Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
Concho Health & Rehabilitation Center, (CCN: 45-5737),	)	Date: August 29, 2008
Petitioner,	)	Docket No. C-06-344
	)	Decision No. CR1836
v.	)	
Centers for Medicare & Medicaid Services.	)	

DECISION

Petitioner, Concho Health & Rehabilitation Center, violated 42 C.F.R. §§ 483.13(c), 483.15(g)(1), 483.25, 483.25(c), 483.25(f)(1), 483.25(h)(2), and 483.25(i)(1),[1] based on surveys of Petitioner's facility completed from August 5, 2005 through January 25, 2006, and all the violations caused actual harm to Petitioner's residents. Petitioner was not in substantial compliance with Medicare participation requirements from August 5, 2005 through February 1, 2006. A civil money penalty (CMP) of $400 per day for the period from August 5, 2005 through February 1, 2006, is reasonable. The total amount of the CMP is $72,400. A denial of payment for new admissions (DPNA) from October 19, 2005 through February 1, 2006 is also reasonable. Petitioner's authority to conduct a Nurse Aide Training and Competency Evaluation Program (NATCEP) was required to be withdrawn for the two year period August 5, 2005 through August 4, 2007.

[1] All references are to the version of the Code of Federal Regulations (C.F.R.) in effect at the time of the surveys, unless otherwise indicated.

I. Background

Petitioner is a skilled nursing facility located in Eden, Texas, licensed by the State of Texas and authorized to participate in the federal Medicare program as a skilled nursing facility (SNF) and the state Medicaid program as a nursing facility (NF). The Texas Department of Aging and Disability Services (the state agency) completed surveys of Petitioner's facility on August 5, 2005,[2] October 5, 2005, December 15, 2005, and January 25, 2006. CMS Exhibits (CMS Exs.) 7, 22, 28, 41. The surveyors found on each survey that Petitioner was not in substantial compliance with program participation requirements. Petitioner was cited with multiple deficiencies by the four surveys, including eight deficiencies at a "G" scope and severity (S/S) level, a finding that there was actual harm to residents but not immediate jeopardy.

The Centers for Medicare and Medicaid Services (CMS) notified Petitioner by letter dated October 4, 2005, that based on the deficiencies found by the August 5, 2005-survey CMS was imposing a CMP of $600 per day beginning on September 6, 2005; a DPNA beginning on October 19, 2005 and continuing until Petitioner returned to substantial compliance; termination of Petitioner's provider agreement on February 5, 2006, if Petitioner did not return to substantial compliance before that date; and withdrawal of Petitioner's authority to conduct a NATCEP. Joint Stipulation (Jt. Stip.) ¶ 6. CMS notified Petitioner by letters dated January 25, 2006 and February 2, 2006, that based upon the surveys completed on October 5, 2005, December 15, 2005, and January 25, 2006, the CMP of $600 began on August 5, 2005 (rather than September 6, 2005 as Petitioner was notified by the October 4, 2005-letter), and the other remedies previously imposed or proposed were unchanged. Jt. Stip. ¶¶ 7-8. CMS notified Petitioner by letter dated March 15, 2006, that a revisit survey found that Petitioner returned to substantial compliance. The letter did not state the date on which Petitioner returned to substantial compliance, but it did advise Petitioner that CMS was instructing the intermediary to make payments for covered services beginning on February 2, 2006. Thus, Petitioner was in substantial compliance again on February 2, 2006. The March 15 letter also advised Petitioner that CMS reduced the CMP from $600 per day to $400 per day for the period August 5, 2005 to February 1, 2006, for a total CMP of $72,400; the DPNA that commenced on October 19, 2005, ended effective February 1, 2006, and the termination action was rescinded. CMS Ex. 1.

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[2] The Life Safety Code portion of this survey was completed on August 3, 2005, but no alleged deficiency from that survey is at issue before me. CMS Ex. 4.

Petitioner requested a hearing by letter dated March 22, 2006. The case was assigned to me for hearing and decision on April 7, 2006, and a Notice of Case Assignment and Prehearing Case Development Order (Prehearing Order) was issued at my direction. The case was set for hearing in San Antonio, Texas on September 26 and 27, 2006. On September 15, 2006, Petitioner filed a waiver of oral hearing and the parties filed a joint report on their agreement regarding a briefing schedule on September 29, 2006. I set a briefing schedule by Order dated October 12, 2006. The parties filed their opening briefs (CMS Brief and P. Brief, respectively) with their documentary evidence on November 17, 2006. Each of the parties advised me by separate letters dated December 4, 2006, that they did not intend to file reply briefs. CMS offered proposed exhibits 1 through 58[3] (CMS Exs. 1-58), and Petitioner offered proposed exhibits 1 through 87 (P. Exs. 1-87).[4] No objections were made to the admission of either parties' exhibits, and all are admitted into the record.

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[3] The exhibit list included in the CMS amended prehearing exchange filed November 17, 2006, is incorrect and the CMS exhibits submitted for my consideration are misnumbered. The CMS exhibit list includes CMS Exs. 1 through 45 with CMS Exs. 42 through 45 listed as the affidavits of Vanoss, VanArsdale, Stemen, and McElroy, respectively. After comparing the exhibits with the list, I find that CMS Exs. 1 through 41 appear to be correctly marked and listed. However, the exhibit list omits exhibits which are marked as follows: CMS Ex. 42, Surveyor Notes Worksheet – Fiveash; CMS Ex. 43, Surveyor Notes Worksheet – Vanoss; CMS Ex. 44, Surveyor Notes Worksheet – Stemen; CMS Ex. 45, Investigation Report; CMS Ex. 46, Clinical Records – Resident 29; CMS Ex. 47, Policy – Accidents and Incidents – Investigating and Reporting; CMS Ex. 48, Minimum Data Set (MDS) – Resident 30; CMS Ex. 49, Nurses Notes – Resident 30; CMS Ex. 50, Clinical Records – Resident 30; CMS Ex. 51, Hand-written Statement – Galvan; CMS Ex. 52, Clinical Records – Resident 30; CMS Ex. 53, Social Work Request Log; CMS Ex. 54, Time Card Report. The CMS exhibits include the affidavits of Vanoss, VanArsdale, Stemen, and McElroy, marked CMS Exhibits 42 through 45, respectively. However, the affidavits are incorrectly numbered as the exhibit numbers 42 through 45 were used by CMS for other documents. Accordingly, I have remarked the affidavits as follows: CMS Ex. 55 – Affidavit of Vanoss; CMS Ex. 56 – Affidavit of VanArsdale; CMS Ex. 57 – Affidavit of Stemen; and CMS Ex. 58 – Affidavit of McElroy.

[4] Petitioner's exhibit list submitted with its brief describes P. Ex. 72 as "Medical Records of Resident 22" but, in fact, the documents are the medical records of Resident 29. P. Brief at 22.

II. Discussion

A. Findings of Fact

The following findings of fact are based upon the exhibits admitted. Citations to exhibit numbers related to each finding of fact may be found in the analysis section of this decision if not indicated here.

1. Facts related to Resident 1 from the August 2005 survey, 42 C.F.R. § 483.25(c) (Tag F314):

    a. Resident 1 developed a pressure ulcer while in Petitioner's care that was discovered on or about April 12, 2005.

    b. Resident 1's pressure ulcer worsened while in Petitioner's care between April 12, 2005 and May 3, 2005, when she was sent to the hospital for wound treatment.

    c. Between March 1 and April 27, 2005, Petitioner's assessments of Resident 1's skin were missing or deficient.

    d. Petitioner failed to consult Resident 1's physician immediately when it appeared Resident 1's pressure ulcer was worsening on April 18 and 19, 2005.

2. Resident 1's care plan dated June 6, 2005, listed several interventions, including that the resident be cleaned after each incontinent episode. CMS Ex. 8, at 36.

    a. A surveyor observed Resident 1 on August 3, 2005, at 10:55 a.m. and again at 11:25 a.m. with a Stage II pressure ulcer, redness on her left buttock and gluteal fold, and feces between her buttocks and on the dressing covering the pressure ulcer.

    b. The surveyor's observation of feces on the dressing of the pressure sore for approximately 30 minutes shows that Petitioner did not provide necessary care and services to keep the wound clean of fecal matter to promote healing of the ulcer.

    c. Resident 1 was, at times, noncompliant with Petitioner's staff instructions and her diet.

d. The evidence does not show that Resident 1's development of a pressure ulcer and its subsequent worsening were unavoidable.

e. Resident 1 suffered actual harm.

3. Facts related to Resident 4 from the August 2005 survey, 42 C.F.R. § 483.25(c) (Tag F314):

a. Resident 4 was assessed as at risk for development of pressure ulcers in February 2005 and she was supposed to receive weekly skin assessments.

b. Petitioner's records do not show that Resident 4 received weekly skin assessments between February 2005 and March 31, 2005.

c. On March 31, 2005, a pressure ulcer was discovered on Resident 4's right heel, while she was in Petitioner's care.

d. On April 7, 2005, the pressure sore on Resident 4's right heel had worsened and required debridement.

e. Resident 4 was in an acute care hospital from May 9 through July 19, 2005, for treatment of the pressure sore on her right heel.

f. Between July 19 and August 4, 2005, Petitioner did not document assessments of Resident 4's pressure sore.

g. Resident 4's right heel pressure sore did not show signs of improvement between July 19 and August 4, 2005.

h. Resident 4 suffered actual harm.

i. The evidence does not show that Resident 4's development of a pressure ulcer or its subsequent worsening was unavoidable.

4. Facts related to Resident 8 from the August 2005 survey, 42 C.F.R. § 483.25(c) (Tag F314):

a. Resident 8 developed multiple pressure sores between November 8, 2004 and August 9, 2005.

b. The evidence does not show that Resident 8's development of pressure ulcers was unavoidable.

5. Facts related to Resident 23 from the December 2005 survey, 42 C.F.R. § 483.25(c) (Tag F314):

   a. On December 6, 2005, Resident 23 had no pressure sore.

   b. On December 14, 2005, the surveyor observed that Resident 23, who was in his wheelchair, was not checked for incontinence or repositioned for approximately 1 hour and 50 minutes; when checked the surveyor observed that the resident was wet with urine, his buttocks were bright red, and he had a Stage II pressure ulcer below the coccyx.

   c. Resident 23's skin care plan dated November 18, 2005 required that his skin be kept clean and dry. CMS Ex. 35, at 51.

   d. Resident 23 developed a pressure ulcer while in Petitioner's care.

   e. Resident 23 suffered actual harm.

   f. The evidence does not show that Resident 23's pressure ulcer was unavoidable.

6. Facts related to Resident 2 from the August 2005 survey, 42 C.F.R. § 483.25(i)(1) (Tag F325):

   a. Between February 2005 and August 3, 2005, Resident 2's weight dropped from 120 pounds to 88.1 pounds.

   b. Petitioner does not deny and offers no explanation for why the June 9, 2005 physician order (CMS Ex. 9, at 21; P. Ex. 4, at 1, 3) to give Resident 2 a liquified diet in a sippy cup and a supplement shake with each medication pass was not implemented.

   c. The evidence does not show that Petitioner provided Resident 2 adequate nutrition to maintain her weight.

   d. The evidence does not show that Resident 2's clinical condition made it impossible for her to maintain weight, or that weight loss was unavoidable.

   e. Resident 2 suffered actual harm.

