Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Country Villa Watsonville East Nursing Center
(CCN: 05-5240),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-08-662

Decision No. CR2181

Date: July 13, 2010

DECISION

Petitioner, Country Villa Watsonville East Nursing Center, was not in substantial compliance with program participation requirements for the period June 5, 2008 through September 7, 2008. A per instance civil money penalty (PICMP) of $3,000 for the violation of 42 C.F.R. § 483.25[1] and a $3,000 PICMP for the violation of 42 C.F.R. § 483.25(h) are reasonable enforcement remedies in this case. At hearing, Petitioner waived review of other deficiencies. In addition, Petitioner waived review of whether a denial of payment for new admissions (DPNA) for the period July 10, 2008 through September 7, 2008, is a reasonable enforcement remedy. Accordingly, the DPNA for the period July 10, 2008 through September 7, 2008, is a reasonable enforcement remedy.

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[1] References are to the 2007 revision of the Code of Federal Regulations (C.F.R.), unless otherwise indicated.

I. Background

Petitioner, located in Watsonville, California, is authorized to participate in Medicare as a skilled nursing facility (SNF). Petitioner was subject to a survey by the California Department of Public Health (the state agency) that was completed on June 5, 2008. The Centers for Medicare and Medicaid Services (CMS) notified Petitioner by letter dated June 25, 2008, that, based on deficiencies that the survey identified, CMS was imposing: a PICMP of $3,000 for a violation of 42 C.F.R. § 483.25 (Tag F309); a PICMP of $3,000 for a violation of 42 C.F.R. § 483.25(h) (Tag F323); a DPNA beginning on July 10, 2008, and continuing until Petitioner returned to substantial compliance; and termination of Petitioner's provider agreement on December 5, 2008, if Petitioner did not return to substantial compliance before that date. CMS notified Petitioner by letter dated October 2, 2008, that: Petitioner was found to have returned to substantial compliance effective September 8, 2008; the DPNA ended effective that date; and the termination remedy was rescinded. Joint Stipulation of Undisputed Facts dated October 27, 2008 (Jt. Stip.); CMS Exhibit (CMS Ex.) 6; Petitioner's Prehearing Brief at 3; CMS Prehearing Brief at 3; CMS Proposed Finding of Fact 8.

Petitioner requested a hearing by letter dated August 5, 2008. The request for hearing was docketed as C-08-662 and assigned to me for hearing and decision on August 13, 2008. A Notice of Case Assignment and Prehearing Case Development Order (Prehearing Order) was issued at my direction on August 13, 2008.

I convened a hearing in San Jose, California on February 10 and 11, 2009. CMS offered, and I admitted, CMS Exhibits 1 through 6, 14, 16, 19, 20, 24, 39 through 41, 43, 44, 47, 50 through 52, and 55 through 57. Transcript (Tr.) at 27. Petitioner offered, and I admitted, Petitioner Exhibits (P. Ex.) 1 through 4.[2] Tr. at 29. CMS elicited testimony from Surveyors Elizabeth Wagner and Madelyn Winterbourne. Petitioner elicited testimony from Julie Velez, Petitioner's Social Services Director at the time of the survey. The parties submitted post-hearing briefs (CMS Brief and P. Brief, respectively) and reply briefs (CMS Reply and P. Reply, respectively).

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[2] Petitioner submitted a List of Admitted and Withdrawn Exhibits with its post-hearing reply brief on which Petitioner states that only P. Exs. 3 and 4 were admitted. Petitioner's list is in error, as P. Exs. 1 through 4 were offered (Tr. at 28) and admitted (Tr. at 29) at the hearing. Counsel for Petitioner explained at hearing that the pages in its exhibits are not consecutively numbered, as pages were removed from the exhibits after they were exchanged and before they were offered at hearing to ensure that Petitioner's exhibits did not duplicate those of CMS and to eliminate pages not relevant to the issues remaining at hearing. Tr. at 28-29.

II. Discussion

A. Issues

The issues in this case are:

> Whether there is a basis for the imposition of an enforcement remedy; and
>
> Whether the remedy imposed is reasonable.

B. Applicable Law

The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 (SNF) and 1919 (nursing facilities (NF) under the state Medicaid program) of the Act and at 42 C.F.R. Part 483. Section 1819(h)(2) of the Act vests the Secretary of Health and Human Services (Secretary) with authority to impose enforcement remedies against a SNF for failure to comply substantially with the federal participation requirements established by sections 1819(b), (c), and (d) of the Act.[3] Pursuant to 1819(h)(2)(C), the Secretary may continue Medicare payments to a SNF not longer than six months after the date the facility is first found not in compliance with participation requirements. Pursuant to 1819(h)(2)(D), if a SNF does not return to compliance with participation requirements within three months, the Secretary must deny payments for all individuals admitted to the facility after that date – commonly referred to as the mandatory, or statutory, DPNA. In addition to the authority to terminate a noncompliant SNF's participation in Medicare, the Act grants the Secretary authority to impose other enforcement remedies, including a discretionary DPNA, civil money penalties, appointment of temporary management, and other remedies, such as a directed plan of correction. Act § 1819(h)(2)(B).

The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. "*Substantial compliance* means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301 (emphasis in original). A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act or the Secretary's

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[3] Section 1919(h)(2) of the Act gives similar enforcement authority to the states to ensure that NFs comply with their participation requirements that sections 1919(b), (c), and (d) of the Act established.

regulations at 42 C.F.R. Part 483, Subpart B. State survey agencies may survey facilities that participate in Medicare on behalf of CMS to determine whether the facilities are complying 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. 42 C.F.R. § 488.406.

The regulations specify that a civil money penalty (CMP) that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of a CMP, $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. § 488.438(a)(1)(i), (d)(2). "*Immediate jeopardy* means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301 (emphasis in original). The lower range of a CMP, $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy but either cause actual harm to residents, or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii).

