Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

All-American Restorative Care of Washington,
(CCN: 16-5453),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-12-626

Decision No. CR2929

Date: September 25, 2013

DECISION

Over six days in January and February 2012, the Iowa Department of Inspections and Appeals (state agency) conducted a complaint investigation survey of All-American Restorative Care of Washington (Petitioner). Based on the survey findings, the state agency determined that Petitioner was not in substantial compliance with the Medicare participation requirements for skilled nursing facilities. The state agency imposed a civil money penalty (CMP) based on Iowa regulations and recommended that the Centers for Medicare & Medicaid Services (CMS) also impose enforcement remedies against Petitioner. CMS agreed with the state agency's determination of noncompliance and imposed a denial of payment for new admissions (DPNA) between March 13, 2012 and April 27, 2012. Petitioner appeals the noncompliance findings and DPNA enforcement remedy.

For the reasons set forth below, I find and conclude that Petitioner was not in substantial compliance with Medicare participation requirements at the time of the complaint survey, and the DPNA is an authorized enforcement remedy.

I. Case Background & Procedural History

Petitioner is a long-term care facility located in Washington, Iowa, that participates in the Medicare and Medicaid programs. Following its survey of Petitioner's facility, the state agency determined that Petitioner was not in substantial compliance with three Medicare participation requirements *apropos* the care that Petitioner's nursing staff provided to several residents:

- 42 C.F.R. § 483.25 (Tag F-309) — provide necessary care and services to attain or maintain a resident's highest well-being in accordance with the comprehensive assessment and plan of care;

- 42 C.F.R. § 483.25(a)(3) (Tag F-312) — provide care for a dependent resident to maintain good nutrition, grooming, and personal and oral hygiene; and

- 42 C.F.R. § 483.25(h) (Tag F-323) — prevent accidents and provide adequate supervision and assistance devices.

The state agency imposed a $15,000 CMP based on Iowa law, and recommended that CMS impose a DPNA. CMS Ex. 3, at 4. In a letter dated February 27, 2012, CMS imposed the recommended DPNA effective March 13, 2012. CMS Ex. 1. A revisit survey determined that Petitioner achieved substantial compliance on April 27, 2012. CMS Ex. 2, at 1. CMS lifted the DPNA as of that date.

Petitioner timely requested a hearing to challenge the noncompliance findings as well as the DPNA. CMS submitted its prehearing exchange, including 12 proposed exhibits (CMS Exs. 1-12). Petitioner submitted its prehearing exchange, including 31 proposed exhibits (P. Exs. 1-31). On February 25 and 28, 2013, I held a two-day hearing by video teleconference, with the parties and witnesses located in West Des Moines, Iowa. At the hearing, CMS and Petitioner each offered an additional exhibit (CMS Ex. 13 and P. Ex. 32, respectively). I admitted CMS Exhibits 1-13 and Petitioner's Exhibits 1-32 into the record. CMS presented the testimony of the state surveyor, Robert Reck, RN. Petitioner presented the testimony of facility owner Jerry Rhoads, director of operations Kip Rhoads, and a licensed practical nurse (LPN) at Petitioner's facility, Lisa Fry. The transcript (Tr.) of the proceedings has been incorporated into the written record, subject to the modifications established in my Order Settling Transcript and Establishing a Briefing Schedule dated April 30, 2013. Each party has submitted post-hearing briefs (CMS Br. and P. Br.) and post-hearing reply briefs (CMS Reply Br. and P. Reply Br.).

II. Issue Presented

This case presents the following issue for my consideration:

1. Whether Petitioner was in substantial compliance with Medicare participation requirements during the cited period.

Petitioner argues that the scope and severity of its noncompliance, if any, is also at issue. P. Br. at 2. It is not. A facility may only challenge the scope and severity level of noncompliance if: (1) CMS has made a finding of "substandard quality of care" that affects the facility's authority to conduct a nurse aide training and competency evaluation program (NATCEP); or (2) a successful challenge to the scope and severity of noncompliance would affect the range of the CMP that may be imposed. 42 C.F.R. § 498.3(b)(14). Here, a successful challenge would not affect the range of CMP that CMS may impose. The only range for a possible CMP based on noncompliance that does not pose immediate jeopardy, such as in this case, is between $50 and $3,000 per day. 42 C.F.R. § 488.438(a)(1)(ii). Moreover, CMS did not make a finding of "substandard quality of care" as that phrase is defined in the regulations, which requires either immediate jeopardy, a pattern of actual harm, or widespread potential for more than minimal harm. 42 C.F.R. § 488.301. Here, the state agency found two deficiencies were isolated instances of actual harm that were not immediate jeopardy, and one deficiency was a pattern of no actual harm but with the potential for causing more than minimal harm. CMS Ex. 4. Thus, the scope and severity of Petitioner's noncompliance is not at issue and will not be reviewed.

Also, the reasonableness of the enforcement remedy imposed is not at issue in this case. The only enforcement remedy imposed by CMS was a DPNA. If Petitioner was not in substantial compliance with Medicare participation requirements, then CMS had the authority by regulation to impose a discretionary DPNA. *See* 42 C.F.R. §§ 488.406(a), 488.417(a). There is no right to appeal the choice of enforcement remedy. 42 C.F.R. § 488.408(g)(2). Therefore, the only issue before me in this appeal is whether CMS was authorized to impose a DPNA, which, in turn, hinges upon whether Petitioner was in substantial compliance with Medicare participation requirements. 42 C.F.R. § 488.406(a).

III. Statutory & Regulatory Framework

The Social Security Act (Act) establishes the requirements that a long-term care facility must meet to participate in the Medicare and Medicaid programs and authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations

implementing those statutory requirements. Act §§ 1819, 1919.[1] Specific Medicare participation requirements for long-term care facilities are at 42 C.F.R. Part 483. A long-term care facility must remain in substantial compliance with program requirements to participate in Medicare. 42 C.F.R. § 483.1(b). "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. By contrast, "noncompliance" means "any deficiency that causes a facility not to be in substantial compliance." *Id.* A "deficiency" is a violation of any statutory or regulatory participation requirement. *Id.*

The Act authorizes the Secretary to impose enforcement remedies against a long-term care facility for failure to comply substantially with federal participation requirements. *See* Act § 1819(h); 42 C.F.R. § 488.402. The Secretary may not continue Medicare payments to a long-term care facility for more than six months after the facility is first found not to be in substantial compliance. Act § 1819(h)(2)(C). If a facility does not return to substantial compliance 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. *See* Act § 1819(h)(2)(D).

