Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
Shakamak Good Samaritan Center (CCN: 15-5303),	)	Date: December 18, 2008
Petitioner,	)	
	)	Docket No. C-06-594
v.	)	Decision No. CR1874
Centers for Medicare & Medicaid Services.	)	

DECISION

Petitioner, Shakamak Good Samaritan Center, was not in substantial compliance with program participation requirements from May 17, 2006 through September 19, 2006. A civil money penalty (CMP) of $5500 per day from May 17, 2006 through May 21, 2006 and $200 per day from May 22, 2006 through September 19, 2006, a total CMP of $51,700; and a denial of payment for new admissions (DPNA) from June 22, 2006 through September 19, 2006, are reasonable enforcement remedies. Petitioner's authority to conduct a Nurse Aide Training and Competency Evaluation Program (NATCEP) was required to be withdrawn for the two year period May 22, 2006 through May 21, 2008.

I. Background

Petitioner is located in Jasonville, Indiana and authorized to participate in Medicare as a skilled nursing facility (SNF) and the Indiana Medicaid program as a nursing facility (NF). On May 22, 2006, surveyors from the Indiana State Department of Health (the state agency) completed an annual survey of Petitioner, the results of which are reported in a statement of deficiencies (SOD) of that date. The surveyors found that Petitioner was not in substantial compliance with program participation requirements. The state agency notified Petitioner by letter dated May 30, 2006, of the survey findings, that it was imposing a DPNA effective June 22, 2006, and of the right to request a hearing by an administrative law judge (ALJ). Petitioner requested a hearing by an ALJ by letter dated July 27, 2006. Joint Stipulation (Jt. Stip.).

The state agency completed a revisit survey of Petitioner on July 27, 2006, and found that Petitioner remained out of compliance with program participation requirements. CMS notified Petitioner by letter dated August 16, 2006, that it was imposing a CMP of $5500 per day for five days from May 17, 2006 through May 21, 2006 and a CMP of $200 per day beginning on May 22, 2006, in addition to the DPNA imposed by the state effective June 22, 2006. CMS also advised Petitioner that its participation agreement would be terminated on October 22, 2006. On September 20, 2006, the state agency completed a second revisit survey and found that Petitioner returned to substantial compliance on that date. CMS notified Petitioner by letter dated October 17, 2006, that the DPNA was discontinued effective September 20, 2006. CMS further advised Petitioner that the total CMP was $51,700, based upon a $5500 CMP for May 17, 2006 through May 21, 2006, and $200 per day for May 22, 2006, through September 19, 2006, and that the termination of Petitioner's provider agreement was rescinded. Jt. Stip.; P. Ex. 16.

A hearing was convened in this case on July 24, 25, and 26, 2007, in Indianapolis, Indiana. CMS offered and I admitted as evidence CMS exhibits (CMS Ex.) 1 through 32, 35 through 37, 39 through 50, 53, 55 through 63, 65, and 67 through 106. Tr. 24. Petitioner offered and I admitted Petitioner's exhibits (P. Ex.) 1 through 12, 15 and 16, 18 and 19.[1] Tr. 27, 547. CMS elicited testimony from Surveyor Melinda Lewis, Surveyor Anne Marie Crays, Surveyor Marla Potts, Surveyor Donna Downs, Surveyor Creva Ruth Kixmiller, and Sharon Roberts, R.N. (Registered Nurse). Petitioner called its current administrator Joan Foradori-Cook to testify. The parties submitted post-hearing briefs and reply briefs (CMS Brief, P. Brief, CMS Reply, and P. Reply, respectively).

II. Discussion

A. Issues

The issues in this case are:

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

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[1] CMS Exs. 33, 34, 38, 51, 52, 54, 64, and 66 and P. Exs. 13, 14, and 17 were withdrawn and not offered. Tr. 12, 24. Petitioner did not submit a document marked P. Ex. 17. Rather than admit P. Ex. 20, I advised the parties that I took administrative notice of the on-line version of the State Operations Manual (SOM). Tr. 432, 436, 547.

B. Applicable Law

The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 (SNF) and 1919 (NF) of the Act and at 42 C.F.R. Part 483. Section 1819(h)(2) of the Act vests the 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.[2] 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 (CMP), appointment of temporary management, and other remedies such as a directed plan of correction. Act § 1819(h)(2)(B).

The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. "*Substantial compliance* means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301 (emphasis in original). A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act or the Secretary's regulations at 42 C.F.R. Part 483, Subpart B. Facilities that participate in Medicare may be surveyed on behalf of CMS by state survey agencies in order to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-488.28, 488.300-488.335. The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406.

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, of from $3050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents, and in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). Pursuant to 42 C.F.R. § 488.301, "*(i)mmediate jeopardy* means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury,

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

harm, impairment, or death to a resident." (emphasis in original). The lower range of CMP, from $50 per day to $3000 per day, is reserved for deficiencies that do not constitute immediate jeopardy but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii).

In this case, the state agency was required to withdraw Petitioner's approval to conduct a NATCEP. Pursuant to sections 1819(b)(5) and 1919(b)(5) of the Act, SNFs and NFs may only use nurse aides who have completed a training and competency evaluation program. Sections 1819(e) and 1919(e) of the Act impose upon the states the requirement to specify what NATCEPs they will approve that meet the requirements established by the Secretary and a process for reviewing and reapproving those programs using criteria set by the Secretary. Pursuant to sections 1819(f)(2) and 1919(f)(2) the Secretary was tasked to develop requirements for approval of NATCEPs and the process for review of those programs. The Secretary promulgated regulations at 42 C.F.R. Part 483, Subpart D. Pursuant to 42 C.F.R. § 483.151(b)(2) and (e)(1) a state may not approve and must withdraw any prior approval of a NATCEP offered by a SNF or NF: (1) that has been subject to an extended or partial extended survey under sections 1819(g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Act; (2) that has been assessed a CMP of not less than $5000; or (3) that has been subject to termination of its participation agreement, a DPNA, or the appointment of temporary management. Extended and partial extended surveys are triggered by a finding of "substandard quality of care" during a standard or abbreviated standard survey and involve evaluating additional participation requirements. "Substandard quality of care" is identified by the situation where surveyors identify one or more deficiencies related to participation requirements established by 42 C.F.R. § 483.13 (Resident Behavior and Facility Practices), § 483.15 (Quality of Life), or § 483.25 (Quality of Care) that are found to constitute either immediate jeopardy, a pattern of or widespread actual harm that does not amount to immediate jeopardy, or a widespread potential for more than minimal harm that does not amount to immediate jeopardy and there is no actual harm. 42 C.F.R. § 488.301.

The Act and regulations make a hearing before an ALJ available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act § 1128A(c)(2); 42 C.F.R. §§ 488.408(g); 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et al*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Cal Turner Extended Care*, DAB No. 2030 (2006)*; The Residence at Salem Woods*, DAB No. 2052 (2006). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e) and 498.3. However, the choice of remedies by CMS or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge would affect the range of the CMP that could be imposed by CMS or impact upon the facility's authority to conduct a

NATCEP. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i). CMS's determination as to the level of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9, 38 (2000), *aff'd, Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g.*, *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Review of a CMP by an ALJ is subject to 42 C.F.R. § 488.438(e).

When a penalty is proposed and appealed, CMS must make a *prima facie* case that the facility has failed to comply substantially with federal participation requirements, i.e. CMS must show a violation of a participation requirement, statutory or regulatory, and that the violation posed more than minimal harm to a resident or residents. "*Prima facie*" means that the evidence is "(s)ufficient to establish a fact or raise a presumption unless disproved or rebutted." *Black's Law Dictionary* 1228 (8th ed. 2004); *see also Hillman Rehabilitation Center*, DAB No. 1611, at 8 (1997), *aff'd Hillman Rehabilitation Center v. U.S. Dep't of Health & Human Services*, No. 98-3789 (GEB) (D.N.J. May 13, 1999). To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Evergreene Nursing Care Center*, DAB No. 2069, at 7-8 (2007); *Emerald Oaks*, DAB No. 1800 (2001); *Cross Creek Health Care Center*, DAB No. 1665 (1998); *Hillman Rehabilitation Center*, DAB No. 1611.

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 parties agreed at hearing that only the following alleged deficiencies remain in issue from the May 2006 survey: 42 C.F.R. §§ 483.15(g) (Tag F250), cited at a scope and severity (s/s) of K;[3] 483.25(h)(2) (Tag F324), s/s K; and 483.25(i)(l) (Tag F325), s/s G.

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[3] Scope and severity levels are used by CMS and a state when selecting remedies. The scope and severity level is designated by an alpha character, A through L, selected by CMS or the state agency from the scope and severity matrix published in the SOM, Chap. 7, § 7400E. A scope and severity level of A, B, or C indicates a deficiency that presents no actual harm but has the potential for minimal harm, which is an insufficient basis for imposing an enforcement remedy. Facilities with deficiencies of a level no greater than C remain in substantial compliance. 42 C.F.R. § 488.301. A scope and severity level of D, E, or F indicates a deficiency that presents no actual harm but has the potential for more than minimal harm that does not amount to immediate jeopardy. A scope and severity level of G, H, or I indicates a deficiency that involves actual harm that does not amount to

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Tr. 36; Jt. Stip. ¶ 7;[4] Joint Statement of Issues Presented for Hearing. CMS proceeded upon and presented evidence at hearing only as to the following alleged deficiencies from the July 2006 survey: 42 C.F.R. §§ 483.20(k)(3)(i) (Tag F281), s/s D; 483.25(h)(2) (Tag F324), s/s E; 483.25(i)(l) (Tag F325), s/s G; 483.25(j) (Tag F327), s/s G; and 483.75(l)(1) (Tag F514), s/s D.[5] Tr. 36; CMS Brief at 1, 23-31. Petitioner does not dispute that CMS had a basis for imposing a DPNA based on the unchallenged deficiencies cited by the May 2006 survey. However, Petitioner challenges the deficiencies that are the basis for the CMP. Tr. 33.

1. Petitioner was not in substantial compliance with participation requirements, and Petitioner's noncompliance posed immediate jeopardy to its residents as of May 17, 2006.

a. Petitioner violated 42 C.F.R. § 483.15(g)(1) (Tag F250).

A facility must care for its residents in a manner and in an environment that promotes the maintenance or enhancement of each resident's quality of life. 42 C.F.R. § 483.15. A specific quality of life requirement is that a facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 42 C.F.R. § 483.15(g)(1).

In the SOM,[6] CMS explains that "'[m]edically-related social services' means services provided by the facility's staff to assist residents in maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs." CMS Ex. 65, at 1.

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[3](...continued)
immediate jeopardy. Scope and severity levels J, K, and L are deficiencies that constitute immediate jeopardy to resident health or safety. The matrix, which is based on 42 C.F.R. § 488.408, specifies which remedies are required and optional at each level based upon the frequency of the deficiency. *See* SOM, Chap. 7, § 7400E.

[4] Petitioner did not dispute the deficiencies from the May 2006 survey cited under Tags F311 at a s/s of E and F314 at a s/s of G. Jt. Stip. ¶ 7.

[5] An alleged violation of 42 C.F.R. § 483.10(b)(11) (Tag F157), s/s D, was deleted by the Informal Dispute Resolution process. P. Ex. 15.

[6] Although the SOM does not have the force and effect of law, the provisions of the Act and regulations interpreted by the SOM clearly do have such force and effect. *State of Indiana by the Indiana Department of Public Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991); *Northwest Tissue Center v. Shalala*, 1 F.3d 522 (7th Cir. 1993). Thus, while the Secretary may not seek to enforce the provisions of the SOM, he may seek to enforce the provisions of the Act or regulations as interpreted by the SOM.

(SOM, App. PP, Tag F250). The SOM states that social services, by staff or referral, should be provided to residents in response to conditions including, among others, behavioral symptoms, striking-out at other residents, difficulty with personal interaction and socialization skills, chronic disabling medical or psychological conditions such as Alzheimer's disease, inability to cope with loss of function, and need for emotional support. CMS Ex. 65, at 3. The SOM provides an example of how a facility should respond to a resident with dementia who exhibits aggressive behaviors towards other residents:

> If a resident with dementia strikes out at another resident, *the facility should evaluate the resident's behavior*. For example, a resident may be re-enacting an activity he or she used to perform at the same time everyday. If that resident senses that another is in the way of his re-enactment, the resident may strike out at the resident impeding his or her progress. The facility is responsible for the safety of any potential resident victims while it assesses the circumstances of the residents behavior.

CMS Ex. 65, at 3 (emphasis added). The example provided by the SOM reflects the standard of care for patients who strike-out at other residents. Under the standard of care, a facility assesses and evaluates the residents' behavior and then develops and implements interventions to prevent the behavior from occurring or to allow the behavior to occur in a safe manner. Tr. 47, 214-15, 315-21, 355-58, 564-65. *See Brookshire Healthcare Center*, DAB No. 2190 (2008).

The surveyors allege in the SOD that the facility failed to identify residents with new behaviors, assess residents with behaviors and implement an individualized plan to prevent further behaviors, and failed to make revisions to plans to prevent behaviors resulting in resident-to-resident altercations. P. Ex. 1, at 6-7. The surveyors list six residents in the SOD, R27, R18, R41, R16, R14, and R6, however no allegations regarding R6 appear in the SOD and the example of R6 is not considered further as a basis for a violation of 42 C.F.R. § 483.15(g)(1). P. Ex. 1, at 7-47; Tr. 18-24, 146-49.

CMS alleges that the facility violated this participation requirement because it did not adequately assess the residents cited as examples and then implement effective interventions to address their behaviors, either stopping them or permitting them to occur safely. CMS Brief at 2; Tr. 30.

Discussion of three examples cited in the SOD related to residents, R27, R41, and R16, is sufficient to establish the violation.

(1) Resident 27

R27[7] had diagnoses including Alzheimer's disease, dementia, short and long-term memory problems, and moderately impaired cognitive skills for decision-making. She also had left foot drop, a defect in range of motion of the ankle. CMS Ex. 32, at 2-3, 10-11; Tr. 42-43. Her March 30, 2006 Minimum Data Set (MDS) stated that she wandered daily and exhibited verbally and physically abusive and socially inappropriate behaviors that were not easily altered one to three days a week during the assessment period. CMS Ex. 32, at 2; Tr. 43. R27's care plans dated January 16, 2006 and April 6, 2006, addressed her impaired cognitive status, which was manifested by wandering, threat of self-harm, and throwing feces, with numerous interventions or approaches listed.[8] CMS Ex. 32, at 6-8, 13-16. Among the interventions that both the January 16 and April 6, 2006 care plans implement is the use of a behavior documentation form. Staff were required to record when a targeted behavior occurred, what intervention was used in response to the behavior, and whether the intervention was successful. CMS Ex. 32, at 4-6, 12-13.

Progress notes, incident reports, ADL documentation, and behavior logs show that from January 2006 through May 2006, R27 exhibited multiple dangerous behaviors. She resisted care and was combative with staff, hitting, pinching, and biting staff members who were providing care at least 26 times. She got into arguments with residents and hit and threw objects at other residents on at least four occasions from January through May. CMS Ex. 32. R27 was often found wandering around the facility, and on at least seven occasions during this period, she was found wandering into other resident rooms. She threw feces (at least nine recorded incidents), cursed at staff, made negative comments about herself, and pulled off her clothes. CMS Ex. 32; P. Ex. 1, at 158-196.