The Act and regulations make a hearing before an administrative law judge (ALJ) available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act §§ 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *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, at 11 (2001); *Anesthesiologists Affiliated*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); 42 C.F.R. §§ 488.330(e), 498.3. However, CMS's choice of remedies, or the factors CMS considered when choosing remedies, are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance that CMS found if a successful challenge would affect the range of the CMP that CMS could impose or impact the facility's authority to conduct a Nurse Aide Training and Competency Evaluation Program. 42 C.F.R. § 498.3(b)(14), (d)(10)(i). The CMS determination as to the level of noncompliance, including the finding of immediate jeopardy, "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). *Woodstock Care Ctr.*, DAB No. 1726, at 9, 38 (2000), *aff'd*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g.*, *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). ALJ Review of a CMP is subject to 42 C.F.R. § 488.438(e).

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. *See Batavia Nursing& Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x. 181 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800; *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998); *Hillman Rehab. Ctr.*, DAB No. 1611 (1997), No. 98-3789, 1999 WL 34813783 (D.N.J. May 13, 1999).

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold followed by my findings of fact and analysis.

The Statement of Deficiencies (SOD) for the survey that ended on June 5, 2008, alleges twenty-four regulatory violations. However, the surveyors did not cite three of the alleged violations as having the potential to cause more than minimal harm, and, because those deficiencies cannot be a basis for an enforcement remedy, those deficiencies are not before me for a decision. Of the remaining twenty-one deficiencies, the surveyors allege that nineteen posed the risk for more than minimal harm that was not immediate jeopardy and with no actual harm. In addition, two allegedly involved actual harm that was not immediate jeopardy. CMS Ex. 1. On February 17, 2009, the parties filed a Joint Stipulation to Limit the Issues to be Resolved at Hearing, dated February 9, 2009 (Jt. Stip. Limiting Issues). The parties stipulated and agreed that Petitioner no longer contested the nineteen deficiencies that were not alleged to have caused actual harm. The parties stipulated and agreed that Petitioner no longer contested the reasonableness of the DPNA for which the nineteen uncontested deficiencies provide an adequate basis. The parties also stipulated and agreed that the issues before me are limited to whether: (1) Petitioner violated 42 C.F.R. §§ 483.25 (Tag F309) and 483.25(h) (Tag F323); (2) if either or both regulations were violated, one or both are an adequate basis for the $3,000 PICMP that CMS proposed for each; and (3) the proposed PICMPs are reasonable. The parties' stipulations and agreements were accepted at hearing. Tr. at 18-19.

1. Petitioner violated 42 C.F.R. § 483.25, Tag F309.

Petitioner is obligated as a program participant to ensure that each resident receives 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." 42 C.F.R. § 483.25. The surveyors allege in the SOD that Petitioner failed to provide the necessary care and services for Resident 13 when she was found not breathing, without a pulse, and with dilated pupils, and staff failed to immediately begin cardiopulmonary resuscitation (CPR). The surveyors also allege that Petitioner failed to

ensure that two staff members had necessary CPR training.[4] CMS Ex. 1, at 48. I conclude that Petitioner violated the regulation, and the deficiency caused actual harm to Resident 13.

a. Facts

Resident 13 was admitted to Petitioner's facility on April 3, 2008, and she was 46 years old when the events underlying the alleged deficiency occurred. CMS Ex. 16, at 5, 66-67. Resident 13's diagnoses included: cellulitis and abscess of the foot; unspecified osteomyelitis (an infection of bone or bone marrow), involving her ankle and foot; diabetes mellitus; depressive disorder; and a history of gastrointestinal hemorrhage. CMS Ex. 16, at 5, 71. Resident 13 had poorly controlled diabetes, and, prior to her admission to Petitioner, she was diagnosed with an infection of the bone in her right foot that required a bone resection. She was sent to Petitioner, while she continued to receive intravenous antibiotics. CMS Ex. 16, at 129-43; Tr. at 57. A report of medical consultation done while Resident 13 was in the hospital indicated that she had a poor prognosis given her overall medical condition. CMS Ex. 16, at 131. Minimum Data Sets (MDS) with assessment reference dates of April 10 and 25, 2008, show that Resident 13 did not have a Do Not Resuscitate (DNR) advanced directive in her medical record. CMS Ex. 16, at 68, 78, 85. The MDSs show that Resident 13 was responsible for herself and that she possessed the cognitive skills to independently make decisions. CMS Ex. 16, at 68, 78, 85. A physician's order for Resident 13 dated April 3, 2008, shows that she was a "full code" and that CPR should be administered in an emergency. P. Ex. 3 at 31; CMS Ex. 16, at 12. A facility document titled "Advance Directive/ Preferred Intensity of Care Documentation" that Resident 13 signed on April 3, 2008, shows that Resident 13 elected to be resuscitated in the event of an emergency and that no restrictions existed on medication that could be used. CMS Ex. 16, at 49.

A progress note entry at 5:45 a.m. on May 7, 2008, by Licensed Vocational Nurse (LVN) Judy Andrade states that she entered Resident 13's room to administer pain medication to the resident and found her unresponsive. The note states that Resident 13's body was cold, her pupils were dilated, she was not breathing, and she had no pulse. The note states that LVN Andrade called for an ambulance right away while other staff did CPR, and she called the physician. A note at 6:00 a.m.[5] states that paramedics told LVN

[4] I conclude that a deficiency exists based upon the failure to provide Resident 13 necessary care and services. Thus, it is not necessary for me to discuss the alleged failure to ensure staff was properly qualified or had required certifications.

[5] The time is clearly an error, as the evidence shows that Resident 13 was not pronounced dead until 6:20 a.m. CMS Ex. 16, at 162.

Andrade that Resident 13 was dead. The note states she called Resident 13's mother but there was no answer, and she left it to the day shift to continue attempts to contact the mother. P. Ex. 3 at 207; CMS Ex. 16, at 6. LVN Andrade's subsequent statement during the facility investigation is consistent with her progress notes. CMS Ex. 16, at 155-56.