The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility not in substantial compliance with program participation requirements. State agencies survey facilities on behalf of CMS to determine whether the facilities comply with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335. The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. *See* 42 C.F.R. § 488.406. Among the enforcement remedies available to CMS is a discretionary DPNA. *Id.* §§ 488.406(a)(2)(ii), 488.417(a).

A long-term care facility may request a hearing before an administrative law judge to challenge a noncompliance finding and enforcement remedies such as a discretionary DPNA, which CMS imposed in this case.[2] Act §§ 1128A(c)(2), 1866(h); 42 C.F.R.

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[1] The Act, as amended, is available at http://www.ssa.gov/OP_Home/ssact/ssact.htm. On this website, each section of the Act contains a reference to the corresponding chapter and section in the United States Code.

[2] With regard to a facility's right to challenge a noncompliance finding leading to the imposition of a discretionary DPNA, the Departmental Appeals Board has explained:

> Section 498.5, in turn, sets out appeal rights applicable to various kinds of affected parties. Specifically, among the affected parties is a provider

(*continued on next page. . .*)

§§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is *de novo*. *Residence at Salem Woods*, DAB No. 2052 (2006); *Cal Turner Extended Care*, DAB No. 2030 (2006); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Emerald Oaks*, DAB No. 1800 (2001); *Anesthesiologists Affiliated*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991). The choice of remedies or factors CMS considered when choosing remedies is not subject to review. 42 C.F.R. § 488.408(g)(2).

The standard of proof, or quantum of evidence required, is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a *prima facie* showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *Batavia Nursing & Convalescent Center*, DAB No. 1904 (2004), *aff'd*, 129 F. App'x. 181 (6th Cir. 2005); *see Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd*, No. 98-3789, 1999 WL 34813783 (D.N.J. May 13, 1999).

IV. Findings of Fact & Conclusions of Law

Four findings of fact and conclusions of law (FFCLs) support this decision. Each FFCL is set forth below in bold and italic font, followed by an analysis for that FFCL. Either of the first two FFCLs supports the remedy imposed, but in the interest of thoroughness and clarity, this Decision addresses all of the cited deficiencies.

1. ***Petitioner was not in substantial compliance with the general quality of care requirement at 42 C.F.R. § 483.25 because Petitioner's staff did not recognize that Resident 2 and Resident 4 had fallen, or provide a meaningful assessment before moving them after their falls.***

(*continued*)

"dissatisfied with an initial determination to terminate its provider agreement . . . ." 42 C.F.R. § 498.5(b). The right to appeal noncompliance findings leading to the imposition of a DPNA is not expressly set out in either the Act or the regulation at section 498.5. However, section 498.3 provides that certain initial determinations also lead to hearing rights under section 498.5, including "a finding of noncompliance . . . that results in the imposition of a remedy specified in § 488.406 . . . ." 42 C.F.R. § 498.3(b)(12). A DPNA is among the remedies specified in section 488.406. 42 C.F.R. § 488.406(a)(2)(i)(A).

Cary Health & Rehabilitation Center, DAB No. 1771, at 6 (2001).

The lead-in language of 42 C.F.R. § 483.25 states:

> 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 Departmental Appeals Board (Board) has explained that this regulation "imposes on facilities an affirmative duty designed to achieve favorable outcomes to the highest practicable degree." *Windsor Health Care Center*, DAB No. 1902, at 16-17 (2003), *aff'd sub nom. Windsor Health Center v. Leavitt*, 127 F. App'x. 843 (6th Cir. 2005). "The facility must take 'reasonable steps' and 'practicable measures to achieve that regulatory end.'" *Golden Living Center - Foley*, DAB No. 2510, at 23 (2013) (quoting *Clermont Nursing & Convalescent Center*, DAB No. 1923, at 21 (2004)). The regulation implicitly imposes on a facility the duty to provide care and services that, "at a minimum, meet accepted professional standards of quality 'since the regulations elsewhere require that the services provided or arranged by the facility must meet such standards.'" *Id.* (quoting *Spring Meadows Health Care Center*, DAB No. 1966, at 17 (2005)). In *Crestview Parke Care Center v. Thompson*, 373 F.3d 743 (6th Cir. 2004), the court concluded that the general quality of care regulation is not a "strict liability" regulation. 373 F.3d at 753-54. The court explained that the word "practicable" suggests that a "'reasonableness' standard inheres in the regulation" and that it would be possible for a facility to show "a justifiable reason for the violation of [section] 483.25." *Id.* at 754.

Here, despite their serious behavioral problems, it is apparent from the record that Petitioner's staff did not provide Resident 2[3] and Resident 4 with the necessary care and services to maintain their highest practicable well-being.

a. *Resident 2*

Resident 2, a 58-year-old resident at the time of the survey, was admitted to Petitioner's facility on September 20, 2011. She had a history of dementia, depression, non-organic psychosis, bipolar disorder, and muscle weakness, among other things. CMS Ex. 5, at 20-21. Her minimum data set (MDS) stated that she did not have a history of falls before or after admission to Petitioner's facility. CMS Ex. 5, at 24. Resident 2 routinely cursed

[3] To protect the residents' confidentiality, the state agency referred to each resident by a specific number rather than by name or initial. This Decision uses the same identifiers that the state agency assigned to each resident.

at and struck nursing staff. CMS Ex. 5, at 257-60. In middle-to-late December 2011, she began to develop hallucinations. CMS Ex. 5, at 16. To address her mental health concerns and attain the goal of "not injur[ing] self or others," her care plan required staff to, among other things, "[w]ork with resident to indentify effective coping mechanisms / time alone in room / food / drink / toileting / activity." CMS Ex. 5, at 42.