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[7] R27 is referred to as R5 in the July 2006 survey.

[8] Interventions listed included: inviting the resident to large group activities; providing the resident with opportunities to be in a comfortable and stimulating environment; reassuring the resident; observing the resident for elopement risk; providing 24-hour reality orientation as needed; providing cognitive stimulation through one-on-one visits, activities, and conversations during activities of daily living; redirecting the resident to a quiet environment when agitated; anti-psychotic and anti-depressant medications as ordered; redirecting the resident with a positive conversation; putting the resident's underpants on over her incontinence briefs; and redirecting the resident to the east end solarium for rest periods. CMS Ex. 32, at 13-15. Her care plan dated April 6, 2006 added redirecting the resident calmly out of a room when she was found in an inappropriate area and toileting the resident per toileting schedule, but it did not include the interventions of using anti-psychotic medications or putting the resident's underwear on over her incontinence briefs. CMS Ex. 32, at 4, 7.

From January 2006 through May 2006, R27 wandered in and out of other residents' rooms or was found in another resident's room at least seven times, and sometimes acted aggressively toward the residents. CMS Ex. 32, at 5, 21, 33, 35, 39, 57, 61, 63, 67, 74. On February 14, 2006, R27 was found in another resident's room while that resident was sleeping, and R27 became very angry when staff removed her. CMS Ex. 32, at 74. On February 18, 2006, R27 wandered into a resident's room, became angry, and slapped the resident, who was laying in bed, on the arm. CMS Ex. 32, at 57. On February 19, 2006, R27 went into another room and slapped a resident on the arm. CMS Ex. 32, at 21, 35. On April 17, 2006, R27 refused to be cleaned up for bed. R27 had been with another resident, R18. R27 became combative with staff because she did not want to leave R18, who wanted her to lay in his bed. CMS Ex. 32, at 63-66. On May 10 and 11, 2006, she again wandered into other residents' rooms. CMS Ex. 32, at 5. On May 10, 2006, staff heard yelling and found that R27 had wandered into another room. When R27 exited the room, the staff's response was to tell her to stay out of other residents' rooms. CMS Ex. 32, at 5. The next day, May 11, 2006, R27 wandered into another resident's room, R29, and threw a bed pad at her, hitting R29 in the face. CMS Ex. 32, at 5.

In addition to the altercations that took place in other residents' rooms, R27 slapped another resident in the dining room on February 3, 2006, during a dispute regarding seating. CMS Ex. 32, at 19-20, 32; CMS Ex. 39, at 1; CMS Ex. 40, at 2. On April 12, 2006, when she was not able to remove her WanderGuard® from her ankle, R27 became angry and picked up another resident's walker, threw the walker, shoved a chair against the wall, and slapped the Activity Director on the arm. The Activity Director was unable to redirect R27. CMS Ex. 32, at 39-40.

When staff redirected R27, she often exhibited combative behavior. CMS Ex. 32, at 33; CMS Ex. 40, at 2. For example, on February 26, 2006, R27 was found asleep in the west wing of the facility. Staff woke her to take her back to her room in the east wing, and she became combative and tried to slide out of the wheelchair they brought to transport her. R27 injured her finger on the safety belt of the wheelchair, sustaining a 3 cm by 2 cm skin tear, when a Certified Nurse Assistant (CNA) tried to restrain her. CMS Ex. 32, at 23-24, 36, 74.

R27 was also combative with staff who were providing care. On March 2, 2006, March 15, 2006, April 3, 2006, April 17, 2006, and April 20, 2006, she hit, slapped, punched, pinched, bit, threatened, and/or cursed at staff who were providing care. CMS Ex. 32, at 37, 59, 64, 66. When she hit or slapped, R27 often swung forcefully. For example, on February 13, 2006, R27 hit a CNA who tried to assist her so hard that she knocked the CNA's glasses off. CMS Ex. 32, at 57. On February 23, 2006, R27 slapped a CNA who was trying to provide morning care leaving welts on the CNA's arm. CMS Ex. 32, at 27.

While there are numerous accounts of R27's dangerous behaviors, staff did not consistently document R27's behaviors in the behavior documentation form – the tool implemented by the facility to track the frequency of behaviors and the effectiveness of the interventions used. R27's behavior documentation form does not reflect the incidents on February 14, 2006 (CMS Ex. 32, at 74,[9] entering another resident's room); February 19, 2006 (CMS Ex. 32, at 35, 74, entering another resident's room and slapping the resident); February 20, 2006 (CMS Ex. 32, at 36, throwing feces and resisting care); February 26, 2006 (CMS Ex. 32, at 36, 74, resisting transfer from another resident's room, sustaining a skin tear on her finger); March 2, 2006 (CMS Ex. 32, at 37, hitting staff); and April 7, 2006 (CMS Ex. 32, at 39, hitting, biting, kicking staff), were not recorded in the behavior documentation forms (CMS Ex. 32, at 54-57; 58-62; 63-66).

Surveyor Lewis questioned the Social Services Director and the Director of Nursing (DON) about the May 10 and May 11 incidents when R27 entered other residents rooms, engaged in yelling and threw a bed pad at one resident. CMS Ex. 32, at 5; P. Ex. 1, at 21. The Social Services Director was not aware of the May 11 incident, and the DON was not aware of either incident. Subsequently, the Social Services Director advised her that the incident was not properly reported and that an investigation would begin immediately. P. Ex. 1, at 21; CMS Ex. 22, at 10-11; Tr. 50-51.

Surveyor Lewis testified that her concern in citing this deficiency was that Petitioner's staff only reacted to the incidents caused by R27 rather than being proactive by developing a plan and then "tweaking the plan to make it individualized for resident 27." Tr. 46-47. Surveyor Lewis testified that the facility did the right thing by redirecting R27 when an incident occurred. However, she testified that Petitioner's staff should have assessed the resident to try to identify why she was acting out by looking for triggers such as hunger, thirst, pain, or a need to go to the bathroom. Ms. Lewis also noted that because people with Alzheimer's disease live in the past, investigation into their past life helps to determine why an individual is exhibiting a certain behavior. Tr. 47-48. She clarified on cross-examination that she did not know whether Petitioner collected detailed social histories on residents, but her opinion was that use of social history was not reflected in the care plan for R27. Tr. 96-97. She also expressed concern that Petitioner resorted to drugs to control R27's behavior before attempting other interventions based on investigation of her history, hobbies, lifestyle, and similar areas. Tr. 61. Surveyor Lewis testified that R27 posed a risk of injury to herself and other residents. Tr. 61-66.

From February 2006 to March 2006, R27 threw feces at least nine times. CMS Ex. 32. Surveyor Melinda Lewis testified that Petitioner's DON told her that R27 was throwing feces because she was constipated. Surveyor Lewis was concerned because her review

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[9] R27's behavior documentation forms and related notes for February 2006 through May 2006 are at CMS Ex. 32, at 54-72. Activities of Daily Living logs and notes for February through April 2006 are at CMS Ex. 32, at 73-94.

showed that R27 started throwing feces around February 1, 2006; Petitioner implemented the intervention of having R27 wear underwear over her incontinence brief; but a stool softener was not initiated by the facility to address R27's constipation until February 20, 2006. According to Surveyor Lewis, the number of incidents involving throwing feces declined after the stool softener was introduced .[10] Tr. 56-58; CMS Ex. 32, at 32, 36, 46; P. Ex. 1, at 21, 159, 161, 180. I note that R27's care plan dated January 16, 2006 shows she had a problem with throwing feces when that care plan was drafted. CMS 32, at 12. Records from January 2006, also show stool softeners and laxatives had been used before. CMS Ex. 32, at 28, 49.

Petitioner argues that the surveyors did not observe R27 wander into other rooms during the survey; and that the facility was clearly aware of the resident's history. P. Brief at 2-3; P. Reply at 3-4. However, these points do not address the issue of whether or not Petitioner assessed behaviors and the effectiveness of existing interventions to address those behaviors and then implemented or modified existing interventions to stop the behaviors or permit them to occur in a safe environment.

Petitioner's staff failed to document behaviors using the behavior documentation form as required by the resident's care plan, showing that the tool adopted by Petitioner was not effectively used. The fact that the Social Services Director and DON were not aware of incidents on May 10 and 11, 2006, reflects that staff was not communicating behavior problems. The example of R27 throwing feces demonstrates that, to the extent Petitioner was responding to R27's behaviors, it was doing so slowly. The long list of incidents involving R27 compared to the few changes to her care plan from January to May 2006, raises the inference that Petitioner's staff was not assessing the needs of the resident to have her behavior addressed to either prevent it or allow it to occur in a safe place. The evidence also raises the inference that Petitioner's staff was not assessing the effectiveness of the chosen interventions even though repeated behaviors showed that those interventions were not effective. Petitioner makes the point that the allegations under F250 are not that Petitioner failed to act to address certain behaviors, rather the surveyors questioned the efficacy or appropriateness of certain interventions. P. Reply at 3. Petitioner's observation is correct. The key to understanding the gist of the deficiency allegation is that it is insufficient for Petitioner to simply implement interventions; the interventions must be effective to accomplish the goal that the care plan established. Thus, it is necessary for a facility to assess the effectiveness of interventions, and adjust or change them if they are not effective. In this case, the allegation is that there was a care

[10] Sharon Roberts, R.N., testified that when a resident throws feces, a facility should assess the resident's bowel to determine if the resident had hemorrhoids, is impacted, her stool is too hard, etc. Tr. 307.

plan with interventions, but the effectiveness of the interventions was not being assessed, and ineffective interventions were not being eliminated or changed. To the extent that staff may have attempted interventions not reflected in the care plans or other clinic records, they are undocumented and cannot be proved and their effectiveness is unknown.

(2) Resident 41

R41 had diagnoses of Alzheimer's disease and dementia, short and long-term memory loss (he was unable to find his room), and had a history of physical aggression. CMS Ex. 35, at 5, 6, 16, 163, 165-66; P. Ex. 1, at 228, 245; Tr. 213. Petitioner's clinical records for R41 include care plans dated December 8, 2005 and March 21, 2006, both of which required staff to record his behaviors on a behavior documentation form, noting what intervention was used to respond to a specific behavior, and whether the intervention was successful. CMS Ex. 35, at 7-8, 14-15.[11]

Petitioner's clinical records for R41 include numerous entries reflecting his aggression toward staff and other residents, including hitting, kicking, pinching, grabbing, squeezing, and throwing items.

On January 15, 2006, R41 swung at two CNAs attempting to provide care and then kicked one of them in the knee. CMS Ex. 35, at 72. On January 20, 2006, he swung at CNAs who tried to change his brief and squeezed their hands. CMS Ex. 35, at 24, 72. On January 21, 2006, when two CNAs attempted to assist the resident up after breakfast, he laughed and said, "do you want me to hurt you?" He then grabbed one of the CNA's arms and squeezed it hard. CMS Ex. 35, at 72. On January 22, 2006, he hit the CNA who was assisting him with showering and pulled the CNA's hair. CMS Ex. 35, at 74, 98. Increased aggression was noted on January 22, 2006 in Behavior Documentation Notes. CMS Ex. 35, at 71, 74. Inter-Disciplinary Progress notes reflect that R41's physician was notified of an increase in his aggressive behaviors on January 23, 2006. CMS Ex. 35, at 24. On January 24, 2006, R41's physician ordered that he be given Ativan (an anti-anxiety medication) as needed to address his aggressive behavior. CMS Ex. 35, at 13, 24, 118, 156, 158. On January 24, 2006, R41 attempted to hit a nurse and CNA assisting him with toileting. CMS Ex. 35, at 24. On January 31, 2006, at 5:30 a.m., a nurse responded to R41's alarm, but R41 was not in his room. The nurse proceeded to R10's room because

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[11] His care plan also instructed staff to provide him with verbal prompts regarding the location of his room, to encourage conversation with him, to provide one-to-one social services as needed, and when the resident is aggressive, to check the resident for physical discomfort and to speak to him in a calm tone of voice and allow physical space between the resident and the staff. CMS Ex. 35, at 16. In response to R41's Alzheimer's disease, the care plan directed staff to invite the resident to small group activities, offer diversional activities, and offer gardening and farming books. CMS Ex. 35, at 9-10, 15-16.

R10 had activated the call-light. When the nurse entered R10's room, she found R41 hitting R10 on the back with a shoe. R41 threatened to hit the nurse with the shoe and two CNAs had to assist the nurse by holding R41's hands to keep him from hitting. After the January 31, 2006 incident, the facility discontinued the use of R41's walker because it was considered a safety hazard. CMS Ex. 35, at 26, 59-61, 74; CMS Ex. 40, at 2-3.

On February 1, 2006, R41 attempted to strike a nurse when she tried to put on his Ted hose. CMS 35, at 30. On February 9, 2006, when a nurse and CNA assisted R41 to the bathroom, R41 grabbed the nurse's hair and put her in a head lock. When the CNA tried to get R41 away from the nurse, R41 slammed the nurse's head on the shower. CMS Ex. 35, at 32. In response to the February 9, 2006 incident, the resident was placed in a recliner in the solarium with a chair clip alarm and given Ativan. CMS Ex. 35, at 32, 118. On February 11, 2006, R41 grabbed and twisted the hands and fingers of a nurse and CNA who were assisting him with toileting. When they took R41 from the bathroom to the recliner, R41 shoved the CNA into the recliner, causing her to fall into the chair. CMS Ex. 35, at 32. On February 12, 13, 14, 17, and 22, 2006, R41 was combative with staff, hitting, pinching, and/or squeezing the hands of staff. CMS Ex. 35, at 33-35, 103. On February 13, R41 took broken pieces of cookie out of the trash and threw them at other residents. CMS Ex. 35, at 33, 76. His increased aggressive behavior was reported to his physician on February 13, 2006, and Risperdal (an anti-psychotic) was ordered. CMS Ex. 35, at 33, 120, 130. On February 23, 2006, R41 was found in his room, walking without assistance, naked. CMS Ex. 35, at 103. Staff noted in Behavior Documentation notes on February 23, 2006, that all planned interventions were attempted and none worked to calm the resident. CMS Ex. 35, at 76. On February 24, 2006, he was found in another resident's room. When staff asked him to leave, he told staff to "leave him the hell alone." CMS Ex. 35, at 76. On February 24, 2006, R41 told staff that he would "stomp" them, and he held up his fists and asked if they "wanted some." CMS Ex. 35, at 36. In his room, he hit at staff with a magazine, tried to step on their feet, and squeezed their hands. When a nurse attempted to give him Ativan by mouth, he kicked the nurse in the chest and stomach, and the nurse called the physician and obtained authorization to give an injection of Ativan. CMS Ex. 35, at 36; P. Ex. 1, at 235. On February 25, 2006, R41 was found taking off his clothes and attempting to get out of the recliner. CMS Ex. 35, at 37. He was placed in a Broda chair with a tray, but there was no indication that he had exhibited aggressive behavior. The next day the facility used the Broda chair twice, but again without noting any aggressive behaviors.[12] CMS Ex. 35, at 38. On February 27, 2006,

[12] The February 25, 2006 order to use the Broda chair (a reclining chair used as a form of restraint in this case) with a tray as a restraint when R41 was aggressive is reflected in Petitioner's restraint assessment dated February 24, 2006 at CMS Ex. 35, at 128-29 and the restraint log for R41 at CMS Ex. 35, at 125-26 and the order at CMS Ex. 35, at 159 and P. Ex. 1, at 236. On February 28, 2008, the facility received a facsimile from R41's physician clarifying that the Broda chair should only be used as needed and for no longer than two hours. CMS Ex. 35, at 41, 159. Use of the Broda chair was

(continued...)

