Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Perry Green Valley,	)	Date: April 18, 2007
(CCN: 37-5373)	)	
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-06-380
	)	Decision No. CR1587
Centers for Medicare & Medicaid	)	
Services.	)	
	)	

DECISION

Petitioner, Perry Green Valley (Petitioner or facility), is a long-term care facility located in Perry, Oklahoma and certified to participate in the Medicare program as a provider of services. Here, Petitioner appeals the Center for Medicare and Medicaid Services' (CMS's) determinations that, from September 7 through 29, 2005, it was not in substantial compliance with Medicare program requirements, including 42 C.F.R. § 483.25(h)(2), and that, on September 7, 2005, its conditions posed immediate jeopardy to resident health and safety. The parties have agreed that this matter may be decided on the written record, without an in-person hearing. For the reasons set forth below, I find that the facility was not in substantial compliance for the period in question, and that, on September 7, 2005, its deficiencies posed immediate jeopardy to resident health and safety. I also sustain the $4,150 penalty imposed.

I. Background

Following a survey completed September 8, 2005, surveyors from the Oklahoma State Department of Health (State Agency) concluded that the facility was not in substantial compliance with federal requirements for nursing homes participating in the Medicare program. Specifically, they found that the facility did not meet federal requirements under:

- 42 C.F.R. § 483.25(h)(2) (Tag F-324 – Quality of Care: Failure to Prevent Accidents) at a "J" level of scope and severity (isolated instance of immediate jeopardy to resident health and safety);

- 42 C.F.R. § 483.20(b)(2)(ii) (Tag F-274 – Resident Assessment) at a "D" level of scope and severity (isolated deficiency that caused no actual harm with the potential for more than minimal harm);

- 42 C.F.R. §§ 483.20(d) and 483.20(k)(1) (Tag F-279 – Comprehensive Care Plans) at scope and severity level "D";

- 42 C.F.R. § 483.25(d) (Tag F-315 – Quality of Care: Urinary Incontinence) at an "E" level of scope and severity (pattern of noncompliance that caused no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.35(i)(2) (Tag F-371 – Dietary Services: Sanitary Conditions) at scope and severity level "E";[1] and

- 42 C.F.R. § 483.60(a) (Tag F-426 – Pharmacy Services: Procedures) at scope and severity level "D."

CMS Ex. 4; P. Ex. 31.

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[1] Although neither party mentions it, the statement of deficiencies incorrectly cites 42 C.F.R. § 483.35(h)(2) for deficiencies that instead violate § 483.25(i)(2). CMS Ex. 3, at 25. Nevertheless, the survey report quotes the text of the correct sub-section, and lays out in sufficient detail the bases for its findings. *Id.* at 25-26. I consider this sufficient notice of violations. *Cedar View Good Samaritan*, DAB No. 1897, at 7-9 (2003) (quoting the text of the regulation held sufficient notice of violations, without actual citation to the regulation). Moreover, as discussed below, the deficiencies cited under 42 C.F.R. § 483.25, by themselves, justify the penalties imposed, without considering the deficiencies cited under dietary services.

CMS agreed with the surveyors' conclusions, and has imposed a Civil Money Penalty (CMP) of $3,500 for the one day of immediate jeopardy (September 7), plus $50 per day from September 8 through 29, 2005, for a total CMP of $4,150. P. Ex. 21.

Petitioner timely appealed and the matter was assigned to me as Docket No. C-06-12. In that case, I issued an initial order on October 19, 2005, directing CMS to file its prehearing exchanges on or before February 21, 2006. Unfortunately, the attorney who was then representing CMS, Mr. Kermit Williams, simply ignored my order. CMS filed no submission and no request for an extension of time in which to file. In an email sent March 8, 2006, we directed the parties to provide a status report no later than close of business that day. Petitioner promptly responded; CMS did not. In an Order to Show Cause dated March 10, 2006, I directed CMS to show cause why, in light of CMS's failure to proceed, I should not remand the matter to CMS. On March 21, 2006, Mr. Williams finally responded, indicating that he was not prepared to comply with my order and asking for additional time. I considered this response inadequate, and, on March 22, 2006, remanded the case to CMS to determine whether it was interested in pursuing the matter.