Video footage of a hallway in Petitioner's facility from December 23, 2011 (CMS Ex. 10) shows that staff removed Resident 2 from a room, and then left her standing alone in the hallway.[4] She began to stagger, then fell backwards from a standing position and struck the back of her head against the floor. At the time of the fall, the timestamp on the video was 14:51:13. Resident 2 immediately reached up and grabbed the back of her head. Another resident appeared at the end of the hallway and looked down at Resident 2, while staff moved around at the nursing station, also at the end of the hallway about 40 feet away. Resident 2 continued to hold her head. Seven minutes later, Resident 2 was still lying on the floor and rolled to her left side while another resident walked past her, and stared at her. Just over 48 minutes later, three staff members approached Resident 2 while she was lying prone on the floor. The timestamp on the video when the staff members approached was 15:39:49. Two staff members stood over Resident 2 and patted and rubbed her back as if to arouse her from sleep. They attempted to roll Resident 2 over, but were unsuccessful at first. Resident 2, meanwhile, was motionless. The third staff member intervened, and all three rolled Resident 2 onto her back. Resident 2 swung her arm around, and appeared at that point to be awake. The staff members stood Resident 2 up; one staff member braced Resident 2 under her armpits, while the other staff members pulled on her arms. The staff members then guided Resident 2 into her room. CMS Ex. 10. Once inside Resident 2's room, a certified nursing assistant (CNA)

[4] Petitioner attempts to discredit its own video surveillance system, pointing out that it was motion-activated but did not always sense every motion in the hallway. According to Petitioner, the video is unreliable because it may not have captured all of the events in the hallway at relevant times. P. Br. at 4-6. To the contrary, I find that the video footage in CMS Exhibit 10 is highly reliable and probative of the actions that took place in "Hallway 4" on December 23, 2011, between 2:51 p.m. and 3:40 p.m. Petitioner has not shown that the footage captured on the video was unreliable or that the imbedded timestamps were incorrect. Petitioner merely posits that some intervening action may have happened between the time when Resident 2 fell and when staff finally approached her. P. Br. at 5. But mere speculation that *something* happened, without any evidence to support that anything actually happened, does not come close to discrediting the reliable and damning evidence that CMS Exhibit 10 provides.

discovered a large laceration to the back of Resident 2's head.[5] CMS Ex. 5, at 91. She was subsequently transported to the hospital and received four medical staples to close the laceration. CMS Ex. 5, at 58.

During interviews with the surveyor, staff members involved in the incident confirmed that they did not approach Resident 2 for over 48 minutes. *See* CMS Ex. 11, at 3, 5-7. One CNA, J.B., wrote in a statement that she "asked [Resident 2] from a distance if she was ok," to which Resident 2 allegedly said "yes she was." CMS Ex. 11, at 3. Another CNA, A.S., wrote in a statement that she "tapped [Resident 2] on her shoulder and asked her if she was alright," to which there was "no response." CMS Ex. 11, at 5. CNA A.S. stated that they sat Resident 2 up and "she began to come to a little bit." CMS Ex. 11, at 5. CNA A.S. asked Resident 2 if she was hurt, but Resident 2 "didn't say too much and didn't remember falling; she seemed pretty out of it." CMS Ex. 11, at 5. LPN Fry, however, who also testified at the hearing, provided a conflicting account. She initially told the surveyor that she spoke with Resident 2 when she approached her in the hallway, and Resident 2 was responding normally, able to move her arms and legs, and did not appear injured. CMS Ex. 11, at 7; *see* Tr. 278-80.

Petitioner claims that its staff members presumed that, based on her earlier behavior, Resident 2 lay down on the floor, but did not fall. *See, e.g.*, CMS Ex. 11, at 3, 7; *see also* Tr. 277-78, 299; P. Br. at 10. Indeed, the record reflects several instances where Resident 2 lay down on the floor: on December 15, 2011, Resident 2 "sat self on floor several times" (CMS Ex. 5, at 139); on December 17, 2011, she was "laying on floor and talking to [illegible] in room" (CMS Ex. 5, at 135); and on December 21, 2011, she was found on the floor and stated she laid down because "it's cooler down here" (CMS Ex. 5, at 126). Petitioner argues that lying on the floor was an "effective coping mechanism" for Resident 2 to address her mental health and behavioral issues. P. Br. at 10; P. Ex. 9. Her care plan stated that staff would "work with resident to identify effective coping mechanisms" to attain the goal of "not injur[ing] self or others." CMS Ex. 5, at 42.

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[5] It is unclear whether the laceration was the result of Resident 2's fall, although that is highly probable. The location of the laceration, coupled with the area of Resident 2's head that struck the ground, is strong evidence that the fall caused the laceration. *See* CMS Ex. 5, at 59; CMS Ex. 10. However, as Petitioner points out, there is no blood visible on the floor in the video. In any event, whether the fall caused the laceration, and thus caused *that* actual harm, is not relevant to the outcome here because the scope and severity of any noncompliance is not at issue. Even if the scope and severity of noncompliance was at issue, Resident 2 struck her head against the hard floor and immediately grabbed it, a clear indication of pain and actual harm. CMS Ex. 10.

However, there are no contemporaneous records documenting that staff members actually considered Resident 2's lying-down behavior an "effective coping mechanism" in accordance with her care plan. Assuming, *arguendo*, that staff may have considered Resident 2's behavior as a coping mechanism, that behavior was never listed in her care plan and not approved by an interdisciplinary team. *See* CMS Ex. 5, at 42-43; *see also* 42 C.F.R. § 483.20(k)(2)(ii) ("A comprehensive care plan must be . . . [p]repared by an interdisciplinary team . . . ."). Moreover, the staff had no measures in place to determine why Resident 2 was on the floor, *i.e.*, as a result of a fall or lying down. If they presumed — as they did here — that every time Resident 2 was on the floor it was the result of her intentionally lying down, staff would never assess Resident 2 for a fall and could overlook the potential for serious injury — again, as they did here.[6] Any staff determination about Resident 2's lying-down behavior, assuming there actually was one, must have been *ad hoc*. However, that *ad hoc* determination was without approved interventions, and led to complacency among Petitioner's staff, a serious problem highlighted by Resident 2's fall. In essence, Petitioner's staff employed a "there she goes again" mentality, a dangerous mindset for nursing staff to have, and a dubious defense to inadequate care.