7. Facts related to Resident 5 and 6 from the October 2005 survey, 42 C.F.R. § 483.25(h)(2) (Tag F324):

   a. Resident 5 had a physician's order dated September 1, 2005, that required he be transferred only with a mechanical lift.

   b. On October 4, 2005, the surveyor observed two staff transfer Resident 5 without a mechanical lift.

   c. Transferring Resident 5 without a mechanical lift posed the risk for accidental injury and more than minimal harm to the resident or staff.

   d. Resident 6 was a big man and was assessed as requiring the assistance of two persons for all transfers.

   e. On September 9, 2005, a nurse aide attempted to transfer Resident 6 alone from the toilet to his wheelchair and the resident fell.

   f. On September 9, 2005, Resident 6 suffered a fractured right hip and a fractured right clavicle due to his fall.

   g. Resident 6 suffered actual harm.

8. Facts related to the violation of 42 C.F.R. § 483.13(c) cited by the January 2006 survey:

   a. Petitioner's policy, adopted pursuant to the requirement of 42 C.F.R. § 483.13(c), requires that Petitioner: (1) provide for the immediate safety of a resident upon suspected abuse, including moving the resident to another unit or room, providing one-on-one monitoring, suspending an accused employee pending investigation, and implementing the discharge process immediately for a resident who is a danger to self or others; and (2) initiate behavior crisis management interventions as applicable.

   b. Petitioner did not fully implement either intervention of its policy when Resident 31 alleged abuse, sexual or physical, by Resident 29.

   c. Petitioner failed to implement its policy prohibiting physical or mental abuse of its residents.

9. Facts related to the violation of 42 C.F.R. § 483.15(g)(1) cited by the January 2006 survey:

   a. Resident 29 was in need of medically-related social services from August 24, 2005 to January 23, 2006.

   b. Medically-related social services were not provided to Resident 29 from August 24, 2005 to January 23, 2006.

   c. Resident 31 was in need of medically-related social services in January 2006.

   d. Medically-related social services were not provided to Resident 31 from January 23, 2006 to January 26, 2006.

   e. Resident 29 suffered actual harm.

   f. Resident 31 suffered actual harm.

10. Facts related to Resident 30 from the January 2006 survey, 42 C.F.R. § 483.25 (Tag F309):

   a. Resident 30 refused to bear weight on his legs during a transfer on December 3, 2005, which was contrary to his usual practice of pivoting on his feet during transfers.

   b. No assessment was done to determine why Resident 30 refused to bear weight on his legs on December 3, 2005.

   c. Resident 30 complained of pain in his right thigh during an Occupational Therapy evaluation on December 7, 2005.

   d. On December 8, 2005, Resident 30 complained during a Physical Therapy evaluation of pain in his right leg and the physical therapist observed the swelling of the right leg.

   e. On December 8, 2005, Resident 30's right leg was assessed based upon a report to the DON that he complained of pain, his right upper leg was swollen, warm to the touch, bruising was noted to the inner and outer thigh, his right foot was rotated outward as he lay in bed, and he complained of pain with movement.

f. An x-ray obtained on December 8, 2005 showed that Resident 30's had an intertrochanteric fracture of the right femur at the hip.

g. Resident 30 was given no pain medication despite his complaints of pain.

h. Resident 30 suffered actual harm.

11. Facts related to the violation of 42 C.F.R. § 483.25(f)(1) from the January 2006 survey:

a. Resident 29 displayed mental or psychosocial adjustment difficulty as alleged by the surveyor after she was moved from her old unit and room on December 30, 2005.

b. Petitioner failed to implement intervention strategies to treat Resident 29's increased behavioral symptoms of wandering, and physical and sexual aggression after her move on December 30, 2005, other than to obtain a prescription of Ambien to help her sleep.

c. Resident 29 received no treatment or services to address her mental or psychosocial difficulty adjusting to the move from her old unit to the new unit, other than a prescription for Ambien to help her sleep.

d. Resident 29 received a psychosocial assessment, but not until January 23, 2006, the day before discharge.

e. Resident 29 displayed mental or psychosocial adjustment difficulty after the alleged assault by Resident 29.

f. Resident 29 was referred to social work for another incident involving her shoving another resident on January 26, 2005, but there is no evidence that Resident 29 was assessed or treated for mental or psychosocial adjust difficulty.

g. Resident 29 suffered actual harm.

12. Petitioner returned to substantial compliance as of February 2, 2006.

B. Conclusions of Law

1. Petitioner's request for hearing was timely and I have jurisdiction.

2. Petitioner waived the right to an oral hearing.

3. Petitioner violated 42 C.F.R. § 483.25(c) (Tag F314, S/S G) as alleged by the August and December 2005 surveys.

4. Petitioner violated 42 C.F.R. § 483.25(i)(1) (Tag F325, S/S G) as alleged by the August 2005 survey.

5. Petitioner violated 42 C.F.R. § 483.25(h)(2) (Tag F324, S/S G) as alleged by the October 2005 survey.

6. Petitioner violated 42 C.F.R. § 483.13(c) (Tag F224, S/S G) as alleged by the January 2006 survey.

7. Petitioner violated 42 C.F.R. § 483.15(g)(1) (Tag F250, S/S G) as alleged by the January 2006 survey.

8. Petitioner violated 42 C.F.R. § 483.25 (Tag F309, S/S G) as alleged by the January 2006 survey.

9. Petitioner violated 42 C.F.R. § 483.25(f)(1) (Tag F319, S/S G) as alleged by the January 2006 survey.

10. Petitioner was not in substantial compliance with Medicare participation requirements from August 5, 2005 through February 1, 2006.

11. A CMP of $400 per day for the period August 5, 2005 through February 1, 2006, and DPNA from October 19, 2005 through February 1, 2006, are reasonable enforcement remedies.

12. A CMP of $400 per day for the period August 5, 2005 through February 1, 2006, and DPNA from October 19, 2005 through February 1, 2006, are not punitive.

13. The state agency was required to prohibit Petitioner from conducting a NATCEP pursuant to 42 C.F.R. §§ 483.151(b)(2) and (e)(1) for the two-year period from August 5, 2005 through August 4, 2007.

C. Issues[5]

The issues in this case are:

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

D. Applicable Law

The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Social Security Act (Act) and at 42 C.F.R. Part 483. Sections 1819 and 1919 of the Act vest the Secretary of the Department of Health and Human Services (the Secretary) with authority to impose civil money penalties against a long-term care facility for failure to comply substantially with federal participation requirements.

Pursuant to the Act, 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 the Secretary through his 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. CMS may impose a per instance or per day CMP against a long-term care facility when a state survey agency concludes that the facility is not complying substantially with federal participation requirements. 42 C.F.R. §§ 488.406; 488.408; 488.430. The regulations also give CMS a number of other enforcement remedies that may be imposed if a facility is not in compliance with Medicare requirements. 42 C.F.R. § 488.406.

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[5] Petitioner asserts that it has raised numerous legal issues in its request for hearing that are not within my authority to address and, therefore, Petitioner does not address those issues in briefing before me. Petitioner's Prehearing Brief (P. Prehearing Brief) at 2-3. I do not address the issues to which Petitioner only alludes.

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 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). The upper range of CMP, from $3050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(I), (d)(2). Pursuant to 42 C.F.R. § 488.301, "*(i)mmediate jeopardy* means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." (Emphasis in original). Immediate jeopardy is not alleged in this case.

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 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 governed by 42 C.F.R. § 488.438(e).

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 taken 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 skilled nursing or nursing facility: (1) that has been subject to an extended or partial extended survey under sections 1819(g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Act; (2) that has been assessed a CMP of not less than $5000; or (3) that has been subject to termination of its participation agreement, a DPNA, or the appointment of temporary management. Extended and partial extended surveys are triggered by a finding of "substandard quality of care" during a standard or abbreviated standard survey and involve evaluating additional participation requirements. "Substandard quality of care" is identified by the situation where surveyors identify one or more deficiencies related to participation requirements established by 42 C.F.R. § 483.13 (Resident Behavior and Facility Practices), § 483.15 (Quality of Life), or § 483.25 (Quality of Care) that are found to constitute either immediate jeopardy, a pattern of or widespread actual harm that does not amount to immediate jeopardy, or a widespread potential for more than minimal harm that does not amount to immediate jeopardy and there is no actual harm. 42 C.F.R. § 488.301.

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. "*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. Dept. of Health and 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.

E. Analysis

The parties stipulated that Petitioner was cited with the following deficiencies (regulatory violations) by the survey that ended on August 5, 2005:[6] 42 C.F.R. §§ 483.10(e) (Tag

[6] Three other deficiencies were cited in the Statement of Deficiencies (SOD) for this survey but all at a scope and severity of B, which means there was not even minimal

(continued...)

F164,[7] at a scope and severity level (S/S) D[8]); 483.13(a) (Tag F221, S/S D); 483.15(a) (Tag F241, S/S E); 483.20(k)(2)[9] (Tag F280, S/S D); 483.25(a)(3) (Tag F312, S/S D); 483.25(c) (Tag F314, S/S G); 483.25(h)(1) (Tag F323, S/S E); 483.25(h)(2) (Tag F324, S/S D); 483.25(i)(1) (Tag F325, S/S G); 483.65(a)(1)-(3) (Tag F441, S/S E); 483.70 (K Tag 069, S/S F); and 483.75(f) (Tag F498, S/S E). Jt. Stip.; *see also*, Joint Statement of Issues (Jt. Statement).

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[6](...continued)
harm due to the deficiency. CMS Ex. 7. Thus, those alleged deficiencies could not be the basis for the imposition of an enforcement remedy and were not subject to my review. 42 C.F.R. §§ 488.330(e), 488.408(g)(1), and 498.3

[7] This is a "Tag" designation as used in the State Operations Manual (SOM), Appendix PP – Guidance to Surveyors for Long Term Care Facilities. The "Tag" refers to the specific regulatory provision allegedly violated and CMS's guidance to surveyors. Although the SOM does not have the force and effect of law, the provisions of the Act and regulations interpreted 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 the regulations as interpreted by the SOM.

[8] 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. 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 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.

[9] The parties indicate in their stipulation that the applicable regulations are actually at 42 C.F.R. §§ 483.10(k)(2) and 483.20(d)(3).

The parties stipulated that Petitioner was cited with the following deficiencies by the survey that ended on October 5, 2005: 42 C.F.R. §§ 483.20(k)(2)[10] (Tag F280, S/S D); 483.483.25(h)(2) (Tag F324, S/S G); and 483.60(e) (Tag F432, S/S E). Jt. Stip.; Jt. Statement.

The parties stipulated that Petitioner was cited with the following deficiencies by the survey that ended on December 15, 2005: 42 C.F.R. §§ 483.13(a) (Tag F221, S/S D); 483.25(a)(3) (Tag F312, S/S D); 483.25(c) (Tag F314, S/S G); 483.25(f)(1) (Tag F319, S/S D); 483.25(j) (Tag F327, S/S D); 483.60(a) (Tag F426, S/S D); 483.65(a)(1)-(3) (Tag F441, S/S D); and 483.75(f) (Tag F498, S/S E). Jt. Stip.; Jt. Statement.

The parties stipulated that Petitioner was cited with the following deficiencies by the survey that ended on January 25, 2006: 42 C.F.R. §§ 483.12(a)(7) (Tag F204, S/S D); 483.13(c) (Tag F224, S/S G); 483.13(c)(1)(ii) & (iii), (2), (3), & (4) (Tag F225, S/S D); 483.15(g)(1) (Tag F250, S/S G); 483.25 (Tag F309, S/S G); and 483.25(f)(1) (Tag F319, S/S G). Jt. Stip.; Jt. Statement.