On March 31, 2006, CMS issued a new initial determination, which Petitioner again appealed. The case was then reassigned to me as Docket No. C-06-380. The parties filed their initial briefs (CMS Pre-hearing Br. and P. Pre-hearing Br.) and submissions. Petitioner also moved for summary judgment, which CMS opposed, suggesting (without filing its own motion) that CMS was instead entitled to summary judgment. In a ruling dated August 24, 2006, I denied summary judgment. Although the parties agreed that one of the facility residents (R4) was at significant risk for falls, that she had suffered multiple falls and some injuries, and that the facility had taken some steps to prevent falls and injury, they disputed the adequacy of the facility's actions. Under the Departmental Appeals Board's reasoning in *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004), summary judgment is generally not appropriate where the parties dispute the degree of resident risk or the appropriateness of a facility's plan to address that risk.

The parties subsequently agreed that the case could be decided on their written submissions, without an in-person hearing. *See* Agreed Motion to Supplement Testimony (September 11, 2006); Amended Order and Schedule for Briefing (September 11, 2006); 42 C.F.R. § 498.66 (waiver of right to appear and present evidence). The parties have filed closing briefs (CMS Br. and P. Br.) and reply briefs (CMS Reply and P. Reply). CMS has filed 14 exhibits (CMS Exs. 1-14). Petitioner has filed 32 exhibits (P. Exs. 1-32).[2] In the absence of any objection, I admit CMS Exs. 1-14 and P. Exs. 1-32.

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[2] P. Exhibit (Ex.) 1 consists of six sub-parts, Exs. 1a through 1f.

II. Issues

This case presents the following questions:

- Whether from September 7 through 29, 2005, the facility was in substantial compliance with requirements for facilities participating in the Medicare program. I consider specifically the facility's compliance with 42 C.F.R. § 483.25(h)(2).[3]

- If the facility was not in substantial compliance on September 7, 2005, did its conditions pose immediate jeopardy to resident health and safety?

- Since CMS has imposed the statutory minimum penalty amounts ($3,050 for one day of immediate jeopardy, and $50 per day for each day of substantial noncompliance), the question of whether those penalties imposed are reasonable is not before me. *See, e.g. Hermina Traeye Memorial Nursing Home*, DAB No. 1810, at 16 (2002). Nor do I consider the duration of the $50.00 per day CMP, since Petitioner has not raised that issue.[4]

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[3] Although CMS cited additional deficiencies, the parties have focused exclusively on the immediate jeopardy finding, 42 C.F.R. § 483.25(h)(2). Inasmuch as this deficiency, by itself, justifies the penalties imposed, I need not review the remaining citations. *Batavia Nursing and Convalescent Center*, DAB No. 1904, at 23 (2004); *Beechwood Sanitarium*, DAB No. 1824, at 19 (2002).

[4] In an event, where (as here) the facility's deficiencies have the potential for more than minimal harm, the facility is generally considered out of compliance "from the date of the completion of the survey in which these deficiencies were cited until the date of the resurvey in which substantial compliance is established." *Lake City Extended Care*, DAB No. 1658, at 14-15 (1998). And the burden is on the facility to prove that it has resumed complying with program requirements, not on CMS to prove that the deficiencies continued to exist after they were discovered. *Hermina Traeye Memorial Nursing Home*, DAB No. 1810, at 10 (2002).

III. Discussion

A. The facility did not provide Resident 4 (R4) with adequate supervision to prevent accidents and was therefore not in substantial compliance with the program participation requirement set forth at 42 C.F.R. § 483.25(h)(2).

Under the statute and "quality of care" regulation, each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being, in accordance with the resident's comprehensive assessment and plan of care. Act, section 1819(b); 42 C.F.R. § 483.25. The regulation 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); *Woodstock Care Center,* DAB No. 1726, at 25 - 30 (2002). Among other specific requirements, the facility is required to "take reasonable steps to ensure that a resident receives supervision and assistance devices designed to meet his or her assessed needs and to mitigate foreseeable risks of harm from accidents." 42 C.F.R. § 483.25(h)(2); *Windsor,* DAB No. 1902, at 5 (2003); *Asbury Center at Johnson City,* DAB No. 1815, at 12 (2002); *Koester Pavilion,* DAB No. 1750, at 25 - 26 (2000); *Woodstock,* DAB No. 1726, at 25 (2002). The regulation requires the facility to anticipate what accidents might befall a resident and to take steps – increased supervision or the use of assistance devices – to prevent them. *Guardian Health Care Center*, DAB No. 1943, at 18 (2004).

