented immediately. Tr. at 526-33. DON Balzer testified that giving a resident cooled-down coffee is a standard precaution when the facility does not fully understand a resident's status. She testified that hot liquids might be removed for 90 days while the resident was monitored to see if he or she was losing strength in his or her grip or undergoing a change in mental status. Petitioner does not refer to documentation that this is its policy. It only refers to the testimony of DON Balzer and RN Orta.[9] Neither DON Balzer nor RN Orta, or Petitioner, explained why this plan was not considered or followed in the case of the other residents who were burned.

DON Balzer testified that Resident 28 drank coffee served to her at the table and did not have a history of spills. Tr. at 534-41, 646; P. Ex. 27. DON Balzer testified that Resident 28 hit her coffee mug while reaching for something else and spilled coffee on her lap. Tr. at 541; P. Exs. 8, 28. RN Orta testified the incident was witnessed by aides in the dining room. Tr. at 702. DON Balzer believes the spill occurred the same day it was reported to Resident 28's nurse. Tr. at 543; 701; P. Ex. 8, 28. However, there is no documentary evidence that the resident hit her coffee mug while reaching for something else and no documentary evidence as to when the spill occurred.

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[9] Petitioner also attempts to impeach Surveyor Persefield's testimony discussing his observations of Resident 27. Tr. at 307-12, 323, 328-35, 339-40. Petitioner argues that it is not clear that in noting shakiness in the resident's right hand and seeing him spill water it is clear whether Surveyor Persefield was even looking at Resident 27. Petitioner also complains that Surveyor Persefield did not assess the resident. P. Br. at 12. Petitioner also notes that Surveyor Persefield agreed that if the resident passed a hot liquid assessment he should be allowed to have hot coffee. *Id*. However, in reviewing the evidence, I rely on the exhibits in evidence which are principally copies of records prepared by Petitioner's staff in their daily business, not observations of residents made by surveyors made after the spills in question. And, whether or not a resident passed a hot liquid safety screen, or whether or not the screen was done to appease the state agency surveyors, does not alone prove that Petitioner was in compliance with participation requirements. It is up to Petitioner to overcome CMS's *prima facie* case by rebutting CMS's evidence or by affirmatively showing its compliance.

Petitioner asserts that after the spill Resident 28 was served coffee cooled with ice and monitored in the dining room. DON Balzer testified that the increase in monitoring was communicated on the shift report, which is a verbal report, as opposed to the 24-hour report which is written. Tr. at 546; P. Ex. 8. I note, however, that with regard to Petitioner's assertions as to how the coffee was served to Resident 28, Petitioner's Accident Incident and Investigation Report, dated March 4, 2009, clearly notes as a corrective action that it "counseled res. to put ice cubes in coffee to cool it down before drinking." CMS Ex. 20, at 36; P. Ex. 8, at 1. It does not state that it would be providing cooled coffee to her.

Petitioner asserts that Resident 14 did not serve himself coffee, it was brought to him at his table. Tr. at 551; P. Ex. 17.[10] Petitioner asserts that Resident 14 spilled coffee on himself during breakfast on April 5, 2009, when someone bumped his wheelchair. The ADON was present at the time and brought the resident to his nurse. He was taken to his room and assessed. No injury was found, so his clothes were changed and he was wheeled back to the dining room. The second degree burn later developed. He had no other spills before or after the incident. Tr. at 558-60; 694-97; P. Ex. 21. P. Ex. 21 consists of nurse's notes from the relevant time, which contain nothing about Resident 14 being brought back to his room and changed. There is no contemporaneous evidence about how the accident occurred and no eyewitness testimony to the accident was offered.

