Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Golden Years Homestead,	)	Date: March 12, 2009
	)	
Petitioner,	)	
	)	
- v. -	)	Docket Nos. C-07-348
	)	C-07-469
Centers for Medicare & Medicaid Services.	)	Decision No. CR1924
	)	

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose a civil money penalty (CMP) of $3650 per day from January 16 through January 18, 2007, against Petitioner, Golden Years Homestead, for failure to comply substantially with federal requirements governing the participation of long-term care facilities in the Medicare and Medicaid programs at an immediate jeopardy level. Additionally, I sustain the determination of CMS to impose a CMP of $100 per day from January 19, 2007 through April 8, 2007.

I. Background

By notice dated March 21, 2007, CMS informed Petitioner that based on a January 17, 2007 Life Safety Code survey and a January 19, 2007 health survey and complaint investigation, Petitioner was found to be out of compliance with Medicare and Medicaid requirements, with the most serious deficiency at an immediate jeopardy level cited under tag F324. CMS also determined that Petitioner remained out of compliance after a revisit survey on March 7, 2007. The March 7, 2007 survey found two deficiencies at tags F282 and F314. Petitioner was found to be back in compliance effective April 9, 2007. CMS imposed a CMP of $3650 per day from January 16 through January 18, 2007, for the period of immediate jeopardy and a CMP of $100 per day from January 19 through April 8, 2007. The total CMP imposed was $18,950. A mandatory denial of payment for new admissions (DPNA), effective April 19, 2007, did not go into effect because the facility returned to substantial compliance. In addition, CMS prohibited Petitioner from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP)

for two years from January 19, 2007, because it determined that Petitioner was providing substandard quality of care.

I convened a hearing in Fort Wayne, Indiana on December 9 and 10, 2008. At the hearing, CMS submitted exhibits (CMS Exs.) 1, 3-5, 7, 9-11, and 15-34. Petitioner submitted exhibits (P. Exs.) 1-7, and 9-11. I admit into evidence CMS Exs. 1, 3-5, 7, 9-11, 15-34, and P. Exs. 1-7 and 9-11. The parties both filed post-hearing briefs (Br.) and post-hearing reply briefs (Reply Br.).

The parties agreed to limit the issues before me to the accident deficiency found during the January 19, 2007 survey (but only to the example concerning Resident (R) 100) and to the two deficiencies found during the March 7, 2007 survey. CMS Br. at 5, 21; P. Reply Br. at 1-2. The January 17 and January 19, 2007 surveys included a number of other deficiencies that were never challenged by Petitioner. The unchallenged deficiencies have become administratively final. Further, the immediate jeopardy deficiency at tag F324, concerning 42 C.F.R. § 483.25(h)(2), included three other residents at a non-immediate jeopardy level in addition to R100 at an immediate jeopardy level. Petitioner did not challenge tag F324 as to the three residents at the non-immediate jeopardy level.[1] Therefore, tag F324 is also administratively final at a non-immediate jeopardy level. Petitioner stated that it was challenging only the finding which relates to R100. I therefore conclude that from January 16, 2007 through March 6, 2007, based on the unchallenged deficiencies of the January 17 and 19, 2007 surveys, Petitioner was out of substantial compliance with federal Medicare and Medicaid requirements.

II. Applicable Law and Regulations

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. Section 1819(h)(2) of the Act vests the Secretary of Health and Human Services (Secretary) with authority to impose enforcement remedies for failure to comply substantially with the federal participation requirements established by sections 1819(b), (c), and (d) of the Act. Pursuant to 1819(h)(2)(C), the Secretary may continue Medicare payments not longer than six months after the date the facility is first found not in compliance with participation requirements. Pursuant to 1819(h)(2)(D), if a facility does not return to compliance with participation requirements within three months, the Secretary must deny payments for all individuals admitted to the facility after that date – commonly referred to as the mandatory or statutory DPNA. In addition to the authority to terminate a noncompliant facility's participation in Medicare, the Act grants the Secretary authority to impose other enforcement remedies, including a discretionary DPNA, CMP,

[1] Petitioner waived any dispute regarding three of the four residents, R91, R95, and R98, whose care also formed the basis for the F324 deficiency that was cited in the January 19, 2007 survey. CMS Br. at 6.

appointment of temporary management, and other remedies such as a directed plan of correction. Act § 1819(h)(2)(B).

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. "*Substantial compliance* means 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 (emphasis in original). A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act or the Secretary's regulations at 42 C.F.R. Part 483, Subpart B. Facilities that participate in Medicare may be surveyed on behalf of CMS by state survey agencies in order to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-488.28, 488.300-488.335. The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406.

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, of from $3050 per day to $10,000 per day, is reserved for deficiencies that pose 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). Pursuant to 42 C.F.R. § 488.301, "*(i)mmediate jeopardy* means 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." (emphasis in original). The lower range of CMP, from $50 per day to $3000 per day, is reserved for deficiencies that do not constitute immediate jeopardy but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii).