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

Windsor, DAB No. 1902, at 5 (2003).

In this case, R4 was a 55-year-old woman with diagnoses of malignant brain cancer, obsessive-compulsive disorder, and dementia. She suffered significant long and short-term memory loss. "Verbal reminders seem to fall on deaf ears at times." CMS Ex. 7, at 6. She was unable to walk and required total assistance with all transfers. She spent her days up in a wheelchair, wandering the halls, asking for cigarettes and Pepsi. *Id.*

R4 was admitted to the facility on May 4, 2004. She was at high risk for falls, and, to prevent accidents, the facility provided her with a Wanderguard bracelet, as well as bed and chair alarms, and kept her mattress at a low level. P. Ex. 1e, at 1-5. However, as the record shows, these interventions were not particularly effective in preventing accidents.

- On May 6, 2004, at 4:15 a.m., an aide responded to the sound of R4's bed/chair alarm, and found her lying on the floor of her room. R4 said that she "sat up on the side of bed and tried to stand up and ended up on the floor." No additional precautions seem to have been taken to prevent recurrence, except "frequent bed checks" and to continue with the bed alarm and low bed.

P. Ex. 1b, at 2; P. Ex. 17, at 2.

- On May 17, 2004, a nurse observed R4's attempt to enter her room. R4 was unable to get her wheelchair over the threshold and fell forward out of the chair. Initially, no injuries were reported, although a subsequent entry in the nursing notes mentions a red hematoma on her right forearm. Staff apparently took no action to prevent a recurrence except to remind R4 to ask for assistance if she needed it.

P. Ex. 1b, at 3; P. Ex. 17, at 3.

- On May 23, 2004, at 3:15 p.m., R4 (who was incontinent and required diapers) "was found" on the floor near the toilet in the Hall 6 bathroom. She said that she fell trying to sit on the toilet. Again, no steps were taken to prevent recurrence except to instruct R4 to ask staff for assistance.

P. Ex. 1b, at 4; P. Ex. 17, at 4.

- But on May 26 at 11:30 a.m., a nurse again found R4 on the bathroom floor in front of the toilet. Her wheelchair alarm was turned on but was not going off. Staff replaced the batteries in her chair alarm, and reminded her to ask for assistance.

P. Ex. 1b, at 5; P. Ex. 17, at 6.

- At 2:45 p.m. the same day, a nurse found R4 sitting on the floor at the side of her bed. The nurse reminded R4 to use her call light, and the resident agreed to do so. Either no incident report was generated following this incident, or Petitioner decided not to produce it.

P. Ex. 1b, at 5.

- On May 31, 2004, at 9:30 p.m., a nurse aide found R4 sitting on the floor facing her bed. She told the aide that she had needed to go to the bathroom. The facility's response was to remind the resident to leave her alarms on, and to call for help. Staff also placed a mat beside her bed.

P. Ex. 1b, at 6; P. Ex. 17, at 7.

- On June 19, 2004, R4 was in the dining room, attempting to wheel her wheelchair away from the table, when she "scooted out" of the wheel chair. According to the incident report, a pressure sensitive chair matt was ordered for R4's wheelchair. Subsequent notes refer to the incident as a "fall."

P. Ex. 1b, at 7; P. Ex. 17, at 8.

- On July 4, 2004, R4 was again "found on floor," with the chair alarm beeping. She said that she had slipped. Again, Petitioner provides no evidence that an incident report was generated following the July 4, 2005 incident.

P. Ex. 1b, at 8.

- An incident report indicates that at 9:00 p.m. on July 14, 2004, R4 went into her room and shut the door. The alarm sounded. When the nurse arrived and found her on the floor, she said that she had slipped. Nurses notes do not mention the incident.