DON Balzer and RN Orta testified that Petitioner implemented a number of interventions to reduce the risk of burns before the spills occurred. It asserts it utilized: continuing assessment of resident capabilities and needs with corresponding adjustments to changes in resident status; ample supervision in the dining room where most coffee was served; use of sturdy, easy to maneuver, hard plastic coffee mugs with wide bases and large handles; serving coffee for residents who could not reach coffee dispensers or with impairments (wheelchair use); serving coffee when residents were seated and placing the

[10] Petitioner complains that Surveyor Briggs, who was responsible for the findings regarding Resident 14, did not determine whether the resident could safely handle hot coffee, did not see him with hot liquids, and did not know whether supervision was provided to him when served hot liquids. P. Br. at 14-15. Petitioner also asserts that her observations on April 22, 2009, did not refer to Resident 14, but to another resident. Thus, her testimony is not credible. As I stated previously, it is not up to the surveyors to assess specific residents. Once CMS makes its prima facie case, it is up to Petitioner to rebut that case, either by rebutting CMS's evidence or by proving facts which show substantial compliance. Petitioner is in the best position to do this, as it produced the records relied on by CMS and cared for the residents in question. Whether or not the surveyors observed the residents being served or drinking hot liquids, or whether they knew whether the supervision they received included assistance, is only relevant insofar as Petitioner can rebut that evidence with credible contradictory evidence.

mug on a flat surface; limiting access to coffee and serving it to residents on the Alzheimer's unit; providing safety reminders and cues; cooling coffee before serving on an as-needed basis; and not filling mugs more than two-thirds full. P. Br. at 17-18; Tr. at 706-11; 721-22; 513-16. As a testament to its success, Petitioner notes there were no spills on the Alzheimer's unit or with the coffee bars on the units and kitchenette. P. Br. at 18.

Petitioner did recognize in early April that there was a problem with hot liquid spills and burns. A group consisting of the regional nurse, dietary manager and speech therapist reviewed all four incidents in early April to determine whether there were patterns that led to the spills or whether something could be done to prevent spills. They reviewed the charts and incident reports and interviewed nurses, residents, and families. P. Br. at 18; P. Exs. 34, 35; Tr. at 737, 784-85. They discovered no meaningful pattern to the spills, as the only pattern they saw was that three of the four spills occurred during breakfast in the dining room. P. Br. at 18; Tr. at 701-07, 737. The facility considered use of cups with a lid and two handles ("sippy" cups) and travel mugs. It determined, however, that the risks of those cups outweighed the benefits, in that spills can occur through the smaller opening and burn the mouth and lip and, because the cups are cool to the touch and have a lid, there is not the same reminder that the cup is hot. P. Br. at 19; Tr. at 737-39; 517-19.

After deciding the risks of "sippy" cups and travel mugs did not outweigh the benefits, the facility decided to try lowering coffee temperatures. On April 6, 2009, Petitioner's administrator directed its dietary manager to find the lowest possible brewing temperature, which was confirmed to be 160 degrees (it was lowered from 185 degrees). When transferred to air pump canisters for serving, the coffee was cooled with ice to 140 degrees F. The dietary manager put a sign out to warn staff about the importance of cooling the coffee. P. Exs. 34, 35; CMS Ex. 5, at 15. Residents complained that the coffee was not worth drinking and they had a right to have coffee at their preferred temperature. DON Balzer referred to it as a "rebellion" or "mutiny" and, as RN Orta described it, the residents "went wild." In response, someone in the dietary department raised the temperature, but it was returned to the reduced temperature and then returned up, in response to resident complaints, for the non-Alzheimer's unit population to about 160 degrees F. P. Br. at 19-20; Tr. at 745-47; 569-70; P. Exs. 34, 35.

Petitioner also asserts that when it did the safety screens as part of its action plan to remove immediate jeopardy, no additional burns were noted. However, additional approaches were imposed in order to get the state agency to lift the immediate jeopardy (not, according to Petitioner, because Petitioner thought they were necessary). Coffee bars on the units and in the kitchenettes had the temperature reduced to 140 degrees F and in the dining room to 160 degrees F; Alzheimer's unit residents were served coffee at 140 degrees F; large travel mugs with handles and non-skid flat bottoms were used for a resident with a prior burn or who required cuing or assistance with eating; and those

requiring eating assistance had the mug held by a nurse or feeding assistant. P. Br. at 20; Tr. at 728-29, 739-40, 504, 546-47, 569-70.

Petitioner asserts that, because these approaches were so unpopular, it had to develop a dietary waiver for hot liquids. After verifying that a resident understood the types of accidents and risk of harm, about three-quarters of the residents signed a waiver (waivers are also used by Petitioner for residents who refuse a prescribed diabetic or pureed diet). Tr. at 502-05, 641-42; P. Ex. 32.