In this case, the state agency was required to withdraw Petitioner's approval to conduct a NATCEP. Pursuant to sections 1819(b)(5) and 1919(b)(5) of the Act, facilities may only use nurse aides who have completed a training and competency evaluation program. Sections 1819(e) and 1919(e) of the Act impose upon the states the requirement to specify what NATCEPs they will approve that meet the requirements established by the Secretary and a process for reviewing and reapproving those programs using criteria set by the Secretary. Pursuant to sections 1819(f)(2) and 1919(f)(2) of the Act, the Secretary was tasked to develop requirements for approval of NATCEPs and the process for review of those programs. The Secretary promulgated regulations at 42 C.F.R. Part 483, Subpart D. Pursuant to 42 C.F.R. § 483.151(b)(2) and (e)(1), a state may not approve and must withdraw any prior approval of a NATCEP offered by a facility: (1) that has been subject to an extended or partial extended survey under sections 1819(g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Act; (2) that has been assessed a CMP of not less than $5000; or (3) that has been subject to termination of its participation agreement, a DPNA, or the

appointment of temporary management. Extended and partial extended surveys are triggered by a finding of "substandard quality of care" during a standard or abbreviated standard survey and involve evaluating additional participation requirements. "Substandard quality of care" is identified by the situation where surveyors identify one or more deficiencies related to participation requirements established by 42 C.F.R. § 483.13 (Resident Behavior and Facility Practices), § 483.15 (Quality of Life), or § 483.25 (Quality of Care) that are found to constitute either immediate jeopardy, a pattern of or widespread actual harm that does not amount to immediate jeopardy, or a widespread potential for more than minimal harm that does not amount to immediate jeopardy and there is no actual 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 care facility against which CMS has determined to impose an enforcement remedy. Act § 1128A(c)(2); 42 C.F.R. §§ 488.408(g); 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et al*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Cal Turner Extended Care*, DAB No. 2030 (2006)*; The Residence at Salem Woods*, DAB No. 2052 (2006). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e) and 498.3. However, the choice of remedies by CMS or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge would affect the range of the CMP that could be imposed by CMS or impact upon the facility's authority to conduct a NATCEP. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i). CMS's determination as to the level of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9, 38 (2000), *aff'd, Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g.*, *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Review of a CMP by an ALJ is subject to 42 C.F.R. § 488.438(e).

When a penalty is proposed and appealed, CMS must make a *prima facie* case that the facility has failed to comply substantially with federal participation requirements, i.e. CMS must show a violation of a participation requirement, statutory or regulatory, and that the violation posed more than minimal harm to a resident or residents. "*Prima facie*" means that the evidence is "(s)ufficient to establish a fact or raise a presumption unless disproved or rebutted." *Black's Law Dictionary* 1228 (8th ed. 2004); *see also Hillman Rehabilitation Center*, DAB No. 1611, at 8 (1997), *aff'd, Hillman Rehabilitation Center v. U.S. Dep't of Health & Human Services*, No. 98-3789 (GEB) (D.N.J. May 13, 1999). To

prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Evergreene Nursing Care Center*, DAB No. 2069, at 7-8 (2007); *Emerald Oaks*, DAB No. 1800; *Cross Creek Health Care Center*, DAB No. 1665 (1998); *Hillman Rehabilitation Center*, DAB No. 1611.

III. Issues

1. Whether the facility was complying substantially with federal participation requirements on the dates CMS determined to impose a CMP.

2. Whether CMS's determination of immediate jeopardy was clearly erroneous.

3. Whether the amount of the penalty imposed by CMS is reasonable, if noncompliance is established.

IV. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below, in italics and bold, as a separately numbered heading, followed by a discussion of these Findings.

1. The facility was not in substantial compliance with federal participation requirements from January 16 through January 18, 2007, at an immediate jeopardy level because it failed to provide R100 with adequate supervision and assistance devices to prevent accidents.

Based on the documentary evidence, the written arguments of the parties, the testimony at hearing, and the applicable law and regulations, I find that, from January 16, 2007 through January 18, 2007, Petitioner was not in substantial compliance with the federal participation requirement at 42 C.F.R. § 483.25(h)(2) at an immediate jeopardy level.

The survey report listed an alleged deficiency at Tag 324 (which references deficiencies cited at 42 C.F.R. § 483.25(h)(2)) at an immediate jeopardy level, with regard to Petitioner's treatment of R100. CMS Ex. 3, at 42-59. That section of the regulations, entitled "Quality of care," provides —

> *(h) Accidents*. The facility must ensure that —
>
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

R100 had Alzheimer's disease, glaucoma, and osteoarthritis, and resided on the 500 hall, a secured unit in the facility, with 15 other residents. CMS Ex. 11, at 3-4, 11-12; CMS Ex. 17, at 2.

On January 11, 2007, R100 was observed in her wheelchair during the survey as having purplish discoloration around both eyes and sutures on her nose. Nurse's notes dated January 11, 2007, indicated that R100 was found on the floor close to the bathroom door dripping blood from her nose and with a hematoma on her mid-forehead. The facility had determined that R100 had fallen on the way to the bathroom after getting out of bed on her own at 4:30 a.m., without calling for assistance. CMS Ex. 11, at 9. As a result, R100 was taken to the hospital and returned to the facility at 10 a.m. the same day. Surveyor Julie Lynn White indicated, at hearing, that the survey team decided to make falls a focus of the survey as a result of the observation of R100. Tr. 36.[2] A physician's order dated January 11, 2007, the same day as R100's fall, indicated a tab alarm was to be used when R100 was in a wheelchair as a safety measure and an overbed alarm was to be used when R100 was in bed as a safety measure. CMS Ex. 3, at 50.