P. Ex. 17, at 10; *See* P. Ex. 1b, at 34.

- On July 25, 2004, at 10:20 a.m., R4 was found outside her bathroom, sitting on the floor in front of her wheelchair with her feet extended in front of her. She said that she tried to go to the bathroom. Again, the facility responded by encouraging her to ask for assistance in transferring. The CNA was also encouraged to toilet R4 every two hours and as needed.

P. Ex. 1b, at 8; P. Ex. 17, at 9.

- On August 15, 2004, at 2:30 p.m. a nurse found R4 lying on her back on the floor of her room. She said that she had attempted to put herself to bed and fell. To prevent recurrence, the incident report mentions bed/chair alarms, and wheelchair

pad, and suggests offering to lay her down before a shift change. The following day, R4 attempted to rise from her chair, the alarm went off, but a nurse caught her.

P. Ex. 1b, at 9; P. Ex. 17, at 12.

- On August 27, 2004, however, at 9:05 a.m., R4 was again found in a bathroom on Hall 3, wedged between the toilet and the wall; she was sitting up with her back against the wall and legs out in front of her. She said that she was just trying to get to the bathroom. The chair alarm is described as in place and working properly. R4 was reminded to call for assistance, but "is very forgetful." According to the incident report, staff was also encouraged to monitor her frequently.

P. Ex. 1b, at 10; P. Ex. 17, at 11.

- On September 3, 2004, at 6:45 p.m., R4 again attempted to put herself from wheelchair to bed, and fell on the floor. She apparently suffered scratches down her back. To prevent recurrence, the incident report says "assist to bed quickly when she asks" and refers to the wheelchair pad.

P. Ex. 1b, at 11; P. Ex. 17, at 14.

- On October 5, 2004, R4 was found sitting on the floor. Staff again instructed her to use the call system.

P. Ex. 1b, at 11; P. Ex. 17, at 15.

- On October 7, 2004, at 10:45 a.m., a housekeeper found R4 sitting on the floor in front of her bed, her feet out in front of her. The chair alarm was sounding "upon entering the room." R4 said that she slid off the bed trying to "△" herself. Again, she was encouraged to call for assistance, but "is very forgetful." Staff were again encouraged to check her frequently.

P. Ex. 1b, at 12; P. Ex. 17, at 16.

- On October 16, 2004, at 9:20 a.m., an aide found R4 lying on the floor by the head of her bed. She was lying on her left side with a large body pillow under her armpit and was reading a book. She said that she had tried to get up and go to bed. Staff again write that her chair alarm is in place and working, that the resident is encouraged to call for assistance, and that staff is encouraged to monitor her frequently.

P. Ex. 1b, at 13-14; P. Ex. 17, at 17.

- On November 18, 2004, at 10:00 p.m., R4 was found on the floor in the smoking room.

P. Ex. 1b, at 15; P. Ex. 17, at 18.

- On December 2, 2004, R4 was found sitting on the floor in front of her wheelchair, next to her bed. Her feet were folded under her. She said that she had been trying to get out of bed. The facility's response was to encourage her to use the call light for assistance and encourage staff to check her more frequently.

P. Ex. 1b, at 16; P. Ex. 17, at 19.

- On December 28, 2004, at 9:55 a.m., the resident was escorted out to the patio to smoke a cigarette. She was apparently left there, because five minutes later, she "was found" lying on her left side, with "bright red bleeding" from her left nostril. She had abrasions on the right side of her face and around her right eye. She had abrasions on her left elbow and knee. She was unable to say how she fell, but another resident said that she leaned forward and fell from the wheelchair, scraping the right side of her face and hitting her nose on the ground. Remarkably, given the seriousness of this accident, the facility either failed to generate an incident report or Petitioner decided not to produce it.

P. Ex. 1b, at 17.

- On February 14, 2005, at 1:30 p.m., R4 was found on the floor in front of her wheelchair. She said that she tried to get into bed and fell. In response, the incident report indicates that the CNAs should lay her down for a nap after lunch.

P. Ex. 1b, at 18; P. Ex. 17, at 20.

- A February 24, 2005 nursing assessment notes R4's unsteady gait, inability to ask for assistance in transferring, and history of frequent falls. The assessment notes that her brain cancer affects her memory and her ability to understand.