The evidence shows that the first two staff members into Resident 13's room did not check her airway or begin CPR, including rescue breathing. When a staff member did start CPR, her technique had to be corrected, and some staff had no current CPR certification. CMS Ex. 16, at 148-63; CMS Ex. 52. Petitioner sent a letter to the state agency dated June 6, 2008, in which Petitioner states that a Certified Nurse Assistant (CNA) and a LVN found Resident 13 at approximately the same time, and the letter supports an inference that neither checked Resident 13's airway or initiated CPR, when it was determined that she had no pulse. CMS Ex. 52, at 1. A statement of CNA Ester Flores indicates that she found Resident 13 first. Her statement indicates that, despite finding the resident ashen in color, moving her mouth, but with no sound emitting, she did not check to determine whether the resident was breathing or choking, and she did not take any action to initiate CPR when the resident no longer had a pulse. CMS Ex. 52, at 25-28. The progress notes of LVN Andrade and her written statement given during Petitioner's investigation show that she found Resident 13, but she did not immediately begin CPR. LVN Andrade called for help and then left another nurse and several CNAs to administer CPR, while she went to call for an ambulance and to call the physician. CMS Ex. 16, at 6, 148, 155-56; CMS Ex. 52, at 4-7, 11-12; P. Ex. 3, at 207. LVN Emma Lombaio's written statement reflects that another nurse had to show her "the right place to perform the CPR . . .." CMS Ex. 16, at 153-54; CMS Ex. 52, at 9-10. The statement of Registered Nurse (RN) Andrea Okonkwo shows that she arrived at the facility and found LVN Andrade on the telephone. LVN Andrade asked her to help staff. When RN Okonkwo arrived at Resident 13's room, she saw that CPR was not being performed, and staff was trying to assemble respirator equipment. She sent someone for oxygen and positioned LVN Emma Lombaio to do CPR. She left the room to call for the ambulance but then heard the siren and returned to the room, where she observed CPR being performed until emergency medical technicians (EMT) arrived and took over.[6] CMS Ex.

[6] Petitioner attempted to discredit the statement of RN Okonkwo in its letter to the state agency dated June 6, 2008. CMS Ex. 52 at 1-2. It is not necessary for me to determine whether RN Okonkwo exaggerated her role. LVN Lombaio admits in her statement (CMS Ex. 52, at 9-10) that she started chest compressions, and then RN Okonkwo showed her the right place to perform CPR, which is consistent with that assertion in RN Okonkwo's statement. However, the failure to initiate CPR provides sufficient basis for my finding of a violation without the need to determine whether staff actually knew the correct CPR procedures or whether RN Okonkwo actually came to the rescue, albeit too late.

16, at 154, 157. The written statement of CNA Gaberg shows that when she arrived at Resident 13's room, LVN Andrade was in the room with two CNAs, Esther and Mary. LVN Andrade was checking the resident's pulse, and she then told CNA Gaberg to get the crash cart and oxygen. When CNA Gaberg returned, LVN Emma Lombaio was performing CPR. CMS Ex. 16, at 158-59; CMS Ex. 52, at 14-15. The emergency medical service dispatch record shows that the call was received at 5:49 a.m. The EMTs arrived on scene at 5:53 a.m., and Resident 13 was pronounced dead at 6:20 a.m. According to the dispatch record, when the EMTs arrived, Petitioner's staff was performing CPR, Resident 13 had no pulse, she was not breathing, her pupils were fixed and dilated, there was no obvious rigor mortis to her jaw, and she was cold to the touch. EMTs continued CPR for approximately 25 minutes with no change in condition, and Resident 13 was pronounced dead. CMS Ex. 16, at 162.

The actual cause of Resident 13's death is not clear from the record before me. Because the alleged violation is based on the failure of staff to deliver CPR, it is not necessary for CMS to show, or for me to attempt to find, the cause or mechanism of Resident 13's death. The record indicates at least three possible causes or mechanisms of death. A statement signed by CNA Ester Flores, dated May 7, 2008, indicates that she was with Resident 13, before the resident was found unresponsive. CNA Flores states that she gave the resident an orange and then left the resident's room. CNA Flores returned to Resident 13's room and described what happened next as follows:

> When I came back to the room to attend to my resident I seen her on her bed, color ashy and her mouth was opening and shutting. She wasn't even making any noise. I began to just rub her chest and asked are you all right? But she didn't respond. So I went to the door to get my co-worker to get the charge nurse. The nurse came running. Emma started to do CPR and I ran for the crash cart. I started the ambu bag while the nurse kept doing CPR.

CMS Ex. 52, at 25-27. CNA Flores' statement reveals that she gave the resident an orange to eat, and, when she returned to Resident 13's room, she displayed classic signs of choking – her color was ashen and her mouth was opening and shutting, but she was making no noise. CNA Flores did not state that she checked the resident's airway or attempted the Heimlich maneuver to clear her airway, but she stated that she just rubbed the resident's chest. Initiating CPR is one of the general job functions for a CNA working at Petitioner's facility. CMS Ex. 24, at 1. None of the statements that Petitioner obtained indicates that any staff member ever checked the resident's airway to ensure that it was clear and that the resident had not choked. Determining whether a victim is breathless and then opening and maintaining an open airway are steps 5 and 6 of Petitioner's CPR policy. P. Ex. 2, at 6; CMS Ex. 20, at 74. The surveyors focused upon another possible cause as suggested by allegations in the SOD, that one of Resident 13's

pain medications posed a risk for depressing respiratory rate and that Petitioner's staff was not monitoring her respiratory rate. CMS Ex. 1, at 49-50; CMS Exs. 39-40, and 41, at 23; Tr. at 63-64. Surveyor Wagner testified at hearing that Resident 13 may also have been suffering from low blood sugar (Tr. at 57-59) or that she might have choked on the piece of fruit she was given earlier. Tr. at 83. No matter the cause of death, CPR should have been initiated when the resident was found not breathing and/or without a pulse.