R41 was combative with staff, including cursing, hitting, kicking, and biting, and he pulled his light cord out of the wall and swung it like a whip at the Social Services Director. CMS Ex. 35, at 38-41.

On March 1, 2006, the facility received an order to send R41 to the hospital for evaluation and treatment because he was a danger to himself and other residents. CMS Ex. 35, at 41, 159. On March 2, 2006, when transport arrived to take R41 to the hospital, he became aggressive, kicking, biting, and hitting and the ambulance personnel had to restrain him. CMS Ex. 35, at 43, 168-69. On March 9, 2006, the hospital reported that R41 was pleasant, laughing, and feeding himself and that he was being returned to Petitioner. R41 returned to the facility on March 9. CMS Ex. 35, at 43-44. On March 20, 2006, R41 was in the solarium when another resident wheeled by yelling. R41 got up and slapped the resident's face. CMS Ex. 35, at 50, 69-70, 124; CMS Ex. 39, at 3. Staff responded by separating the residents. CMS Ex. 35, at 50, 70. A new care plan was issued for R41 dated March 21, 2006, with little or no change in the interventions to deal with R41's aggressive behavior from the prior care plan dated December 8, 2005.[13] CMS Ex. 35, at 7-8, 10, 14-16. On March 24, 2006, R41 refused to leave the dining room after lunch, threatened to hit two CNAs who attempted to walk him out of the dining room, and threw a gait belt at a CNA. CMS Ex. 35, at 51.

On April 3, 2006, R41 was wandering the hallways at 12:30 a.m. and went into a female resident's room and began yelling and threatening her. He threatened to hurt the resident if she did not get out of his room and bed. When two CNAs helped him to return to his room, he threatened them both. CMS Ex. 35, at 84, 109. On April 21, 2006, R41 was reported to be aggressive and swinging at CNAs, yelling pinching, kicking, hitting, and bending their fingers back. CMS Ex. 35, at 54, 109.

On February 24, 2006, R41' s care plan was updated to include the assistance of two staff members with ambulation and the use of a Broda chair with a tray for up to two hours to provide rest periods for the resident's aggressive behaviors. CMS Ex. 35, at 14, 18; P. Ex. 1, at 236. On February 24, 2006, R41's interdisciplinary team met and reviewed his care plan and behaviors, the use of an Ativan injection and use of a Broda chair. The team found staff used all current interventions and used medication for the resident's safety.

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[12](...continued)
discontinued on March 23, 2006. CMS Ex. 35, at 125.

[13] The December 2005 care plan under the problem "cognitive issues" reflects hand-written modifications but not dates on which those modifications were made. CMS Ex. 35, at 15-16. I infer that the modifications were made during the effective period of that care plan. The March 2006 care plan lists the same interventions noted on the modified December 2005 care plan. CMS Ex. 35, at 9.

R41's physician was also called to the facility to review the care plan. CMS Ex. 35, at 37. R41's care plan team met again on February 27, 2006 to review his behaviors. The team noted he had another increase in physical aggression. The team felt he might need "hospitalization to review our current interventions [and] to attempt to find/learn interventions to assist [R41] in maintaining his safety [and] safety" of other residents. CMS Ex. 35, at 41. R41's care plan team met on April 5, 2006, and decided he was no longer an elopement risk as he could no longer independently ambulate, with or without assistance devices. CMS Ex. 35, at 52.

R41's clinical records show frequent aggressive acts toward residents and staff from January through April 2006. However, many of the incidents were not documented on R41's behavior documentation form as required by his care plans from December 2005 and March 2006. Staff did not document incidents on the behavior documentation form that occurred on January 24, 2006 (combative with staff during toileting, attempting to hit with clenched fists); February 1, 2006 (combative with staff, kicking and hitting); February 9, 2006 (combative with staff during toileting, putting nurse in a headlock, slamming nurse's head into shower); February 11, 2006 (combative with staff during toileting, grabbing and twisting staff's fingers, threatening, shoving); February 12, 2006 (grabbing at staff, raising clenched fists); February 14, 2006 (combative with staff when walking to dining room, holding onto staff member's hand tightly); February 17, 2006 (combative with staff when dressing, hitting, pinching, grabbing hands); February 22, 2006 (combative with staff, hitting and pinching); February 24, 2006 (combative with staff, cursing, threatening, hitting, squeezing hands, kicking); February 25, 2006 (*not* combative, took off clothes, placed in Broda chair); February 27, 2006 (combative with staff, attempting to hit, bite, kick); March 2, 2006 (combative with staff during toileting, hitting, grabbing, pinching) (combative during transfer to hospital, pinching, biting, kicking); March 20, 2006 (slapped another resident for yelling); March 24, 2006 (combative with staff, threatening, threw gait belt at CNA); and April 21, 2006 (combative with staff, yelling, pinching, kicking, hitting, bending CNA's fingers back). CMS Ex. 35, at 71-88.

Surveyor Marla Potts testified that her concern when citing R41 as an example was Petitioner's failure to thoroughly assess R41, including obtaining, for example, information regarding work, educational, and military history, and his behaviors and to implement effective interventions to prevent his aggressive behaviors. Tr. 214-15, 238, 271. The CMS expert witness, R.N. Sharon Roberts, testified that the standard of care for an aggressive resident like R41 is to assess why the behaviors are happening with modification to the care plan to address the cause for the behaviors and, she opined, Petitioner failed to do the assessment or modify the care plan. Tr. 315-19.

Petitioner argues that its staff was aware of R41's history, specifically that he was a Petty Officer in World War II, and used this information in planning interventions. Petitioner also notes that the surveyors observed no aggressive behavior toward another resident during the survey and none is recorded after April 3, 2006. P. Brief at 4-5. Although it is

not readily apparent to me that Petitioner considered R41's military service when developing interventions to deal with his aggressive behavior, I accept that Petitioner did so. However, between January 2006 and April 2006, whatever interventions Petitioner implemented were either not effective or not effectively implemented as R41's aggressive behavior obviously continued. Petitioner's focus on the fact staff recorded no aggressive behavior toward another resident after April 3, 2006, is too narrow. The specific quality of life requirement at issue here is whether Petitioner provided medically-related social services to help R41 attain or maintain the highest practicable physical, mental, and psychosocial well-being. 42 C.F.R. § 483.15(g)(1). The focus is upon R41 and his aggressive behavior (whether directed at residents or staff), the causes of that behavior, and what could be done to help R41 end the behavior so he could attain the highest practicable well-being. The record shows R41 was aggressive with staff on April 21, 2006, clearly showing that Petitioner's interventions were not effective as late as that date.

Petitioner argues that the CMS theory that the resident may have been agitated by noise fails to account for the fact that R41 was hard-of-hearing. P. Reply at 5-6. Whether or not the CMS theory is well-founded is not the issue. The focus is not upon whether the surveyors or CMS correctly assess the cause of resident behaviors. The focus is upon whether or not Petitioner assessed the possible causes of negative behaviors and then implemented interventions to eliminate the negative behaviors or to permit them to occur safely.

The clinical record produced for R41 shows that his care planning team met and made decisions for his care and treatment that were implemented. However, Petitioner has not presented evidence that shows that the care planning team assessed on an ongoing basis the causes of R41's aggressive behaviors resulting in modification of existing interventions or implementation of new interventions to prevent the behaviors or permit them to occur in a safe environment. There are two care plans in the record. The care plan effective December 8, 2005, reflects modifications that are then incorporated in the March 21, 2006 care plan with no change. On February 24, 2006, R41' s care planning team approved the use of restraint in the form of a Broda chair with a tray for up to two hours to provide rest periods for the resident's aggressive behaviors and the use of the drug Ativan. CMS Ex. 35, at 14, 18, 37; P. Ex. 1, at 236. On February 27, 2006, the care planning team met again and noted R41 had another increase in physical aggression and decided he needed to be hospitalized so that interventions could be reviewed and new interventions identified. CMS Ex. 35, at 41. R41's care plan team met on April 5, 2006, and decided he was no longer an elopement risk as he could no longer independently ambulate, with or without assistance devices. CMS Ex. 35, at 52.

The evidence shows that the care plan requirement to document behavior was not consistently used by staff, thus rendering that intervention ineffective.

(3) Resident 16

R16 was an 83 year old female with diagnoses of Alzheimer's disease and dementia with agitation, long and short-term memory problems, and moderately impaired decision-making skills. CMS Ex. 30, at 4, 70-84; P. Ex. 1, at 253; Tr. 124. Surveyor Anne Marie Crays testified that the dangerous behavior of R16 that caught her attention was her repeated attempts to transfer R11 from her wheelchair to a bed or toilet. Petitioner's primary intervention for the behavior was to redirect R16, and in Surveyor Cray's opinion that intervention was inadequate because it was reactive and did not serve to prevent the behavior. Tr. 124-25. Surveyor Cray testified that beginning in December 2005, Petitioner attempted therapeutic work activity but R16's participation declined and Petitioner did not modify the activity to keep R16 engaged. Tr. 125-27. Surveyor Crays testified that she was concerned also because Petitioner did not document R16's behavior of transferring R11 in R16's behavior documentation form, although it was a behavior that put both residents at risk for harm. Tr. 130. R16 also behaved aggressively toward another resident and staff. CMS Ex. 30, at 28, 38-39; Tr. 131. Surveyor Crays opined that Petitioner did not provide R16 the medically related social services necessary to address her recurring behavior. Tr. 133-34. On cross-examination Surveyor Crays agreed that a resident pushing another resident in a wheelchair could be good therapy, so long as it was done with supervision and she did not find supervision in the case of R16 pushing R11. Tr. 181. She also agreed on cross-examination that for most of the cited instances where R16 attempted to transfer R11, staff was able to respond to R11's seatbelt alarm before a transfer actually occurred. Tr. 194-96. Surveyor Potts testified that reminding R16 not to transfer R11 was not an effective intervention due to her memory impairment. Tr. 223. R.N. Roberts opined that redirecting and reminding R16 not to transfer R11 was not effective due to her memory problems. Tr. 302. Therapeutic work was not effective because R16 did not engage in the work for long. Tr. 303. R.N. Roberts also opined that Petitioner's response to R16's behavior was not consistent with the standard of care because Petitioner did not try different approaches to prevent the behavior.

Petitioner's clinical records for R16 show that on December 20, 2005, the facility's social worker met with the DON, R16, and R16's son to discuss R16's behavior of transferring R11, who R16 thought was her aunt. R16's son explained to her that this was dangerous and R16 agreed not to transfer R11 again, and R16's son agreed to remind R16 at least every other day that she should not transfer R11. CMS Ex. 30, at 25. Four days after the meeting, on December 24, 2006, R16 attempted to transfer R11. A staff member reminded R16 that she should not assist R11 with transfers. CMS Ex. 30, at 25. On December 30, 2005, R16 again tried to transfer R11 to the bathroom, but R11's seatbelt alarm sounded and a CNA intervened reminded R16 that she should not transfer R11. CMS Ex. 30, at 25. On January 2, 2006, a nurse saw R16 pushing R11 around in her wheelchair and R16 had

turned off R11's chair alarm and removed her seatbelt. The nurse turned on the alarm and replaced the seatbelt. CMS Ex. 30, at 26. The Interdisciplinary Progress Notes do not reflect that the nurse told R16 that she should never turn off R11's chair alarm or remove her seatbelt. CMS Ex. 30, at 26.

On January 6, 2006, it is documented that a CNA found R16 trying to transfer R11 when R11's seat-belt alarm sounded; R16 would not leave R11 alone; that R16 hovered over R11 throughout the day shift; and that R16 had to be redirected several times with staff explaining that they had to do transfers. CMS Ex. 30, at 26. On January 23, 2006, a nurse passed R16's room and heard an alarm sounding. R16 had undone R11's seatbelt and transferred R11 into R16's bed. R11 was moved, but the only intervention used was to tell the residents that they should not help each other into bed. CMS Ex. 30, at 27. On January 27, 2006, a nurse noted that R16 was complaining that staff was not doing enough for R11 and that R16's behavior of interfering with R11 was "becoming more of a problem." CMS Ex. 30, at 27.

Besides the behaviors that threatened her own safety and R11's, R16 sometimes behaved aggressively towards other residents. On January 30, 2006, she approached a resident and began yelling at him, then slapped him for an unknown reason. R16's son was notified, and he agreed to persuade her to engage in therapeutic activities. CMS Ex. 30, at 28, 38-39. This is the first time an intervention other than redirecting is mentioned in the notes.

On January 31, 2006, staff received an order from R16's physician for therapeutic work. R16 began therapeutic work on February 1, 2006, folding laundry and assisting dietary and housekeeping. CMS Ex. 30, at 29. She engaged in therapeutic activities, primarily assisting housekeeping with folding linens, for approximately four hours a week. But her participation declined after the first week, and for the rest of the month she participated for one to one and a half hours per week. CMS Ex. 30, at 66. On February 21, 2006, she was again found transferring R11 out of bed when the bed alarm sounded and she became agitated and verbally aggressive when staff tried to redirect and told her to stop interfering. CMS Ex. 30, at 30. On February 24, 2006, R16 was found in the shower room attempting to transfer R11 to the toilet when R11's seatbelt alarm sounded. CMS Ex. 30, at 31. When she was informed that she could not engage in this behavior, R16 became agitated. According to the Inter-Disciplinary Notes dated February 24, 2006, the nurse filled out a "Suggestion/Concern" to give to social services. CMS Ex. 30, at 31.

On March 6, 2006, the facility's Behavior Management Committee met to review R16's behaviors. CMS Ex. 30, at 23. The committee reviewed R16's behaviors; noted that she was participating less often in therapeutic work; that staff continued to have to redirect her from assisting R11 out of her wheelchair; and decided to continue with her current behavior plan. The notes from the meeting do not include an analysis of the efficacy of the interventions that were used to prevent R16 from assisting R11 with transfers. CMS Ex. 30, at 23. Ten days after that meeting, on March 16, 2006, R16 was attempting to

push R11 in her wheelchair and when a CNA asked her not to, R16 yelled at and hit the CNA. CMS Ex. 30, at 48. On March 20, 2006, a social worker reviewed R16's behavior plan and found that it should be continued without modification. CMS Ex. 30, at 32. On March 26, 2006, and March 28, 2006, R16 was found assisting R11. She was reminded not to move the resident. CMS Ex. 30, at 32, 48. On May 3, 2006, R16 was found preparing to transfer R11 from her wheelchair to the toilet when R11's seatbelt alarm sounded. When a CNA told her she should not transfer R11, R16 slapped the staff member on the arm and prepared to hit her again but was redirected by a second CNA. CMS Ex. 30, at 37.