P. Ex. 1b, at 19.

- On March 3, 2005, at 6:00 p.m., R4 was again found on the floor of her room; she reported that she had "scooted out" of her wheelchair. The incident report indicates that the resident should lie down for a nap mid-afternoon.

P. Ex. 1b, at 19; CMS Ex. 8, at 1; P. Ex. 17, at 21; CMS Ex. 9, at 1.

- A March 18, 2005 nursing assessment again notes R4's history of falls, and use of a chair alarm for safety, but says nothing more about the effectiveness (or lack thereof) of these interventions.

P. Ex. 1b, at 20.

- On April 4, 2005, at 6:15 p.m., R4 was again found on the floor of the Hall 3 bathroom, wedged between the wall and the toilet. She said that she had been trying to use the bathroom. Staff assisted her back into her wheelchair and encouraged her not to attempt to get out of it without assistance, but the nurse notes "unsure if she understood."

P. Ex. 1b, at 20; CMS Ex. 8, at 2; P. Ex. 17, at 22; CMS Ex. 9, at 2.

- At 11:00 a.m. on April 10, 2005, R4 was reaching for something on the floor, and "toppled" onto the floor. She hit the side of her right eye on the bedside table, and the area was "blue in color." The incident report acknowledges that because of her cognitive impairment, R4 does not remember verbal cautioning.

P. Ex. 1b, at 21, 22 (small purple bruise to right eye); CMS Ex. 8, at 3; P. Ex. 17, at 23; CMS Ex. 9, at 3.

- On April 19, 2005, at 1:35 p.m. she was found lying on the floor, face down on her right side. Her nose was bleeding; she had a bruise and bump on the left side of her forehead. She said that she had been reaching forward to reach a book on her bedside table, and had fallen forward, hitting her head. A bruise subsequently appeared on her left forearm, and she complained of pain. Again, the incident report says that she is encouraged to call for assistance. Staff were also encouraged to leave items within her reach.

P. Ex. 1b, at 22, 23; CMS Ex. 8, at 4, 5; P. Ex. 17, at 24; CMS Ex. 9, at 4.

- A nursing entry dated April 20, 2005, notes that staff are "encouraged" to anticipate and meet her needs to prevent a recurrence.

P. Ex. 1b, at 23.

- But at 6:15 a.m. on April 25, 2005, a nurse aide found R4 lying on the floor on her left side "with a large (one foot in diameter) pool of blood from her nose on the floor, coagulated blood streaming from both [nostrils]." The nursing entry indicates that she was unable to explain what happened, but had been in her wheelchair prior to the fall. She was taken to the emergency room via ambulance. She returned at 9:00 a.m., her face bruised and swollen. The incident report suggests no new interventions to prevent recurrence ("keep bed/chair alarm on resident [at] all times"), but nursing notes indicate that her family asked that she be given a safety belt to prevent falls, and staff suggested a lap buddy. Her physician ordered a lap buddy on April 25, 2005.[5]

P. Ex. 1b, at 23, 24; CMS Ex. 7, at 5; CMS Ex. 8, at 5, 6; P. Ex. 17, at 25; CMS Ex. 9, at 5.

- But at 7:30 - 7:45 p.m. on April 26, 2005, she was again "found" on the floor of her room. She said that she "just fell/slid out of my chair." The incident report indicates that a lap buddy had been ordered.

P. Ex. 1b, at 25; CMS Ex. 8, at 7; P. Ex. 17, at 26; CMS Ex. 9, at 6.

- At 7:00 a.m. the following morning, R4 was wheeling herself into the dining room for breakfast when she fell forward out of her wheelchair, hitting her right forehead to the floor. A mechanical lift was used to return her to her wheelchair. She suffered a bloody nose and additional bruising to her face. According to a CNA witness, she had been leaning forward in the chair at the time of the fall. Nursing notes report that during the afternoon R4 became lethargic and her right pupil was "sluggish." Upon examination, she was minimally responsive. She was eventually taken to the emergency room by ambulance.

P. Ex. 1b, at 25-27; CMS Ex. 8, at 7-9; P. Ex. 17, at 26-27; CMS Ex. 9, at 7.

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[5] A lap buddy is a laptop cushion that should fit snugly between the resident and the wheelchair frame to facilitate upper body positioning and reduce falls. CMS suggests that R4's lap buddy did not fit snugly; it was too small for the chair.