Petitioner disputed and requested review as to all the foregoing alleged deficiencies in its March 22, 2006, request for hearing. The parties agreed in their Joint Statement of Issues filed on June 22, 2006 that all the foregoing alleged deficiencies were before me for hearing and decision and they also stipulated to that in the Joint Stipulation of Undisputed Facts filed the same day. However, in its Prehearing Brief filed on July 6, 2006, CMS only discusses those deficiencies cited at a scope and severity level of G (actual harm but no immediate jeopardy). Petitioner also limits the discussion in its prehearing brief to the deficiencies cited at a scope and severity of G. Similarly, the parties only discuss the G-level deficiencies in their briefs on the merits, filed on November 17, 2006. The parties do not disclose whether there is a *sub rosa* agreement or other reason that the parties address only the deficiencies cited at a scope and severity of G. However, counsel for CMS has the apparent authority to pursue on behalf of its client (the Secretary and CMS) only the deficiencies it deems appropriate to pursue. I construe the CMS prehearing briefing and briefing on the merits to be conclusive evidence that CMS elects to pursue as a basis for the proposed enforcement remedies only the alleged deficiencies at a scope and severity of G and that CMS has waived proceeding on any of the deficiencies cited at another scope and severity level. My conclusion is consistent with the CMS argument that the $400 per day CMP for the period August 5, 2005 through February 1, 2006 is reasonable based upon the eight deficiencies cited at a scope and severity of G, *i.e.*, actual harm but no immediate jeopardy. CMS Prehearing Brief at 20; CMS Brief at 5-6. My

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[10] The parties indicate in their stipulation that the applicable regulations are actually at 42 C.F.R. §§ 483.10(k)(2) and 483.20(d)(3).

review of only the G-level deficiencies does not prejudice CMS given the decision in this case. I also find no prejudice to Petitioner by reviewing fewer than all the alleged deficiencies alleged to have posed more than minimal harm. I specifically do not consider deficiencies not reviewed in this decision when assessing the reasonableness of the enforcement remedy imposed.

Based upon the foregoing discussion, I conclude that only the following deficiencies remain at issue before me: (August Survey) 42 C.F.R. §§ 483.25(c) (Tag F314, S/S G); 483.25(i)(1) (Tag F325, S/S G); (October Survey) 483.483.25(h)(2) (Tag F324, S/S G); (December Survey) 483.25(c) (Tag F314, S/S G); (January Survey) 483.13(c) (Tag F224, S/S G); 483.15(g)(1) (Tag F250, S/S G); 483.25 (Tag F309, S/S G); and 483.25(f)(1) (Tag F319, S/S G).

1. Petitioner violated 42 C.F.R. § 483.25(c) (Tag F314, S/S G) as alleged by the August and December 2005 surveys.

Petitioner is obligated, by its participation in Medicare, to provide and ensure that each resident receives the "necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." 42 C.F.R. § 483.25. The facility, as part of its obligation to deliver quality care under 42 C.F.R. § 483.25, must ensure that a resident who enters the facility without a pressure sore does not develop one unless the resident's clinical condition demonstrates that development of a pressure sore is unavoidable. The regulation also requires that, for a resident with a pressure sore on admission, the facility must deliver care and services necessary to promote healing, prevent infection, and prevent development of new sores. 42 C.F.R. § 483.25(c).

The application of this regulation is well-established by decisions of various appellate panels of the Board. *Koester Pavilion*, DAB No. 1750 (2000) and *Cross Creek Health Care Center*, DAB No. 1665 (1998) are leading decisions in this area. The Board has noted that the pressure sore regulation contains two prongs: (1) a facility must ensure a resident who enters the facility without sores does not develop sores unless the resident's clinical condition demonstrates that pressure sores are unavoidable; and (2) a resident with pressure sores must receive necessary treatment and services to promote healing, prevent infection and prevent new sores. With respect to prevention and treatment of pressure sores, the Board has concluded that a facility bears a duty to "go beyond merely what seems reasonable to, instead, always furnish what is necessary to prevent new sores unless clinically unavoidable, and to treat existing ones as needed." *Koester Pavilion*, DAB No. 1750, at 32; *see also*, *Meadow Wood Nursing Home*, DAB No. 1841 (2002)

(loose dressing contaminated with fecal matter constitutes violation); *Ridge Terrace*, DAB No. 1834, at 15-16 (a single observation by a surveyor of a nurse aide cleaning an open sore area with a stool-stained washcloth was sufficient to sustain a deficiency finding under this Tag).

An appellate panel of the Board, in *Clermont Nursing and Convalescent Center*, DAB No. 1923 (2004), *aff'd, Clermont Nursing and Convalescent Ctr. v. Leavitt,* 142 Fed.Appx. 900 (6th Cir. 2005), provided the following analysis:

> The standard of necessity is expressly articulated in the regulation. The primary regulatory requirement is that residents must receive, and facilities must provide, "the necessary care and services" for attainment or maintenance of the highest practicable resident well-being. 42 C.F.R. § 483.25 (emphasis supplied). The regulation then goes on to provide that a resident with pressure sores must receive "necessary treatment and services" for healing, prevention of infection, and prevention of yet more pressure sores. 42 C.F.R. § 483.25(c)(2)(emphasis supplied). We therefore reject Clermont's contention that the standard is "nowhere in the regulation." That argument is belied by the plain language of the regulation.
>
> Moreover, as we explained in *Koester Pavilion*, in the preamble to the final regulation, CMS expressly declined to use "less demanding" language with respect to a facility's obligation to "ensure" outcome of treatment for pressure sores. *Koester Pavilion* at 30, quoting 56 Fed. Reg. 48,826, at 48,850 (Sept. 26, 1991). CMS recognized that factors beyond required treatment and services, such as disease process and resident compliance, affect care outcome. *Id.* However, CMS also recognized that the regulation allows a facility to put forward "available clinical evidence" to show that "a negative resident care outcome was unavoidable." *Id.* The preamble further provides that facilities "should always furnish the necessary treatment and services" for pressure sore prevention or healing. *Id.* at 30-31 (emphasis supplied). Thus, a facility may provide necessary treatment and services

> to ensure the prevention or healing of pressure sores, yet still be confronted with a negative outcome. In that instance, the facility may put forward clinical evidence to show that the outcome was unavoidable.

See also, Woodland Village Nursing Center, DAB No. 2172, at 12-14 (April 23, 2008).

a. August 2005 Survey.

The surveyors alleged in the SOD that the regulation was violated because Petitioner failed to ensure that Resident 1 and Resident 4 received consistent assessments and care to prevent the decline of their pressure sores.[11] The surveyors also alleged that Petitioner failed to identify the development of a pressure sore on Resident 8 who was admitted with no pressure sores. CMS Ex. 7, at 19-20.

(1) Resident 1.

It is alleged in the SOD that a surveyor observed Resident 1 on August 3, 2005, at 10:55 a.m. The surveyor observed that the resident had a Stage II ulcer with some redness noted on her left buttock and gluteal fold, and that there were feces between her buttocks and on the dressing covering the pressure ulcer. The surveyor observed Resident 1 again 30 minutes later at 11:25 a.m., with feces on the gluteal fold. CMS Ex. 7, at 20. Upon inspection of Petitioner's records, the surveyors did not find Resident 1 listed on Weekly Skin Condition Reports and they found no indication in Nurse's Notes for the period March 1 through 13, 2005, that Resident 1 had any skin assessments done. A Weekly Skin Condition Report dated April 11, 2005, listed Resident 1 with skin condition noted to be fair with no reference to any pressure ulcers. However, the surveyors located a nurse's note dated April 12, 2005 that indicated that the resident complained of discomfort at her buttocks and assessment revealed a Stage II pressure ulcer. The surveyors observed that the Weekly Skin Condition Report dated April 12, 2005 did not include the assessment of Resident 1. However, the Weekly Skin Condition Report dated April 18, 2005, listed her skin assessment as fair with a Stage II ulcer that was larger than the original assessment. The surveyors reported that they found no other Weekly Skin Condition Report dated in April 2005 that mentioned Resident 1. The surveyors note that Nurse's Notes for April 27, 2005 show that Resident 1's ulcer had worsened but they

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[11] "Pressure sore" means ischemic ulceration and/or necrosis of tissues overlying a bony prominence that has been subjected to pressure, friction or shear. SOM, App. PP, Guidance To Surveyors, Tag F314. Pressure sore and pressure ulcer are synonymous as used in this decision.

found no evidence that her physician was consulted until April 28, 2005. The surveyor alleged that Nurse's Notes for April 30 and May 1, 2005 show the pressure ulcer continued to decline and that Resident 1 was transferred on May 3, 2005 to an acute care hospital for wound care. CMS Ex. 7, at 21-22.

The surveyors alleged that Petitioner was deficient in the care of Resident 1 because she developed a pressure ulcer about April 12, 2005, which then worsened. The surveyors alleged that Petitioner's assessments of the resident's skin were absent or deficient between March 1 and April 27, 2005; that Petitioner failed to consult the resident's physician when it was noted the ulcer had worsened; and that on August 3, 2005, the resident had feces on her pressure ulcer dressing and buttocks that was not cleaned for 30 minutes.

My review of Petitioner's clinical records for Resident 1 introduced by CMS is consistent with the surveyors' allegations. Resident 1's MDS with an assessment reference date of January 19, 2005, the last day of the seven-day assessment period, shows that she required extensive assistance for bed mobility, was totally dependent for transfers, but she was able to move in her room and on the unit once in her wheelchair. The MDS also shows she was incontinent of bowel, she suffered from diabetes and multiple sclerosis (MS), she had partial-loss of use of both legs and feet, her skin was desensitized to pain or pressure, she had pressure relieving devices for her bed and wheelchair, she was on a turning/repositioning program, and she had application of medicine or ointments and other preventative treatment to skin other than just her feet. The MDS shows she had no ulcers, stasis or pressure. CMS Ex. 8, at 37-40. Resident 1's MDS with an assessment reference date of April 18, 2005, contains the additional diagnoses of congestive heart failure, peripheral vascular disease, hypertension, and cancer. The April 18 MDS also shows that the resident had a Stage II pressure ulcer, reports that the resident had an ulcer that was resolved or cured in the last 90 days, that she was receiving treatment for the ulcer, but otherwise the MDS is similar to the previous MDS. Monthly Resident Status reports dated January 4, 2005, February 4, 2005, and March 5, 2005, show that the resident's skin was assessed and she had no pressure ulcers. CMS Ex. 8, at 22-33. Nurse's Notes dated March 1 through 13, 2005, do not show any assessment of skin integrity or any skin problems. CMS Ex. 8, at 12-14. A Nurse's Notes entry dated April 12, 2005, records that the resident complained of discomfort on her buttocks and, upon examination, it was discovered that she had a Stage II pressure sore on her left inner buttock measuring 2 cm by 1.5 cm by 1 cm and a facsimile was sent to her doctor. CMS Ex. 8, at 15, 17. Notes from April 13 through April 17, 2005, show that Lantispetic was applied to the buttock wound, that Resident 1 was turned and repositioned while in bed, and that she would reposition herself in her wheelchair, but the notes do not indicate whether or not the repositioning in the wheelchair was consistent with physician or staff direction. CMS Ex. 8, at 15-16. A note dated April 17, 2005, states that the ulcer had