Five days later, on January 16, 2007, Surveyor White observed R100 sitting unattended on the toilet of her bathroom in the early morning at 4:39 a.m. Surveyor White was following Certified Nurse Assistant (CNA) Lois Daye while she provided care to other residents beginning at 4:32 a.m.[3] Transcript (Tr.) 54; CMS Ex. 33; CMS Ex. 15, at 12. After seven minutes of following CNA Daye, Surveyor White observed R100 through the resident's partially open bathroom door sitting on the toilet. Tr. 121. R100 had been placed on the toilet some time before 4:32 a.m. by CNA Daye. CNA Daye did not come into R100's room until 4:42 a.m. to help R100 off the toilet and further assist R100. Tr. 129; CMS Ex. 33; CMS Ex. 15, at 12. According to Surveyor White, R100 had been unattended on the toilet and unsupervised by a staff member for at least ten minutes. Tr. 78; CMS Ex. 33;

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[2] Surveyor White reviewed records of the 16 residents on the 500 hall and found that there were four falls that occurred between 4:30 a.m. and 6:15 a.m, the same approximate time as R100's fall. These falls occurred on October 26, 2006, November 26, 2006, January 10, 2007, and January 11, 2007, a period of two and one-half months.

[3] Surveyor White made the following clarification in a statement dated March 19, 2008: "Although the Statement of Deficiencies states that my tour of the 500 hall initiated at 4:38 a.m., my notes show that the tour actually started at 4:32 a.m. I am certain that Resident 100 was left alone for at least ten minutes (4:32 a.m. to 4:42 a.m.), because I followed the only staff member on the unit-CNA Lois Daye (identified as CNA #1 in the Statement of Deficiencies)-while she provided care to residents in other rooms from 4:32 a.m. until 4:39 a.m., at which time I went into Resident 100's room and saw her on the toilet through her partially open bathroom door. CNA Daye did not come into Resident 100's room until 4:42 a.m., when she assisted the resident with perineal care, dressed her, and transferred her to a wheelchair." CMS Ex. 33, at 4.

CMS Ex. 15, at 12. At the time of this observation, the only staff member on the 500 hall was CNA Daye. During the ten minutes at issue, CNA Daye was attending other residents. Tr. 83-84; CMS Ex. 33. Surveyor White interviewed CNA Daye about this incident on January 16, 2007, at 7:16 a.m. During the interview, CNA Daye confirmed that she had placed R100 on the toilet and left her there unsupervised and stated that R100 would do well and would not get up. Tr. 143; CMS Ex. 33; CMS Ex. 15, at 15.

R100 was assessed as being at risk for falls in a Fall Risk Assessment dated November 6, 2006, where she received a risk score of 18 (where 16 is considered at risk for falling). Social Services Notes, dated December 1, 2006, indicated that a CNA stated that "R100 displays moderately impaired decision making" and "will attempt to sit before she has turned enough to sit down in a safe manner," that R100 "puts herself on the toilet without waiting or using a call light to ask for assistance," and takes herself "in/out of bed again without using [a] call light to obtain assistance." The December 1, 2006 Social Services Notes identifies R100 as at risk for falls with a prior history of falls. CMS Ex. 11, at 18. An undated Resident Assessment Protocol (RAP) Summary indicates that R100 has memory impairment, moderately impaired decision making, moderately impaired cognition, and "staff reports res [resident] conducts self transfers on and off the toilet, [and] in and out of bed" and in and out of her wheelchair. P. Ex. 2, at 10. The RAP summary indicates that alarms are attached to R100's bed and wheelchair to alert staff of self transfers because R100 was a fall risk due to her unsteadiness. *Id.* The Fall Risk Assessment dated January 15, 2007, the day before the January 16, 2007 observation by Surveyor White, indicated a risk score of 32, a significantly higher score than previously noted in November, indicating that R100 was at greater risk for falls than in the past.[4]

R100's Minimum Data Set (MDS), dated November 8, 2006, indicates that R100 requires limited assistance of one person for transfers and ambulation/walking and has impaired short and long term memory. A MDS, dated August 16, 2006, assessed R100 as requiring extensive physical assistance by one staff member for toilet use as indicated by a score of three for self performance and a score of two for staff support. P. Ex. 2, at 3. The resident's care plans, initiated on September 6, 2005, and updated August 23, 2006 and November 15, 2006, indicate that R100 is at risk for falls due to unsteady gait, impaired balance, and the use of psychotropic medications. CMS Ex. 3, at 46.

A bladder assessment dated November 8, 2006, indicated that R100 made poor decisions requiring supervision and that R100 was totally dependent on staff to walk to the bathroom or transfer to the toilet. CMS Ex. 11, at 15. Surveyor White testified that in a case such as R100, someone should be present during the complete toileting process. Tr. 66.