Petitioner argues that CMS's approval to serve coffee at 140 degrees F, and for some residents at 150 degrees F, is inconsistent with its conclusion that all residents are at a heightened risk of hot liquid spills given their physical and cognitive status. Petitioner asserts that there is no way to eliminate the risk of hot liquid burns unless all hot liquids are eliminated. Petitioner argues that its implementation of hot liquid safety screens, reductions in coffee temperatures, and the use of travel mugs was nothing more than an attempt to satisfy the state agency and does not reflect that its previous efforts "fell short." P. Br. at 22.

With specific reference to 42 C.F.R. § 483.25(h) (F Tag 323), Petitioner argues that the regulation does not require that a facility maintain an impossible standard – here an accident free environment for all 89 residents who drink hot beverages. Instead, it requires the facility to maintain an environment as free of accident hazards as possible. Petitioner notes that Captain McElroy testified that if any resident, other than a resident who wants and can handle hot coffee, can be burned, there is an unacceptable safety risk (although noting that Captain McElroy did not agree that his approach would preclude serving hot coffee in nursing facilities). Tr. at 408-17. That standard, however, is impossible. P. Br. at 26.

Petitioner also argues that CMS acknowledges that when considering appropriate responses to accident hazards resident rights cannot be ignored. However, CMS ignores that it is obvious that coffee drinkers are aware of the risks of spilling coffee. P. Br. at 27.

Petitioner asserts that while Resident 26 was not supervised at the time of his spill there is no evidence he needed supervision or that supervision would have prevented the spill. P. Response at 4.[11] Petitioner also asserts that no amount of supervision will prevent an individual from dropping or spilling a cup of coffee, or prevent a burn, because no one can move that fast. P. Br. at 27-28.

[11] Petitioner also states that CMS did not offer evidence regarding the level of supervision that Residents 14, 27 and 28 required. However, it is not up to the surveyors or to CMS to assess the level of supervision required, that is Petitioner's responsibility.

Petitioner argues that Resident 14's spill was not caused by a lack of supervision or assistive devices, but by someone bumping into his wheelchair (P. Br. at 28, citing Tr. at 134-37, 154, 548-50, 554, 701; P. Ex. 17; CMS Ex. 17, at 27-30), although there is no contemporaneous documentary evidence that this is how the accident occurred. Petitioner argues also that the residents were thoroughly assessed and amply supervised in the dining room. Petitioner also asserts that the surveyors did not ask whether there had been a coffee spill associated with the coffee stations or Alzheimer's unit, and argues that if CMS was concerned about cognitive impairment as a risk factor a number of spills should have occurred on that unit.

In sum, Petitioner argues that the four hot coffee spills were not caused by a lack of supervision or a failure to assess or investigate. Nor did the travel mugs Petitioner eventually used eliminate the risk of a spill; their use only changed the risk. Lowering coffee temperatures was not a workable solution for the facility. The risk of the hot coffee could not be eliminated without violating residents' rights to self-determination and choice and to live in a homelike environment with dignity. Petitioner notes there is a delicate balance between resident choice and a safe environment. Lowering coffee temperatures for residents who understand the risk of hot coffee and have demonstrated the functional ability to handle it, argues Petitioner, is a violation of their rights and an unwarranted over-reaction to an isolated problem. Petitioner describes its actions in trying to reconcile residents' right to choose to drink coffee at palatable temperatures with efforts to reduce risk as demonstrations that it did not violate 42 C.F.R. § 483.25(h). Petitioner asserts its actions made the facility environment as free of hazards as possible in light of resident rights.

After consideration of all the evidence and argument, I find that CMS put forward a *prima facie* case that Petitioner failed to maintain an environment as free of accident hazards as possible and failed to provide adequate supervision and assistance devices to prevent accidents that Petitioner has not succeeded in rebutting.