It is not disputed that when Resident 13 died, Petitioner had written policies and procedures governing the administration of CPR that had been in effect since 1994. P. Ex. 2; CMS Ex. 16, at 100-02; CMS Ex. 20, at 73-77. No dispute exists that Petitioner's policy required the initiation of CPR for Resident 13. CMS does not allege that Petitioner's policies were not consistent with standards of care and practice for the administration of CPR on May 7, 2008, when Resident 13 died.

b. Analysis

The general quality of care regulation requires that each resident receive care and services necessary to attain and maintain the highest practicable physical, mental, and psychosocial well-being of the resident. The care and services are to be based upon the resident's comprehensive assessment and plan of care. 42 C.F.R. § 483.25.

The surveyors allege in the SOD that Petitioner violated 42 C.F.R. § 483.25 (Tag F309), because Petitioner's staff did not initiate CPR immediately for Resident 13 when she was found not breathing, without a pulse, and with dilated pupils on May 7, 2008, and that the failure is contrary to facility policy. CMS Ex. 1, at 48. The surveyors also alleged in the SOD that Petitioner failed to ensure that two of six night shift employees who provide direct care had current CPR certification and that this failure placed residents at risk for insufficient CPR that could potentially lead to preventable injury or death. CMS Ex. 1, at 48.

Petitioner's records reflect the events leading to Resident 13's death. Sometime before 5:45 a.m. on May 7, 2008, CNA Flores gave Resident 13 an orange and then departed her room, promising to return shortly. Around 5:45 a.m., CNA Flores returned and found Resident 13 on her bed. Resident 13 was ashen, and her mouth was opening and shutting; however, she was not making any noise, probably because she was choking and could not expel breath. CNA Flores asked Resident 13 if she was ok and rubbed her chest. When Resident 13 did not respond, CNA Flores did not check her breathing or whether she was choking. Instead, she went to find help. LVN Andrade then arrived in Resident 13's room and determined that Resident 13 was not breathing, had no pulse, had dilated pupils, and was cool to the touch. LVN Andrade did not check Resident 13's airway, and she did not begin CPR but left the room. These facts are undisputed and are sufficient to establish a prima facie case that Petitioner failed to ensure that Resident 13 received necessary care and services, a violation of 42 C.F.R. § 483.25. No dispute exists

that Resident 13 had not executed a DNR order and that Petitioner was obligated to ensure that emergency procedures were initiated to attempt to ensure her survival. P. Ex. 2, at 2; CMS Ex. 16, at 100.

Petitioner's argument that CMS failed to make a prima facie showing of a deficiency under 42 C.F.R. § 483.25 is without merit. P. Brief at 5; P. Reply at 1-3. Petitioner correctly states that Surveyor Wagner agreed with counsel for Petitioner that the American Heart Association guidelines set forth that CPR "should be commenced with (sic) four to six minutes." P. Brief at 6 (citing Tr. at 78). Petitioner argues that CMS failed to show as part of its prima facie case that CPR was not initiated within four to six minutes. However, Petitioner misunderstands it burden. In this case, the evidence shows that two staff members found Resident 13 in distress. Petitioner's CPR policy, which is consistent with standards of practice, required that they initiate CPR, but they did not. Resident 13 died, which is indisputably actual harm, and, therefore, a prima facie showing exists of a failure to deliver a necessary care or service under 42 C.F.R. § 483.25 that resulted in actual harm. Petitioner bears the burden of rebutting the prima facie showing or establishing an affirmative defense. Thus, the burden was upon Petitioner to show that the cares and services delivered were those that were necessary for Resident 13; for example, that CPR was initiated within not more than four to six minutes and that it was properly done. Petitioner failed to meet its burden.[7]

Accordingly, I conclude that Petitioner violated 42 C.F.R. § 483.25, and Resident 13 suffered actual harm as a result.

2. Petitioner violated 42 C.F.R. § 483.25(h), Tag F323.

The regulation requires that a facility ensure that the resident environment remains as free of accident hazards as possible and that residents receive adequate supervision and assistance devices to prevent accidents. The surveyors allege that Petitioner violated the regulation, because Resident 10 was allowed to keep matches and a cigarette lighter in his room. On May 4, 2008, he set his bedding on fire, which resulted in burns to his

[7] Petitioner's documentation of the incident did not contain the level of detail that its policy required for such incidents. CMS Ex. 20, at 77; P. Ex. 2, at 9. Petitioner was not cited for insufficient documentation, but the dearth of documentation makes it difficult for Petitioner to satisfy its burden to show that necessary care and services were provided. Petitioner did not provide testimony from any of the staff involved in the incident -- testimony that might have established facts not documented in Petitioner's records. Whether Petitioner could have presented facts to show that no delay existed between the discovery of Resident 13 in distress and the initiation of emergency measures is something only Petitioner knows.

finger and thigh. The surveyors cited the incident as resulting in actual harm without immediate jeopardy. CMS Ex. 1, at 57-58. I conclude that Petitioner violated the regulation and that the deficiency resulted in actual harm to Resident 10.

a. Facts

Resident 10, a male, was 41 years old when the incident occurred that triggered the deficiency citation. CMS Ex. 14, at 29, 31. His diagnoses included: a schizoaffective disorder, bipolar type; hypokalemia (low blood potassium level); end-stage liver disease; chronic obstructive pulmonary disease (COPD); seizure disorder; hepatitis C; hypothyroidism, gastroesophageal reflux disease (GERD); hypertension; and rheumatoid arthritis. CMS Ex. 14, at 25-26, 30. It was reported that at age 12, Resident 10 had undergone neurosurgery with irradiation for astrocytoma, with subsequent neurological complications. CMS Ex. 14, at 26. No dispute exists that Resident 10 liked to smoke cigarettes and that he did so at least seven to ten times each day. Tr. at 137.