Surveyors observed R16, unsupervised, pushing R11 in her wheelchair and wandering into other resident rooms during the survey. On May 11, 2006, at 10:55 a.m. surveyors observed R16 pushing R11 in the hall in her wheelchair. At 11:00 a.m. R16 was observed pushing R11 down the hall passing several staff members. At 12:25 p.m. R15 was observed to enter a residents room that was not hers and then exit, and she was heard to ask another resident if he had a car because she was looking for a way home. On May 16, 2006, at 11:30 a.m., surveyors saw R16 pushing R11 in her wheelchair into the dining room. At 12:45 p.m. surveyors observed R16 pushing R11 in her wheelchair in the hall. P. Ex. 1, at 43; CMS Ex. 21, at 7; CMS Ex. 23, at 6, 13-14; Tr. 132, 223. One staff member actually directed R16 as to where to push R11 on May 16, 2006. CMS Ex. 21, at 7.

The Social Services Director told surveyors that she was responsible for the behavior plans and that it was her understanding that R16's behaviors were being addressed with therapeutic work. However, the Social Services Director did not know how often R16 participated in therapeutic work. She also told Surveyor Crays that she believed that staff would listen for R11's chair alarm to sound in order to know when R16 was assisting R11. P. Ex. 1, at 43-44; CMS Ex. 23, at 14; Tr. 126. When asked about R16's declining participation in therapeutic work, the Activity Director, who is responsible for overseeing therapeutic work activities, told surveyors that R16 “just stopped coming.” She also said that the housekeeping was responsible for asking residents if they wanted to participate in work activities. P. Ex. 1, at 44; Tr. 126-27. Surveyor Crays testified that she could not find evidence that Petitioner’s staff tried to find other therapeutic work or some other activity that might have kept R16 engaged. Tr. 127. Surveyor Crays opined that staff waiting to hear R11's alarm to signal that R16 was attempting to transfer R11, was not a good approach because by the time they responded R11 could already be on the floor. Tr. 128.

The clinical records for R16 placed in evidence included behavior documentation forms for February 2006 through May 2006. Target behaviors listed for February, March, and April are: not putting dirty clothes in laundry; refusing showers; and physical aggression. CMS Ex. 30, at 44, 46, 49. Target behaviors listed for May include: not putting dirty

clothing in laundry, refusing showers, physical aggression; and yelling. CMS Ex. 35, at 51.[14] The behavior documentation forms do not list R16's transfer of R11 or pushing R11 in her wheelchair as target behaviors.

The portion of a Comprehensive Care Plan for R16 introduced as evidence is dated March 20, 2006. The use of a behavior documentation form is required and targeted behaviors listed are: not putting dirty clothing in laundry; refusing showers; and physical aggression. CMS Ex. 30, at 58-59. R16's wandering, emotional conflicts, aggressive behavior including hitting, and agitation are listed as problems. CMS Ex. 30, at 56, 61. Interventions listed are: inviting and assisting to large group activities; offering opportunities for success and praise; complimenting on participation and efforts; inviting for walks outside when weather permits; identification of source of anger and removing to a quiet environment; contact family and request they come and assist if R16 cannot be redirected; advise nurse when R16 refuses weekly shower and nurse will advise family and offer another time; offer therapeutic work with laundry, housekeeping and dietary staff; praise for participation in therapeutic work; respect right to refuse therapeutic work; involve in group activity or provide one-to-one visit if needed; encourage to voice feelings; give information regarding daily schedule; do not tell R16 she is in a nursing home; remind R16 she is not to help anyone out of a wheelchair; staff to remove dirty laundry and if R16 becomes angry, will do so after she is asleep. CMS Ex. 30, at 56, 59, 61. A hand-written note, that is partially visible in the copy admitted, advises staff to be aware of R16's history of transferring other resident, however there is a line through this entry. CMS Ex. 30, at 61. The portion of the March 20, 2006 care plan admitted only includes the two references to R16 transferring another resident and the only listed intervention is to remind R16 not to transfer other residents. R16 pushing another resident in a wheelchair is not listed as a problem in the care plan. The behavior documentation requirement of the care plan does not list as problem behavior R16 pushing another resident in a wheelchair or transferring another resident and does not require documentation of such behaviors. CMS Ex. 30, at 58-59.

Because the surveyors indicate that residents pushing the wheelchairs of other residents may be a beneficial intervention if properly supervised, I focus on the behavior of R16 transferring R11 as both parties recognize that there is some risk of harm to both residents involved. R16 was delusional in her belief that R11 was her relative and that R16 needed to care for her. R16's attempting to transfer R11 was a recurring behavior. However, the troublesome behavior was not included on the care plan as a behavior subject to behavior documentation. The inference that arises is that the care plan did not require ongoing assessment of the behavior to determine causes and possible interventions to prevent the behavior. The portion of the care plan admitted as evidence also included no intervention

[14] I note that the behavior documentation form at CMS Ex. 30, at 52, 54, and 55 are for another resident and not R16, based on comparison of admit date, birth date, and diagnosis.

that might have addressed directly the apparent cause of the behavior, i.e. the delusional belief that R11 was a relative who required R16's assistance. Rather, the care plan included the intervention to remind R16 not to attempt transfers without also including direction to staff to do reality orientation or a similar intervention. Of course, given R16's assessed memory impairment, reminding and reality orientation were not likely to be highly successful interventions.

There is evidence that R16's care planning team met, assessed, and developed interventions. On March 6, 2006, the facility's Behavior Management Committee met to review R16's behaviors. CMS Ex. 30, at 23. The committee reviewed R16's behaviors; noted that she was participating less often in therapeutic work; that staff continued to have to redirect her from assisting R11 out of her wheelchair; but then decided to continue with her current behavior plan. The notes from the meeting do not include an analysis of the efficacy of the interventions that were used to prevent R16 from assisting R11 with transfers. CMS Ex. 30, at 32. Ten days after that meeting, on March 16, 2006, R16 was attempting to push R11 in her wheelchair and when a CNA asked her not to, R16 yelled at and hit the CNA. CMS Ex. 30, at 48. On March 20, 2006, a social worker reviewed R16's behavior plan and found that it should be continued without modification. CMS Ex. 30, at 32. On March 26, 2006, and March 28, 2006, R16 was found assisting R11. The evidence shows that while the staff and the care planning team was aware of R16's behavior and that interventions were ineffective, the decision was made to continue with the current interventions even though they were obviously not effective to stop the behavior or permit it to occur in a safe environment.

Petitioner argues that R11's seatbelt alarm was effective to alert staff to prevent transfers on all but one occasion. P. Brief at 6, 8. The evidence supports Petitioner's position that the seatbelt alarm was a good intervention to help keep R11 safe. However, the seatbelt alarm was an intervention that focused upon R11 rather than upon addressing the cause for R16's negative behavior and either preventing the behavior or permitting it to occur in a safe manner.

Based upon the examples cited in the SOD related to R16, R41, and R27, I conclude that the facility did not provide the residents with medically related social services because it failed to adequately assess cause for and respond to the residents' behaviors to either prevent them or to permit them to occur in a safe environment. Petitioner did not engage in an ongoing assessment of the resident modifying existing interventions and adopting new interventions to prevent the behaviors or to permit them to occur safely.

b. The CMS determination that Petitioner's violation of 42 C.F.R. § 483.15(g)(1) posed immediate jeopardy is not clearly erroneous.

The surveyors cited the violations of 42 C.F.R. §§ 483.15(g)(1) and 483.25(h)(2) at a scope and severity of K, which denotes immediate jeopardy. The surveyors declared immediate jeopardy as of May 17, 2006, based on the teams' finding of "a pattern of resident to resident physical altercations with a lack of supervision by facility staff of residents with aggressive behaviors . . . ." P. Ex. 1, at 95. The surveyors further found that the immediate jeopardy was abated on May 22, 2006, after Petitioner adopted and implemented a plan of correction. However, the surveyors also found that Petitioner continued to be noncompliant with program participation requirements with a pattern of incidents that caused no actual harm but posed the potential for more than minimal harm that is not immediate jeopardy. P. Ex. 1, at 95.

Petitioner argues that the declaration of immediate jeopardy based upon deficiencies cited under Tags F250 and F324, was clearly erroneous. Petitioner argues that the surveyors only allege four resident-to-resident altercations involving R41 and R27 and other residents. Petitioner characterizes the incidents involving the two residents as isolated and not supportive of a finding of a systemic problem or pattern. P. Brief at 14-15; P. Reply Brief at 11-12.

Pursuant to 42 C.F.R. § 488.301, "*(i)mmediate jeopardy* means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." (emphasis in original). Based upon the foregoing discussion of the behaviors of R41 and R27 and the evidence and argument offered by Petitioner, I cannot find clearly erroneous the CMS determination that immediate jeopardy was present. The fact that the residents only made direct contact slapping other residents on a couple occasions is not determinative. The regulation does not require actual harm only that there is a likelihood of serious injury, harm, impairment, or death. The surveyors concluded based on the evidence that the residents had struck other residents and that R41 was physically aggressive with staff demonstrating the physical strength and potential to act aggressively. Tr. 217. I find persuasive the evidence that these aggressive residents posed the likelihood of serious injury, harm, impairment, or death for other residents.[15] Joan Foradori-Cook, Petitioner's Administrator, testified that she did not understand the declaration of immediate jeopardy because there was no harm. Tr. 575. However, as I have already noted there is no requirement that actual harm or injury have occurred to support a declaration of immediate jeopardy.

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[15] Although not specifically cited by the surveyors in the SOD as a basis for declaring immediate jeopardy, R16's transfers of R11 posed the risk of serious harm to both R16 and R11. Tr. 124, 135.

c. Petitioner violated 42 C.F.R. § 483.25(h)(2) (Tag F324).

The regulation requires that a facility ensure "[e]ach resident receives adequate supervision and assistance devices to prevent accidents." 42 C.F.R. § 483.25(h)(2). Section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, however, it does require the facility to take all reasonable or practicable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm to the resident from accidents. Although a facility can choose the method of supervision it uses to prevent accidents, the method chosen needs to be "adequate." To determine if the supervision is "adequate," one must look at the resident's ability to protect himself or herself from harm. *Woodstock Care Center v. Thompson*, 363 F.3d. 583, 589-90 (6th Cir. 2003); *Clermont Nursing and Convalescent Center*, DAB No. 1923 (2004), *aff'd, Clermont Nursing and Convalescent Center. v. Leavitt,* 142 Fed.Appx. 900 (6th Cir. 2005).[16] 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 F324; *Woodstock Care Center*, DAB No. 1726, at 4.

The surveyors allege in the SOD that the facility violated this requirement by failing to ensure residents requiring alarms were not left alone by staff in the bathroom without alarms; failing to supervise a cognitively impaired resident to keep her from helping another cognitively impaired resident; failing to ensure alarms were applied correctly; failing to promptly respond to resident alarms which resulted in resident-to-resident altercations; failing to supervise wandering residents to prevent them from wandering into other residents' rooms which resulted in residents being afraid and resident-to-resident physical altercations; and failing to provide supervision to prevent choking. P. Ex. 1, at 58. The findings of noncompliance involved six residents.

CMS argues that the focus of the citation under Tag F324 was Petitioner's failure to supervise residents who exhibited negative behavior to prevent them from causing serious harm to themselves, staff, or other residents. Tr. 30. It is sufficient to discuss only two of the examples cited by the surveyors, R41 and R7, to illustrate the violation. CMS argues that R41 was at high risk for falls and for aggressive behavior with other residents and Petitioner failed to provide adequate supervision to avoid the foreseeable risks of harm.

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[16] Appellate panels of the Board have extensively discussed facilities' obligations under 42 C.F.R. § 483.25(h)(2) in many cases, including in the following: *Estes Nursing Facility Civic Center*, DAB No. 2000 (2005); *Northeastern Ohio Alzheimer's Research Center*, DAB No. 1935 (2004); *Guardian Health Care Center*, DAB No. 1943, at 17-18 (2004); *Woodstock Care Center*, DAB No. 1726, at 28 , *aff'd, Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003).

CMS Brief at 15; CMS Reply at 14-15. CMS argues that Petitioner failed to provide R7 adequate supervision to ensure that she did not choke. CMS Brief at 18; CMS Reply at 15.

(1) Resident 41

R41 was discussed as an example under Tag F250. He had diagnoses of Alzheimer's disease and dementia, short and long-term memory loss (he was unable to find his room), and had a history of physical aggression toward staff and other residents that has already been described in some detail. CMS Ex. 35, at 5, 6, 16, 163, 165-66; P. Ex. 1, at 228, 245; Tr. 213. R41 was also assessed at high risk for falling in October 2005, January 2006, February 2006 and March 2006. CMS Ex. 35, at 132, 134, 136,138. Petitioner's clinical records for R41 include care plans dated December 8, 2005 and March 21, 2006. CMS Ex. 35, at 6-12, 13-17. Initially, the December 2005 care plan indicated that R41 was independent for transfers and ambulation but staff was to assist him to a chair to rest if imbalance and a complaint of headache were noted. Hand-written annotations dated December 23, 2005, January 31, 2006, February 24, 2006, and March 9, 2006, required a physical therapy evaluation, permitted independent ambulation in the room, use of a roller walker when out-of-room and verbal reminders to use the walker, more verbal cues in the evening when he was fatigued, a restorative program for ambulation, a mobility monitor when he was up in a recliner in the solarium, ambulating with a gait belt and assistance of two staff when out of room, assistance to the toilet after supper, assistance of two persons for ambulation, a bed pad monitor, transfers with gait belt and assistance of two staff, and use of a Broda chair with a tray when R41 was having aggressive behavior. Several of the interventions on the December 8, 2005 care plan were lined-through indicating the interventions were no longer in effect. CMS Ex. 35, at 17-18. The March 21, 2006 care plan identified the problem as potential for fall with injury due to recent complaints of headache with stumbling, and gait dysfunction. The goal of the March 2006 falls care plan was to have no falls or injuries through June 21, 2006. Specific interventions included rehabilitation or a restorative program for ambulation with a roller walker and verbal cues; transfers were to be with a gait belt and the assistance of one staff member; ambulation in room was to be independent but with the assistance of two and a gait belt outside the room; R41 was to be assisted to his chair if staff noted imbalance and complaint of headache; a motion sensor was to be used with its functioning checked at the beginning of each shift; a clip alarm was to be used when the resident was up in a chair; and a bed pad monitor was to be used and the functioning was to be checked at the beginning of each shift. CMS Ex. 35, at 11.