worsened, increasing in size with a yellow area in the inner edge and that Resident 1 refused to lie down after lunch. Other Nurse's Notes entries on April 18 and 19, 2005, show that the wound was not improving, that Lantispetic continued to be applied, but there is no indication that the physician was consulted. There are no Nurse's Notes entries between April 19 and 27, 2005. A Nurse's Notes entry on April 27, 2005, shows that the decubitus ulcer on the resident's left inner buttock had increased in size, had necrotic tissue, and serosanguineous drainage. Registered Nurse (R.N.) Davis was informed and she was going to advise the physician and obtain an order for different treatment. CMS Ex. 8, at 16; P. Ex. 3, at 3. A Nurse's Notes entry on April 28, 2005, at 10:00 a.m. shows that a new order had been received directing changes to the treatment of the left inner buttock pressure ulcer. A Nurse's Notes entry at 9:00 p.m. states that treatment was done to the left inner buttock; I infer that this was the first implementation of the new orders from 10:00 a.m. as there are no intervening notes. The note indicates that there was necrotic tissue surrounded by yellow; the skin around the wound was bright red; there was a foul odor from the ulcer; and a moderate amount of serosanguineous drainage. The note indicates that Resident 1 was aware that she needed to stay off the wound as much as possible but she said she was not staying in bed all the time. CMS Ex. 8, at 19; P. Ex. 3, at 4. A note dated April 29, 2005, at 9:30 a.m. shows treatment was given for the wound and it had an "extremely foul odor" and that the resident was removed from bed and put in her wheelchair per her demand. CMS Ex. 8, at 19; P. Ex. 3, at 4. The Nurse's Notes for May 3, 2005, show that the resident was sent to the hospital for treatment of the ulcer, which was noted to be surrounded by dark pink, with yellow and black necrotic tissue, a strong foul odor, and a large amount of drainage. Resident 1 complained of pain but refused pain medication. CMS Ex. 8, at 20.

The evidence shows that Resident 1 developed a pressure ulcer while in Petitioner's care which was discovered on April 12, 2005, and that ulcer worsened. The resident suffered actual harm in the form of the ulcer and associated pain. I conclude based upon the evidence that CMS has made a prima facie showing of a violation of 42 C.F.R. § 483.25(c) and the resident suffered actual harm.

Resident 1's care plan dated June 6, 2005, listed several interventions, including that the resident is cleaned after each incontinent episode. CMS Ex. 8, at 36. The surveyor's observation that the resident had feces on and near the dressing on her pressure sore on August 3, 2005, is unrebutted. Thus, the evidence shows that Petitioner's care planned intervention to clean the resident after each incontinent episode was not followed on August 3, 2005. I infer that the planned intervention was deemed necessary by Resident 1's care planning team to promote healing of her left buttock pressure ulcer. I conclude that the surveyor's observation shows that Petitioner did not provide necessary care and services to promote healing of the ulcer.

Petitioner does not deny that Resident 1 developed a pressure ulcer on her left buttock about April 12, 2005. Petitioner notes that when the ulcer was discovered, treatment orders were obtained and care was initiated. Petitioner does not deny that the wound worsened before the resident was sent to the hospital on May 3, 2005. Petitioner argues that the resident was noncompliant because she refused to lie down on April 17, 2005; because she wanted to be out of bed in her wheelchair on April 28 and 29, 2005; and because she refused to comply with her diabetic diet. However, Petitioner cites no evidence of any interventions to deal with the Petitioner's noncompliance. Petitioner mentions that Resident 1 could reposition herself in her wheelchair but does not characterize that as a problem of noncompliance. Petitioner argues that interventions were ordered and implemented after Resident 1 returned from the hospital. Petitioner does not dispute that the surveyor observed feces on Resident 1's buttocks on the dressing on her pressure ulcer or that the feces remained for 30 minutes in contravention of an intervention to keep the resident clean. Petitioner offers no opinion, medical or otherwise, and does not argue that the development of the ulcer or its worsening was unavoidable because the resident was noncompliant with interventions or due to the nature of her health problems. P. Brief at 7-10.

I conclude that Petitioner has failed to show it was in substantial compliance or had an affirmative defense in the case of Resident 1.

(2) Resident 4.

The surveyors alleged that Resident 4 was returned to Petitioner on July 19, 2005, after treatment at a long-term acute care hospital for treatment of a right heel pressure ulcer. Resident 4 was assessed as at risk for development of pressure ulcers in February 2005 and she was supposed to receive weekly skin assessments. The surveyors reviewed Petitioner's Weekly Skin Condition Report book which contained only reports dated March 23 and 29, 2005 and neither mentioned Resident 4. Nurse's Notes on March 31, 2005 show that a Certified Nurse Assistant (CNA) discovered and reported a reddened area on the resident's right heel. The resident's physician issued orders. Nurse's Notes dated April 7, 2005, showed that the pressure sore had worsened and was debrided. A Weekly Skin Condition Report dated April 11, 2005, showed that the ulcer had worsened. The surveyors reviewed a Weekly Skin Condition Report dated April 18, 2005 but they do not report what it said. On May 9, 2005, the resident was transferred to the acute care hospital for wound treatment. The surveyors reviewed Resident 4's MDS dated July 25, 2005, which showed she continued with a Stage III pressure ulcer on her right heel, after her return from the hospital. The surveyors found no evidence that, between July 19, 2005 and August 4, 2005, staff assessed or documented any changes in the resident's pressure ulcer. CMS Ex. 7, at 22-25.

The allegations are that Resident 4 was assessed as at risk for pressure ulcers in February 2005, the evidence the surveyor reviewed did not show regular assessments for the resident's skin, an ulcer was discovered on Resident 4's right heel on March 31, 2005, the ulcer worsened until the resident had to be transferred to the hospital for wound treatment, and after her return assessments were not documented as having been done. The surveyors' allegations are consistent with the evidence offered by CMS. CMS Ex. 11.

Resident 4's MDS with an assessment reference date of January 20, 2005, shows that she had no ulcers but she had pressure relieving devices for her chair and bed and that she had application of ointments, medications, and other protective skin care. CMS Ex. 11, at 42-44. A significant change MDS with an assessment reference date of February 16, 2005, shows that she had no pressure ulcers and the pressure relieving devices for her chair and bed and other skin care was unchanged from the prior MDS. CMS Ex. 11, at 52, 55. A Monthly Resident Status report dated March 15, 2005, stated that Resident 4's skin was easily bruised but her skin integrity was intact. CMS Ex. 11, at 71. Nurse's Notes entries for March 10 through 21, 2005, give no indication of any problem with ulcers. A note dated March 31, 2005, shows that a CNA discovered a reddened area on the resident's right heel that appeared as a blister 4 cm by 2 cm, with a slightly yellow center, but was not open. Resident 4's physician was notified and ordered that Duoderm, a special dressing often used with ulcers, be applied. Another note on March 31, 2005, indicates that staff encouraged Resident 4 to use a pillow to "float" the heel. CMS Ex. 11, at 28. The Nurse's Notes entries show that staff found it difficult to keep the Duoderm in place. A note on April 7, 2005 records that the ulcer was open and bleeding with a very foul odor and the physician, who was present, ordered that the wound be debrided. CMS Ex. 11, at 26. Nurse's Notes show that Resident 4 was readmitted to Petitioner on July 19, 2005, and she continued to have a right heel ulcer and she was noted to have a Stage II decubitus ulcer on her right buttock. CMS Ex. 11, at 29.

A Nurse's Note entry dated July 19, 2005 at 3:00 p.m. states that the right and left heels will be assessed "tomorrow." CMS Ex. 11, at 29. A note dated July 20, 2005, at 10:00 a.m. indicates that the dressing on the right heel was changed but no observations regarding the wound are listed. CMS Ex. 11, at 30. A note dated July 21, 2005, at 2:00 a.m. shows Resident 4 complained of pain in both lower extremities, the dressings were noted to be dry and intact, the resident was given Lortab, and the nurse noted that monitoring would continue. A note at 10:00 a.m. on July 21, 2005, discusses right and left lower legs but not the right heel. CMS Ex. 11, at 30. Notes on July 22, 23, and 25, 2005, indicate that right heel was treated as ordered but the wound on the right heel is not

described. CMS Ex. 11, at 32. A note dated July 26, 2005, at 2:30 p.m. shows that the physician was there to see the resident's right heel ulcer and right leg, a culture from the wound on the right leg showed positive for MRSA infection (Methicillin-resistant Staphylococcus aureus) but the right heel ulcer is not described. CMS Ex. 11, at 31.

Resident 4's MDS with an assessment reference date of July 22, 2005, shows that she had one Stage II and one Stage III pressure ulcer. CMS Ex. 11, at 13. Her pressure ulcer care plan dated July 19, 2005, showed she had a Stage II or III ulcer on the side of her right heel with purulent drainage. Interventions listed included assessing the ulcer daily. CMS Ex. 11, at 47. A Skin Grid – Other Skin Problems dated July 19, 2005, does not list the right heel ulcer. CMS Ex. 11, at 76-77. A Weekly Skin Assessment dated July 19, 2005, does not list the right heel ulcer. CMS Ex. 11, at 78-79. A physician order dated July 21, 2005, reflects a change in treatment for the right heel ulcer but provides no detail for the state of the wound. CMS Ex. 11, at 80.

The evidence shows Resident 4 developed a pressure ulcer on her right heel that was discovered by a CNA on March 31, 2005, while the resident was in Petitioner's care. Between March 31 and April 7, 2005 the ulcer worsened and Resident 4 was sent to the hospital for care of the wound. After the resident was returned to Petitioner on July 19, 2005, the evidence does not show that the resident's right heel ulcer was assessed although a care plan was created. Between the resident's return to Petitioner on July 19, 2005, and the date of the survey there is no assessment in the records obtained by CMS that show there was any improvement in the right heel ulcer. Accordingly, I conclude that CMS has made a prima facie showing of a violation of 42 C.F.R. § 483.25(c) due to the development and worsening of the right heel ulcer in March and April 2005, and the absence of evidence of improvement in the ulcer after the resident's return to Petitioner on July 19, 2005. The resident suffered actual harm evidenced by the development of the wound and pain related to the wound.

Petitioner argues that there was no assessment documented between April 1 and 7, 2005, because the assessments were only planned to be done weekly. Petitioner also argues that because the dressing was coming off the right heel wound in April, staff was obviously seeing the wound as did the physician who assessed the wound himself and had the resident sent out for debridement. Petitioner points to a physician's progress note dated July 26, 2005 (P. Ex. 6, at 1), and asserts it states no recent drainage from wounds, but my review of the document reveals that it was based on a patient report and does not specify which of multiple wounds were included. Petitioner introduced a Month Resident Status Report dated August 28, 2005 (P. Ex. 6, at 12-15) that described the wound. P. Brief at 10-11. I note, however, that this report is from 23 days after the survey and because there are no assessments in the record done between July 19 and August 28, 2005, it is not possible for me to determine whether or not Petitioner provided necessary care to improve

the wound. Petitioner points to no opinion and does not argue that the development of the right heel pressure ulcer was unavoidable. Petitioner also fails to offer opinion, argument, or documentary evidence that the right heel ulcer ever improved while Resident 4 was in Petitioner's care.