Petitioner had a policy entitled "Smoke-Free Environment" with an effective date of December 1, 1997, which was revised on February 1, 1998. The policy prohibited smoking inside the facility; specified that smoking was to occur outside on the back parking lot; and required that the Interdisciplinary Team (IDT) develop an individualized plan for safe storage of smoking materials that was to be recorded on the resident's assessment and care plan. CMS Ex. 14, at 54.

Petitioner's IDT completed a Safe Smoking Assessment form on November 18, 2005, and assessed Resident 10 as able to smoke independently and without supervision based on the following factors: he understood the proper area for smoking; he agreed to not smoke in the facility; he was not an elopement risk if allowed to smoke independently; he was able to light a cigarette and hold it without the risk of danger to himself or others; and he was able to safely extinguish the smoke and place it in the proper receptacle. P. Ex. 4, at 72. On April 5, 2007, Petitioner was noted by his IDT to have a history of aggressive and disruptive behavior and a history of injuring himself, but he was assessed as able to smoke independently without supervision. It was further determined that his smoking materials did not need to be secured at the nurses' station. P. Ex. 4, at 74; CMS Ex. 14, at 72. An individualized plan for the safe storage of Resident 10's smoking materials in his room, or on his person, is not reflected in the evidence before me.[8]

[8] Although Resident 10 was assessed as able to maintain his smoking materials in his possession or room, no plan exists that states how the materials are to be secured to ensure that others did not obtain and misuse them.

A progress note dated February 25, 2008, indicates that: (1) Resident 10 was outside "nodding out;" (2) it was difficult to arouse him; and (3) he had singed his eyelashes with his lighter. CMS Ex. 14, at 48; CMS Ex. 51, at 4. A short-term care plan dated February 25, 2008 and adopted after the eyelash incident, included the approach to "[m]ake sure that resident's cigarette lighter flame is adjusted to a normal level. Remind resident of safety when using lighter. Smoking assessment reevaluation." P. Ex. 4, at 41; CMS Ex. 51, at 1, 10. A smoking assessment dated February 29, 2008, reflected periods of altered levels of consciousness, aggressive and disruptive behavior, and weakness; however, he was assessed as able to smoke independently without supervision, and his smoking materials did not need to be secured at the nurses' station. P. Ex. 4, at 73; CMS Ex. 14, at 71. An individualized plan for the safe storage of Resident 10's smoking materials in his room, or on his person, is not reflected in the evidence before me. Furthermore, no direction for staff exists as to how the new interventions were to be effectuated.[9]

A smoking assessment dated March 13, 2008, noted that Resident 10 had slow mental processing, a history of negative behaviors, and slow movements. The assessment also noted that he refused to use a smoking apron, but he was assessed as able to smoke independently, albeit with supervision. The form did not indicate that his smoking materials needed to be secured at the nurses' station. P. Ex. 4, at 76; CMS Ex. 14, at 70. An individualized plan for the safe storage of Resident 10's smoking materials in his room, or on his person, is not reflected in the evidence before me.

Resident 10's care plan dated March 13, 2008, listed as a concern/problem a potential for injury related to smoking and listed the approach that "[s]moking materials to be obtained and distributed by designated staff." CMS Ex. 14, at 79, 84. The text quoted was machine printed on the form, as were other entries for the March 13, 2008 care plan. Entries entered on the care plan after the May 4, 2008 incident are hand-written. Hence, I infer that the quoted language was an intervention listed on the March 13, 2008 care plan that the IDT developed. An individualized plan for the safe storage of Resident 10's smoking materials in his room, or on his person, is not reflected in the evidence before me. Further, the care plan did not specify where designated staff was to obtain Resident 10's smoking materials – from Resident 10, the nurses' station, the medication room or cart, or some other location. If the intent of the plan was for Resident 10 to retain his smoking materials, it is incongruous that staff needed to obtain the materials from Resident 10 only to redeliver the same materials to him, when he arrived at the designated smoking area.

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[9] For example, the plan does not specify how staff was to be alerted that Resident 10 was going out to smoke so that staff could provide the planned supervision to ensure that the flame on his lighter was adjusted properly and to deliver the reminder to be safe.

A progress note dated May 4, 2008, shows that a staff member heard a noise in Resident 10's room, and, when she checked the room, the resident was on his bed, and the plastic mattress cover was burning. The staff member used a wet blanket to extinguish the fire. Police and the fire department responded when called. Matches and a cigarette lighter were found on the resident's shelves. The police decided that Resident 10 was to be sent to the emergency room due to concern that he was a danger to himself. CMS Ex. 14, at 41. The emergency room history and physical shows that Resident 10 arrived by ambulance on May 4, 2008, complaining of burns to his right index finger and anterior thigh. The report shows that his burns, a partial-thickness burn to the right index finger and a scant burn of the anterior thigh, were dressed. The report also shows that he subsequently became combative and belligerent, and he had to be physically restrained and then sedated. CMS Ex. 14, at 29-30. Resident 10 underwent a psychiatric evaluation on May 5, 2008. In the evaluation report, the attending physician stated that the resident had not wanted to harm any other residents at the facility but had wanted to burn himself. The physician stated that the resident "seemed hopeless, did not feel that there was a reason to go on with his life." CMS Ex. 14, at 32. Resident 10's IDT directed that his smoking materials be secured at the nurses' station, when he was assessed upon return to the facility on May 13, 2008. P. Ex. 4, at 75; CMS Ex. 14, at 69.