The record demonstrates that after Resident 2 fell, Petitioner's staff took no meaningful action to assess, care for, or provide any contemporaneous services to Resident 2. Asking a "yes-or-no" question from a distance of 40 feet about whether Resident 2 was "ok" is not an assessment, and provides staff members with little information about Resident 2's actual medical condition or how she ended up on the floor. The staff's failure to evaluate whether or not Resident 2 had fallen when they saw her on the floor is far short of the "necessary care and services" required for Resident 2 to "attain or maintain the highest practicable physical, mental, and psychosocial well-being" in accordance with her care plan. *See* 42 C.F.R. § 483.25. The deficiency in providing the necessary care and services had the potential for more than minimal harm, as Resident 2 may have had a serious but unassessed injury — which, in fact, she did. Accordingly, the mere fact that Petitioner's staff allowed Resident 2 to lie on the floor for 48 minutes after falling and striking her head, without any attempt to determine whether she fell or placed herself on the floor volitionally, demonstrates that Petitioner was not in substantial compliance with Medicare participation requirements.

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[6] Dr. Rey Chi Lin, a psychiatrist caring for Resident 2, stated that "it was reasonable for staff to believe that [Resident 2] had placed herself on the floor on the date in question." P. Ex. 9, at 1. But Dr. Lin does not address the more fundamental question of how staff would ever know whether Resident 2 had fallen. Dr. Lin's statement with regard to the belief held by Petitioner's staff members appears to be a *post facto* rationalization of the staff's complacency, and worthy of little weight in this Decision.

In addition, when staff approached Resident 2, they rolled her over, lifted her up, and made her walk without first attempting any meaningful assessment. CMS Ex. 10; CMS Ex. 11, at 3, 5-7. Petitioner's director of nursing and LPN Fry both state that if a resident falls, staff must assess that resident for injuries. CMS Ex. 11, at 9; Tr. 295; *see also Golden Living Center - Foley*, DAB CR2625, at 17 (2012), *aff'd*, DAB No. 2510 (2013) ("It is a basic standard of practice for a nurse to immediately assess a resident after a fall, before the resident is moved."). Even though Petitioner's staff was operating under the misconception that Resident 2 had put herself on the floor on purpose, there were signs that Resident 2 may have fallen and should have been assessed before being moved. CNA A.S. described Resident 2 as unresponsive to her voice, "out of it," and without any memory of falling. CMS Ex. 11, at 5. The video footage corroborates CNA A.S.[7] That footage shows Resident 2 lying still while staff approached her and began patting her back, consistent with CNA A.S.'s statement that she was unresponsive. CMS Ex. 10. For staff to come across a resident lying prone in the hallway, unresponsive to voice, "out of it," and without any recollection of how she ended up on the floor are all signs that something more serious than simply lying down may have occurred. Resident 2's care plan sets as a goal that she will not "injur[e] self or others," CMS Ex. 5, at 42, but staff did nothing to ensure this goal was met when they found her under the circumstances they did, and based upon the condition she was in. There was no reference to an "effective coping mechanism" in Resident 2's medical records that established staff would permit her to lie in a hallway unassessed for 48 minutes, then move her and stand her up, despite her exhibiting signs that she may have injured herself by falling. Accordingly, the conduct Petitioner's staff provided, *vel non*, in response to Resident 2's fall violated the requirement that Resident 2 be provided necessary care and services to attain or maintain her highest practicable well-being in accordance with her comprehensive assessment and care plan.[8]

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[7] I place little weight on the testimony of LPN Fry, which contradicts CNA A.S. LPN Fry claimed that Resident 2 was responsive and moving her arms and legs when the three staff members approached her in the hallway. Tr. 296; CMS Ex. 11, at 7. The video footage, however, shows that Resident 2 was not moving when staff approached her, but only started moving after staff had rolled her over and had begun to sit her up. *See* CMS Ex. 10.

[8] Petitioner argues that citing a deficiency under 42 C.F.R. § 483.25 is not appropriate in this case because the facts related to the cited deficiency relate to assessments, which are addressed in another regulatory provision. *See* P. Br. at 3. However, the regulation related to assessments refers to the initial assessment to establish a care plan, not the acute assessment of a resident after a fall. 42 C.F.R. § 483.20. Therefore, as in *Golden*

(*continued on next page. . .*)

b. *Resident 4*

Resident 4, a 69-year-old resident at the time of the survey, was admitted to Petitioner's facility on April 19, 2010. She had a history of a prior stroke, schizophrenia, and dementia, among other things. CMS Ex. 6, at 24-25. Her MDS stated that she needed "extensive assistance" for transfers and was "not steady" for all types of transitions and walking. CMS Ex. 6, at 21-22. A fall risk assessment from January 18, 2012, determined that Resident 4 was at "high risk" for falls. CMS Ex. 6, at 108. Her care plan documented several falls between May and November 2011; it also noted that Resident 4 "will walk out to hall [and] hold onto rail or lay [down] on floor often refusing staff assist." CMS Ex. 6, at 47.

On January 19, 2012, a CNA found Resident 4 lying on the floor in the hallway. No one witnessed Resident 4 fall or lie on the floor. Before assessing Resident 4, the CNA lifted her off the floor and placed her in a wheelchair. CMS Ex. 6, at 135. A nurse later assessed Resident 4 but did not find any injuries. CMS Ex. 6, at 135.

When a staff member found Resident 4 on the floor but had not witnessed her fall or lie down, Petitioner's staff was obliged to assess Resident 4 to determine whether or not she fell and, in turn, determine the necessary care and services to attain or maintain Resident 4's highest practicable well-being in accordance with her comprehensive assessment and care plan. She was assessed to be at "high risk" for falls and "unsteady," yet — as with Resident 2 — a staff member presumed she had not fallen when he found Resident 4 lying on the hallway floor. Resident 4 had a history of several falls, and her care plan set the goal of "not hav[ing] serious injury if fall should occur." CMS Ex. 6, at 52. Petitioner's staff overlooked the potential for a serious injury after a possible fall when the staff member picked Resident 4 up without any assessment. The staff's conduct ignored Resident 4's assessed risk of falls and the goal of not sustaining serious injury from falls. Staff's conduct had the potential to cause Resident 4for more than minimal harm as the movement of Resident 4 may have exacerbated a fall-related injury that was not recognized or assessed. Accordingly, Petitioner was not in substantial compliance with 42 C.F.R. § 483.25 by not ensuring that Resident 4 received necessary care to attain or maintain her highest practical well-being in accordance with her comprehensive assessment and care plan.

(*continued*)

Living Center - Foley, DAB CR2625, it is appropriate for CMS to cite the failure of a facility to assess a resident after a fall under 42 C.F.R. § 483.25 (Tag F-309).