- When she returned to the facility that day, staff put a "landing strip" next to her bed, and instructed her not to get out of bed "for any reason" unless staff is there to help.

P. Ex. 1b, at 28.

- On May 1, 2005, at 6:00 a.m., R4 was found on the floor of her room, abrasions on both knees. She said that she had been leaning forward when she fell. An incident report describing the accident says that she is in a low bed with a safety mattress on the floor, and that she uses a lap buddy. A 1:00 p.m. note says "lap buddy in place when in [wheelchair]," although I don't know if this means it was in place prior to her fall, or was subsequently put in place.

P. Ex. 1b, at 30; CMS Ex. 8, at 12; P. Ex. 17, at 30; CMS Ex. 9, at 10.

- In a separate incident, at 8:00 p.m. the same day, the CNA again found R4 on the floor of her room. The nursing notes and incident report are not wholly consistent as to the circumstances of this incident. The nursing note says that the nurse instructed her to leave the lap buddy on at all times, and told the CNA to lay her down immediately after dinner, suggesting that she fell from her chair. But the incident report indicates that she "slid out" of bed. It also indicates that she was in a low bed, with a safety mattress on the floor.

Compare P. Ex. 1b, at 30 *with* P. Ex. 17, at 28. Notes thereafter include complaints of headache and facial pain from her bruises. *See* P. Ex. 1b, at 31.

- At 9:30 p.m. on May 2, 2005, the nurse was called to the resident's room where R4 was lying on the mat on the floor, a bleeding abrasion on her forehead. The

  > incident report indicates that she rolled out of bed onto the safety mat, and that her mattress is in a low position.

P. Ex. 1b, at 31; P. Ex. 17, at 29.

- A May 4, 2005 entry indicates that R4 removed the lap buddy four times on that shift, and "is able to remove [it] herself." She was encouraged to leave it in place.

P. Ex. 1b, at 32.

- An assessment dated May 5, 2005, reports R4's increased incidence of falls, and notes that, even though a lap buddy was put on her chair, she is able to remove it and continues to fall. Staff were still to keep her bed low with a safety mattress on the floor; remind her to use her call light; evaluate causes of falls; gather and assess information on her falls.

CMS Ex. 7, at 6-9.

- On July 21, 2005, a CNA found R4 on the floor in her room. She had removed the lap buddy, tried to get up, but fell. She said that she had wanted to get into bed. She also complained that she hurt "all over," but a head-to-toe assessment found no injuries. The facility's response was to encourage her to use her call light, to request assistance, and not to remove the lap buddy herself.

P. Ex. 1b, at 34; P. Ex. 17, at 31.

- Finally, at 7:00 p.m. (per nursing notes) or 7:30 p.m. (per incident report) on September 1, 2005, R4 was found on the floor of her room with the lap buddy underneath her. She said that she was trying to get up and into bed. One nurse writes that "this lady should be put to bed by 7:00 p.m. as she is up all day [and] is ready by that time.[6] This might avoid incidents of this nature." But under steps taken to prevent recurrence, the facility's response, once more, is "instructed resident to not remove lap buddy [and] use call light when needing assist[ance]."

P. Ex. 1b, at 36; P. Ex. 17, at 32.

Overwhelming evidence thus establishes that, from the time of R4's admission, her high risk of injury from falls was plainly foreseeable. To establish its substantial compliance with § 483.25(h)(2), the facility must show that it took "reasonable steps to ensure" that she receive the level of supervision and assistive devices she needed in order to be safe.

Petitioner acknowledges R4's propensity to fall, attributes it to her deteriorating condition, and argues that it "successfully implemented interventions after each fall that reduced the likelihood of that particular type of fall recurring." P. Br. at 1-2. But the evidence before me does not establish that the facility was adequately responding to R4's alarming rate of accidents. In fact, after implementing its initial efforts (bed/chair alarms and low level mattress) – which did not effectively prevent accidents – about the only

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[6] That R4 was "up all day" suggests that staff *did not* "lay her down before shift change" (P. Ex. 17, at 12) and *did not* "lay her down for a nap after lunch" (P. Ex. 17, at 20) as recommended in the earlier incident reports.

additional step the facility took was to provide R4 a lap buddy. It did so at the family's request sometime in April 2005, after almost a full year of R4's experiencing frequent and dangerous accidents. P. Ex. 1b, at 23; P. Ex. 17, at 25, 26. But the lap buddy was plainly ineffective since R4 was able to remove it, and, in fact, she removed it repeatedly. P. Ex. 1b, at 32, 34, 36; CMS Ex. 7, at 6, 7. The two falls that most immediately preceded the survey (July 21 and September 1, 2005) involved her removing the lap buddy. P. Ex. 1b, at 34, 36.