Petitioner's position is that a hot coffee (or any hot liquid) spill can happen to anyone and that these four spills were simple accidents and did not have a negative impact upon the care it provided its residents. Petitioner misses the point. These were not average individuals. These individuals resided in a nursing facility and all four had some degree of cognitive or physical disability. Petitioner's failure here was in not recognizing after each burn that the resident in question should have been specifically assessed for his or her ability to handle hot liquids, especially hot coffee.[12] While Petitioner asserts that it assessed these individuals, the records Petitioner referenced did not specifically assess their ability to handle such liquids after coffee spills with burns. Further, Petitioner's

[12] Although I have referred to the coffee spills here as spills, it is perhaps more accurate to term them coffee burns. I have no way of knowing whether any other residents at Petitioner's facility spilled coffee on themselves and were not burned by it.

recognition that it had a population of veterans who were heavy coffee drinkers should have caused Petitioner to assess all its residents for hot liquid safety in order to provide them with the assistive devices they needed (such as cups with lids) and adequate supervision (such as Resident 26 drinking hot liquids in the dining hall instead of in bed) that they were not safe without. Petitioner recognized in early April 2009 (prior to the survey) that it had a problem with hot coffee spills and burns, but, even recognizing this, it failed to adequately address the situation and provide consistent interventions until forced to do so by the survey.

Petitioner argues that its residents had the right to have access to and drink hot coffee. It argues that the SOM, in discussing Tag F 323, acknowledges an acceptable trade-off between accepted risks for the benefit of maintaining residents' dignity, self-determination, and control over their daily lives. P. Response at 8-9. What the SOM actually states is that it is a "facility's responsibility to accommodate individual needs and preferences and abide by the resident's right to choice and self-determination" but that the choice "must be balanced against compliance with F323 to protect the resident. Documentation regarding the resident's choices will assist the survey team in making compliance decisions." The goal is to protect resident safety, not tacitly or passively to allow a resident to make a risky choice, especially a choice made without proper documentation regarding a facility's assessment of the resident's capabilities absent some specific waiver. P. Ex. 39, at 29. DON Balzer recognized this when she testified with regard to a resident with a wanderguard leaving the facility,

> It is a resident's right to leave the facility when they want to. However, you err on the side of safety for somebody that might not be able to maintain their wheelchair or something else like that, if they're going to fall off the curb, if they're going to have an accident on the concrete or something.

Tr. at 612. Although DON Balzer would argue that there is a "big difference" between spilling a cup of coffee and an elopement and injury outside the facility (Tr. 612-13) there is really no difference in concept. Although a resident may have a right to drink hot coffee or any other hot liquid, just as that resident has the right to leave the facility, it is up to Petitioner to assess whether that resident is capable of doing so given that resident's mental processes and physical condition and to attempt interventions to make sure the resident remains safe. As DON Balzer explained, "you err on the side of safety." Tr. 612.

As noted, the facility recognized the spills and ensuing burns as a problem in early April and attempted to implement a "fix" prior to the survey. It did so by lowering coffee temperatures for the entire facility. This was not an effective or appropriate response according to Surveyor Persefield. Tr. 356-57.

While Petitioner contends that through the testimony of its witnesses (P. Br. at 8), and the exhibits, it provided evidence of extensive and continual assessment of its residents, Petitioner did not provide any documentary evidence that it assessed the four residents after their burns to determine whether they were able to safely handle hot liquids.[13] The corrective action taken, for instance, in the accident/incident and investigation report for Resident 26, was to mop the floor. For Resident 27 the only corrective action was for the resident to be given no hot beverages at any time, and his care plan update on February 2 only included that hot liquid would be cooled with ice and the nurses were to remind him of safety when requesting hot beverages. There was no evidence that he had been given any screening for his ability to handle hot coffee or any other hot liquid and no evidence that Petitioner followed up on these actions. Resident 28 was only counseled to put ice cubes in her coffee before drinking. There was no assessment of the resident's ability to handle hot coffee or any other hot liquid, or to determine whether she was, in fact, receiving cooled coffee.[14] Hot liquid assessments at the facility were only performed after the immediate jeopardy was identified by the surveyors. Tr. 705; 768-69; CMS Ex. 56. Had Petitioner identified the coffee spill burns as an accident hazard earlier, resident assessments could have been conducted sooner, reducing the risk of other burns occurring, potentially avoiding the three later spills.