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[4] The January 15, 2007 Fall Assessment did not include the fact that a fall had occurred on January 11, 2007 and would have indicated a higher score than 32 if completed correctly. Tr. 65; CMS Ex. 11, at 3.

The CNA Assignment Sheet for the 500 hall indicates that 16 out of 16 residents on the 500 hall needed fall precautions. The special assignments section of the CNA Assignment Sheet lists R100 as "assist w/ADLs [activities of daily living] do not leave alone to do ADLs." Activities of daily living include toileting. Tr. 70.

On January 16, 2007, at the time R100 was observed, unattended and sitting on the toilet in her bathroom, the only staff member present in the 500 hall, CNA Daye, was assisting another resident four doors down the hall. CMS Ex. 3, at 47. CNA Daye was the only staff member on the 500 hall from the time the surveyors arrived at 4:32 a.m. until 5:34 a.m., when another staff member, RN Greg Wright, came onto the 500 hall. Tr. 83-84; CMS Ex. 33; CMS Ex. 15, at 12-13. RN Wright had been covering both the 300 and 500 halls (both secured units) during the night shift along with CNA Daye on the 500 hall and two CNAs on the 300 hall.[5] Tr. 84; CMS Ex. 33; CMS Ex. 15, at 13; CMS Ex. 3, at 47. The surveyor determined that there was insufficient staff to provide needed supervision, especially during the early morning hours when so many residents had to be gotten up and made ready for breakfast.[6]

Petitioner's Director of Nursing (DON) Rhonda Tucker testified that normal staffing for the 16-bed unit known as the 500 hall during the night shift (11:00 p.m. to 7:30 a.m.) is one CNA and a nurse that floats between the 300 hall and the 500 hall. Tr. 371, 389, 391, 392. There is also a 30-minute overlap with the day shift CNA who arrives at 7:00 a.m. to assist getting residents ready for breakfast that begins at 7:30 a.m. Tr. 350, 392. Petitioner's own DON confirmed the fact that, at the time of the observation of R100, which was before 5:00 a.m., there was no other staff member on the 500 hall other than CNA Daye, since RN Wright was on the 300 hall. It is also evident that with only a 30-minute overlap with the day shift CNA, the burden of getting the 16 residents of the 500 hall ready for breakfast at 7:30 a.m. fell largely on CNA Daye.

CNA Daye testified that, after assisting R100 to the toilet, she shut the door to the bathroom leaving only a slight opening because of R100's desire for privacy. Tr. 349, 351, 352, 366. CNA Daye claims that R100 told her to leave because R100 couldn't "do anything if you [CNA Daye] are going to stand there and look at me [R100]." Tr. 351, 352, 366. CNA Daye emphasized that R100 activated the call light whenever she was finished toileting and had never attempted to get up after toileting without assistance during the entire time she had been caring for R100. Tr. 349, 350, 352, 357, 360.

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[5] The 300 hall was on the other side of the facility from the 500 hall. Tr. 215.

[6] The surveyors' findings regarding a staff shortage on the 500 hall were cited under tag F353 during the same survey but Petitioner did not appeal this deficiency. CMS Ex. 3, at 62-64.

DON Tucker testified that R100 never tried to get off the toilet by herself whenever she assisted R100. Tr. 373, 375. DON Tucker also testified that the Social Service Notes are inaccurate because they conflict with reports that she had received from staff that R100 does not attempt to transfer herself off the toilet. Tr. 489. The DON's statement, however, is not supported by any documentation.

Petitioner states that Surveyor White hypothesized that there was a potential that R100 might try to stand up and wash her hands after voiding instead of using the call light to summon staff to help clean her and claims that this theory is just speculation. Tr. 137; P. Br. at 4, 17. Petitioner argues that the documentation does not show that R100 needed someone to stay with her after she was placed on the toilet, but only that R100 needed help getting to the toilet, removing her clothing before toileting, and cleaning herself after toileting. *Id.* at 5. Petitioner misapprehends CMS's concern here. CMS's primary concern was that without supervision, R100, who was cognitively impaired and documented as a poor decision maker, would attempt to transfer off the toilet and attempt to ambulate without assistance and would be at risk for a fall. Petitioner admits that R100 required assistance getting to the toilet but denies that there was any risk to R100 getting up off the toilet and possibly attempting to ambulate on her own. I find Petitioner's argument to be disingenuous. R100 is a resident with cognitive impairment and not a machine that only goes in one direction and never in another direction. In fact, the facility documented R100's attempts to transfer off the toilet on her own without waiting or calling for assistance.

Petitioner attacks Surveyor White's credibility and claims that Surveyor White distorts facts, exaggerated while writing the Statement of Deficiencies (SOD), and puts words in the mouths of the persons she interviews. *Id.* at 8. I find Petitioner's argument without merit. Petitioner points to instances concerning other residents and other deficiency tags not at issue before me, but does not dispute Surveyor White's actual observation of R100. In fact, CNA Daye admitted to leaving R100 unattended.