The incident reports mention a number of other potential interventions: "frequent bed checks" (P. Ex. 17, at 2); "encourage CNA to toilet every 2 hrs. and as needed" (P. Ex. 17, at 9); "lay her down before shift change" (P. Ex. 17, at 12); "lay her down for a nap after lunch" (P. Ex. 17, at 20); "encourage staff to monitor frequently" (P. Ex. 17, at 11, 16, 17, 19); "staff encouraged to leave items w/in her reach" (P. Ex. 17, at 24); staff "encouraged to anticipate and meet her needs" (P. Ex. 1b, at 23); "this lady should be put to bed by 7:00 p.m." (P. Ex. 1b, at 36). But not one shred of evidence suggests that the facility ever implemented any of these suggestions in any systematic, reliable way. I see no evidence that these interventions were incorporated into R4's care plan. CMS Ex. 7, at 8. Petitioner does not even define "frequent" checks, much less offer evidence that staff was monitoring R4 at regular intervals.

Most often, the facility responded to R4's accidents by "reminding" or "encouraging" her to ask for assistance. P. Ex. 17, at 3, 4, 6, 7, 14, 15, 16, 17, 19, 22, 24, 31, 32. But, as facility staff well understood, this response was useless. R4 simply could not remember such cautions. *See, e.g.,* CMS Ex. 7, at 6, 7; P. Ex. 1b, at 19, 20, 23 (because of her cognitive impairment, does not remember verbal cautioning).

Petitioner's expert witness, former nurse surveyor Linda Wilkerson, claims that the facility took some additional intervening steps to prevent accidents because staff took R4's blood pressure every week; and periodically checked her medication levels. P. Ex. 32, at 2, 9-10. I do not see a lot of evidence linking these practices to accident prevention, although that may be attributable to the absence of specific citations to the clinical records in Petitioner's argument.[7] R4's blood pressure was normal, and nothing in the record suggests that her propensity to fall was related to either blood pressure or medication issues. According to her assessments, she was at risk because she was unable to walk or transfer without total assistance. CMS Ex. 7, at 6. But she could not remember that she was unable to walk; she also tended to lean too far forward in her

[7] Throughout their briefs, both parties make many broad assertions without specific reference to the record, which makes it much more difficult to credit their arguments.

wheelchair and fell out. In any event, even assuming that it was necessary to eliminate blood pressure and medication as factors contributing to R4's risk, doing so did not substitute for providing her adequate supervision and assistive devices to prevent accidents.

Nurse Wilkerson also points to the bed and chair alarms as devices that allow for staff's "rapid response," so they can intervene quickly and prevent further injury. P. Ex. 32, at 4. Bed and chair alarms *can* do that, and, the record here includes one occasion where responding to an alarm likely prevented an accident. P. Ex. 1b, at 9. More often, however, staff either did not hear an alarm, or were unable or unwilling to respond quickly enough to prevent accidents. A bed or chair alarm is not an adequate substitute for supervision, and the record is striking for how often R4 is "found" lying on the floor. P. Ex. 1b, at 2, 4, 5, 6, 8, 9, 10, 11, 12, 13-14, 15, 16, 17, 18, 19, 20, 22, 23, 25-27, 30, 31, 34, 36; P. Ex. 17, at 10.