Accordingly, I conclude that Petitioner has failed to show it was in substantial compliance or that it had an affirmative defense relative to Resident 4.

(3) Resident 8.

The surveyors reviewed Resident 8's MDS dated November 8, 2004 and noted the MDS indicated that she had no pressure ulcers. However, Resident 8's quarterly review assessment on May 6, 2005 showed she had two Stage I pressure ulcers. Physician's progress notes dated July 15, 2005, showed the resident suffered from peripheral vascular disease with poor circulation. On August 3, 2005, the surveyor observed that Resident 8 had a Stage II pressure ulcer on her right buttock, even though the surveyors were told the previous day that no one on the unit had a pressure ulcer. The surveyors found no evidence that Resident 8 had a skin assessment between May 29, 2005 and July 11, 2005, despite the fact that her care plan required assessments and that the assessments be recorded. CMS Ex. 7, at 25-26; CMS Ex. 56, at 6-7. Petitioner does not address Resident 8 in its brief and the observations of the surveyors in the SOD are unrebutted and not disputed. The evidence Petitioner produced confirms that Resident 8 was assessed on August 9, 2005, with a Stage I decubitus ulcer on her left buttock, a Stage II on her coccyx, and a Stage II on her right buttock. P. Ex. 8, at 5. A physician progress note dated August 5, 2005, mentioned a Stage II ulcer on the resident's coccyx. P. Ex. 8, at 1. Nurse's Notes entries from August 5 and 7, 2005, show the resident had a Stage II ulcer on her coccyx, a Stage I on her left buttock, and a Stage II on her right buttock. P. Ex. 8, at 3. Petitioner presents no evidence or argument to show that Resident 8 was properly assessed or that the resident's ulcers were unavoidable. Accordingly, I conclude Petitioner violated 42 C.F.R. § 483.25(c). Resident 8 suffered actual harm in the form of the ulcers that developed in early August 2005.

b. December 2005 Survey.

The SOD from the survey that ended on December 15, 2005, alleged that Petitioner failed to ensure that Residents 5, 23, and 28, who entered the facility without pressure ulcers, received the treatment and service necessary to prevent the development of ulcers. CMS Ex. 28, at 6-7. It is sufficient to show a violation of the regulation with one example cited by the surveyors. In the interest of judicial economy, I address the first example presented by the surveyors in the SOD, Resident 23.

The surveyors alleged that Resident 23's MDS dated November 18, 2005, showed no pressure ulcers. A Monthly Summary dated November 24, 2005, showed no pressure ulcers. A Weekly Skin Assessment dated December 6, 2005, also showed no new areas, which the surveyors apparently interpreted to mean no pressure ulcers. The SOD reports that a surveyor continuously observed the resident on December 14, 2005, from 11:20 a.m. to 1:10 p.m.; the resident was sitting in his wheelchair and was not checked for incontinence or repositioned during the period. At 1:10 p.m. on December 14, the surveyor observed Resident 23 transferred to his room and bed and he was provided incontinent care. At 1:15 p.m. the surveyor observed that the resident's buttocks were wet with urine, excoriated, and bright red. The surveyor also observed an open sore below the coccyx, approximately 0.5 cm in diameter, that extended through layers of skin that was subsequently assessed by Petitioner's staff as a Stage II pressure sore. The SOD reports the surveyor was told at 1:30 p.m. by a nurse responsible for skin assessments that the pressure ulcer had not previously been observed, which conflicted with the report of the resident's wife that an aide told her the resident had bed sores. CMS Ex. 28, at 7-8.

The clinical records presented by CMS are consistent with the allegations in the SOD. Resident 23's MDS signed November 21, 2005, showed that the resident had no pressure ulcers during the assessment period. However, he apparently was assessed as at risk for pressure ulcers or other skin problems as the MDS indicates that he had pressure relieving devices for his bed and chair. CMS Ex. 35, at 24. A Weekly or Monthly Summary report dated November 24, 2005, shows no pressure ulcers but reports that the resident had abrasions or bruises and skin tears. CMS Ex. 35, at 57.

Resident 23 had a care plan for bowel and bladder incontinence dated November 18, 2005, that required staff to assess skin for breakdown and to report any skin changes. CMS Ex. 35, at 47, 48. Resident 23 had been assessed as at risk for impaired skin integrity and had a care plan dated November 18, 2005, that required his skin is kept clean and dry, that he be repositioned every two hours and as needed, and that there be weekly skin assessments, among other things. CMS Ex. 35, at 51. A Weekly Skin Assessment form shows skin assessments were done weekly from November 15 through December 15, 2005, however except for one instance, the form gives no explanation of the results but refers to a skin grid that was not provided by CMS. CMS Ex. 35, at 55.

A Nurse's Notes entry dated December 14, 2005, at 1:30 p.m. shows that the nurse was notified by staff that the resident had an open area on his coccyx that was assessed by the nurse as 0.5 cm in diameter and a Stage II pressure sore. The note indicates the nurse notified the Director of Nursing (DON) and Assistant DON of the new sore. CMS Ex. 35, at 31.

The surveyor's observation that the resident was not checked for incontinence between 11:20 a.m. and 1:10 p.m. on December 14 and that he was wet when checked, shows that Petitioner was not complying with its care plan to keep the resident's skin clean and dry. The surveyor's observation of the pressure sore on the coccyx and Petitioner's records of the existence of that ulcer following prior assessments by Petitioner that showed no ulcers, establishes that the Resident 23 developed an ulcer while in Petitioner's care. The Stage II ulcer amounts to actual harm. Thus, I conclude CMS has made a prima facie showing that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(c) as alleged by the December survey.

Petitioner argues, citing P. Ex. 49, at 11-14, 38, 42, that Resident 23 was aggressive with staff which tended to delay his repositioning. Petitioner also notes that Resident 23's physician assessed him on December 13, 2005, but did not discover a coccyx wound (P. Ex. 49, at 15). Petitioner also states that when the wound was identified on December 14 orders were obtained for treatment (P. Ex. 49, at 15). P. Brief at 19. Petitioner does not argue and provides no evidence that Resident 23's development of a pressure ulcer was unavoidable. The evidence does not show that Resident 23's combative or aggressive behavior prevented Petitioner's staff from cleaning the resident after an episode of bowel or bladder incontinence or that it prevented staff from assessing him for incontinence. The evidence also does not show that his combative or aggressive behavior prevented skin care or assessment. I conclude that Petitioner has not established that Resident 23's development of a pressure ulcer was unavoidable. Accordingly, Petitioner has failed to show that it was in substantial compliance or had an affirmative defense.

2. Petitioner violated 42 C.F.R. § 483.25(i)(1) (Tag F325, S/S G) as alleged by the August 2005 survey.

Included in the requirement that a facility must provide quality care is the requirement that a facility must ensure "[b]ased upon a resident's comprehensive assessment . . . that a resident . . . [m]aintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible." 42 C.F.R. § 483.25(i)(1). The Guidance to Surveyors in the SOM specifically cautions surveyors that ideal body weight charts have not been developed for institutionalized elderly residents. Thus, a resident's weight gain or loss should be considered in light of the resident's former life style, current diagnosis, the resident's usual weight through adult life, the assessment for potential weight loss, and the care plan for weight loss. SOM, App. PP, Tag F325.

Appellate panels of the Board have discussed deficiency citations under Tag F325 in *The Windsor House*, DAB No. 1942 (2004) and *Carehouse Convalescent Hospital*, DAB No. 1799 (2001). *See also, Bradford County Manor*, DAB No. 2181, at 21-32 (2008). In *Carehouse*, the Board interpreted the regulation not to require that a facility maintain a resident's weight at a fixed level. The Board also determined that a facility is not strictly liable for a resident's weight loss. The Board said that the regulation requires maintenance of weight only to the extent that weight is a "parameter of nutritional status," *i.e.*, if a resident receives adequate nutrition and weight loss is due to non-nutritive factors then the weight loss is not a "parameter of nutritional status and the weight loss alone is not a basis for a deficiency finding." *Carehouse*, DAB No. 1799, at 21. Nevertheless, the Board concluded that weight loss raises an inference of inadequate nutrition sufficient to be a CMS *prima facie* showing of a deficiency. *Id.* at 22. A *prima facie* case based upon the inference arising from weight loss is rebutted if the facility shows by a preponderance of the evidence that it "provided the resident with adequate nutrition" or weight loss was due to non-nutritive factors. *Id.* In *Windsor*, the Board used the formulation that a "facility is responsible for taking all reasonable steps to ensure that the resident receives nutrition adequate to his or her needs." *Windsor*, DAB No. 1942, at 18. The Board explained that if CMS makes a *prima facie* showing based on weight loss, the facility may rebut that showing with evidence that the resident did receive adequate nutrition or that weight loss was due to non-nutritive factors, such as the resident's clinical condition. *Id.* The Board commented that the "clinical condition exception" is a narrow one that applies only when the facility demonstrates that it cannot provide nutrition adequate for the resident's overall needs so that weight loss is unavoidable. *Id.* The Board affirmed the ALJ's findings and conclusions in *Windsor,* indicating that the ALJ correctly concluded that the presence of a significant clinical condition alone does not prove that weight loss is unavoidable. Rather, the Board noted that the ALJ correctly focused upon Windsor's own assessment of the residents' nutritional needs and whether Windsor met its own plan for how to meet those needs. *Id.* at 17-18.

The surveyors alleged in the SOD that Petitioner failed to maintain Resident 2's weight and her weight loss was avoidable. CMS Ex. 7, at 32. The surveyors alleged that Resident 2's usual weight was 120 pounds and that between February 2005 and June 2005 her weight dropped from 120 pounds to 97.1 pounds. The surveyors calculated a total weight loss of 26.5% from February 1, 2005 to July 2, 2005. A surveyor observed the resident being weighed on August 3, 2005 and she weighed 88.1 pounds. The surveyors alleged that Petitioner did not comply with a June 9, 2005 physician order to serve the resident a pureed diet in a sippy cup based on a surveyor's observations during the noon meals on August 3 and 4, 2005, that Resident 2 was being fed a pureed diet by spoon and no sippy cup was present. The surveyors also alleged that Petitioner violated a June 9, 2005, order to give the resident a nutrition supplement shake at each medication time, but the shake was not listed on the medication administration record (MAR) and the

nurse who administered medication was unaware of the requirement for a shake. CMS Ex. 7, at 32-34. The allegations of weight loss are consistent with the evidence presented by CMS. CMS Ex. 9, at 10-12, 18. Petitioner does not dispute the fact that weight loss was experienced by Resident 2.

Because it is undisputed that Resident 2 lost weight as alleged by the surveyors in the SOD, I conclude that CMS has made a prima facie showing of a violation of 42 C.F.R. § 493.25(i)(1). *See, e.g., Carehouse*, DAB No. 1799, at 22.