During January and February 2006, R41 fell four times. Early in the morning on January 14, 2006, a CNA heard movement in R41's room. She entered the room and found R41 on the floor in a puddle of urine stating, "[g]et me up from here." CMS Ex. 35, at 23, 57-58. In response, the facility implemented the use of a mobility monitor at all times and toileting every two hours. CMS Ex. 35, at 58. The next night, R41 was found walking in

the hallway; he had detached his bed clip alarm. Staff redirected R41 to his room and replaced his bed clip alarm with a pressure bed pad alarm. CMS Ex. 35, at 13, 23-24, 155, 157. On February 6, 2006, at 12:30 a.m., R41's bed alarm sounded. A CNA found him sitting on the floor beside his bed unable to explain what happened. CMS Ex. 35, at 31, 62-63; CMS Ex. 39, at 1. In response, the facility replaced the bed pressure alarm with a motion sensor. CMS Ex. 35, at 13, 20, 101. Staff were also instructed to assist R41 to toilet after supper and to wake him at 5:30 a.m. for toileting, in addition to an existing intervention that required a toileting schedule with morning and afternoon care, every shift, before and after meals, on request, and with each bed check if awake. CMS Ex. 35, at 13, 18. The February 6, 2006, Interdisciplinary Assessments and Summary Reviews entry, states that the toiletting plan was changed based upon the fall review and R41 was to be waked at 12:00 a.m. and 5:30 a.m., but the December 2005 care plan that was in effect at the time was not updated consistent with this note. CMS Ex. 35, at 20. The resident was placed on hourly checks to observe for injury. CMS Ex. 35, at 63. The hourly checks intervention appears to have been temporary and was not added to R41's care plan. R41 fell on February 9, 2006, when trying to transfer himself from a chair to a standing position; no new interventions were implemented. CMS Ex. 35, at 20,[17] 64; CMS Ex. 39, at 1. On February 13, 2006, the resident's care plan was modified to include the assistance of two staff with all care. CMS Ex. 35, at 13. On February 24, 2006, the care plan was modified to require the assistance of two staff for ambulation and on February 25 to require transfers with the assistance of two staff. CMS Ex. 35, at 18. On February 25, 2006, a CNA found R41 on the floor in the middle of the night. He was laying on his left side along the side of his bed, naked, with his gown and pull-up brief on the floor, and his rib cage and left shoulder were red. CMS Ex. 35, at 37, 66-68, 103, 129; CMS Ex. 39, at 2. He was placed on hourly checks to observe for injury and due to his continuing attempts to get out of bed. CMS Ex. 35, at 67. The hourly checks were for a limited period and were not added to the care plan. The clinical records that record this fall do not indicate that any alarm sounded but the "Narrative of the Incident," which indicates on its face that it is not part of the medical record and is attorney work product, states that the CNA heard an alarm sound. CMS 35, at 68. After the fall, R41 continued to get out of bed unassisted. CMS Ex. 35, at 103. R41 was hospitalized due to his aggressive behaviors from March 2 to 9, 2006. On March 10, 2006, at 11:30 p.m., R41 was found in the hallway by himself with his alarm sounding; a nurse noted that he had removed his clip alarm multiple times. CMS Ex. 35, at 46. On March 20, 2006, R41 got up from his chair unassisted and struck another resident causing his alarm to sound. CMS Ex. 35, at 50, 124. A note dated March 29, 2006 at 1:30 a.m., indicates that R41 was up walking the halls but he did not go into any rooms, which causes me to conclude he was ambulating without assistance, albeit with supervision. CMS Ex. 35, at 51. A Behavior Documentation note dated April 1, 2006, reflects that R41 was repeatedly setting off his

[17] This February 13, 2006 note refers to review of a fall that occurred on February 10, 2006. However, there is no other evidence of a fall on February 10, and I conclude the writer was reviewing the fall of February 9, 2006.

alarm attempting to get out of bed and the alarm agitated him. CMS Ex. 35, at 84. Behavior Documentation and Activities of Daily Living (ADL) notes dated April 3, 2006, indicate R41 was wandering the halls and went into another resident's room and was yelling and threatening the resident and threatened staff when they intervened, causing me to believe the resident was unsupervised and unassisted before staff intervened. CMS Ex. 35, at 84. A progress note dated April 5, 2006, indicates that R41 is able to get up to the bathroom on his own but, he is taken to the toilet every two hours by staff and he had some type of alarm. However, another note dated April 5, 2006 at 2:30, indicates R41's interdisciplinary team met and concluded he was no longer an elopement risk because he could not ambulate independently, with or without assistance devices. CMS Ex. 35, at 52. On April 21, 2006 a note at 10:00 a.m. states that R41 was up walking in the hallway and I conclude he was not assisted by staff because the note states he was in his undergarment and he started swinging when the CNAs tried to redirect him and they could not place a gait belt on him. The note does not indicate that any alarm sounded. CMS Ex. 35, at 54. A note dated May 7, 2006, indicates that R41 was getting-up by himself and attempting to walk in the hall by himself, triggering his alarm. CMS Ex. 35, at 56. A note dated May 16, 2006, reflects that a bed pad alarm and motion sensor were continued for safety, that R41 required assistance of two with the gait belt for ambulation outside his room, and he was toileted every two hours. CMS Ex. 35, at 56.

Petitioner argues that it implemented many interventions for R41 and did not just rely upon alarms to minimize his risk for harm from falls or aggressive behavior with staff and other residents. P. Brief at 12. R41's December and March care plans certainly list a number of interventions in addition to the use of alarms and the other clinical records reflect additional interventions not listed on the care plans. Nevertheless, the ineffectiveness of the interventions, individually and collectively, to reduce the risk of harm to R41 from falling and his aggressive behaviors is shown by entries in the clinical records that show R41 continued to get up and wander unsupervised and unassisted. Petitioner argues that it was not obliged to determine the cause for R41's behaviors, rather the regulatory requirement is to "safely manage the behavior." P. Brief at 13. Petitioner however failed to either safely manage R41's behaviors or to minimize the foreseeable risk of harm from falling. Petitioner recognized in December 2005 that R41 required assistance with ambulation in the halls to prevent him from falling. However, despite alarms and the other interventions listed on the care plans, as late as May 7, 2006, R41 was still getting out of bed and attempting to walk in the hall by himself. It is not for the surveyors, CMS, or me to suggest effective interventions, however, it is obvious in the case of R41 that he required closer supervision than he received. His clinical records for the period amply demonstrate that alarms were not "close" enough supervision. Although onerous, requiring staff to do frequent checks, maintain direct visual observation, or one-on-one supervision may have been the necessary level of supervision to prevent attempts

to ambulate unassisted and mitigate the foreseeable risk for harm and to prevent aggressive behaviors with other residents. The clinical record does not show that Petitioner implemented such close supervision or evaluated its effectiveness, except on a couple of occasions after falls when hourly checks were implemented.

I conclude that Petitioner failed to provide R41 with adequate supervision.

(2) Resident 7

R7 was a 94 year old female with diagnoses of Alzheimer's disease, arteriosclerotic heart disease, a history of stroke, she had cataracts and suffered macular degeneration and was legally blind, and she suffered from arthritis. CMS Ex. 27, at 7. R7 was also diagnosed with dysphagia, a condition that impaired her ability to swallow. CMS Ex. 27, at 18. She required the total assistance of at least one person to eat. CMS Ex. 27, at 14. On January 11, 2006, R7's physician ordered that she receive a Level 1 diet,[18] which included nectar thickened liquids. CMS Ex. 27, at 33, 36.

An Interdisciplinary Progress Notes entry dated March 15, 2006, at 12:30 p.m. describes the event that caused the surveyors to cite a violation. On March 15, R7 was in the dining room sitting at the rehabilitation table. A CNA was feeding R7, when R7 "choked on some food" and started vomiting "fluid" and "phlegm." CMS Ex. 27, at 26. It is recorded that the nurse then took R7 to the nurse's station where she and another nurse sat R7 upright and leaned her over so she could finish vomiting. According to the note, R7 had a large amount of emesis or vomit that included whole kernel corn, chicken, dumplings, and fluid. The note states the nurse worked with R7 until her lung-sounds were clear, and the resident reported she was clear and finally "got it down." CMS Ex. 27, at 26. The facility had revised its Choking Prevention Policy and Procedures a year earlier in February 2005. The policy required that staff "be trained on checking to ensure the resident's meal/snack matches the diet card." CMS Ex. 56, at 2. The progress note dated March 15, 2006, states that the nurse took the initiative spoke with the dietary manager and counseled the CNA that dietary cards must be checked before feeding. CMS Ex. 27, at 26. The incident report indicates that the immediate intervention was to require staff to look at the dietary card before feeding. CMS Ex. 27, at 38.

Petitioner argues that the incident did not occur because of a lack of supervision. P. Brief at 13; P. Reply at 9. While the resident may have been supervised by the CNA, the supervision provided was not "adequate" because the CNA was clearly not aware that R7 could not have whole food but was on a pureed diet, which has an unmistakable similarity to pudding. Furthermore, the CNA began feeding R7 without checking the dietary card as

[18] Petitioner adopted the National Dysphagia Diet which defines a Level 1 as "foods are pureed, cohesive and homogeneous." CMS Ex. 56, at 2. Level 1 requires little or no chewing.

required by Petitioner's policy, reflecting her supervision was not adequate as she was either not trained in accordance with Petitioner's policy or not competent in her position. The progress note and incident report imply that it may have been common for dietary cards to be unavailable to staff entrusted with feeding or common for staff not to check but I need make no conclusion in this regard as this is not separately charged as a deficiency.

Petitioner also argues that the CNA who fed the resident the wrong meal reacted quickly and appropriately when she started choking as did the nurse. P. Brief at 13; P. Reply at 9-10. I am not convinced that taking a choking resident or a vomiting resident to the nurse's station is an appropriate response to either medical event. However, the CNA's and nurse's responses are not the issue. The issue is whether the supervision was adequate to prevent the foreseeable risk of harm. R7 was assessed as at risk for harm if she did not receive a pureed diet and had an order to that effect. Therefore the risk of harm was foreseeable. The CNA fed R7 whole food rather than pureed food, from which I infer she did not know R7 was at risk for harm and required only pureed food. Accordingly, I conclude that the CNA was not providing adequate supervision to mitigate the foreseeable risk of harm.

d. The CMS determination that Petitioner's violation of 42 C.F.R. § 483.25(h)(2) posed immediate jeopardy is not clearly erroneous.

The surveyors cited the violation of 42 C.F.R. § 483.25(h)(2) at a scope and severity of K indicating that the deficiency posed immediate jeopardy to one or more residents. I cannot find that the declaration of immediate jeopardy was clearly erroneous based upon the examples of R41 and R7. The evidence shows that R41 and R7 were not adequately supervised to minimize a foreseeable risk of harm to themselves, and in the case of R41, to others also. R41 was at risk for serious injury or death from falling as a result of unsupervised ambulation or attempts to ambulate and he posed a risk for serious injury or worse to other residents due to his aggressive behaviors. R7 was at risk for serious injury or death from choking on whole foods because staff assigned to supervise her was not aware or was inattentive to the fact that she could not safely swallow other than pureed foods.

e. Petitioner violated 42 C.F.R. § 483.25(i)(1) (Tag F325).

This regulation requires that, based on a resident's comprehensive assessment, a facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's condition demonstrates that this is not possible. 42 C.F.R. § 483.25(i)(1).

The SOM instructs surveyors that "(p)arameters of nutritional status which are unacceptable include unplanned weight loss . . . ." CMS Ex. 67, at 1. However, the SOM cautions that ideal body weight charts have not been validated for the institutionalized elderly and weight loss is only a guide for determining nutritional status.[19] Thus, the SOM directs that weight loss or gain be analyzed in the context of the resident's former life style and current diagnosis, recognizing that weight loss or gain is not adequate evidence alone of a nutritional problem. Similarly, the Board has stated that weight loss alone does not support a deficiency but weight loss does trigger an inference of inadequate nutrition. *Carehouse Convalescent Hospital*, DAB No. 1799, at 21–22 (2001). If a facility shows by a preponderance of the evidence that it "provided the resident with adequate nutrition" or that the weight loss was due to non-nutritive factors, it can rebut a prima facie case based on such an inference. *Carehouse*, DAB No. 1799, at 22. The Board's interpretation of the regulation is that a facility is not strictly liable for a resident's weight loss (*Carehouse*, DAB No. 1799, at 21) but a "facility is responsible for taking all reasonable steps to ensure that the resident receives nutrition adequate to his or her needs" (*Windsor House*, DAB No. 1942, at 18 (2004)). The "clinical condition exception" is narrow and applies only when a facility demonstrates that it cannot provide nutrition adequate for the resident's overall needs so that weight loss is unavoidable. *Id*. The Board has indicated that the presence of a significant clinical condition alone does not prove that maintaining acceptable nutrition is unavoidable. *Id*. In *Windsor*, the Board found that surveyor observations that a resident was not properly assisted with eating or that the facility was slow to react to a resident's weight loss was sufficient evidence that the facility failed to provide the resident with adequate nutrition. *Id*.

The surveyors allege that Petitioner violated the regulation because Petitioner failed to ensure that two cognitively impaired residents maintained their body weight. The surveyors allege specifically that in the cases of R16 and R6, Petitioner failed to develop interventions to promote weight maintenance; failed to implement interventions to promote weight maintenance; and failed to follow recommendations from a dietary consultant. P. Ex. 1, at 96. The CMS arguments are consistent with the allegations of the surveyors. Tr. 30; CMS Brief at 21-23; CMS Reply at 17-19.

The example of R16 is sufficient to establish the violation. R16 was one of the residents discussed under Tag F250. R16 was an 83-year-old female with diagnoses of Alzheimer's disease and dementia with agitation, long and short-term memory problems, and moderately impaired decision-making skills. CMS Ex. 30, at 4, 70-84; P. Ex. 1, at 253;

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[19] The SOM provides some suggested parameters for surveyors to consider when evaluating the significance of weight loss. Significant loss is weight loss of 5 percent in one month, 7.5 percent in three months, or 10 percent in 6 months. Severe weight loss is loss greater than 5 percent in one month, 7.5 percent in three months, or 10 percent in 6 months. CMS Ex. 67, at 2.