Petitioner also argues that CNA Daye's practice of assisting R100 to the toilet and allowing her ample time to complete the voiding process maintained R100's desire for privacy and allowed R100 to maintain her independence as much as possible while toileting. P. Br. at 14. Nowhere are R100's requests for privacy documented in the facility's records even though DON Tucker testified that it was customary for the facility to document residents' requests for privacy in their care plans. Tr. 370, 472. Petitioner's privacy argument is unpersuasive and was rationalized after the survey. Petitioner's own documentation shows that R100 needed supervision because she was at risk for falls and R100 had just had a fall five days earlier. The CNA Assignment Sheet indicates that R100 was not to be left alone during ADLs. The MDS assessed R100 as needing extensive assistance from one staff member with toileting. The bladder assessment showed that R100 was totally dependent on staff for toileting. In the circumstances of this case, any privacy concerns would have to be balanced by the need to provide the necessary

supervision to prevent a fall. What took CNA Daye away from R100 was not the desire to provide R100 with privacy, but, rather, the need to provide care to other residents on the 500 hall. Even acknowledging that privacy may be a legitimate concern for residents of long-term care facilities when toileting, Petitioner had determined that R100 required assistance with toileting and should not be left alone during ADLs. In fact, DON Tucker testified that on the occasions she assisted R100, she would stand outside the resident's partially open bathroom door, outside of the resident's line of vision and within earshot of the resident in case she called for assistance. Tr. 372, 373. In contrast, CNA Daye was down the hall attending to another resident for at least ten minutes. Surveyor White confirmed that privacy concerns could be satisfied by standing outside R100's partially open bathroom door. Tr. 81. Such action by Petitioner's staff would have also complied with R100's care plan that required staff to "provide verbal cues" and "assist . . . if needed." CMS Ex. 11, at 22.

Petitioner relies on *Burton Health Care Center,* DAB No. 2051 (2006). In *Burton*, an aide was providing one-on-one supervision to a resident sitting in a wheelchair next to the toilet. The aide, in *Burton*, momentarily turned her back to get a diaper, while remaining in the bathroom with the resident, and the resident tried to self transfer to the toilet and fell. The Board found that CMS's evidence in *Burton* did not establish that the resident's fall was foreseeable. *Burton* is distinguishable from the case before me. In *Burton*, the aide turned away only momentarily; however, in the matter before me, R100 was unattended for at least ten minutes, with the only staff member on the 500 hall, CNA Daye, down the hallway attending to another resident. It is entirely foreseeable that in a period of time that lasted for at least ten minutes, a resident such as R100 with Alzheimer's disease who had been assessed only the day before on a Fall Risk Assessment with a score of 32 and who had fallen only five days before when she attempted to get to the bathroom without calling for assistance would attempt to transfer herself without calling for assistance and would be at risk for a fall.

In contrast, CMS relies on *Rosewood Care Center-Edwardsville*, DAB CR1036 (2003), aff'd, DAB No. 1898 (2003). In Rosewood, the facility's staff member left a resident with a history of falls alone on the toilet for only about one minute in order to assist a second CNA in providing care to other residents. The two CNAs in *Rosewood* were within ten feet of the resident when she fell. The resident had been left alone for only about one minute. In *Rosewood,* the Board upheld a deficiency under tag F324. The case before me is even more egregious than in *Rosewood*. CNA Daye left R100's room (the bathroom was in R100's room) entirely and was down the hallway attending to another resident and would not have known if R100 needed assistance, attempted to transfer herself, or fell. Further, R100 was left unattended for at least 10 minutes. The record contained documentation that R100 had attempted to self-transfer and ambulate without using a call light and waiting for assistance from staff. The alarm sensors on her bed and wheelchair, ordered by her doctor, would provide no protection to her while she was left unattended on the toilet. The facility did not attach a personal alarm to R100 or the grab bars by the

toilet. Petitioner's own documentation states that R100 "conducts self transfers on and off the toilet" (P.Ex. 2, at 10 (RAP Summary)) and "takes herself in/out of bed again without using call light to obtain staff assistance" (CMS Ex. 11, at 18 (Social Services Note)).

The regulation at 42 C.F.R. § 483.25(h)(2) requires that a facility ensure that each resident receives adequate supervision and assistance devices to prevent accidents. I must, therefore, determine whether the facility did everything in its power to prevent accidents. *Coquina Center*, DAB No. 1860, at 11 (2002). In regards to R100, the documentation shows that R100 was at risk for falls, had suffered a fall only five days before the incident at issue, was clearly left alone and unsupervised on the toilet on January 16, 2007, for at least ten minutes while the only staff member available was down the hall attending to another resident, required extensive assistance with using the bathroom, had cognitive impairment, was a poor decision maker, had Alzheimer's disease, and was known to attempt to self-transfer on and off the toilet. Additionally, express written instructions not to leave R100 alone during ADLs were on the CNA Assignment Sheet. It is against this backdrop that the incident of January 16, 2007, took place. I, therefore, find that Petitioner did not do everything in its power to prevent a fall. Additionally, the potential consequences of leaving R100 unattended were foreseeable.