Julie Velev, Petitioner's Social Services Director from April 2004 until January 2008, testified that as a member of the IDT, she participated in developing care plans for Resident 10 and was also involved in his assessments. Tr. at 133-36, 140-44, 147.[10] Ms. Velev stated that she knew Resident 10 "pretty well." Tr. at 136-37. Ms. Velev testified that Resident 10 was allowed to smoke independently from the time of his admission to the facility in 2005, up until February 2008. Tr. at 139. According to Ms. Velev, smoking was Resident 10's main activity. It was something he enjoyed, and it was a way for him to keep his independence. She testified that he also liked painting and drawing, and playing solitaire on the computer. Tr. at 137-38. She testified that he smoked seven to ten times a day, every day. Tr. at 137. She testified that he had no instance of self-inflicted injury while at the facility prior to May 2008. Tr. at 138. Ms. Velev stated that Resident 10 was always allowed to keep his smoking materials at his bedside. Tr. at 146-47. When asked about the February 2008 incident involving Resident 10, Ms. Velev testified that Resident 10 told her that he had been outside, and, as he attempted to light his cigarette with his Bic® lighter, the wind blew the flame and singed his eyelashes. Tr. at 139-40, 148. Ms. Velev testified that she believed Resident 10 did not intentionally try to injure himself and that the incident was an accident. Tr. at 140. She stated that, in response to the accident, the IDT updated Resident 10's care plan and completed a new smoking assessment. Tr. at 140-43. According to Ms. Velev, the interventions that staff

[10] At the hearing, Ms. Velev testified that she currently holds the position of Staffing Coordinator at Petitioner's facility. Tr. at 133.

adopted were to ensure that the resident's cigarette lighter flame was adjusted to a normal level and to remind him of safety when using a lighter. Tr. at 142, 143. Ms. Velev stated that the IDT, which was comprised of the Director of Nursing (DON), the Resident Care Coordinator, and herself, did a new smoking assessment on February 29, 2008. Tr. at 142; P. Ex. 4, at 73. Ms. Velev testified further that she discussed the use of a smoking apron with Resident 10, but he declined.[11] Tr. at 143, 147. She testified that the IDT did another smoking assessment on March 13, 2008, which was the quarterly assessment. Tr. at 144. According to Ms. Velev, the IDT decided to supervise Resident 10's smoking "on a trial basis," and either Ms. Velev or the DON provided supervision, essentially by going outside with him when he smoked. She did not know whether any other staff ever supervised Resident 10's smoking. Tr. at 144. Ms. Velev testified that the IDT considered taking away Resident 10's smoking materials and storing them at the nurses' station, but, since smoking was the "one thing that he enjoyed most," the IDT did not do so, since they felt that they "would be taking away whatever he had left." Tr. at 149. She testified that she was surprised when Resident 10 lighted his bed on fire. Tr. at 145.

Ms. Velev did not testify that an individualized plan for the safe storage of Resident 10's smoking materials in his room, or on his person, was ever developed or implemented. She did not testify as to how she or the DON was alerted that Resident 10 wanted to smoke, except she indicated that sometimes Resident 10 asked her to take a break with him. Ms. Velev did not testify as to how staff was to effectuate the interventions adopted after the February 2008 eyelash incident, which required the supervision of the flame on Resident 10's lighter and the delivery of the reminder to be safe. Ms. Velev did not testify as to the planned duration for the intervention of supervision on a "trial basis" that the IDT adopted on March 13, 2008. Ms. Velev's testimony supports a finding that the IDT determined that supervision, at least on a trial basis, was necessary. Ms. Velev's testimony that, on March 13, 2008, the IDT planned more supervision of Resident 10 is consistent with the intervention listed on the March 13, 2008 care plan that "[s]moking materials to be obtained and distributed by designated staff." CMS Ex. 14, at 79, 84. She did not explain where staff was to find Resident 10's smoking materials. Her testimony that Resident 10 was always intended to maintain possession of his own smoking materials is inconsistent with the requirement of the language of the intervention that staff was to obtain the smoking materials from an unspecified location and then distribute them to Resident 10. Ms. Velev did not testify as to whether: supervision was an effective intervention; the IDT assessed the effectiveness of the intervention; or the IDT decided to terminate the supervision following an assessment that it was unnecessary.

[11] Ms. Velev testified that a smoking apron, which is fire-resistant, is offered to smokers to protect them from any accidents or injuries. Tr. at 143.

b. Analysis

The general quality of care regulation, 42 C.F.R. § 483.25, requires that a facility ensure that each resident receives the necessary care and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care that the resident's care planning team developed in accordance with 42 C.F.R. § 483.20. The quality of care regulations impose specific obligations upon a facility related to accident hazards and accidents.

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

42 C.F.R. § 483.25(h). The State Operations Manual (SOM), CMS's guidance to surveyors, instructs surveyors that the intent of 42 C.F.R. § 483.25(h)(1) and (2) is "to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents." The facility is expected to: identify, evaluate, and analyze hazards and risks; implement interventions to reduce hazards and risks; and monitor the effectiveness of interventions and modify them when necessary. SOM, app. PP, Guidance to Surveyors Long Term Care Facilities, F323, Quality of Care (Rev. 27; eff. Aug. 17, 2007).

The Board has provided interpretative guidance for adjudicating alleged violations of 42 C.F.R. § 483.25(h)(1):

> The standard in section 483.25(h)(1) itself - that a facility "ensure that the environment is as free of accident hazards as possible" in order to meet the quality of care goal in section 483.25 -- places a continuum of affirmative duties on a facility. A facility must determine whether any condition exists in the environment that could endanger a resident's safety. If so, the facility must remove that condition if possible, and, when not possible, it must take action to protect residents from the danger posed by that condition. [Footnote omitted.] **If a facility has identified and planned for a hazard and then failed to follow its own plan, that may be sufficient to show a lack of compliance with [the] regulatory requirement.** In other cases, an ALJ may need to

> consider the actions the facility took to identify, remove, or protect residents from the hazard. Where a facility alleges (or shows) that it did not know that a hazard existed, the facility cannot prevail if it could have reasonably foreseen that an endangering condition existed either generally or for a particular resident or residents.