Pointing to an entry in the nurses' notes, Nurse Wilkerson also claims that the facility moved R4 to a room nearer the nurses' station. P. Ex. 32, at 8; P. Br. at 5. A May 6, 2005 entry says that, after a discussion with R4's mother, the facility intended to move R4 from Room 34 to Room 12, a room "closer to the center of the building." P. Ex. 1b, at 33. As with so many of the facility's purported interventions, however, no evidence establishes that this was ever implemented. To the contrary, the record entries consistently show that R4 remained in Room 34. The incident reports put her in Room 34 prior to May 6, 2005, when the entry was written (P. Ex. 17, at 2, 3, 7, 10,12, 14, 15, 16, 17, 19, 23, 24, 25, 26, 28, 29). She was there on May 6, 2005 (P. Ex. 17, at 30), and, she was still there at the time of her most recent falls, July 21, and September 1, 2005. P. Ex. 17, at 31, 32. *See also* P. Ex. 1a, at 2 - 10 (medication records throughout her stay show that she is in Room 34); P. Ex. 1b (from time of her admission through September 20, 2005, virtually every page of the nurses' notes places her in Room 34).[8]

Finally, Petitioner complains that the immediate jeopardy penalty was imposed for one day in September, pointing out that, as of the time of the survey, R4 had fallen only twice since May (on July 21, 2005 and again on September 1, 2005). Indeed, even though the facility failed to prevent accidents for a 16-month period, CMS has only imposed a penalty effective September 7, 2005. Certainly, CMS might have determined that the

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[8] Facility staff obviously know whether R4's room was changed, and no staff person has suggested that it was. That Nurse Wilkerson would make this claim without regard to the overwhelming evidence to the contrary, suggests that she did not verify her factual assertions, and raises serious questions about the credibility of her statements and opinions.

facility's failure to supervise began well before then, and could justifiably have imposed penalties from an earlier date. However, CMS's disinclination to do so does not mean that the facility was in substantial compliance on September 7, 2005. The evidence establishes on September 7 and thereafter, R4 was at high risk for falls, the facility recognized that risk, but was not providing her the "necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being," as required by the regulation.[9] I must therefore sustain CMS's determination that the facility was not in substantial compliance.

B. The facility conditions posed immediate jeopardy to resident health and safety.

I next consider whether CMS's immediate jeopardy finding was "clearly erroneous." 42 C.F.R. § 498.60(c)(2). The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy, and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1962, at 11 (2005); *Florence Park Care Center*, DAB No. 1931, at 27-28 (2004), *citing Koester Pavilion*, DAB No. 1750 (2000).

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. Here, R4 suffered some serious injuries as a result of falls. P. Ex. 1b, at 17, 22, 23. Her falling – particularly falling head-first out of her wheelchair – created the likelihood of more serious injury. CMS's immediate jeopardy determination is therefore not clearly erroneous, and must be affirmed.

C. The facility's per day CMP for the day of noncompliance at the immediate jeopardy level must be at least $3,050, and the CMP for each day of noncompliance that is not immediate jeopardy must be at least $50.

The statute and regulations limit my authority to review the amount of the CMP. In situations such as this, where the deficiencies constitute immediate jeopardy, CMS may impose a CMP in the range of $3,050 to $10,000 per day. 42 C.F.R. § 488.438. Where a

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[9] Following the survey, the facility initially provided one-on-one supervision, during which time the resident attempted to remove the lap buddy, but the nurse prevented her from doing so. P. Ex. 1b, at 36, 41. The facility ordered a drop seat for her wheelchair to discourage her from standing. The lap buddy, bed and chair alarms, were continued. She was also supposed to lie down after meals. P. Ex. 1f, at 1; *see also,* CMS Ex. 5.

CMP of $3,050 per day is imposed, the daily amount must be sustained unless the nursing home establishes that the determination of immediate jeopardy is clearly erroneous. *Hermina Traeye Memorial Nursing Home*, DAB No. 1810, at 16 (2002).

With respect to the days of substantial noncompliance that was not immediate jeopardy, the minimum penalty must be at least $50 per day. 42 C.F.R. § 488.438.

IV. Conclusion

For all of these reasons, I uphold CMS's determination that, from September 7 through 29, 2005, the facility was not in substantial compliance with program participation requirements, specifically 42 C.F.R. § 483.25(h)(2), and on September 7, 2005, its deficiencies posed immediate jeopardy to resident health and safety. I therefore sustain the $4,150 CMP.

/s/
Carolyn Cozad Hughes
Administrative Law Judge