Petitioner points to a note in Resident 4's care plan that states she "will walk out to hall [and] hold onto rail or lay [down] on floor often refusing staff assist." CMS Ex. 6, at 47; P. Br. at 14. However, unless such conduct was observed, staff could not reasonably presume that Resident 4 placed herself on the ground, especially given staff's knowledge of her being at "high risk" for falls and in need of "extensive assistance" for transfers and walking. CMS Ex. 6, at 21-22, 108. Moreover, the note in the care plan does not implement any procedures or steps to determine whether or not Resident 4 had actually fallen if she was found on the floor when no staff members had witnessed how she got to the floor. *See* CMS Ex. 6, at 47. The note in the care plan is nothing more than a factual assertion, but provides no directives and certainly no plan of care to address Resident 4's behavior. Therefore, I do not find the note in Resident 4's care plan excuses the lack of assessment when staff found her on the floor.

2. *Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h) because it did not provide adequate supervision or assistance device to address falls by Resident 4 and Resident 5, and did not safely maintain a hydraulic lift used to transfer Resident 9.*

The participation requirement addressing accident hazards, supervision, and assistance devices states:

> 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.

42 C.F.R. § 483.25(h). The Board has repeatedly explained the requirements of this subsection, stating:

> 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) . . . .

Meridian Nursing Center, DAB No. 2265, at 3 (2009) (some citations omitted).

Section 483.25(h), however, does not impose a strict liability standard against long-term care facilities. The existence of an accident "does not, in itself, prove that the supervision or devices provided must have been inadequate to prevent it." *Josephine Sunset Home*, DAB No. 1908, at 13 (2004). An accident is "relevant to the extent the surrounding circumstances shed light on the nature of the supervision being provided and its adequacy for the resident's condition." *St. Catherine's Care Center of Findlay, Inc.*, DAB No. 1964, at 12 (2005). Rather, the "focus is on whether the facility took all reasonable steps to ensure that a resident receives supervision and assistance devices that met his or her assessed needs and mitigate foreseeable risk of harm from accidents." *Josephine Sunset Home*, DAB No. 1908, at 12 (citing *Woodstock Care Center v. Thompson*, 363 F.3d at 590).

As the Board has explained, "prescience" is not required. *Id*. at 15. Instead, a facility is expected to exercise "reason and professional judgment," to determine what can be done "to make residents (given their special needs) safe, through removing accident hazards, providing appropriate devices, and ensuring adequate supervision." *Id.*

The regulation insists on no rigid means of preventing accidents, and the Board has held that facilities have flexibility in choosing the methods they use to prevent accidents, so long as the chosen methods constitute an adequate level of supervision. *Windsor Health Care Center*, DAB No. 1902. A facility must anticipate what accidents might befall a resident and take steps — such as increased supervision or the use of assistance devices — to prevent them. *Aase Haugen Homes*, DAB No. 2013 (2006).

Here, Petitioner did not ensure that Resident 4, Resident 5, or Resident 9 received adequate supervision or assistance devices to prevent accidents. While CMS also cited the supervision Petitioner's staff provided to Resident 10 as inadequate and a deficiency under 42 C.F.R. § 483.25(h), the record does not support that Petitioner was deficient in its supervision of Resident 10.

a. *Resident 4*

As explained above, Resident 4 needed "extensive assistance" for transfers, was "not steady" for transitions and walking, and was assessed as being at "high risk" for falls. CMS Ex. 6, at 21-22, 108. Under the "problem" section of Resident 4's care plan, it stated that she was at risk for falls and "frequently removes alarm and ambulates into hallway." CMS Ex. 6, at 52. One intervention to address her fall risk and the removal of her alarm was, among other things: "Observe frequently and place in supervised area when out of bed." CMS Ex. 6, at 52. Earlier care plans used a personal alarm for Resident 4, but Petitioner's staff removed that intervention as of April 28, 2011.

Resident 4's care plans noted eleven falls between May and September 2011, though Petitioner's staff did not add any new interventions to address these falls. CMS Ex. 6, at 52, 68. In addition, incident reports show seven occasions when staff found Resident 4 on the floor, only three of which were reported on her care plan:

1. September 14, 2011: staff heard Resident 4 "yelling" and found her on the floor beside her bed. Resident 4 "stated she was moving around in bed and fell out of bed." The incident was not witnessed. Staff placed non-skid strips on the floor. CMS Ex. 6, at 138.

2. September 18, 2011: staff "observed [Resident 4] laying in hallway on right side." Resident 4 told a CNA that "I fell out of my chair. I hit my head." The incident was not witnessed. Staff re-educated Resident 4 to use call light for assistance with her needs. CMS Ex. 6, at 137.

3. September 30, 2011: staff "observed [Resident 4] laying on right side with pillow under head beside bed." Resident 4 said "I fell while I was eating." The incident was not witnessed. Staff reminded Resident 4 to use a call light for assistance. CMS Ex. 6, at 136.

4. January 19, 2012: staff found Resident 4 in the hallway and "picked [her] up and put into [wheelchair]" prior to any assessment. The incident leading to Resident 4's being on the ground was not witnessed. No interventions were put in place. CMS Ex. 6, at 135.

5. January 27, 2012: staff found Resident 4 "on floor outside of her door sitting up [with] legs stretched out in front of her." The events leading to the incident were not witnessed. Staff placed a personal alarm on Resident 4. CMS Ex. 6, at 133.

6. February 1, 2012: upon being summoned, staff found Resident 4 "lying supine on floor in the hallway - not near walls." Resident 4 said she did not fall, but "scooted on my hands and knees." The incident was not witnessed. Staff encouraged Resident 4 to use the call light for assistance. CMS Ex. 6, at 132.

7. February 3, 2012: staff found Resident 4 "sitting on floor near doorway to [her] own room." Her personal alarm was off. The incident was not witnessed. Staff replaced the personal alarm and redirected Resident 4 not to remove the alarm. CMS Ex. 6, at 131.