Petitioner argues in its defense that the resident's weight loss was unavoidable. Petitioner argues that Resident 2 suffered from late stage Alzheimer's (P. Ex. 4, at 7). Petitioner argues that nutrition progress notes show Resident 2 quit eating or drinking July 19, 2005 (P. Ex. 4, at 7). I note that the progress note does not reflect what period or for how long the resident stopped eating. I further note that whoever wrote the note was under the incorrect impression that the resident was receiving a supplement shake with the medication passes. P. Ex. 4, at 7. Petitioner concedes that its July 2005 meal intake records show that the resident had not stopped eating, she refused meals 14 times during the month of July; ate 50 percent or less of 69 of 90 meals, roughly 77 percent of the meals; and she refused supplements 13 times when she refused a meal. P. Ex. 4, at 4. Petitioner argues that there were interventions in place. P. Brief at 12. Petitioner does not deny and offers no explanation for why the physician ordered interventions (CMS Ex. 9, at 21; P. Ex. 4, at 1, 3) to give Resident 2 a liquified diet in a sippy cup and a supplement shake with each medication pass were not implemented. Rather Petitioner argues, without citation to any evidence of record, that weight loss in Alzheimer's patients occurs as the disease progresses. Petitioner also argues that it was speculative that use of a sippy cup and supplements at medication pass would have made any difference without the addition of Megace (an appetite stimulant) that was ordered after the survey. P. Brief at 12.

Petitioner's arguments are insufficient to show that Resident 2's clinical condition made it impossible to maintain her weight as an indicator of her receiving adequate nutrition. Petitioner does not deny that it failed to comply with physician's orders from June 9, 2005 to give the resident a liquified diet in a sippy cup and a supplement shake with medication passes. Because Petitioner did not comply, it is speculative that complying with the order would not have made a difference. Furthermore, it is not possible for Petitioner to show it did what was reasonable to provide Resident 2 adequate nutrition to maintain her weight, because Petitioner did not implement the physician's orders. Petitioner does not dispute that Resident 2 suffered actual harm as a result of her weight loss.

Accordingly, I conclude Petitioner violated 42 C.F.R. § 483.25(i)(1) and Resident 2 suffered actual harm.

3. Petitioner violated 42 C.F.R. § 483.25(h)(2) (Tag F324, S/S G) as alleged by the October 2005 survey.

Part of a facility's obligation to provide quality care is a requirement that a facility must ensure that "[e]ach resident receives adequate supervision and assistance devices to prevent accidents." 42 C.F.R. § 483.25(h)(2). The Board has explained the requirements of 42 C.F.R. § 483.25(h)(2) in numerous decisions. *Eastwood Convalescent Center,* DAB No. 2088 (2007); *Liberty Commons Nursing and Rehab - Alamance,* DAB No. 2070 (2007), *aff'd*, *Liberty Commons Nursing and Rehab Ctr. - Alamance v. Leavitt*, No. 07-1329, 2008 WL 2787675 (4th Cir. July 18, 2008); *Golden Age Skilled Nursing & Rehabilitation Center*, DAB No. 2026 (2006); *Estes Nursing Facility Civic Center*, DAB No. 2000 (2005); *Northeastern Ohio Alzheimer's Research Center*, DAB No. 1935 (2004); *Woodstock Care Center*, DAB No. 1726, at 28 (2000), *aff'd*, *Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). Section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, but it does require that a facility take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents. *Woodstock Care Center v. Thompson*, 363 F.3d at 589 (a SNF must take "all reasonable precautions against residents' accidents"). A facility is permitted the flexibility to choose the methods of supervision it uses to prevent accidents, but the chosen methods must be adequate under the circumstances. *Id*. Whether supervision is "adequate" depends in part upon the resident's ability to protect himself or herself from harm. *Id*. Based on the regulation and the cases in this area, CMS meets its burden to show a *prima facie* case if the evidence demonstrates that the facility failed to provide adequate supervision and assistance devices to prevent accidents, given what was reasonably foreseeable. *Alden Town Manor Rehabilitation & HCC*, DAB No. 2054 at 5-6, 7-12 (2006). An "accident" is "an unexpected, unintended event that can cause a resident bodily injury," excluding "adverse outcomes associated as a direct consequence of treatment or care (*e.g.*, drug side effects or reactions)." SOM, App. PP, Tag F324; *Woodstock Care Center*, DAB No. 1726, at 4.

The surveyors alleged that Petitioner violated 42 C.F.R. § 483.25(h)(2) because Petitioner failed to provide adequate supervision to Residents 5 and 6. Specifically, the surveyors alleged that both residents were improperly transferred and Resident 6 suffered a right hip fracture and clavicle fracture as a result. CMS Ex. 22, at 3-4.

The surveyors' allegations regarding Resident 6 were based upon review of Petitioner's records. The surveyors determined based on review of Resident 6's clinical records confirmed by interviews with the resident's physician and Petitioner's staff that Resident 6 was a big man who always required to staff to assist him with transfers. Petitioner's accident report and the CNA involved agree that the CNA attempted to transfer the resident from the toilet to his wheelchair on September 9, 2005, and when the resident started to fall the CNA was unable to catch or stop him and he hit the floor. Resident 6 suffered a fractured right hip and right clavicle. CMS Ex. 22, at 4-6. The documents introduced by CMS are consistent with the surveyors' allegations. CMS Ex. 24, at 3, 4-16, 17, 20-21; CMS Ex. 55, at 8.

The allegations in the SOD regarding Resident 5 are based upon the surveyor's observations on October 4,[12] 2005, at 3:00 p.m. The SOD reports that the surveyor watched two CNAs transferring Resident 5 without a mechanical lift from bed to a shower chair and the chair rolled, showing the wheels were not locked. The surveyor also found in Petitioner's records a physician's order dated September 1, 2005, which provided that Resident 5 was to be transferred using a mechanical lift only. The surveyor did not allege that an accident occurred or that Resident 5 was injured. CMS Ex. 22, at 6-7. The documents introduced as evidence by CMS are consistent with the surveyor's allegations in the SOD. CMS Ex. 26, at 5; CMS Ex. 55, at 10.

Petitioner does not dispute the facts as alleged in the SOD. Rather, Petitioner argues that it provided training to its staff regarding proper transfers, that the three CNAs were individually malfeasant, and that the CNAs were properly disciplined by Petitioner. P. Brief at 13-17.

Regarding Resident 6's fall, Petitioner does not dispute the allegations in the SOD and agrees its records required a two-person assist for transfers. P. Brief at 14; P. Ex. 39, at 3-6. Actually, a Monthly Resident Status Report dated September 21, 2005, indicates that

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[12] The SOD states the observation occurred on September 4, 2005. The affidavit of Bill Vanoss, R.N., the surveyor who participated in the survey and drafted this deficiency in the SOD, also indicates the observation occurred on September 4, 2005. CMS Ex. 42, at 10. In fact, there is no evidence that Surveyor Vanoss was in the facility on September 4, 2005. CMS Ex. 55, at 2, 6. Rather, it is more likely than not that his observation was made on October 4, 2005, when he was in the facility for the complaint survey and incident investigation for which he drafted this deficiency finding in the SOD.

the resident was a two to four-person assist for all transfers. P. Ex. 39, at 3. An October 28, 2005 Care Plan Conference Summary specified a two-person assist for transfers and transfers by mechanical lift. P. Ex. 39, at 12. Petitioner blames the attending CNA for not complying with the resident's care plan. Petitioner argues that:

> The nurse aide totally disregarded the information available to her regarding the Resident's care and made a significantly poor call with regard to her convenience versus the Resident's safety.

P. Brief at 14. Petitioner asserts that the CNA had been properly trained and she was disciplined for the error she committed.

Petitioner conceded Resident 5's records showed he required a two-person assist for transfers. P. Brief at 13; P. Ex. 38, at 4, 7. Petitioner states that "[t]here was no reason for the two involved nurse aides to transfer the Resident without following the care plan and use a Hoyer Lift." P. Brief. at 13-14.

Petitioner argues that the actions of the CNAs do not reflect the policy or the training of the facility. Petitioner analogizes its situation with that discussed by another ALJ in *JFK Hartwick at Edison Estates*, DAB CR 840 (2001). In *Hartwick at Edison*, the ALJ determined, as to one of many alleged deficiencies, that it was not reasonable for the facility to foresee that a single staff member would use a mechanical lift in violation of facility policy that at least two staff members should be present and the evidence did not show that the use of the lift by one staff member caused, directly or indirectly, injury to the resident. The *Hartwick at Edison* decision is inapposite. The allegation in *Hartwick at Edison* appears to have been that a single staff member violated a facility policy to have two staff present when a mechanical lift was used. In this case, at least three CNAs violated their training and physician's orders or care plans in two separate incidents, which is unlike the situation in *Hartwick at Edison*. Further, in this case the issue is not what was required by facility policy, rather each resident's care plan and/or physician orders required multiple person assists for transfers or the use of a mechanical lift. The care plan teams for the residents presumably imposed the requirements for the safety of the residents and staff after determining that a single assist or transfer without a mechanical lift was unsafe. Thus, it was clearly foreseeable, *i.e.,* Petitioner knew or should have known, that if staff did not comply with the requirement to use a multiple person assist or a mechanical lift, an accident could occur with injury to staff or the residents. Although Petitioner argues it trained its staff, training alone is insufficient. There must also be supervision of staff to ensure that training is effective and that physician orders and care plans are properly and effectively executed. Petitioner has not shown that it provided the supervision necessary to prevent the accidents with Resident 5 and 6 and the injury to Resident 6.

Moreover, Petitioner cannot disassociate itself from the actions of its employees where those actions are taken in the staff member's official capacity as a representative of the facility. A facility can act only through its employees. While the CNAs may have been derelict in their responsibility by not adhering to physician's orders or the care plan, Petitioner cannot avoid its responsibility for the CNAs' actions. In *Cherrywood Nursing and Living Center*, DAB No. 1845 (2002), the Board made it clear that a petitioner:

> [C]annot simply claim that it should not be held responsible for the incidents involving the resident because the nurse aides failed to follow the care plan. The Board has consistently held that a facility cannot disavow responsibility for the actions of its employees. In a case involving a facility where a nurse failed to respond to calls for assistance from the visiting spouse of a resident who was experiencing trouble breathing, the Board stated: "[The nurse's] employer cannot disown the consequences of the inadequacy of care provided by the simple expedient of pointing the finger at her fault, since she was the agent of the employer empowered to make and carry out daily care decisions.

Cherrywood, at 14, *citing Emerald Oaks*, DAB No. 1800, at 7, n.3 (2001); *Ridge Terrace*, DAB No. 1834 (2002). The Board further stated that a "facility is responsible for ensuring that services are provided to meet the residents' needs, whether those services are provided by professionals, nurse aides, or other employees." *Id.*

I conclude that Petitioner did not take reasonable steps to prevent accidents from improper transfers. Petitioner violated 42 C.F.R. § 483.25(h)(2) and Resident 6 suffered actual harm as a result.

4. Petitioner violated 42 C.F.R. § 483.13(c) (Tag F224, S/S G) as alleged by the January 2006 survey.

Long-term care facilities that participate in Medicare or Medicaid are required to "protect and promote the rights of each resident, including. . . . [t]he right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms." Act, §§ 1819(c)(1)(A)(ii) (SNFs) and 1919(c)(1)(a)(ii) (NFs). The Secretary has implemented the statutory requirements through 42 C.F.R. § 483.13(c)(1)(i) which provides:

> (c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
>
> (1) The facility must –
>
> (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; . . . .