Tr. 124. Although she was cognitively impaired, Petitioner assessed her as being able to independently perform many of her activities of daily living, except she required set-up help at meals and she required supervision with bathing. CMS Ex. 30, at 70-71. The "Initial Nutritional Data Collection Tool" dated April 29, 2004,[20] shows that R16 was 62-inches-tall, she weighed 102 pounds, and her ideal body weight was 99-121 pounds. The dietician assessed R16 as at risk for nutrition problems due to her medications, her body mass index was outside normal parameters, and she had medications with major nutritional impact. The dietician estimated R16 needed 1456 calories per day and 46 grams of protein. A regular diet was ordered and the dietician planned to continue to monitor R16's weight. CMS Ex. 30, at 5-6. Petitioner maintained a weight record for R16 that conflicts with the dietician's assessment. The dietician recorded R16's weight as 102 pounds on or about April 29, 2004. CMS Ex. 30, at 6-7; P. Ex. 1, at 396. Petitioner's weight record shows that R16 weighed 105.8 pounds in April 2004 and 106.6 pounds in May 2004 and never records a weight of only 102 pounds for R16. CMS Ex. 30, at 6-7; P. Ex. 1, at 396 . Because the dietician's academic degrees reflect a level of training, because the evidence shows that the dietician either weighed or supervised the weighing of R16 on about April 29, 2004, because the dietician was charged with doing a nutrition assessment and plan for R16, and because it is not clear who conducted the weighing of R16 or recorded the weights on the weight record, I accept the dieticians weight of 102 pounds for R16 as the more accurate weight for R16 at the end of April 2004. Petitioner's weight record shows R6's weight increased to 120.4 pounds by July 2004. She had lost 1.2 pounds when weighed in August 2004, but had increased steadily to 130.4 pounds by January 2005. R26 was down to 129.6 in February 2005 but was up to 132.9 pounds in May 2005, 30 pounds heavier than when she entered the facility a year before and 11.9 pounds above her ideal body weight. In June 2005 she weighed-in at 134 pounds. Between June 2005 and May 9, 2006 her weight fluctuated and then dropped steadily to 118.8 pounds. CMS Ex. 30, at 7; P. Ex. 1, at 396. Thus, from June 2005 to May 2006, R16 lost 15.2 pounds or 11.3 percent of her highest weight in June 2005. In November 2005, R16 weighed 132.2 pounds. CMS Ex. 30, at 7; P. Ex. 1, at 396. During the six-month period from November 2005 to May 8, 2006, R15's weight dropped from 132.2 pounds to 118.8 pounds, a loss of 13.4 pounds or 10.1 percent of R16's November 2005 weight. According to the SOM (CMS Ex. 67, at 2) weight loss of more than 10 percent is considered severe.

In October 2005, physician's orders indicate that R16 was to continue on a regular diet. CMS Ex. 30, at 62. R16's annual dietary assessment was entered in the clinical record on March 13, 2006. The note indicates that R16 ate in the assisted dining room with supervision and she ate 75 to 100 percent of most meals with supervision and encouragement.[21] The plan was to continue the current care plan, monitor, and weigh

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[20] R16's admission was April 5, 2004. CMS Ex. 30, at 5.

[21] The note does not reflect how the writer knew that R16 was consuming 75 to

(continued...)

monthly. CMS Ex. 30, at 24. A comprehensive care plan for R16 dated March 20, 2006, lists a problem of potential for alteration in nutrition related to a history of low weight, with a goal of gaining one to two pounds before for the next review on June 20, 2006. She was noted to be on a regular diet and interventions listed were to provide diet per the physician's order and to provide snacks daily. CMS Ex. 30, at 56. R16 weighed 133.4 pounds on October 4, 2005, about the time her doctor ordered that she continue on a regular diet. By March 1, 2006, before her annual dietary assessment on March 13 and her new care plan dated March 20, 2006, R16's weight was down to 123.4, a weight loss of 10 pounds. CMS Ex. 30, at 7; P. Ex. 1, at 396.

Nursing documentation dated January 25, 2006, February 20, 2006, March 5, 2006, March 14, 2006, and April 14, 2006 is marked to indicate R16's nutrition was not at risk. CMS Ex. 30, at 14, 16, 18, 20, 22. A dietary quarterly review dated December 21, 2005, states that there were no nutritional issues and the plan was to continue to monitor meal intake[22] and weight monthly. There is no indication in the note that the dietician recognized that R16 was losing weight. CMS Ex. 30, at 23. Nurse's notes from December 20, 2005 through May 4, 2006, do not indicate that nursing staff took any action related to R16's weight loss. CMS Ex. 30, at 25-37. A resident assessment protocol summary signed March 13 and 20, 2006, shows that R16's nutritional status was not considered at sufficient risk to trigger further assessment and care planning. CMS Ex. 30, at 82. Between October 4, 2005 and May 4, 2006, the clinical records for R16 admitted as evidence reflect no indication, other than the monthly weight record (CMS Ex. 30, at 7; P. Ex. 1, at 396) and the care plan dated March 20, 2006, that any member of R16's care planning team or staff recognized that she had suffered a significant to severe weight loss or that any interventions were implemented during that period in recognition of the weight loss. Although the care plan dated March 20, 2006, included the intervention to provide snacks in addition to the diet as ordered by her physician, the clinical record does not show that any snacks were actually offered. The surveyor testified that she believed that Petitioner obtained an order for R16 to receive ice cream at supper and lunch. Tr. 137. However, that testimony is inconsistent with the clinical evidence and I conclude that she was confusing the evidence related to R6, who did receive an order for ice cream, with the evidence related to R16, who did not receive such an order in March 2006. P. Ex. 1, at 389-90.

Petitioner argues that R16 was within ideal body weight at all times. P. Brief at 16-17; P. Reply at 13. However, whether or not the resident was within the range of her ideal body weight does not establish that she was receiving adequate nutrition. R16's weight loss triggered the inference that she was not receiving adequate nutrition. Thus, it was

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[21](...continued)
100 percent of her meals.

[22] No documentation of daily intake has been admitted as evidence.

incumbent upon Petitioner to show by a preponderance of the evidence either that the weight loss was actually planned or that it was providing adequate nutrition but the weight loss was unavoidable. Petitioner has failed to meet its burden.

2. Petitioner was not in substantial compliance with participation requirements as of July 27, 2006.

a. Petitioner violated 42 C.F.R. § 483.20(k)(3)(i) (Tag F281).

A facility is required to develop a comprehensive care plan for each resident to meet the resident's medical, nursing, and mental and psychosocial needs as identified by the required comprehensive assessment. 42 C.F.R. § 483.20(k)(1). Further, the services provided or arranged by the facility to meet the resident's assessed and care planned needs must "(m)eet professional standards of quality." 42 C.F.R. § 483.20(k)(3)(i).

The surveyor alleges in the SOD that the facility did not meet this requirement because Petitioner did not have evidence that R3's complaints of pain were assessed. The surveyor alleges more specifically, that while she was interviewing R3 on July 26, 2006, R3 complained of right arm pain and stated that she had reported the pain to staff. During the interview with R3, a Licensed Practical Nurse (L.P.N.) entered the room, transferred R3 from a recliner to her wheelchair, R3 complained of pain in her right arm and was holding her arm. The nurse did not question the resident regarding her arm pain or assess the mobility of the arm or R3's level of pain. The surveyor later on July 26 reviewed the clinical record but could find no record of R3's complaint of pain or evidence of an assessment. The surveyor advised the Administrator. CMS Ex. 74, at 5-7; P. Ex. 11, at 6-7. CMS argues that Petitioner failed to provide R3 with services meeting professional standards of quality in violation of the regulation. CMS Brief at 23-24; CMS Reply at 20.

Donna Downs, the surveyor who interviewed R3 on July 26, 2007, testified at hearing. Surveyor Downs testified that she drafted the allegations under Tag F281 for the July 2006 survey. Surveyor Downs testified about her interview with R3 described in the SOD and the L.P.N. not responding to R3's complaint. She also testified that it is a nursing standard of practice to assess a resident who complains of pain, to ask the level of the pain, where the pain is located, and to offer pain medication if the resident has a medication ordered, or to call the doctor if this is a change. Tr. 373-375. She testified that the fact that staff had assessed R3 for right shoulder pain two days earlier on July 24, 2006 (P. Ex. 11, at 51-52), was not sufficient to address the complaint of pain on July 26, 2006 and a new assessment should have been done by the nurse when the complaint was made. Tr. 376, 410-11.

R3 had no short or long-term memory problems, she was able to make herself understood and had no difficulty understanding others, and she was independent in decision-making. CMS Ex. 82, at 9; Tr. 373.

Petitioner did not offer evidence that the nurse actually did access R3 for pain on July 26, 2006, or present evidence of a standard of care different than that described by Surveyor Downs. Rather, Petitioner attacks the credibility of the surveyor based upon a perceived inconsistency between the surveyor's notes at CMS Ex. 82, at 3, the allegations she drafted in the SOD (P. Ex. 11, at 6-7, 16-17; CMS Ex. 74, at 5-7), and her testimony at hearing (Tr. 412-16). P. Brief at 19; P. Reply at 15. Although, Petitioner is correct that Surveyor Downs included more detail in the SOD and her testimony than in her surveyor worksheet, I do not find that it damages her credibility. Surveyor Down's testimony is consistent with the language she drafted for the SOD. Further, it is clear from reviewing Surveyor Down's notes and the notes of the other surveyors in evidence in this case, that their notes and worksheets are not comprehensive and not as detailed as the actual allegations of the SOD, in most cases. The SOD is the actual report of the investigation and the surveyor's notes and worksheets are no more than what they purport they are. While more detailed and accurate notes and worksheets might bolster a surveyor's testimony, the fact they are not detailed in this instance does not detract from the testimony of Surveyor Downs given the consistency between the SOD and her testimony.

Petitioner also argues that R3 was assessed for pain in her right shoulder two days earlier on July 24 (P. Ex. 11, at 51-52) and that a progress note was completed later in the day on July 26 (CMS Ex. 82, at 63). P. Brief at 19; P. Reply at 15. The unrebutted testimony regarding the standard of care was that the nurse should have assessed R3 for pain when R3 complained even though there was a prior assessment only two days earlier. Surveyor Downs was observing and did not see the nurse make any assessment. When Surveyor Downs checked the records she found no entry by the nurse to reflect R3's complaint. However, charting the complaint is not the issue. The violation was cited because the nurse did not do the assessment. Further, Surveyor Down's testimony that the 3:30 pm note on July 26, 2006, was after she advised the Administrator of the deficiency. Tr. 417-18.

The surveyors cited this deficiency as posing more than minimal harm without actual harm or immediate jeopardy. Petitioner does not offer evidence or allege that the failure to assess R3 did not pose the potential for more than minimal harm.

b. Petitioner violated 42 C.F.R. § 483.25(h)(2) (Tag F324).

Petitioner's regulatory obligation to provide supervision and assistance devices to prevent foreseeable accidents has been discussed in detail in the context of the May 2006 survey above, and is not restated here. The surveyors allege in the July 27, 2006 SOD that the facility violated 42 C.F.R. § 483.25(h)(2) at a scope and severity of E, meaning a pattern of incidents that caused no actual harm but posed the potential for more than minimal harm that is not immediate jeopardy. The surveyors allege specifically that Petitioner failed: (1) to supervise wandering residents to prevent their wandering into other resident rooms or their exit from the facility; and (2) Petitioner failed to ensure that alarms were

used as care planned to prevent potential falls. The surveyors cite three examples involving R3, R5, and R6, to show the violation. P. Ex. 11, at 8-17; CMS Ex. 74, at 7-16. The examples of R5 and R6 are sufficient to demonstrate the existence of the deficiency.

CMS argues that R5 and R6 posed a risk for harm to other residents due to their aggressive behaviors and the fact that they wandered into other residents' rooms. R5 and R6 were also at risk for elopement. Petitioner's plan of correction from the May survey included checking R5 and R6[23] initially every 15 minutes and thereafter hourly. CMS alleges that Petitioner did not consistently implement the intervention of hourly checks, R5 and R6 continued to wander into other resident's rooms, and both attempted to escape from the facility unsupervised. CMS Brief at 24-27; CMS Reply at 21-23.

(1) Resident 6

R6 had diagnoses of Alzheimer's disease and dementia with confusion, he had long and short-term memory problems, was unaware of his own safety, he was mobile without assistance, and he wandered. CMS Ex. 84, at 6-7, 19, 21, 27, 35, 58. R6 was assessed for wandering into other rooms and spitting on the floor and it was opined that he was unable to recall that such behaviors were inappropriate due to his cognitive impairment. CMS Ex. 84, at 25-26. R6 was assessed as having decreased safety awareness, he ambulated and transferred without assistance, but had no record of falls. CMS Ex. 84, at 27. R6's care plan dated June 22, 2006 continued to list as a problem that was previously listed on his April 27, 2006 care plan, that R6 was at risk for elopement. Interventions included use of a WanderGuard® alarm but not monitoring except following chapel service when he was to be escorted away from the door or supervised until visitors left. CMS Ex. 84, at 33. R6's June 22, 2006, care plan also listed wandering into other residents' rooms, inappropriate touching, and spitting as problem behaviors. Interventions included offering to have him sit on the patio in good weather, asking him where he was going and redirecting, offering a spit cup or handkerchief or redirecting him to spit in trash cans, a bed alarm to alert staff when he got up, and following a toileting plan. Additional interventions dated July 13, 2006, included diverting to sitting area in dining room, taking meals to the resident in the sitting area if he was there at meal times, and when the CNA assigned to R6 was on break or caring for another resident the CNA was to ensure another staff member was observing R6. CMS Ex. 84, at 34. ADL Documentation forms for May and June 2006, list as interventions that R6 have a bed pressure alarm and that he have visual supervision when walking. CMS Ex. 84, at 60-61. A behavior documentation form dated June 2006 listed target behaviors of wandering into other residents' rooms, potential for elopement, sexual advances, and pushing another resident. Interventions included use of an electronic wandering device and hourly checks while he was up. CMS Ex. 84, at 62-63.

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[23] R5 was identified as R27 and R6 was identified as R18, during the May survey.

An incident report dated June 3, 2006, shows R6 followed another resident outside after the chapel service and he was redirected back inside. CMS Ex. 84, at 45-46. A progress note dated June 4, 2006 at 10:00 a.m. records the incident of June 3 and provides more details. The note indicates that R6 left the chapel with another resident following services, a staff member heard the door alarm but thought it was caused by someone holding the door open too long, but a visitor then asked if residents were allowed to go outside, and R6 and the other resident were then assisted back to their seats. CMS Ex. 84, at 38. A note dated June 5, 2006, indicates the interdisciplinary team reviewed the incident of June 3, concluded that staff was present at all times, elopement interventions were effective, and the alarms were activated and working. CMS Ex. 84, at 39. The note does not indicate that the team considered that according to the note dated June 4, staff did not respond to the alarm but only responded when a visitor asked if residents were allowed outside.

An incident report dated June 25, 2007, shows R6 left the building and hourly checks and one-on-one monitoring was initiated. CMS Ex. 84, at 49-50. A progress note dated June 25, 2006, provides more detail than the incident report. The note indicates that R6 walked from the east wing to the west wing solarium where he leaned on the door which opened and he then walked outside with another resident. The door alarm sounded and staff brought the residents back inside. CMS Ex. 84, at 40. A progress note dated June 26, 2006, provides further detail on the June 25 incident, indicating that R6 pushed on the fire door until the timer allowed it to open, a CNA saw the resident and immediately brought him back in the facility, R6's ankle bracelet was intact, the alarm sounded as designed and alerted staff, and maintenance was to check the door and reset the timer, if needed. CMS Ex. 84, at 40. The next day, June 27, 2006, R6 was walking down the 200 hall and when a CNA attempted to redirect him, he refused, but no aggressive behavior is noted. CMS Ex. 84, at 40. A progress note dated July 2, 2006 indicates R6 pushed on the solarium door twice setting off the alarm and he was redirected each time. The note also indicates that hourly checks continued. CMS Ex. 84, at 41. Notes from care plan team meetings do not mention the June 3, June 25, or July 2 incidents. But the team decided to continue hourly checks on June 8, 2006. CMS Ex. 84, at 35-36.