Petitioner argues as validation of its approaches that because the four burned residents passed the hot liquid safety screen during the survey the burned residents were able to safely handle hot coffee at the time of their spills. However, Petitioner ignores evidence that as a result of these screens Petitioner assessed Resident 26 (whose spill occurred in his bed) and determined that it would be helpful for him to eat in the dining room for safety and that hot liquids were to be provided and served by staff in a cup with a lid on a stabilized surface; that for Resident 28 she should have hot drinks served in a cup with a lid at room temperature without visible steam, and that she should eat her meals in the dining room to be monitored; and that for Resident 14 he should have hot drinks served in a cup with a lid and at a temperature without visible steam, and that he should be in the dining room for monitoring during meals because his hand-mouth coordination was weak. And, although RN Orta testified that all residents, including the four who were

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[13] Even Petitioner's consultant, RN Morgan, when asked whether a nursing facility should do a safety assessment after a spill, seemed to realize that doing such an assessment might have been a good idea. She replied "[a]fter a spill. I don't know that it would be warranted. I guess if you wanted to see if that resident could, in fact, handle it safely, it would not. I don't know. I really don't." Tr. at 822.

[14] Social Service notes from September 25, 2010, just a few days after the spill and burn, note that the social worker witnessed an altercation between Resident 26 and another resident where the two residents threw their coffee on each other. CMS Ex. 18, at 57. Had the coffee been hot, either resident could have been hurt. Petitioner does not appear to have addressed hot liquid safety after this incident either.

burned, were screened for hot liquids by April 25, 2010 (Tr. at 705-06), there is no screen in the record to show that Resident 27 was assessed for handling hot liquids or what his capabilities were. Moreover, after screening, Petitioner identified other residents as needing cups with lids. RN Orta noted those residents to be, "[a]nybody sitting at a feeder table, that was being fed, anybody at a queuing table that was being queued, got a cup with a lid." Tr. at 778.

2. Petitioner's noncompliance constituted immediate jeopardy to its residents.

I noted in section III above the regulatory definition of immediate jeopardy; "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. Immediate jeopardy thus exists in either of two circumstances. First is when a facility's noncompliance has caused either death or serious harm to one or more residents. Second is when the provider's noncompliance is "likely" to cause death or serious harm. The regulations provide at 42 C.F.R. § 498.60(c) that CMS's determination concerning the level of noncompliance be upheld unless it is "clearly erroneous." Under the regulatory framework, CMS's immediate jeopardy decision is presumed to be correct and the harm to be serious. It is Petitioner's burden to rebut this presumption with evidence and argument that the harm or threatened harm did not meet any reasonable definition of serious. *Daughters of Miriam Center,* DAB No. 2067 (2007).

Surveyor Persefield testified that the surveyors determined that immediate jeopardy existed because there were four residents sustaining skin burns from hot liquids spills and that they and other residents in the facility were at risk for further spills. Surveyor Persefield testified that the residents needed to be individually assessed and have assistive devises in place to prevent future accidents. Tr. 278-79.

Petitioner argues that immediate jeopardy did not exist here because it assessed its residents, provided adequate supervision and assistance devices, and evaluated the circumstances of each spill. P. Br. at 41. Above, I found that they did not do so. Petitioner argues that the surveyors failed to interview residents and staff, do a meaningful record review, and ignored evidence of resident assessments. They did not observe a resident being served hot coffee. They jumped to "their own preconceived, wrong conclusion." Above, I found that the surveyors' responsibility was to make a *prima facie* case, it is Petitioner's responsibility to rebut that case. Petitioner argues that the four residents passed the hot liquid screens completed on April 25th and that the presence of normal temperature coffee (between 158 to 162 degrees F) demonstrates that they were safe to handle coffee. Above, I found that the hot liquid screens were passed only with recommendations for how the residents could safely drink the coffee. Petitioner argues that Residents 27 and 28 were receiving coffee that had been cooled before being served to them. Although that was true for Resident 27 facility records

show only that Resident 28 was herself counseled to put an ice cube in her coffee to cool it. There is no documentary evidence as to how coffee was presented to her. And, more importantly, the residents had not been individually assessed for their ability to handle hot liquids and there was no documented follow-up to show that the recommendations were being followed.