The most common thread — albeit the most troubling one as well — is that Petitioner's staff did not witness any of the incidents where Resident 4 ended up on the floor.[9] Her care plan required staff to "[o]bserve frequently and place in supervised area when out of bed." CMS Ex. 6, at 52. The repeated instances where staff found Resident 4 on the floor after a fall (or possible fall) are inconsistent with carrying out the frequent observations that her care plan required as part of the adequate supervision she needed. Moreover, the numerous unwitnessed falls or instances where Resident 4 ended up on the floor demonstrate that staff was complacent in placing Resident 4 in a supervised area. Had Resident 4 been in a "supervised area" as her care plan required, staff would have been able to monitor her more closely and provide the type of "adequate supervision" contemplated in the regulatory standard. Instead, staff permitted Resident 4, who was at "high risk" for falls, to ambulate in the hallway on her own without any supervision whatsoever. Staff attempted to use a personal alarm system beginning January 27, 2012, but it did not work and staff knew it. Just seven days later, on February 3, 2012, staff again found Resident 4 on the floor outside of her room without her alarm. CMS Ex. 6, at 131. Even though Resident 4 was noncompliant with her personal alarm and continually removed it, Petitioner cannot skirt its responsibility to provide adequate supervision simply because Resident 4 may have thwarted one type of monitoring effort. While one-to-one supervision was likely not necessary, the repeated falls and instances where staff found Resident 4 lying on the floor required more supervision or additional assistance devices than what Petitioner provided. Constantly reminding Resident 4 to use a call light was clearly not effective. *See* CMS Ex. 6, at 136-37. The falls and occasions where staff found Resident 4 on the floor continued, yet Petitioner's staff took no reasonable steps to ensure it was providing adequate supervision or assistance devices to prevent those incidents. At some point, after the repeated falls, Petitioner's staff should have recognized that the supervision provided for in Resident 4's care plan — which staff was not fully implementing — was no longer adequate. Accordingly, Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h).

Petitioner claims that Resident 4 did not fall on every occasion that staff found her on the floor because she would routinely lie down on the floor. P. Br. at 14-15, 21. That certainly may be true. But Petitioner's position underscores the over-arching reality that no one actually knows how Petitioner ended up on the floor because she was not

[9] One incident report not listed above stated that a staff member actually saw Resident 4 trying to sit down on the ground while she was in the dining area, but prevented her from doing so. CMS Ex. 6, at 134. However, that single incident of providing supervision to Resident 4 while she was in a common area does not mitigate Petitioner's overall failure to provide adequate supervision to Resident 4 on the numerous other occasions when she either should have been in a supervised area but was not, or when staff permitted Resident 4 to ambulate into the hallway alone.

receiving the adequate supervision she needed as a resident at high risk for falls and in need of extensive assistance while ambulating. Petitioner only theorizes that Resident 4 did not fall based on some of her prior behavior, but has provided no specific evidence that she did not, in fact, fall on any of the occasions when staff found her on the floor. Instead, on at least three of the occasions, Resident 4 actually told staff that she fell. CMS Ex. 6, at 136-38. It was unreasonable at the time for staff, and equally unreasonable now in this Decision, to infer that Resident 4 intentionally lay down every time she was found on the floor, especially in light of her prior falls and being assessed as "high risk" for falls. Thus, Petitioner's claim with regard to how Resident 4 may have ended up on the floor has no merit. Overall, Petitioner has not provided evidence showing that it provided adequate supervision to Resident 4 in response to her repeated falls and instances of being found on the floor.

b. *Resident 5*

Resident 5, a 73-year-old resident at the time of the survey, was admitted to Petitioner's facility on September 8, 2008. Resident 5 was assessed as "not steady" for all transfers. CMS Ex. 7, at 18. His diagnoses included general muscle weakness. CMS Ex. 7, at 21. Four fall risk assessments completed between May and December 2011 all assessed Resident 5 to be at "high risk" for falls. CMS Ex. 7, at 198. At the time of the survey, Resident 5's two most recent care plans addressed his risk of falls and injuries. Interventions included a call light (added January 8, 2012), non-skid strips in front of his bed (added November 26, 2011, and again on January 23, 2012), and a lipped mattress (undated entry). CMS Ex. 7, at 48-52. He also required "extensive assistance" for bed mobility, transfers, and walking. CMS Ex. 7, at 17.

Resident 5 suffered several falls within a brief period, but Petitioner provided few or no interventions to prevent future falls. Between November 19 and November 26, 2011, Resident 5 fell to the floor three times while getting into or out of his bed. CMS Ex. 7, at 92, 100, 107. Resident 5 first fell on November 19, 2011, when he was sitting on the side of his bed, then "slid on the floor landing on his knees." CMS Ex. 7, at 92. Petitioner's staff notified Resident 5's physician, but did not make any interventions. CMS Ex. 7, at 92. Just four days later, on November 23, 2011, Resident 5 again fell out of his bed. CMS Ex. 7, at 100. Staff assisted him back into bed, but put no additional interventions in place despite the mounting evidence that Resident 5's falls were not isolated incidents, but foreseeable accidents. CMS Ex. 7, at 194. Finally, after the third fall on November 26, 2011, for which Resident 5 was transported to a local hospital's emergency room, Petitioner's staff placed non-skid strips around Resident 5's bed. CMS Ex. 7, at 51. Petitioner eventually fell again on January 8, 2012, trying to get out of bed and into his wheelchair. CMS Ex. 7, at 193. Curiously, one intervention added on Resident 5's care plan on January 23, 2012, was to add non-skid strips around his bed even though that intervention was supposed to be in place since Resident 5's fall on November 26, 2011. *See* CMS Ex. 7, at 48-49.

It is reasonably foreseeable that a resident such as Resident 5, who is assessed to be at "high risk" for falls, will fall. It is also reasonably foreseeable that a resident such as Resident 5, who is need of "extensive assistance" for bed mobility, will fall if not provided with that supervision and assistance. *See* CMS Ex. 7, at 17. Petitioner had several interventions in place to provide Resident 5 with supervision to mitigate this foreseeable risk of falls. *See* CMS Ex. 7, at 50-52. But the supervision associated with "extensive assistance" for transfers in and around bed was not provided to Resident 5 as evidenced by the repeated falls around his bed. Taking no action in the face of repeated falls and, indeed, allowing Resident 5 to continue to attempt transfers in and around his bed despite his need for extensive assistance for those transfers is not "adequate supervision" to prevent falls that, with each fall, became more foreseeable in nature and scope. Petitioner's effort, or lack thereof, with regard to Resident 5 does not comply with the adequate supervision and assistance device requirement at 42 C.F.R. § 483.25(h)(2).