The surveyors alleged in the SOD that Petitioner violated 42 C.F.R. § 483.13(c) because Petitioner failed to fully implement a policy regarding neglect or abuse of residents. The surveyors alleged that the failure is shown by Petitioner's failure to comply with its policy to initiate behavior crisis management interventions and to provide for immediate safety of Resident 31 who alleged that Resident 29 was sexually aggressive with her. CMS Ex. 41, at 3-4; CMS Brief at 14-17. Surveyor Vanoss was the surveyor responsible for this deficiency citation and drafted the allegations in the SOD. According to Surveyor Vanoss, during his initial tour of the facility on January 23, 2006, at 8:55 a.m., Resident 31 approached the staff nurse touring with him and reported that Resident 29 comes into her room at night, "feels her up," and pulls up her gown. CMS Ex. 41, at 4; CMS Ex. 55, at 25. Surveyor Vanoss interviewed Resident 31 the same day and Resident 31 told him that Resident 29 came into her room on January 13, 2006, and she awoke to Resident 29 touching her breasts and lifting up her sleeping gown. Resident 31 told the surveyor that she pushed Resident 29 out of her room, reported the incident to a nurse, and she used a rope to tie her door closed. CMS Ex. 41, at 5; CMS Ex. 55, at 25. Still later the same day, Surveyor Vanoss observed Resident 31 in an office with the DON and Assistant DON and she was telling them that Resident 29 had touched her breasts and vagina, she was concerned she was getting a roommate and would be unable to use the rope to tie her door shut. CMS Ex. 41, at 5-6; CMS Ex. 55, at 26. Surveyor Vanoss interviewed the DON who advised him that she had interviewed and obtained a written statement from the nurse to whom Resident 31 made the initial allegation against Resident 29. The DON advised the surveyor that she made no further investigation, the allegation was not reported to the state, and no measures were implemented to protect the residents. CMS Ex. 41, at 6; CMS Ex. 55, at 26-27. Surveyor Vanoss interviewed Resident 31 again on January 25, 2006, and she told him no one had offered her counseling, psychosocial support, or other services. CMS Ex. 41, at 7; CMS Ex. 55, at 27.

Petitioner does not deny that its policy is reflected in the pages obtained by the surveyors during the survey and introduced as evidence by CMS as CMS Ex. 47. CMS Ex. 47 includes a document "Accidents and Incidents – Investigating and Reporting" and bears a revision date of March 2001 (CMS Ex. 47, at 1-2). CMS Ex. 47 also includes eight pages

from a "Clinical Administrative Manual, Section A, 1.1.1 through 1.1.8,[13] with the Topic: "Prevention and Reporting: Suspected Resident/Patient Abuse, Neglect, and /or Misappropriation of Property." CMS Ex. 47, at 3-10. Petitioner does not deny that this policy is the policy adopted pursuant to the requirement of 42 C.F.R. § 483.13(c). The policy requires that Petitioner: (1) provide for the immediate safety of a resident upon suspected abuse, including moving the resident to another unit or room, providing one-on-one monitoring, suspending an accused employee pending investigation, and implementing the discharge process immediately for a resident who is a danger to self or others; and (2) initiate behavior crisis management interventions as applicable. The surveyor alleged that Petitioner violated 42 C.F.R. § 483.13(c) because Petitioner did not fully implement either intervention when Resident 31 alleged abuse[14] by Resident 29, showing that Petitioner had failed to implement the policy it had developed.

Petitioner discusses in its brief the interventions implemented to address Resident 29's behaviors. P. Brief at 22-24. However, the focus of the deficiency citation is Petitioner's failure to implement its policy that required protection of the victim of the alleged abuse. Petitioner's evidence does show that Petitioner discharged Resident 29 to another facility on January 24, 2006. P. Ex. 72, at 6-7; P. Brief at 24. I note that arranging the discharge of an abuser is one of the accepted means of protecting the resident allegedly abused under Petitioner's policy. According, to Petitioner's Nurse's Notes, the process for discharge began at 9:30 a.m. on January 23, 2006. P. Ex. 72, at 6. According to the SOD, Resident 31 told the surveyor that Resident 29 assaulted her in her room about 10:30 p.m. on January 13, 2006, and that she reported the incident to the nurse on duty that night. CMS Ex. 41, at 4. Petitioner does not deny this assertion of fact. However, I can find no Nurse's Notes entry on January 13 or 14, 2006, in the records of Resident 31 or Resident 29, that records the allegation by Resident 31. CMS Ex. 38; CMS Ex. 46; CMS Ex. 74; P. Ex. 52; P. Ex. 72, at 2-7. On January 23, 2006, at about 1:10 p.m. the surveyor observed Resident 31 telling the DON and Assistant DON that she had been touched on the breast and vagina by Resident 29. CMS Ex. 41, at 5. If Resident 31 reported an assault on January 13, then Petitioner's initiation of discharge of Resident 29 on January 23, 2005, was not immediate. However, if the first notice to Petitioner of an assault by Resident 29 upon Resident 31 was the report observed by the surveyor on January 23, then I find that the discharge process was initiated immediately within the meaning of Petitioner's policy. However, Petitioner does not discuss what steps were

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[13] The pages of the exhibit are not numbered in the correct sequence and are not in the correct order.

[14] The touching described by Resident 31, if unwanted, could be characterized as either physical or sexual abuse under Petitioner's policy. CMS Ex. 47, at 5, 7.

taken to protect Resident 31 from Resident 29 after the allegation of the abuse and the time of Resident 29's discharge, whether that was 24 hours or more than 10 days later. Petitioner has offered no evidence that it moved Resident 31 to another room or unit, that it provided one-on-one supervision for Resident 29 or one-on-one monitoring for Resident 31, the two interventions required by its policy. Petitioner has also offered no evidence that it initiated any crisis behavior management interventions for Resident 31 as required by its policy for the victim of abuse.

Petitioner argues that Resident 31 was bipolar and suffered from paranoia, delusions, hallucinations, and claustrophobia associated with her bipolar disorder. Petitioner alleges that Resident 31 also had behavioral issues. P. Brief at 24. Petitioner does not explain how these facts might excuse its failure to implement its abuse policy or establish that it was complying with 42 C.F.R. § 483.13(c). Petitioner also does not argue and has offered me no evidence that Petitioner found after investigation that Resident 31's allegations were false.

I conclude that CMS made a prima facie showing that Petitioner failed to implement the policy required by 42 C.F.R. § 483.13(c). Petitioner has not shown that it implemented its policy or had an acceptable defense for failing to do so in this case. The observations of Surveyor Vanoss of a tearful and distressed Resident 31 (CMS Ex. 41, at 5-6; CMS Ex. 55, at 26) are not disputed or rebutted by Petitioner. I conclude that the unrebutted evidence shows that Resident 31 suffered actual harm as alleged by the surveyors. CMS Ex. 41, at 3.

5. Petitioner violated 42 C.F.R. § 483.15(g)(1) (Tag F250, S/S G) as alleged by the January 2006 survey.

The Quality of Life regulation, 42 C.F.R. § 483.15, requires that a facility "care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life." A specific requirement is that a facility "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). The SOM indicates that the intent of the regulation is that a facility must ensure that sufficient and appropriate social services are provided to meet the resident's needs. The Guidance to Surveyors further explains that the regulation requires that facilities aggressively identify the need for medically-related social services and ensure provision of the service by the appropriate professional discipline. "'Medically-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." SOM, App. PP, Guidance to Surveyors, Tag F250.

The allegations of the SOD relate to the situation involving Residents 29 and 31 discussed under Tag F224 above. The surveyor alleged in the SOD that Petitioner violated the regulation by not addressing Resident 29's behavioral symptoms including wandering, physical aggression, and sexual aggression. The surveyor alleged that Petitioner failed to provide support, counseling, or comfort measures to Resident 31 after she reported Resident 29's sexual abuse of her. CMS Ex. 41, at 12; CMS Ex. 55, at 27-32; CMS Brief at 17-19.

Petitioner does not deny that Resident 29 had no follow-up by social services between August 24, 2005 and January 23, 2006. Petitioner does not deny the Resident 29 was in need of medically-related social services. Petitioner asserts that Petitioner's current social worker had been hired two weeks before the survey and Resident 29 was discharged from the facility on January 23, 2006.[15] Petitioner does not explain how its recent hiring of a social worker shows that it was complying with 42 C.F.R. § 483.15(g)(1) or that its noncompliance could be excused.

Petitioner also does not deny that Resident 31 received no medically-related social services or that she was in need of such services. Petitioner notes the recent hiring of a new social worker; that at an unspecified time it set up a Behavior Intervention Committee, but not that the committee was involved in the case of either Resident 29 or 31; and that the DON was working to have Resident 29 discharged. Petitioner does not explain how any of these actions shows that it was complying with 42 C.F.R. § 483.15(g)(1) or that its noncompliance could be excused. Petitioner does not deny the allegation of the SOD (CMS Ex. 41, at 12) or provide any evidence to show that Resident 29 and 31 did not suffer actual harm as a result of Petitioner's failure to deliver medically related social services.

6. Petitioner violated 42 C.F.R. § 483.25 (Tag F309, S/S G) as alleged by the January 2006 survey.

The general Quality of Care regulation requires that each resident receive, and the participating facility must provide, the necessary care and services to attain or maintain a resident's highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. 42 C.F.R. § 483.25.

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[15] Petitioner's records show that it discharged Resident 29 to another facility on January 24, 2006. P. Ex. 72, at 6-7.

The surveyor alleged in the SOD, based upon a review of a closed clinical record, that Petitioner violated the regulation because Petitioner failed to assess that Resident 30 had a possible fractured hip and that Petitioner failed to treat the resident's pain, despite the resident's complaint of pain with movement. CMS Ex. 41, at 17. Specifically, the surveyor alleged that Resident 30's MDS showed he had a history of falls and a recent fractured wrist. The surveyor cited a Nurse's Notes entry dated December 3, 2005, that showed the resident refused to bear weight on transfer but the surveyor found no record that there was any follow-up or investigation to determine why he would not stand. The surveyor cites an Occupational Therapy Plan of Care dated December 7, 2005, that shows Resident 30 complained of pain in his right thigh during his evaluation. The surveyor also cites a December 9, 2005 Nurse's Notes entry that shows that on December 8, 2005, the physical therapist saw Resident 30 who complained of pain in his right leg, which she observed was swollen. The physical therapist reported her observation to the DON who documented in the Nurse's Notes entry that the resident's right upper leg was swollen and slightly warm to the touch, that there was bruising on the inner and outer thigh, and that the resident complained of pain with movement. A Nurse's Notes entry dated December 8, 2005, indicated that Resident 3's right foot was rotated outward as he laid in bed and she contacted the physician who ordered an x-ray which showed that the resident had an intertrochanteric fracture of the femur at the hip. The surveyor could find no record that Resident 30 had been given any pain medication. CMS Ex. 41, at 17-20.

My review of the clinical records for Resident 30 introduced by CMS reveals that December 5, 2005, was the assessment reference date or the last day of the MDS observation period for the MDS reviewed by the surveyor. CMS Ex. 48, at 2. The MDS reports no complaints of pain or evidence of pain, in addition to the other findings noted by the surveyor. CMS Ex. 48, at 5. A Nurse's Notes entry dated December 2, 2005, indicates that the resident required a two-person assist with transfers, but he was able to bear weight with his lower extremities to pivot for transfers, and that he voiced no complaints. An entry on December 3, 2005, at 1:00 p.m. shows the resident refused to bear weight on transfers, bent his legs to prevent weight-bearing, and verbalized he did not want to stand. Nurse's Notes entries for December 4 through 7, 2005, show that the resident was transferred with no complaints of pain and no indication that he was not bearing weight. A Nurse's Notes entry dated December 8, 2005, at 10:10 a.m. shows that the CNA and DON were present and observed that Resident 30's right thigh was swollen and bruised and he complained of pain with movement. It was also noted that his right foot was rotated out when he was lying in bed. The physician was notified who ordered that Resident 30's right hip be x-rayed. Four staff members put the resident in a Geri chair and took him for an x-ray. An entry at 11:16 a.m. on December 8, 2005, shows that the doctor called and advised that the resident had a hip fracture and directed that he be sent to the hospital by ambulance. The Nurse's Notes entry on December 9, 2005, at 11:00 a.m. was made by the DON who noted it was a late entry for December 8, 2005.