Progress notes and behavior documentation show that R6 wandered into other residents' rooms on June 9 and July 16, 2006. CMS Ex. 84, at 39, 42. Nursing documentation dated July 5, 2006, indicates that R6 paced the hall when restless. CMS Ex. 84, at 43. 24-Hour Communication Sheets dated June 29 and 30, 2006, indicate R6 was found sleeping in bed in another resident's room. CMS Ex. 84, at 52-53. During the survey, on July 24, 25, 26, and 27, 2006, R6 was observed to leave group activities and wander up and down the hallway. CMS Ex. 74, at 10; CMS Ex. 79.

On 26 days in June and July 2006, staff failed to record all required hourly checks for R6. The recording gaps are significant, ranging from two hours to nine hours. During that time period, recording gaps occurred during all three shifts, and on several days, there are multiple gaps. CMS Ex. 84 at CMS Ex. 84, at 72-75, 78-81, 86, 89, 92-93, 97, 103, 107, 111, 118-19, 124-25, 128, 129, 131-33, 135-43, 145, 147-48, 151, 153.

(2) Resident 5

Resident 5 has already been discussed extensively under Tag F250 from the May 2006 survey, during which she was identified as R27. Her July 2006 MDS observation record indicates that she continued to have wandering behavior. CMS Ex. 83, at 12. Her care plan dated July 19, 2006, listed wandering and elopement risk as problems and included interventions of inviting and guiding R5 to group activities, providing opportunities for her to be in a comfortable and stimulating environment, reassuring her and providing redirection as tolerated, observing for elopement risk and guiding her away from doors, and use of an electronic monitoring device. CMS Ex. 83, at 20, 22. The July 2006 care plan also listed wandering into other residents rooms, socially inappropriate behavior, and physical aggression as problems with interventions of redirection, bed pressure alarm to alert staff she is up, behavior plan, and the CNA assigned to observe R5 was to divert to another staff member when on breaks or caring for another resident. CMS Ex. 83, at 21-22. R5 was also assessed as at risk for falls due to decreased safety awareness and gait problems due to left foot drop, and the interventions included supervision for ambulation, proper fitting footwear during "continuous walks with male resident" (R6), and encouraging rest periods with drinks or food if unsteady. CMS Ex. 83, at 23, 76. R5's care plan dated June 22, 2006, included the same problems and interventions. CMS Ex. 83, at 27, 28, 29. R5's ADL, Behavior Documentation, and Medication Record forms also included interventions to address problem behaviors, including redirection, supervision of ambulation, proper fitting footwear, bed pressure alarm to alert staff she was up and required monitoring to prevent wandering into other resident's rooms, electronic monitoring device (WanderGuard®), and hourly checks when she was up. CMS Ex. 83, at 53-54, 57-58, 63, 70-74.

On May 17, 2006, R5 was placed on fifteen minute checks to address her wandering behavior, but the checks were discontinued on May 22, 2006 and she was placed on hourly checks. CMS Ex. 83, at 77-87. There is no evidence that staff completed observation flow sheets on May 31, 2006, June 15, 2006, July 6, 2006, July 10, 2006, or July 11, 2006. CMS Ex. 83, at 77-186. On many days when observation flow sheets were created, not all checks are documented. A few gaps are only two to four hours long, many gaps are five to eight hours long, but some gaps are 16 to 19 hours long. CMS Ex. 83, at 101-104, 106, 113-16, 118, 120, 123-25, 128, 130, 137, 142-43, 158-62, 171-76, 179, 181.

R5's behavior documentation forms for June and July 2006, list a target behavior of wandering into other residents' rooms but does not list exit seeking behavior. CMS Ex. 83, at 70-74. The behavior documentation forms do not reflect any instances of R5 wandering into another resident's room. A progress note dated June 9, 2006, indicates that R6 had no incidents of wandering into another resident's room since beginning Xanax on May 25, 2006. CMS Ex. 83, at 36. R5 frequently walked in the facility with R6. R5 was the resident with R6 when both attempted to exit the facility on June 3 and June 25, 2006, as discussed above. CMS Ex. 83, at 35, 37. On June 29, 2006, R5's care planning team noted that she continued to wander the halls with R6 and that she was at risk for falls due to decreased safety awareness and difficulty with her gait. CMS Ex. 83, at 30.

Progress notes and an incident report dated July 12, 2006, show that R5 became upset when she was not permitted to go to bed with R6 and she began throwing things at staff from the nurses' station, she wandered off and when she returned to the nurses' station she had a skin tear on her left forearm, the note indicates possibly from staff turning the resident from R6's room or when they tried to put R5 to bed. CMS Ex. 83, at 38, 39, 47-48. On July 13, 2006, R5 was transferred to the hospital for evaluation due to her increased behaviors. CMS Ex. 83, at 40.

Surveyor Downs testified that surveyors focused upon R5 during the July survey because she had been identified as having behavior problems during the May survey and due to an incident report. Petitioner's plan of correction for the May survey included conducting hourly checks of R5 but, Petitioner could not produce documents showing that all hourly checks were done when the surveyors asked. Tr. 380-81.

Petitioner argues that R6's wandering behavior is "intractable" because his cognitive impairment prevents him from remembering it is inappropriate to enter other's rooms. P. Brief at 20. Petitioner argues that R6 had a care plan that required staff to monitor and redirect him from going into inappropriate places. P. Brief at 20. Regarding the two instances when R5 and R6 attempted to leave the facility, Petitioner argues that the alarms worked and staff responded, preventing elopements. P. Brief at 20-21; P. Reply at 15-16. Petitioner also argues that no regulation prevents elopement rather the regulation requires "adequate supervision to provide for the resident's safety." P. Brief at 21; P. Reply at 16.

Petitioner's arguments miss the point. Pursuant to 42 C.F.R. § 483.25(h)(2), Petitioner is obligated to ensure each resident receives supervision and assistance devices to prevent foreseeable accidents. If R6's wandering behavior was intractable, that fact provides no defense for Petitioner. Rather, Petitioner was obliged to provide the supervision and assistance devices necessary to prevent foreseeable accidents based upon R6's assessed needs for supervision and assistance. Thus, the more intractable R6's wandering behavior, the more his need for supervision and the greater Petitioner's obligation to meet the assessed need. Further, while both parties expended much paper discussing the attempted elopements of R5 and R6, the fact that the attempts occurred, that the alarm was raised,

and the resident's did not get far, are not the key facts. Rather, key is that both residents had care plans that called for supervision while walking or ambulating. The fact that the residents got as far as they did, shows that they were not receiving the care planned supervision. Supervision while walking was particularly important for R5, as she was assessed on more than one occasion as being at high risk for falls. R5's clinical record supports a conclusion that she often was walking with or without R6 without direct staff supervision. Direct visual supervision was also a planned intervention for R6. He had a bed alarm that sounded when he got out of bed and staff were then to give direct visual observation when he was out wandering the halls. Nevertheless, R6 managed to get out the door twice and staff had to rely upon the alarms for their alert, showing that visual observation or supervision was not being provided as the care plan required. Furthermore, R6 continued to have reported incidents of being in other residents' rooms. Finally, both residents were assessed as requiring hourly checks and their care plans required hourly checks, at least while they were out of bed. My review of the hourly checks documented shows many blank entries during periods when these residents were likely out of bed, from which I infer that the hourly checks were not being done.

I conclude that Petitioner violated 42 C.F.R. § 483.25(h)(2). Petitioner assessed R5 and R6 as needing supervision, but Petitioner's clinical records show that the supervision was not provided as planned. Therefore, Petitioner did not ensure the residents received the supervision necessary to reduce the foreseeable risk of harm.

c. Petitioner violated 42 C.F.R. § 483.25(i)(1) (Tag F325).

This regulation, related SOM provisions, and Board decisions were discussed in detail under Tag F325 from the May survey. The regulation requires that, based on a resident's comprehensive assessment, a facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's condition demonstrates that this is not possible. 42 C.F.R. § 483.25(i)(1).

The surveyors allege in the SOD that the facility failed to ensure that R1 and R3 did not have unplanned weight loss. CMS Ex. 74, at 17; P. Ex. 11, at 17-18. CMS argues that Petitioner failed to address R1's unplanned weight loss, including failing to monitor her intake at meals and to advise the dietician of the weight loss. CMS Brief at 27-28. CMS argues that Petitioner failed to address R3's weight loss, including failure to obtain a nutritional assessment from the registered dietician, failure to monitor intake, and failure to offer supplements and snacks. CMS Brief at 28-29.

(1) Resident 1

R1 had diagnoses of severe anemia, a history of polio, dementia, a history of stroke, arteriosclerosis of her lower extremities, was legally blind, she had short and long-term memory problems, moderately impaired cognitive abilities, she required the extensive

assistance of one person to eat, was limited to a Level 1 diet and honey thickened liquids, and her physician suspected she had suffered from episodes of aspiration pneumonia. CMS Ex. 81, at 4-6, 9, 13, 27, 30-32, 59. She was on a planned weight change program due to her low weight. CMS Ex. 81, at 6. Her weight record reflected the following weights:

Date	Weight
March 1, 2006	99.2
March 8, 2006	102.6
March 15, 2006	100.2
March 20, 2006	99.4
March 27, 2006	102.4
April 3, 2006	102.4
April 10, 2006	101.6
April 17, 2006	98.6
May 2006	104
June 2006	103.2
July 2006	97.8

CMS Ex. 81, at 11; CMS Ex. 91, at 2. R1's MDS with an assessment reference date of May 7, 2006, records a weight of 98 pounds, which according to the MDS instructions should be the last recorded weight during the preceding 30-day period. CMS Ex. 81, at 6. Her hospital admission record dated April 19, 2006, shows that she only weighed 96 pounds at the time. CMS Ex. 81, at 58. Her hospital admission dated July 25, 2006, shows that she weighed only 92 pounds. CMS Ex. 81, at 81. Thus, R1 lost 6.4 pounds between April 3, 2006 and her hospital admission on April 19, 2006, a 6.5 percent loss in less than a month, which is severe under the SOM guidance; and she lost 12 pounds between May 2006 and July 25, 2006, an 11 percent or severe loss under the SOM guidance. The registered dietitian estimated that R1's ideal body weight was 105 to 115 pounds (CMS Ex. 81, at 12) and she never weighed in the ideal range from March to July 2006.

R1's comprehensive care plan dated June 22, 2006, reflects that she had a problem with nutrition due to impaired swallowing, with a goal to keep intake between 50 and 100 percent without choking episodes. She was on a Level 1 pureed diet with honey thickened liquids. Interventions included house shake's per order, diet per order, encouragement at

meal time, seating at the assist table, following safe swallow strategy and dry swallowing to clear any residual, and the use of a nosey cup (a cup with a nose cut-out to permit drinking without tipping back the head). CMS Ex. 81, at 9, 12, 27. Her care plan did not specifically list tracking intake as an intervention.

Progress notes dated July 12, 2006, show R1's physician was notified by facsimile of her weight loss, he acknowledged the loss of 5.23 pounds in 30 days, but no new orders are noted. CMS Ex. 81, at 20. Surveyor Kixmiller testified that the dietitian told her during the survey that she had not been advised of R1's weight loss, which is consistent with the absence of any entry showing she was contacted during the period of weight loss. Tr. 490-91; CMS Ex. 81, at 12, 17-22.

Meal Intake Records for June and July 2006, are missing many entries for the breakfast, noon, and evening meals, in June there is only one entry indicating a supplement was provided and in July there are many missing entries for delivery of supplements. CMS Ex. 81, at 15-16. According to Petitioner's policy the Meal Intake Record was to be completed after each meal. CMS Ex. 94.

(2) Resident 3

R3 had diagnoses including arteriosclerotic cardiovascular disease with atrial fibrillation and angina pectoris, hypertension, anxiety, anemia, psychosis, and depression. CMS Ex. 82, at 11, 21, 37. She had no long or short-term memory problems and was able to understand others and make herself understood. CMS Ex. 82, at 9. The weight recorded on her April 2006 MDS was 98 pounds, she was not noted to receive any dietary supplements, was not assessed as having a nutritional problem, but was assessed as requiring set-up assistance. CMS Ex. 82, at 12, 15, 16. R3's physician ordered a regular Level 4 diet for her. CMS 82, at 87. A nutritional assessment dated November 15, 2003, reflects that R3's ideal body weight range was 106 to 115 pounds and at the time she weighed 114.8 pounds. The nutritional assessment indicated that she loved biscuits and gravy and disliked ham. The assessment indicated that she had gained weight in the last six months, and concluded with a notation from the dietician to continue to monitor R3's intake. CMS Ex. 82, at 36-37. A nutritional assessment dated July 26, 2006, reflects that R3's weight was 93 pounds, that she continued on a regular diet, and that her intake varied from 25 to 100 percent of meals. The dietician wrote that R3 had gradual weight loss over the past six months and speculated it may have been due to diuretic use. The dietician updated R3's food preferences, stated that R3 should have Popsicles® on request, high calorie cereal, house shakes, and juice with meals. CMS Ex. 82, at 38-39. No other nutritional assessments by the dietician could be located. Tr. 394. R3's medication record shows she that she was to receive a multivitamin but no supplements, shakes, or snacks are listed. CMS 82, at 47, 50.

According to her weight record from January 2001 through June 2006, R3's weight fell below 100 pounds first in March 2005 and her weight only exceeded 100 pounds in April 2005 and March 2006. R3's recorded weights for the first six months of 2006 were:

Date	Weight
January 2006	99.4
February 2006	95.2
March 2006	100.2
April 2006	98.4
May 2006	95.8
June 2006	92.4

CMS Ex. 82, at 40-41. Between March 2006 and June 2006, R3 lost 7.8 pounds or 7.8 percent of her weight, which is considered to be a serve loss under the SOM guidance. A progress note dated June 15, 2006, indicates R3's physician was advised of a 7.5 percent weight loss in 90 days with meal intake of less than 75 percent. CMS Ex. 82, at 59. The dieticians July 2006 assessment reflects that the weight loss was unplanned.

R3's March 13, 2006 and May 11, 2006 care plans listed the goal of increasing her meal intake to 75-100 percent. To accomplish this goal, staff were to provide a diet as ordered, provide snacks daily, cue R3 to come to the dining room, and assist her with setting-up the meal. The care plans also noted that she did not like pastas and barbeque. CMS Ex. 82, at 25, 32, 77, 81.

R3's meal intake of menu items and supplements was to be documented after every meal according to facility policy. CMS Ex. 94. In May 2006, R3 consumed: most of 18 meals; more than half of 14 meals; half of 6 meals; less than half of 16 meals; and none of 7 meals (4 of those meals were refused). CMS. Ex. 82, at 42. Staff did not record R3's intake for 32 meals in May. CMS Ex. 82, at 42. In June 2006, R3 consumed: most of 22 meals; more than half of 12 meals; half of 12 meals; less than half of 11 meals; and none of 7 meals (6 of those meals were refused). CMS. Ex. 82, at 43. She refused a supplement during 3 meals. CMS Ex. 82, at 43. Staff did not record R3's intake for 26 meals in June. CMS Ex. 82, at 43. From July 1, 2006, through July 24, 2006, R3 consumed: most of 17 meals; more than half of 14 meals; half of 11 meals; less than half of 6 meals; and none of 4 meals (with supplement consumed one of those times). CMS. Ex. 82, at 44. Staff did not record R3's intake for 19 meals in July. CMS Ex. 82, at 44. No records of snack consumption could be located during the survey. Tr. 395.