Moreover, it is questionable whether Petitioner actually provided the non-skid strips it eventually determined were adequate to mitigate the risk of Resident 5's foreseeable falls. Petitioner's staff planned to implement the use of non-skid strips on November 26, 2011, yet a later care plan also planned to implement the use of non-skid strips on January 23, 2012. *Compare* CMS Ex. 7, at 51 (implementing non-skid strips on November 26, 2011) *with* CMS Ex. 7, at 49 (implementing non-skid strips on January 23, 2012). The most reasonable inference from the January 23 intervention of adding non-skid strips is that those non-skid strips were not in place before that time. Thus, Petitioner did not provide the non-skid strips that it had added to Resident 5's care plan on November 26, 2011, as a means of mitigating the risk of falls. The failure to continuously use non-skid strips on a resident at high risk for falls, who had recently suffered several falls, and for whom non-skid strips should have been in place, further demonstrates Petitioner's noncompliance with 42 C.F.R. § 483.25(h)(2).

c. *Resident 9*

Resident 9, an 82-year-old resident at the time of the survey, was originally admitted to Petitioner's facility in 2009, then readmitted on June 7, 2011. Resident 9 had a history of dementia, congestive heart failure, and hypertension, among other things. CMS Ex. 8, at 31-32. He used a "geri-chair" and wheelchair, and was rated in his MDS as being totally dependent on nursing staff for mobility and transfers. CMS Ex. 8, at 28. His care plan stated that at least two staff members were needed to assist Resident 9 with transfers and they were to use a Hoyer lift[10] device for those transfers. CMS Ex. 8, at 52.

[10] "Hoyer" is a name brand of a hydraulic-powered sling lift assistance device that transfers residents while they are in a seated position. *See* CMS Ex. 8, at 12-15.

On January 10, 2012, staff attempted to transfer Resident 9 from his bed to a shower chair. CMS Ex. 8, at 16. Staff used the Hoyer lift for the transfer, though staff later noted that the straps were "worn" and "frayed." CMS Ex. 8, at 11, 16. During the transfer, while Resident 9 was "up in the air," the left leg strap broke, then the right side strap "gave," and Resident 9 fell to the floor with his back against the bottom leg of the Hoyer lift. CMS Ex. 8, at 16. The fall resulted in a laceration to Resident 9's left elbow.

CMS submitted evidence showing that Petitioner's laundry staff routinely used bleach to clean the lift straps. CMS Ex. 8, at 8. The manufacturer's care instructions, however, state that use of abrasive cleaners such as bleach are not recommended and will likely result in damage to the straps. CMS Ex. 8, at 12.

Use of a Hoyer lift may certainly be an appropriate intervention for individuals such as Resident 9, who are totally dependent on staff assistance for transfers. *See* CMS Ex. 8, at 28; *see also* CMS Ex. 8, at 14 (stating that the purpose of a Hoyer lift is to "provide safe transfer for non-ambulatory resident"). But the assistance device must be "adequate," *see* 42 C.F.R. § 483.25(h)(2), and, when using it, the facility's staff must continue to "mitigate foreseeable risks of harm from accidents." *Briarwood Nursing Center*, DAB No. 2115, at 11. Here, Petitioner used an assistance device that had noticeable defects to its critical components. The CNA that used the Hoyer lift with Resident 9 noticed that the straps were "worn" and "frayed." CMS Ex. 8, at 11. It was reasonably foreseeable that the "worn" and "frayed" straps were likely to fail under the weight of a resident. Petitioner's nursing staff certainly should have known about the condition of the straps through routine inspection of the lift, although the CNA involved in the incident acknowledged that staff did not inspect the straps before using them, but only after they failed. CMS Ex. 8, at 11; *see* CMS Ex. 8, at 12 (manufacturer's instructions directing users to "Inspect each sling carefully prior to every use"). Perhaps the most compelling piece of evidence is the staff's use of bleach to wash the straps despite the manufacturer's unambiguous care instructions specifically warning against the use of bleach. The warning states: "Never use bleach to wash or clean a Bestcare sling as the material may become damaged." CMS Ex. 8, at 12. The use of bleach, which resulted in "worn" and "frayed" straps, demonstrates that Petitioner's staff, rather than taking steps to mitigate the risk of foreseeable accidents, was actually taking steps to create the risk of accidents and harm to residents by using the Hoyer lift with straps that Petitioner's staff had damaged.

Ultimately, the Hoyer lift was not "adequate" at the time staff transferred Resident 9 because of the condition of its straps, and Petitioner's staff did not mitigate the foreseeable risk of accidents and harm that could result from the use of straps in poor

condition. Petitioner, therefore, was not in substantial compliance with the participation requirement at 42 C.F.R. § 483.25(h)(2) when caring for Hoyer lift straps contrary to the manufacturer's instructions and warnings, and then using the Hoyer lift with worn and frayed straps.

d. *Resident 10*

Resident 10, a 67-year-old resident at the time of the survey, was originally admitted to Petitioner's facility in 2005, then readmitted on October 10, 2010. She had a history of a prior stroke, right-sided hemiparesis, schizophrenia, and muscle weakness, among other things. CMS Ex. 9, at 20-21. Resident 10's MDS stated that she needed "extensive assistance" — at least two-person assistance — for mobility, transfers, and toilet use. CMS Ex. 9, at 17. Four fall risk assessments done between April 2011 and January 2012 all determined that Resident 10 was at "high risk" for falls. CMS Ex. 9, at 6.

On January 20, 2012, Resident 10 fell off the toilet while she attempted to clean herself. CMS Ex. 9, at 68, 71. Two CNAs had assisted Resident 10 to the bathroom; one CNA stayed outside of the bathroom, the other CNA helped Resident 10 inside. CMS Ex. 11, at 10. After voiding, Resident 10 insisted on wiping herself, so the CNA inside of the bathroom stepped out to get a brief. CMS Ex. 11, at 10; CMS Ex. 9, at 68. While both CNAs were out of the bathroom, Resident 10 leaned forward, fell off the toilet, struck her head, and suffered a bruise on the left side of her head and an abrasion on her right knee. CMS Ex. 9, at 68. She was subsequently transported to a local hospital's emergency department for evaluation. CMS Ex. 9, at 68.