Petitioner also argues that serious harm did not occur here as a result of any noncompliance on its part, and that the second degree burns sustained did not meet the criteria for serious injury or harm. CMS has argued that Residents 14, 26, 27 and 28 were identified as having sustained second to third degree burns. Petitioner asserts that none of the residents actually experienced a third degree burn. The only mention of a third degree burn is a reference in Resident 28's MDS noting that she had sustained a second or third degree burn within the past seven days. CMS Exs. 5, at 75; 20, at 27. Petitioner asserts Surveyor Persefield testified that this reference was the sole basis to conclude the burn might have been a third degree burn. However, Petitioner notes that the MDS is a preprinted form with a box that can be checked which describes whether a resident sustained a second or third degree burn within past seven days without further specificity. Tr. at 342-43. Petitioner argues that testimony at hearing and the description of the burn shows it was a second degree burn. Tr. 543, 701; P. Exs. 8, 28. Petitioner argues that this is significant because the SOM provides that accidents in which second degree burns are sustained due to noncompliance are not an immediate jeopardy deficiency unless they cover a large part of the body. P. Ex. 39, at 33-34. Petitioner argues that none of the burns at issue here covered a large proportion of the residents' bodies.

Petitioner misconstrues the guidance. The SOM notes that the survey team must determine the severity of the deficiency based on the resultant effect or potential for harm. It specifically notes the potential harm related to "[t]hermal burns from spills/immersion of hot water/liquids." P. Ex. 39, at 32. It notes how the noncompliance could cause, result in, allow or contribute to the actual or potential for harm. *Id.* It then notes that the survey team must determine whether the noncompliance requires immediate correction to prevent serious injury, harm, impairment, or death to a resident. It does note that when assessing immediate jeopardy, the survey team must have determined noncompliance and that "negative outcomes that occurred or have the potential to occur as a result of the noncompliance might include . . . 3rd degree burn, or a 2nd degree burn covering a large surface area." *Id.* at 33. For purposes of a finding of immediate jeopardy, however, the issue to be assessed by the surveyors is not whether a given resident's burn was a second or third degree burn, but whether the potential for a negative outcome as a result of facility noncompliance might include a third degree burn or a second degree burn covering a large surface. Hot coffee or liquids can cause a third degree burn in just five seconds even at 140 degrees F. Petitioner's failures here left open the possibility that one of its residents could incur a third degree burn from a hot liquid spill.

With regard to the length of the immediate jeopardy cited, Petitioner argues that CMS should have lifted the immediate jeopardy prior to April 27. Petitioner asserts that the surveyors did not accept its action plan at noon on April 24, but instead accepted it as of 9:15 p.m. that night. However, Petitioner argues that the only omission noted was the obligation of the administrator, DON, or designee monthly to address concerns. The issue of whether the surveyors should have accepted an action plan earlier is not properly before me and does not impact my decision here regarding the length of the CMP imposed. Petitioner argues also in support of a shorter period of immediate jeopardy that by April 25, 2009, all of its residents had received a skin assessment and had been evaluated for safety in handling all hot liquids and all of its staff had been in-serviced. However, the evidence referenced (P. Ex. 34; CMS Ex. 56; Tr. at 740) does not support such a finding. Finally, the SOD reflects that coffee temperatures were monitored from April 25, 2009 to April 27, 2009, to ensure that all temperatures were under 140 degrees F. CMS Ex. 5, at 82. It is reasonable that CMS would need time to sample coffee temperatures before lifting the immediate jeopardy.

3. The remedies imposed are reasonable.

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

CMS has not asserted that Petitioner has a negative compliance history. Petitioner has not submitted evidence that it cannot pay the CMPs. I have found immediate jeopardy to exist. The deficiency is serious. Petitioner did not assess these residents for hot liquid safety after the spills. While Petitioner realized in early April that it had a problem with burns from hot coffee spills, it did not implement consistent approaches to deal with those spills until after the issue was raised by the state agency during the survey. The $6,050 per day CMP from April 24 through April 27, 2009, is in the middle range of CMP when immediate jeopardy is found and is reasonable. The $600 per day CMP from April 28 through May 28, 2009, is reasonable as well. Petitioner has not proved that it was in substantial compliance prior to that date.

V. Conclusion

For the foregoing reasons, I conclude that there is a basis for imposition of a CMP and that the $6,050 CMP for the period April 24 through April 27, 2009, and a CMP of $600

per day for the period April 28 through May 28, 2009, totaling $42,800, is a reasonable remedy for Petitioner's noncompliance.

/s/
Richard J. Smith
Administrative Law Judge