Petitioner argues that the surveyors applied the wrong legal standard when citing this deficiency based on their finding of unplanned weight loss. P. Brief at 23; P. Reply at 17. However, as discussed under Tag F325 from the May survey, evidence of unplanned weight loss permits an inference that a facility has not ensured that a resident maintained acceptable parameters of nutritional status. *Windsor House*, DAB No. 1942 (2004). A facility must rebut this by showing by a preponderance of the evidence that it provided the resident with adequate nutrition or that the weight loss was unavoidable. *Id*. Here the facility cannot do so because it failed to document the residents' consumption for many meals.

Petitioner also argues that the residents had medical conditions that made weight loss unavoidable. Petitioner argues that during R1's hospitalization in April 2006, it was determined by a speech pathologist on April 21, that she should have nothing by mouth due to her severe dysphagia and that she was not a good candidate for further treatment other than alternative feeding methods. P. Brief at 23-24; P. Reply at 18; P. Ex. 11, at 108. However, the nutrition progress note completed the same day states that the speech therapy recommendation was for nothing by mouth, with alternate feeding method and nutrition support if R3 was unable to resume receiving nutrition by mouth within three days. P. Ex. 11, at 109. R1's discharge summary indicates that she started a pureed diet on April 22, one day after her speech therapy evaluation. P. Ex. 11, at 107. R1 weighed 98.6 pounds on April 17 and she was admitted to the hospital on April 19 weighing only 96 pounds. However, despite the speech pathologist's opinion, R1 started a pureed diet on April 22 and her weight increased to 104 pounds by May 2006. The inference based upon the increase in R1's weight is that maintaining and increasing R1's weight and ensuring adequate parameters of nutrition was not unavoidable.

Petitioner also argues that its medical director, Dr. Dupree, explained to the surveyors in detail how R1's condition was unavoidable due to her diagnosis of Alzheimer's disease in combination with her other diagnoses. P. Reply at 18. I do not find Dr. Dupree's opinion worthy of significant weight given R1's increase in weight following her April 2006 hospital admission. Further, R1's comprehensive care plan dated June 22, 2006, shows that her care planning team determined to continue her on a Level 1 pureed diet with honey thickened liquids, house shakes per order, diet per order, encouragement at meal time, seating at the assist table, following safe swallow strategy and dry swallowing to clear any residual, and the use of a nosey cup. CMS Ex. 81, at 9, 12, 27. I accept that a medical decision was made by R1's physician and her family that tube feeding or other aggressive approaches to providing nutrition were not to be taken. However, that did not relieve Petitioner of the obligation to provide nutrition in accordance with the best care plan that could be developed under the circumstances. Whether or not the care planned interventions were having any effect could not be determined absent reliable evidence that R1 had regular intake of the nutrition offered. Petitioner's records of intake were incomplete and not reliable to establish that despite the offer of nutrition, Petitioner's intake due to her condition made it impossible for her to maintain adequate parameters of

nutrition. As discussed above, the "clinical condition exception" is narrow and applies only when a facility demonstrates that it cannot provide nutrition adequate for the resident's overall needs so that weight loss is unavoidable. *Windsor House*, DAB No. 1942, at 18. In this case, the facility cannot show what it provided or what the resident consumed due to its incomplete monitoring using its intake tool.

Regarding R3, Petitioner argues that the resident was not determined to be at risk until June 2006, when her weight loss approached 7.5 percent during a three month period; her physician was notified and he determined weight loss was unavoidable. The evidence does not show, and Petitioner does not argue, which of her diagnosis caused her weight loss to be unavoidable. Without some indication of the basis for the treating physician's opinion that weight loss was unavoidable, I do not find that opinion worthy of weight. Petitioner also argues that R3 had a care plan that addressed her dietary assistance needs in March 2006, which would have involved the dietician. P. Brief at 24-25; P. Reply at 19. R3 could eat and had food preferences. On July 26, 2006, the dietician did an evaluation, speculated that weight loss may have been due to diuretic use rather than a disease process, updated R3's food preferences, and ordered that R3 should have Popsicles® on request, high calorie cereal, house shakes, and juice with meals. However, as with R1, Petitioner failed to consistently document R3's consumption. Thus, Petitioner cannot show that it was providing adequate nutrition and that weight loss was unavoidable.

d. Petitioner violated 42 C.F.R. § 483.25(j) (Tag F327).

The regulation requires that a facility provide each resident with sufficient fluid intake to maintain proper hydration and health. The surveyors allege that Petitioner failed to ensure that R1 received an adequate amount of fluid intake to prevent dehydration. P. Ex. 11, at 27; CMS Ex. 74, at 26. CMS alleges that R1 was dehydrated when admitted to the hospital on April 19, 2006 and again on July 24, 2006. CMS Brief at 30-31; CMS Reply at 28.

R1 was discussed under Tag F325 from the July survey. R1 was assessed as at risk for dehydration and her care plan identified interventions to address her risk for dehydration including monitoring her skin for signs of dehydration; encouraging fluid intake during meals, snacks, and personal care time; and observing her for vomiting, diarrhea, and other signs of volume depletion. CMS Ex. 81, at 8. R1's care plan did not specify that staff was to record intake or output of fluids.

On April 19, 2006, R1 was admitted to the hospital with chief complaints of lethargy and decreased oxygen saturation. Her admission summary indicates possible pneumonia and dehydration in addition to her preexisting diagnosis. CMS Ex. 81, at 57-58. R1 was discharged from the hospital on April 24, 2006, and her discharge diagnoses included pneumonia and dehydration among several others. CMS Ex. 81, at 59.

To monitor R1's fluid intake, the facility used a Meal Intake Record and records for June and July 2006 are in evidence. CMS Ex. 81, at 15-16. In June 2006, the facility did not record R1's fluid intake for 44 out of 90 meals. CMS Ex. 81, at 15. R1's Medication Administration Record for July 2006, indicated that she received two 120cc house shakes per day. CMS Ex. 81, at 33. In July 2006, R1's weight dropped to 97.8 pounds. CMS Ex. 91, at 2; P. Ex. 11, at 122. According to the formula in the facility hydration policy (CMS Ex. 96, at 2), based on R1's weight she required 1333cc of fluids a day to maintain hydration.[24] From July 1, 2006, through July 24, 2006, the facility did not record R1's fluid intake for 29 out of 72 meals. CMS Ex. 81, at 16. On the days her fluid intake was recorded, it ranged from 440cc to 1320cc (recorded fluid intake plus house shakes). CMS Ex. 81, at 16, 33. Pursuant to Petitioner's policy, the registered dietician was to assess all residents for fluid requirements, but the dietician notes admitted as evidence do not include an assessment of hydration needs for R1 in June or July 2006. CMS Ex. 81, at 12; P. Ex. 11, at 114, 117, 124-27.

Staff were to monitor R1's vomiting as a symptom of fluid depletion. She vomited on July 16, 2006, and was given the anti-nausea drug Phenergan. Later that morning, she vomited again, and her physician was advised. No new orders were given, and R1 was given another dose of Phenergan. Later that evening she vomited again. CMS Ex. 81, at 20-21.

On July 24, 2006, at 2:00 a.m., R1 was noted not to be voiding and was slow to respond to touch and verbal stimuli. She was not yelling out as she usually did, and her skin was pale, warm, and dry. Late on July 24 or early on July 25, 2006, R1 was transferred to the emergency room and admitted to the hospital with a chief compliant of decreased responsiveness. CMS Ex. 81, at 22, 81. Her assessment upon admission was dehydration, likely due to poor intake. Her treatment plan included IV fluids due to dehydration, and her laboratory tests were consistent with a diagnosis of dehydration. CMS Ex. 81, at 72, 74, 81-82. R1's discharge summary was not admitted as evidence.

The evidence establishes a prima facie case that Petitioner did not ensure R1 was provided sufficient fluids to maintain hydration.

Petitioner argues, as it did under Tag F325, that when R1 was hospitalized in April 2006, it was determined that she was to have nothing by mouth due to her severe dysphagia, and that she was not a good candidate for further treatment including alternative feeding methods. P. Brief at 25-26; P. Reply at 19-20. However, as noted under Tag F325, R1 was placed on a pureed diet the day after her speech therapy evaluation and actually gained weight. Petitioner also argues that Dr. Bourgasser and Dr. Dupree explained to the

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[24] The formula requires converting weight in pounds to weight in kilograms by dividing by 2.2 and then multiplying by 30 ml/cc for estimated fluid requirements in cc. R1 weigh 97.8 pounds which converts to 44.45 kilograms. Multiplying by 30 ml/cc yields a daily fluid intake requirement of 1333.5 cc.

surveyors that in their opinion R1's weight loss and dehydration were unavoidable. P. Brief at 25-27. However, their opinions are not considered weighty given that R1 was actually on a pureed diet after her hospitalization in April and gained weight. Further, after leaving the hospital in April, R1 apparently did not have a problem with dehydration until July 2006.

Petitioner's tool for monitoring R1's fluid intake was the Meal Intake Record. The records for June and July are incomplete. Petitioner's failure to consistently monitor R1's intake prevented effective monitoring of her level of hydration and the effectiveness of the interventions adopted. Further, the credibility of the doctors opinions that R1's dehydration was unavoidable is further undermined by the fact that Petitioner's spotty documentation prevented determination of whether dehydration was due to disease process or failure to follow interventions adopted by the care planning team.

I conclude that Petitioner has failed to establish by a preponderance of the evidence that it provided R1 adequate hydration or that R1's dehydration was unavoidable.

e. Petitioner violated 42 C.F.R. § 483.75(l)(1) (Tag F514).

The regulation governing administration requires facilities to maintain clinical records on each resident in accordance with accepted professional standards and practices that are: complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient evidence to identify the resident, assessments, care plan and services provided, pre-admission screens conducted by the state, and progress notes.

The surveyors allege in the SOD that the facility failed to ensure that clinical records were complete with regard to documentation of behaviors, interdisciplinary note documentation, ambulation, and meal consumption, which affected R3, R5, and R1. CMS Ex.74, at 32; P. Ex. 11, at 33. CMS alleges that the facility failed to maintain complete and adequate records for the residents because it failed to document behaviors, ambulation, attempted self-transfers, meal consumption and fluid intake, and hourly checks as required by the residents' care plans. CMS Brief at 31-33; 29-30. Petitioner argues that the regulation does not require perfect records or perfection in they way they are maintained. P. Brief at 27-30; P. Reply at 21-23.

Throughout this decision there are mentioned examples of errors and omissions in the clinical records of Petitioner's residents. The errors and omissions discussed interfered with proper care planning, with implementation of care planned interventions, assessment of the effectiveness of interventions, and in general, the care of the residents discussed. Furthermore, the errors and omissions identified in the foregoing discussion of deficiencies prevent Petitioner in each case from demonstrating that it was in substantial compliance with participation requirements. Petitioner's records discussed in the context

of the foregoing deficiency citations were neither complete nor accurate and I have no difficulty finding that Petitioner violated this regulations. Furthermore, one need look no further than Tags F325 and F327 related to the nutrition of R1 and R3 and the hydration of R1, for examples of how inaccurate and incomplete records posed more than minimal harm, if not actual harm, for Petitioner's residents.

3. The remedies proposed are reasonable.

The proposed remedies are:

> A civil money penalty (CMP) of $5500 per day from May 17, 2006 through May 21, 2006 and $200 per day from May 22, 2006 through September 19, 2006, a total CMP of $51,700; and a denial of payment for new admissions (DPNA) from June 22, 2006 though September 19, 2006 and loss of NATCEP authority.

Petitioner does not dispute that CMS had a basis for imposing a DPNA based on the unchallenged deficiencies cited by the May 2006 survey. Tr. 33.

I must consider whether the amount of the civil money penalty imposed is reasonable, applying the factors listed in 42 C.F.R. § 488.438(f). *Emerald Oaks*, DAB No. 1800, at 10 (2001); *CarePlex of Silver Spring*, DAB No. 1683, at 16-17 (1999); *Capitol Hill Community Rehabilitation and Specialty Care Center*, DAB No. 1629 (1997). In reaching a decision on the reasonableness of the CMP, I may not look into CMS's internal decision-making process. Instead, I consider whether the evidence presented on the record concerning the relevant regulatory factors supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found and in light of the other factors involved (financial condition, facility history, and culpability). I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard to CMS's discretion. *Community Nursing Home*, DAB No. 1807, at 25 (2002); *CarePlex*, DAB No. 1683, at 17 (1999).

As discussed above, the regulations provide for CMPs ranging from $50 to $3000 per day for noncompliance that does not rise to the level of immediate jeopardy, and CMPs ranging from $3050 to $10,000 per day for noncompliance that constitutes immediate jeopardy. 42 C.F.R. §§ 488.438(a)(1)(i)-(ii), (d)(2). CMS seeks to impose a total CMP of $51,700, based on a $5500 per day CMP for the 5 days from May 17 through 21, 2006, and $200 per day for the 121 days from May 22, 2006, through September 19, 2006.[25]

[25] There is no dispute that Petitioner was found to be in substantial compliance effective September 20, 2006. Jt. Stip. ¶ 12; CMS Ex. 73. The CMP for the five days

(continued...)

In determining whether the amount of a CMP is reasonable, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of non-compliance, 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. Neither party has contended that the penalty amounts should be impacted by Petitioner's compliance history or financial condition. There is no evidence showing that Petitioner has a history of noncompliance other than during this survey cycle. Petitioner has not provided any evidence to show that its financial condition precludes it from paying the proposed CMP totaling $51,700. The sum of $5500 per day is modest considering that the deficiencies not only affected many residents directly, but they also put other facility residents at risk. It comprises slightly more than fifty percent of the maximum allowable CMP amount for immediate jeopardy level penalties. The $200 per day penalty is also modest, less than seven percent of the maximum allowed for non-immediate jeopardy level deficiencies. Given the number of deficiencies and recurrence of deficiencies during two surveys, I conclude that Petitioner was culpable.

I also conclude that the state agency was required to withdraw Petitioner's authority to conduct a NATCEP for a period of two years. Pursuant to 42 C.F.R. §§ 483.151(b)(2) and (e)(1), a state may not approve, and must withdraw, any prior approval of a NATCEP offered by a SNF or NF that: (1) has been subject to an extended or partial extended survey under sections 1819 (g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Act; (2) has been assessed a CMP of not less than $5000; or (3) has been subject to termination of its participation agreement, denial of payment, or the appointment of temporary management. In the case before me, the evidence supports a CMP of more than $5000. Thus, withdrawal of Petitioner's authority to conduct a NATCEP was required.

III. Conclusion

For the foregoing reasons, I conclude that there is a basis for the imposition of enforcement remedies and that the remedies proposed are reasonable.

/s/
Keith W. Sickendick
Administrative Law Judge

[25](...continued)
from May 17 through 21, 2006 amounts to $27,500, at $5500 per day. The CMP for the 121 day period from May 22 through September 19, 2006, at $200 per day, amounts to $24,200. Therefore, the total CMP is $51,700.