The surveyor found that Petitioner did not provide adequate supervision to Resident 10 when she fell forward off of the toilet and struck her head. CMS Ex. 4, at 14-16. However, the evidence shows that staff remained with Resident 10 while she was voiding, and only left Resident 10 to obtain a new brief, just outside the bathroom. CMS Ex. 9, at 68; CMS Ex. 11, at 10. At the exact time staff obtained the brief, Resident 10 leaned forward to clean herself, which resulted in her fall. CMS Ex. 11, at 10. I cannot find that the coincidence of a staff member obtaining a new brief and Resident 10 leaning forward to clean herself violates 42 C.F.R. § 483.25(h)(2). Even if the fall was foreseeable based on Resident 10's weakness and assistance needs for transfers, "adequate supervision" in this case does not require the constant visual observation of Resident 10 voiding and wiping herself as CMS and the surveyor seem to suggest. *See, e.g., Burton Health Care Center*, DAB No. 2051 (2006) (finding that a facility had provided adequate supervision to a resident who fell when attempting to transfer off a toilet at the same time staff momentarily turned around to obtain a brief). Nevertheless, as discussed, there is a basis for noncompliance with that participation requirement with regard to Residents 4, 5, and 9.

3. *CMS has not presented a prima facie case that Petitioner did not substantially comply with the care requirement at 42 C.F.R. § 483.25(a)(3).*

To participate in Medicare, a facility must provide "necessary services to maintain good nutrition, grooming, and personal and oral hygiene" to any resident "unable to carry out activities of daily living." 42 C.F.R. § 483.25(a)(3).

CMS claims that Petitioner's staff did not provide routine, two-hour incontinence checks of residents during the overnight shift. CMS Ex. 4, at 10-11. It is questionable whether CMS should have cited Petitioner under section 483.25(a)(3) for an issue involving incontinence care, which is separately addressed in section 483.25(d). However, insofar as incontinence affects personal hygiene, it may be reviewed applying the standard in section 483.25(a)(3) as well. The statement of deficiencies explains that the surveyor reviewed video footage that showed a four-hour period from when facility staff first entered and then reentered two incontinent residents' rooms. CMS Ex. 4, at 10-11. CMS, however, did not present any evidence to support this deficiency other than the statement of deficiencies and brief testimony of the surveyor at hearing.[11] CMS Ex. 4, at 8-13. The surveyor testified that facility staff was required to check on residents every two hours for incontinence, citing the State Operations Manual (SOM) guidance on pressure sore care. Tr. 123-24. But two-hour checks are not in the plain language of the participation requirement cited, the SOM guidance for that requirement (SOM, CMS Pub. 100-108, App. PP, Guidance for F312), or a facility policy that is in this record. Pressure sores and incontinence are separate issues that involve separate care, and the surveyor's conflation of the two does not conclusively establish a standard of care that Petitioner had to carry out for incontinent residents. He also stated that nurses were arriving on the day shift and finding residents "soaked in urine." Tr. 124. But, as Petitioner points out, nothing in the record establishes that the residents were soaked in urine for a prolonged period or whether an episode of incontinence occurred shortly before the day shift arrived, for example, whether the resident's soaked clothing was warm or cool. Accordingly, CMS has not shown that Petitioner violated a participation requirement or facility policy by not entering an incontinent resident's room for four hours.

CMS also claims that Petitioner's staff did not provide showers and baths to three residents with sufficient frequency to maintain personal hygiene. The Board has explained that bathing or showering a resident with the frequency stated in the relevant facility policy is necessary to maintain good personal hygiene; if the facility does not do so, it is not in substantial compliance with the regulation. *Sunshine Haven Lordsburg*,

[11] The statement of deficiencies referred to the incontinency care for Resident 6 and Resident 7, but CMS did not offer any medical records for either of the residents.

DAB No. 2456 (2012). However, unlike in *Sunshine Haven Lordsburg*, where the facility did not bathe residents according their care plans or the facility policy, CMS offered no evidence here, such as care plans or facility policies, to show how frequently certain residents needed a shower or bath to maintain good personal hygiene. In defending this alleged deficiency, Petitioner submitted the shower log for Resident 11, one of the residents that the surveyor cited as not receiving a bath or shower with enough frequency. P. Ex. 18; CMS Ex. 4, at 12. The shower log for Resident 11 shows that staff did not shower or bathe him for nine consecutive days. P. Ex. 18, at 1. There is no evidence, however, that shows the prolonged period without a shower or bath meant Resident 11 was not being provided necessary care to maintain good personal hygiene. CMS did not submit any evidence related to Resident 11, and there are no facts or evidence in the record from which a reasonable inference can be drawn that nine days without a shower or bath was *per se* insufficient to maintain Resident 11's personal hygiene. The only alleged standard that the surveyor cites is that "most reasonable people prefer to bath [*sic*] with a regular frequency that does not extend for [five] days between one shower and the next." CMS Ex. 4, at 13. The surveyor's blanket statement about his perception of "most reasonable people" is unsupported and carries no weight.

Accordingly, I find that CMS has not established a *prima facie* case that Petitioner did not substantially comply with 42 C.F.R. § 483.25(a)(3). It is nevertheless alarming that Petitioner did not provide a shower to some of its residents for upwards of nine days. However, simply because CMS did not support its claim for this specific deficiency does not mean that Petitioner's conduct is encouraged or is an example of the type of care that a long-term care facility should provide to its residents.

4. *There is a basis for CMS to impose an enforcement remedy.*

As explained above, Petitioner was not in substantial compliance with Medicare participation requirements at the time of the complaint survey. By regulation, CMS is authorized to impose an enforcement remedy when a facility is not in substantial compliance with participation requirements. 42 C.F.R. § 488.402(b). Therefore, there is a basis for CMS to impose an enforcement remedy. The choice of remedy imposed, which in this case was a DPNA, is not subject to review. 42 C.F.R. § 488.408(g)(2).

V. Conclusion

For the foregoing reasons, Petitioner was not in substantial compliance with Medicare participation requirements cited during the six-day complaint survey in January and February 2012, and there is a basis to impose a DPNA between March 13, 2012 and April 27, 2012. Therefore, the noncompliance determination and enforcement remedy are SUSTAINED.

/s/
Richard J. Smith
Administrative Law Judge