In view of the foregoing, I find that CMS established a *prima facie* case that Petitioner was not in substantial compliance with the requirement to provide R100 with adequate supervision and assistance devices to prevent accidents. Petitioner has not overcome that showing by a preponderance of the evidence.

2. CMS's finding of immediate jeopardy was not clearly erroneous.

I have already found that CMS has established a *prima facie* case that Petitioner was not in substantial compliance with federal requirements for skilled nursing facilities participating in the Medicare and Medicaid programs regarding 42 C.F.R. § 483.25(h)(2). Petitioner has not overcome CMS's showing by a preponderance of the evidence. Furthermore, I sustain CMS's finding that Petitioner's level of non-compliance for this deficiency constitutes immediate jeopardy.

The regulations define immediate jeopardy as a situation in which a provider's non-compliance 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 finding of immediate jeopardy does not require "a finding of present harm, but also encompasses a situation that is [likely to cause] harm." *Britthaven*, DAB No. CR1259 (quoting *Hermina Traeye Memorial Nursing Home*, DAB No. 1810 (2002)). CMS's determination of immediate jeopardy must be upheld unless it is clearly erroneous. 42 C.F.R. § 498.60(c)(2). The burden rests on Petitioner to prove that CMS's determination of immediate jeopardy is clearly erroneous. Petitioner has not met that burden here.

Petitioner argues that R100 was assessed as having satisfactory sitting stability and, in fact, did not fall off the toilet on January 16, 2007. Petitioner misapprehends the definition of immediate jeopardy. Immediate jeopardy exists if the facility's noncompliance has caused or is *likely* to cause serious injury, harm, impairment, or death to a resident. 42 C.F.R. § 488.301. In the case before me, immediate jeopardy does not require R100 to have actually fallen, it just requires that it was likely for R100 to have fallen should she have attempted to get off the toilet and ambulate on her own. CMS's determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). To meet its burden, Petitioner must show that the potential harm or injury "did not meet any reasonable definition of 'serious.'" *Daughters of Miriam Center*, DAB No. 2067, at 9 (2007); *Hallmark House Nursing Center*, DAB No. 2226, at 6 (2009). I consider leaving R100 unattended for ten minutes while the only staff member was down the hall attending to another resident to be a noncompliance that is likely to cause serious injury to R100. I therefore do not find clearly erroneous CMS's immediate jeopardy determination.

3. Petitioner was not in substantial compliance with federal Medicare and Medicaid requirements during the March 7, 2007 revisit survey for tag F282 (42 C.F.R. § 483.20(k)(3)(ii)) and tag F314 (42 C.F.R. § 483.25(c)(2)).

Tag F282 (42 C.F.R. § 483.20(k)(3)(ii)) provides:

> The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

CMS alleges that Petitioner was out of compliance with tag F282 because it failed to implement measures in a resident's care plan, particularly those designed to treat and prevent pressure sores as they relate to two residents, R2 and R75.

Tag F314 (42 C.F.R. § 483.25(c)) provides:

> Based on the comprehensive assessment of a resident, the facility must ensure that-
>
> 1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and
>
> 2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

CMS alleges that Petitioner did not comply with tag F314 (42 C.F.R. § 483.25(c)(2)) because it failed to ensure that residents who had existing pressure sores, R2 and R75, received necessary treatment and services to prevent new pressure sores from developing. Under this section of the regulations a facility must, at a minimum, provide the care and treatment it has determined is required according to the plan of care that it has developed for a resident.

a) Resident Number 2

R2 had diagnoses including diabetes mellitus, chronic obstructive pulmonary disease, prostate cancer, and high blood pressure. CMS Ex. 21, at 22. A Braden Scale assessment of R2 completed by the facility on February 22, 2007, assigned him a score of 15, indicating that he was considered "at risk" for pressure sore development. CMS Ex. 12, at 16; Tr. 225. A nursing assessment upon admission dated February 15, 2007, required that R2's legs be elevated (or "floated") with pillows while the resident was in bed. Tr. 228; CMS Ex. 21, at 3. R2's care plan and physician's orders also required that his feet be elevated by the use of a pillow when in bed. Tr. 230; CMS Ex. 21, at 9, 26. Floating a heel means that pillows are placed under a resident's lower legs to elevate the heels. Floating a heel serves the purpose of totally relieving pressure, allows for increased circulation, and facilitates the healing process. Tr. 229. An undated Assignment Sheet showed that R2 was to be repositioned every two hours and have his heels floated while in bed. CMS Ex. 26, at 1; Tr. 231.

On March 5, 2007, while Surveyor Roth was conducting an initial tour of the facility, nurse Michelle Sheets stated that R2 had developed pressure sores on his buttocks, a blister on his right heel, and a soft mushy area on his left heel while he was in the hospital. Tr. 227; CMS Ex. 21, at 3. The blister on R2's heel signified superficial damage under the skin indicating a Stage II pressure sore and the soft, mushy area on R2's left heel indicated the presence of a pressure sore or deep tissue injury. CMS Ex. 32, at 22. On March 5, 2007 and March 6, 2007, R2 was observed without his legs being elevated on four separate occasions by both Surveyors White and Roth. Tr. 113-14, 206-07, 233, 235, 307; CMS Ex. 24, at 5; CMS Ex. 25, at 4-5, 8; CMS Ex. 26. Surveyor Roth also testified that she did not observe an extra pillow in the area of R2's feet that could have been used to elevate his feet during the time of her observations. Tr. 286, 288, 309, 310.