Maine Veterans' Home – Scarborough, DAB No. 1975, at 6-7 (2005) (emphasis added).

The Board has also explained the requirements of 42 C.F.R. § 483.25(h)(2) in numerous decisions. *Golden Living Ctr. – Riverchase*, DAB No. 2314, at 7-8 (2010); *Eastwood Convalescent Ctr.*, DAB No. 2088 (2007); *Liberty Commons Nursing and Rehab - Alamance*, DAB No. 2070 (2007); *Century Care of Crystal Coast*, DAB No. 2076 (2007), *aff'd, Century Care of the Crystal Coast*, 281 F. App'x 180 (4th Cir. 2008); *Golden Age Skilled Nursing & Rehab. Ctr.*, DAB No. 2026 (2006); *Estes Nursing Facility Civic Ctr.*, DAB No. 2000 (2005); *Northeastern Ohio Alzheimer's Research Ctr.*, DAB No. 1935 (2004); *Woodstock Care Ctr.*, DAB No. 1726 (2000), *aff'd, Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003). Section 483.25(h)(2) does not make a facility strictly liable for accidents that occur; however, it does require 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. *Woodstock Care Ctr. v. Thompson*, 363 F.3d at 589 ([A] SNF must take "all reasonable precautions against residents' accidents."). A facility is permitted the flexibility to choose the methods of supervision it uses to prevent accidents, but the chosen methods must be adequate under the circumstances. Whether supervision is "adequate" depends in part upon the resident's ability to protect himself or herself from harm. *Id*. Based on the regulation and the cases in this area, CMS meets its burden to show a prima facie case if the evidence demonstrates that the facility failed to provide adequate supervision and assistance devices to prevent accidents, given what was reasonably foreseeable. *Alden Town Manor Rehab. & HCC*, DAB No. 2054, at 5-6, 7-12 (2006). An "accident" is an unexpected, unintended event that can cause a resident bodily injury, excluding adverse outcomes associated as a direct consequence of treatment or care (e.g., drug side effects or reactions). SOM, app. PP, Tag F323; *Woodstock Care Ctr.*, DAB No. 1726, at 4.

The evidence shows that Resident 10 was both an accident hazard when in the possession of smoking materials, particularly a lighter or matches, and that he required supervision to ensure that he was not injured due to the inability to protect himself from harm. There is no dispute that Resident 10 had a lighter and matches in his room on May 4, 2008, and that he set fire to his plastic mattress pad. Although the violation alleged under Tag F323

is not artfully drafted, the gist of the surveyors' allegation is that Resident 10, who was in possession of matches and lighters, was an accident hazard that Petitioner failed to mitigate or protect against by providing necessary supervision of him and his smoking materials. CMS Ex. 1, at 57-58. I agree.

Petitioner has disputed that Resident 10 was actually injured due to the fire he started in his room on May 4, 2008, relying upon the record of a psychiatric consultation. CMS Ex. 51, at 2. However, I find credible the record of emergency room treatment on May 4, 2008, that shows that Resident 10 was treated for a partial-thickness burn on his finger and a scant burn on his thigh. CMS Ex. 14, at 29-30.

Petitioner argues that it could not reasonably foresee that matches or lighters in Resident 10's possession posed an accident risk. Petitioner argues that CMS has failed to make a prima facie showing of a violation of 42 C.F.R. § 483.25(h), or, in the alternative, that Petitioner has met it burden of showing compliance with the regulation by a preponderance of the evidence. P. Brief at 8-12. Petitioner argues that: (1) Resident 10 was assessed; (2) Petitioner reasonably concluded that Resident 10 could smoke independently and could retain his own smoking materials; (3) no regulation prohibits a resident from having smoking materials in his or her room; (4) no incident of self-inflicted injury occurred to put Petitioner on notice that Resident 10 might try to burn himself; (5) Resident 10 had no prior accident with smoking materials other than singing his eyelashes on February 25, 2008; (6) after the February 25, 2008 accident, another smoking assessment was done, and the IDT directed that Resident 10's lighter be properly adjusted and that he be offered a smoking apron; and (7) the IDT decided not to take Resident 10's smoking materials in the interest of balancing "the care needs with the rights and psycho-social needs of the resident" and initiated supervised smoking rather than taking Resident 10's smoking materials. P. Brief at 9-11. Petitioner also argues that the May 4, 2008 fire was the first incident of attempted self-inflicted injury since Resident 10 first was admitted in 2005. P. Brief at 11. Petitioner argues in its reply brief that it implemented progressive interventions to address Resident 10's smoking. P. Reply at 4-6.

The error in Petitioner's analysis is demonstrated by examining the March 13, 2008, care-planned intervention to require staff to obtain and distribute Petitioner's smoking materials and Ms. Velev's testimony that the IDT intended to supervise Resident 10's smoking, at least on a trial basis. The evidence shows that following the eyelash incident in February 2008, the IDT adopted interventions, but the care plan fails to provide necessary instruction for how to effectuate those interventions. Petitioner's records and the testimony of Ms. Velev establish that, on March 13, 2008, the IDT adopted more aggressive interventions that required closer supervision than initially adopted in February 2008, including the requirement that staff obtain and distribute smoking materials and that staff supervise Resident 10's use of the smoking materials, at least on a trial basis. Petitioner introduced no evidence that the effectiveness of the interventions

adopted after the eyelash incident was assessed or that the IDT ever planned to discontinue those interventions. Ms. Velev's testimony that the IDT intended for Resident 10 to retain his lighter and matches in his room following the February and March IDT assessments and planning is simply not credible. Furthermore, the rationale that Ms. Velev stated that the IDT did not want to deprive Resident 10 of an activity he enjoyed is also not credible. The evidence does not show that the rights of Resident 10 and the benefit to him of possessing smoking materials could not have been preserved by simply allowing him to retain possession of his cigarettes while staff controlled ignition devices. The evidence does not show that the IDT ever assessed that possible intervention. The evidence is more consistent with the IDT having determined that: Resident 10 required stricter supervision; after March 13, 2008, the IDT and care plan intended that smoking materials be secured and that staff obtain those materials and distribute them to Resident 10; and, after the February 2008 eyelash incident, the IDT intended that Resident 10 be supervised when smoking, at least to the extent necessary to ensure that his flame was appropriate and that he was reeducated to be safe. The evidence shows that: Petitioner failed to ensure its care-planned interventions were consistently implemented; the effectiveness of those interventions was assessed; and new interventions were adopted and implemented as necessary.

Contrary to Petitioner's argument, it was not necessary for Petitioner to foresee specifically that Resident 10 would intentionally attempt to injure himself with his lighter or matches. It was sufficient in this case that Petitioner foresaw that a risk for accidental injury to Resident 10 or other residents existed due to his possession of a lighter and/or matches. Evidence of Petitioner's IDT assessments and plans for Resident 10 after the February 2008 eyelash incident demonstrates that Petitioner foresaw a risk for accidental injury. The problem for Petitioner is that the interventions adopted were not reasonable, because they were incomplete, as they did not provide guidance to staff for their effectuation. In addition, the evidence does not show consistent implementation, e.g., Resident 10 had a lighter and matches in his possession on May 4, 2008, and he should not have. The evidence also does not show assessment of the effectiveness of the interventions. Finally, the evidence does not show that the interventions were adjusted as needed.

Petitioner's smoking policy also shows that Petitioner recognized that the presence of smoking materials in the facility posed a risk for accidents and harm and specifically required the development of an individualized plan for safe storage of smoking materials. However, as noted under the statement of facts, Petitioner's IDT did not document such a plan for Resident 10.

Accordingly, Petitioner violated 42 C.F.R. § 483.25(h), and the violation caused actual harm to Resident 10.

3. A PICMP of $3,000 for the violation of 42 C.F.R. § 483.25 is a reasonable enforcement remedy.

4. A PICMP of $3,000 for the violation of 42 C.F.R. § 483.25(h) is a reasonable enforcement remedy.

5. DPNA from July 10, 2008 through September 7, 2008, is a reasonable enforcement remedy.

If a facility is not in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, including a DPNA and a CMP. CMS may impose a CMP for the number of days that the facility is not in compliance, or for each instance that a facility is not in substantial compliance. 42 C.F.R. § 488.430(a). In this case, CMS imposed a PICMP of $3,000 for each deficiency citation discussed above and a DPNA from July 10, 2008 through September 7, 2008, based upon all the deficiencies.

It is not for me to review how CMS exercises its discretion and determines the amount of the CMP to propose. My review of the reasonableness of a proposed CMP is *de novo*, *i.e.*, I make an independent determination as to the reasonableness of a CMP based upon the evidence and regulatory factors. 42 C.F.R. § 488.438(e). The authorized range for a PICMP is $1,000 to $10,000. 42 C.F.R. § 488.438(a)(2). In determining a reasonable CMP, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of noncompliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404; and (4) the facility's degree of culpability. In deciding what penalty amount is reasonable, I must examine the evidence that relates to the regulatory factors. The CMS decision regarding the scope and severity of the deficiencies is not subject to my review, as the scope and severity of a deficiency does not affect the range of authorized PICMPs. 42 C.F.R. §§ 498.3(b)(14), 488.438(a)(2); *see* 42 C.F.R. §§ 498.3(d)(10)(ii), 488.438(e).

Regarding Petitioner's history of noncompliance, CMS asserts that previous surveys cited Petitioner for violating Tag F309 and Tag F323. Citing an On-line Survey, Certification and Reporting System (OSCAR) Report dated May 12, 2008, CMS argues that Petitioner was cited for violating Tag F309 at the "D" scope and severity level during surveys completed on April 11, 2007 and December 2004. CMS Ex. 5, at 1, 4. CMS also argues that Petitioner was cited for violating Tag F323 at the "D" scope and severity level during the survey completed April 11, 2007. CMS Ex. 5, at 1, 4. In addition to these deficiencies, I note that the OSCAR report shows that Petitioner was cited for a number

of other deficiencies by surveys completed in November 2003, December 2004, January 2006, and April 11, 2007, many of which posed the potential for more than minimal harm. CMS Ex. 5 at 1. CMS has shown a history of noncompliance and repeated citations of the same deficiencies cited in this case. Petitioner did not present any evidence or argument regarding its compliance history.

Petitioner has presented no evidence of an inability to pay the CMP. The facts show that Petitioner was culpable by its failure to ensure that both Residents 10 and 13 received the necessary care and services and by its failure to follow its policies.

I find the deficiencies to be serious. Both residents suffered actual harm due to the deficiencies. The PICMPs imposed in this case are in the lower half of the range of authorized PICMPs, but I will not increase the amount based upon either the seriousness of the deficiencies or Petitioner's culpability to avoid the appearance that Petitioner is being penalized for exercising its right to request a hearing. Based upon my evaluation of the required regulatory factors, I conclude that a $3,000 PICMP for each deficiency is reasonable.

I further conclude that the DPNA is reasonable. Pursuant to their Joint Stipulation, the parties stipulated that Petitioner no longer disputed 19 deficiencies cited at a scope and severity level of "D" or above. The nineteen undisputed deficiencies, and the deficiencies cited under Tags F309 and F323, are a sufficient basis for the imposition of a discretionary DPNA, and the DPNA is reasonable based upon my evaluation of the regulatory factors.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner was not in substantial compliance with program participation requirements for the period June 5, 2008 through September 7, 2008. A PICMP of $3,000 for the violation of 42 C.F.R. § 483.25, a PICMP for the violation of 42 C.F.R. § 483.25(h), and a DPNA for the period July 10, 2008 through September 7, 2008, are reasonable enforcement remedies.

/s/
Keith W. Sickendick
Administrative Law Judge