On March 6, 2007, Surveyor Roth observed R2 lying on his back without his heels elevated. Surveyor Roth asked that R2's socks be taken off so that she could observe his heels. Surveyor Roth observed R2's heels. The left heel had an area approximately the size of a fifty-cent piece that was "soft and mushy." Tr. 233, 305; CMS Ex. 25, at 8; CMS Ex. 26, at 1. When License Practical Nurse (LPN) Diana Slate put R2's socks back on after Surveyor Roth had observed his heels, Surveyor Roth observed that no pillow was placed beneath R2's legs to float his heels, and his heels were again left lying directly on a sheepskin pad that was placed on the bed. Tr. 233; CMS Ex. 24, at 8.

LPN Slate and DON Tucker testified that they regularly placed pillows beneath R2's legs to float his heels, but R2 resisted and removed the pillows himself. Tr. 328, 329, 447. They testified that removing the pillows was habitual behavior by R2 and the staff counseled R2 repeatedly about the importance of keeping the pillows beneath his legs. Tr. 330, 331, 449, 450. No documentation supports this statement except for an undated hand written statement prepared by LPN Slate. CMS Ex. 30, at 65. LPN Slate admitted that she did not write this statement until March 20, 2007, after the March 7, 2007 survey was completed. Tr. 341. I give little weight to such statement because it is self-serving. It was written by one of Petitioner's employees for litigation purposes, after the fact, instead of being part of contemporaneous medical records. Habitual behaviors, such as removing pillows, can be addressed by care planning. However, Petitioner failed to do so. Tr. 342.

I find Petitioner's reliance on the Treatment Administration Record (CMS Ex. 30, at 44) as evidence of compliance with the order to float R2's heels, also unpersuasive because the document Petitioner relies on has two different versions, each indicating conflicting information about whether R2's heels were elevated on the day shift of March 2, 2007. *Compare,* CMS Ex. 21, at 22 with CMS Ex. 30, at 44. The existence of two versions of the same document casts doubt on the accuracy of either document. Petitioner also relies on an Appliance Log to show that R2's pillows were properly positioned; however, the Appliance Log does not so indicate. CMS Ex. 30, at 22-26. No contemporaneous documentation reliably indicates that Petitioner's staff properly positioned pillows beneath R2's legs. The surveyors' observations stand undisputed. CMS has met its burden to make a *prima facie* case which Petitioner has failed to overcome by a preponderance of the evidence.

b) Resident Number 75

R75 had diagnoses including Alzheimer's disease, osteoporosis, and coronary artery disease. CMS Ex. 22, at 5. According to the facility's Assignment Sheet, R75 required total assistance with ADLs and required a hydraulic lift (a Hoyer lift) for transfers. CMS Ex. 26, at 2; Tr. 94. A Braden Scale assessment completed on December 20, 2006, documented a score of ten, indicating that R75 was at "high risk" for developing pressure sores. CMS Ex. 22; Tr. 99.

R75's care plan, last reviewed by the facility's interdisciplinary team on December 27, 2006, indicated a problem of "potential for impaired skin integrity." CMS Ex. 22. The care plan, January 2007 physician orders, the Assignment Sheet, and the July 2006 Resident Assessment Protocol all document that R75 was required to have heel protectors while in bed. CMS Ex. 22, at 14, 17; CMS Ex. 26, at 2; CMS Ex. 22, at 8. The heel protectors had been ordered by the physician to "prevent skin breakdown." CMS Ex. 22, at 14. A Wound/Skin Care Management Documentation Form and physician orders dated February 28, 2007, show that R75 had a Stage II pressure sore on her left buttock. CMS Ex. 22, at 7, 12; Tr. 100.

Surveyor White observed R75's pressure sore on March 5, 2007, when staff performed a dressing change on the sore. Tr. 102; CMS Ex. 24, at 4; CMS Ex. 33. She observed that the pressure sore was a "thin slit" in the skin that was open and pink, indicating a Stage II pressure sore. Tr. 102. Surveyor White observed R75 in bed without heel protectors on March 5, 2007, at 1:40 p.m. and from 3:10 p.m. to 3:48 p.m., and on March 6, 2007, at 9:30 a.m. and 1:08 p.m. Tr. 106, 107; CMS Ex. 24, at 3-6; CMS Ex. 33. Surveyor Roth observed R75 in bed without heel protectors from 3:30 p.m. to 3:45 p.m. on March 5, 2007. CMS Ex. 25, at 4. On March 5, 2007, R75 was observed in bed on her left side with a sheepskin pad rolled up at the foot of the bed and not beneath R75's feet. Tr. 106; CMS Ex. 24, at 3; CMS Ex. 33, at 24.

Surveyor White was informed that R75 did not have heel protectors on because R75 had soiled them. Tr. 112; CMS Ex. 24, at 8; CMS Ex. 33. DON Tucker conceded that the facility should have sufficient heel protectors available to replace a soiled set. Tr. 410, 411. However, no replacement heel protectors were put on R75. Petitioner contends that a sheepskin pad was used as a temporary substitute while R75's heel protectors were being cleaned, but never adequately explains why another set of heel protectors was not provided to R75.[7]

DON Tucker contended that a sheepskin pad on the resident's mattress was a suitable replacement for the missing heel protectors. Tr. 402. Surveyor White determined that employing sheepskin pads for R75 was not an adequate substitute for the physician-ordered heel protectors. Heel protectors are physically attached to a resident's heels and provide protection to the heels when a resident is in bed regardless of the resident's positioning, while sheepskin pads are positioned on a resident's bed and will provide no protection to the heels in the event the pad is not directly placed underneath the heels. Tr. 110; CMS Ex. 33. Surveyors observed that R75 sometimes positioned herself on her side in a fetal position with her heels pulled up off the sheepskin pads. Tr. 110; CMS Ex. 33. On March 5, 2007, the surveyors noted that the resident was positioned on her left side, and the sheepskin pad was rolled up at the foot of the bed and not beneath her feet. Tr. 106; CMS Ex. 24; CMS Ex. 33. R75's physician had not approved the substitution of a sheepskin pad for heel protectors.

When R75 was in a fetal position with her heels pulled up off the sheepskin, R75's heels were resting directly on the bed, and she was not receiving anything to help prevent pressure sores on her heels. When R75 was positioned on her side, the lateral portion of her heels would be subject to pressure when no heel protectors were in place. Petitioner claims that R75 had heel protectors while in bed during part of the time of the March 7,

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[7] Petitioner claims that R75 had two sets of heel protectors and both sets were soiled during the March 7, 2007 survey. P. Br. at 21; Tr. 408, 409, 411.

2007 survey,[8] but does not dispute the surveyors' claim that R75 did not have heel protectors on during part of March 5 and 6, 2007.

Petitioner implies that R75 spent most of her time on her side and therefore the bottom or back of R75's heels were not observed in contact with the bed. This argument fails because Petitioner fails to realize that in turning from side to side, R75 had to spend part of the time while in bed on her back with her heels in contact with the bed. In addition, when R75 is on her side in bed without heel protectors, there is still lateral pressure on her heels. Petitioner's argument that a sheepskin pad is an acceptable substitute for heel protectors fails because R75 was observed in a fetal position with her heels directly on the bed, not on the sheepskin pad. Most importantly, Petitioner's arguments fail because the facility was not providing heel protectors to R75 when in bed as required by its own care plan and by R75's physician's orders.

Under the regulations, when a resident has an existing pressure sore, a facility is required to provide necessary treatment and services to promote healing, prevent infections and prevent new pressure sores from developing. This regulation requires that, at a minimum, a facility must comply with the care plan that it developed itself and comply with a resident's physician's orders. I find that Petitioner failed to comply with tags F282 and F314 for R2 and R75 because it failed to provide measures required by the residents' care plans, other facility records, and ordered by the residents' physicians.

4. The amount of the penalty imposed by CMS is reasonable.

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

It is well-settled that, in reaching a decision on the reasonableness of the CMP, I consider whether the evidence presented on the record concerning the relevant regulatory factors supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found and in light of the other factors involved (financial condition, facility history, culpability). I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice

[8] Petitioner states that at 2:54 p.m. on March 6, 2007, Surveyor White saw heel protectors on R75. P. Br. at 20.

of remedies without regard for CMS's discretion. *Barn Hill Care Center*, DAB No. 1848, at 21 (2002); *Community Nursing Home*, DAB No. 1807, at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800, at 9; *CarePlex of Silver Spring*, DAB No. 1683, at 8.

CMS imposed a $3650 per day CMP for the period from January 16 through January 18, 2007 (the period of immediate jeopardy) and a $100 per day CMP from January 19 through April 8, 2007. The total CMP was $18,950. I sustain the penalty imposed. A penalty of $3650 per day falls in the lower range of penalties which may be imposed for deficiencies that are at an immediate jeopardy level of noncompliance. A penalty of $100 per day falls in the lower range of penalties which can be imposed for deficiencies that are at a less than immediate jeopardy level of compliance. I also note that I have no information as to the facility's history of noncompliance. Petitioner has not argued that its financial condition affects its ability to pay the penalty. With respect to the remaining factors, I note that the facility is culpable for disregarding the safety of R100 and its obligations to follow care plans and physician's orders as to R2 and R75. I find that these factors justify the penalty imposed.

V. Conclusion

I conclude that CMS correctly imposed a CMP of $3650 per day, from January 16 through January 18, 2007, against Petitioner for failure to comply substantially with federal requirements governing the participation of long-term care facilities in the Medicare and Medicaid programs at an immediate jeopardy level. Additionally, I conclude that CMS correctly imposed a CMP of $100 per day from January 19, 2007 through April 8, 2007. I also conclude that the CMPs imposed were reasonable.

/s/
José A. Anglada
Administrative Law Judge