The note indicates that on December 8, 2005 she was advised by physical therapy that their evaluation would not be completed due to swelling of Resident 30's right thigh. The physical therapist also advised the DON that Resident 30 complained of pain in his right leg during evaluation on December 7, 2005. The note indicates that the report from physical therapy caused the DON to check the resident on December 8, 2005, and she observed swelling and warmth in the right upper leg, bruising to both the inner and outer aspect of the right thigh, and pain with movement. She noted that the right thigh measured five inches larger than the left and that there was an old bruise on the right hip. CMS Ex. 49, at 1-3. Physical therapy and occupational therapy notes are consistent with the Nurse's Notes. P. Ex. 73, at 9-10.

Petitioner argues that the physician ordered on December 8 that the resident be taken across the parking lot to the hospital for an x-ray and then returned to Petitioner pending the x-ray results. P. Brief at 26; P. Ex. 73, at 7-8. Petitioner argues that Nurse's Notes for December 4 through 5 show that Resident 30 was comfortable and in no acute distress. Petitioner argues that Resident 30 was discharged on December 16, 2005, to a hospital and then to another facility. P. Brief at 26. Petitioner's Nurse's Notes show that at 3:10 p.m. on December 16, 2005, Resident 30 was found sitting on the floor in his room by the bed, his right leg was bent slightly backward, he complained of pain but the author of the Nurse's Notes entry reported that he was in no acute distress. The physician was contacted and ordered that the resident be sent to the hospital. Resident 30 was transported to the hospital and a note dated December 17, 2005, shows he was being moved to another facility upon release from the hospital. CMS Ex. 49, at 7.

Petitioner does not deny that on December 3, 2005, when Resident 30 refused to stand to assist with a transfer as he was reportedly able to do on December 2, 2005, there is no evidence of any assessment of the resident to determine why he refused to stand. Petitioner also does not deny that when Resident 30 complained of pain on December 8, 2005, there is no indication in the Nurse's Notes and no other evidence that the resident was given any pain medication. Based upon the evidence, I find that Petitioner failed to deliver necessary care and services to Resident 30. Petitioner has presented no evidence or argument to show that it did deliver necessary care and services. Although the physician may have ordered that the x-rays on December 8 be done at a location across the parking lot from Petitioner, the evidence does not show that the doctor orders recommended or suggested strapping Resident 30 in a Geri chair and rolling him across the parking lot. Petitioner presents no evidence and offers no explanation for why Resident 30 was not assessed on December 3 when he refused to stand or why he was not offered pain medication when he complained of pain.

I conclude that Petitioner violated 42 C.F.R. § 483.25 and that Resident 30's complaints of pain are sufficient evidence of actual harm.

7. Petitioner violated 42 C.F.R. § 483.25(f)(1) (Tag F319, S/S G) as alleged by the January 2006 survey.

A facility is required, as part of its obligation to provide quality care, to ensure that a resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem. 42 C.F.R. § 483.25(f)(1). The SOM indicates that the intent of the regulation is to ensure that the resident receives care and services to assist him or her to reach and maintain the highest level of mental and psychosocial functioning. "'Mental and psychosocial adjustment difficulties' refer to problems residents have in adapting to changes in life's circumstances." "Mental" refers to the resident's internal thought process while "psychosocial" refers to external manifestations. SOM, Guidance to Surveyors, App. PP, Tag F319.

The surveyor alleged in the SOD that Petitioner failed to implement intervention strategies to treat behavioral symptoms of wandering, and physical and sexual aggression of Resident 29, the same Resident 29 discussed under Tags F224 and F250 above. CMS Ex. 41, at 21. The gist of the surveyor's allegations is that Resident 29 was moved to a new room and unit on December 30, 2005, after Petitioner decided to close the unit where Resident 29 resided to permit construction of offices in the area occupied by that unit. The old unit was separated from the rest of the facility by doors that were closed and had alarms and the old unit had a separate dining room and sitting area. The surveyor alleged that after the move, Resident 29's behavioral symptoms increased, with only two behavioral incidents between December 3 and 29, 2005 on the old unit, compared to 16 behavioral incidents on the new unit between December 30, 2005 and January 23, 2006. The surveyor alleged that Resident 29's Behavior Management Plan of Care dated January 18, 2006, did not address her difficulty adjusting to the new unit and her night-time wandering and inappropriate sexual behaviors. CMS Ex. 41, at 22-29; CMS Ex. 55, at 32-40. The surveyor indicated that the DON advised him that Resident 29's physician had ordered that she be given Ambien, a sleeping pill, beginning January 10, 2006 to try to get her to sleep. CMS Ex. 41, at 26; CMS Ex. 55, at 37. The surveyor also alleged that Petitioner failed to provide medically-related social services to Resident 31 following the alleged sexual abuse by Resident 29 discussed under Tag F224 and to Resident 34 after she was struck by Resident 29.

Resident 29's behaviors, including her attempts to return to her old unit and her wandering and aggression, are reflected in Nurse's Notes entries from December 31, 2005 through January 24, 2006. P. Ex. 72, at 2-7. Nurse's Notes reflect the new order for Ambien, 10 mg was received on January 10, 2006, when Resident 29 was visited by her

physician. P. Ex. 72, at 4, 12. Resident 29's care plan dated December 22, 2005, indicates that she was assessed as being agitated and aggressive, combative with staff and residents, and refused activities of daily living. The care plan goal was to reduce or eliminate the behaviors and 15 interventions were listed. CMS Ex. 46, at 17-18. Resident 29's Behavior Management Plan of Care dated January 18, 2006, noted Resident 29's assessment remained that she had agitation and aggression and was "combative/verbal" toward staff and residents and resisted care. The interventions listed were similar to those on the December 22, 2005, care plan. CMS Ex. 46, at 25; P. Ex. 72, at 22. Surveyor Vanoss was correct that there was no mention of night-time wandering or sexual aggression on the January 18 care plan. A Care Plan Meeting note dated January 20, 2006, states that Resident 29 wanders the hall, does not sleep, and sleeps on the couch in the living room rather than her room and directs that she be referred to social work. P. Ex. 72, at 20. Resident 29 received a psychosocial assessment, but not until January 23, 2006, the day before discharge. P. Ex. 72, at 13; CMS Ex. 46, at 5-8. The social worker agreed with the DON that Resident 29 needed to be transferred to a different facility. CMS Ex. 46, at 4.

Petitioner does not deny that Resident 29 displayed mental or psychosocial adjustment difficulty as alleged by the surveyor after she was moved from her old unit and room on December 30, 2005. Petitioner also does not identify what treatment and services, other than Ambien, were provided to Resident 29 to correct the problem of her increased bad behaviors. Rather, Petitioner argues that the problem was resolved by discharging Resident 29 to another facility on January 23, 2006.[16] P. Brief at 26. Petitioner has given me no evidence that, other than Ambien, Resident 29 received treatment or services to address her mental or psychosocial difficulty adjusting to the move from her old unit to the new unit. The evidence shows that Resident 29 received a psychosocial assessment, but not until January 23, 2006, the day before discharge. P. Ex. 72, at 13. A social work progress note indicates that the social worker agreed that Resident 29 needed to be transferred to a different facility and included no other plan. CMS Ex. 46, at 4. The undisputed research of the surveyor, comparing the period before and after the move, shows a significant increase in wandering, assaultive and sexual behavior after the move. The evidence developed by the surveyor is persuasive as to his conclusion that the increased negative behavior was related to the move. Comparison of the behavior care plans for Resident 29 before and after the move show that Resident 29 was not properly

[16] The regulation actually requires that a resident receive appropriate treatment and services to correct an assessed problem and in this case the evidence shows that the problem was likely never adequately assessed based on my comparison of Resident 29's two care plans. However, the surveyor did not separately charge Petitioner with failure to assess Resident 29, so I do not further consider that possible charge.

assessed, and treatment and services were not provided by Petitioner to address Resident 29's adjustment difficulty, mental and psychosocial. I conclude Petitioner violated 42 C.F.R. § 483.25(f)(1).

The surveyor also alleged that Petitioner failed to deliver treatment and services to Resident 31 who was the victim of alleged assault by Resident 29 discussed under Tags F224 and F250 above. Petitioner alleges that after Resident 29 was discharged from the facility, Resident 31 was interviewed and a social worker was scheduled to evaluate the resident for any emotional or psychological problems. P. Brief at 26. A Nurse's Notes entry from January 26, 2006, at 10:00 a.m., indicates that Resident 31 shoved another resident, the DON was notified, and a social services referral was made. P. Ex. 74, at 3. I find no similar note indicating that Resident 31 was referred to social work due to the incident with Resident 29 on January 23, 2006. In fact, there is no mention of the incident with Resident 29 in the Nurse's Notes for Resident 31 introduced as evidence by Petitioner, and there are no Nurse's Notes entries for the period January 18 through 25, 2006. P. Ex. 74, at 3. Furthermore, the referral to social work is only the first step in the process of accessing a resident, planning care, and implementing care by the delivery of needed treatment or service. Petitioner has presented no evidence that the social work assessment occurred, whether Resident 31 was assessed as in need of treatment or services due to the incident with Resident 29, or whether any treatment or services were delivered. I conclude that Petitioner violated 42 C.F.R. § 483.25(f)(1).

The surveyor alleged that actual harm was suffered by Petitioner's residents as a result of this regulatory violation by Petitioner (CMS Ex. 41, at 12) but does not specify whether actual harm was suffered by all three residents involved. I find it unnecessary to inquire further in this regard. The observations of Surveyor Vanoss of a tearful and distressed Resident 31 (CMS Ex. 41, at 5-6; CMS Ex. 55, at 26) are not disputed or rebutted by Petitioner. I conclude that the unrebutted evidence shows that Resident 31 suffered actual harm as alleged by the surveyor. CMS Ex. 41, at 3. Accordingly, Petitioner was not in substantial compliance with participation requirements as alleged.

8. A CMP of $400 per day for the period August 5, 2005 through February 1, 2006, and DPNA from October 19, 2005 through February 1, 2006, are reasonable.

CMS notified Petitioner by letter dated March 15, 2006, that a revisit survey found Petitioner returned to substantial compliance effective February 2, 2006. CMS Ex. 1. Petitioner does not specifically argue, and the evidence does not show, that Petitioner returned to substantial compliance at an earlier date. In fact, Petitioner's alleged completion date for its plan of correction was February 2, 2006, for the deficiencies cited by the survey that ended January 25, 2006. CMS also advised Petitioner by its March 15

letter that the CMP was reduced from $600 per day to $400 per day for the period August 5, 2005 through February 1, 2006[17]; the DPNA was in effect from October 19, 2005 through February 1, 2006; and the termination action was rescinded. CMS Ex. 1.

If a facility is not in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, including a DPNA and a CMP. CMS may impose a CMP for the number of days that the facility is not in substantial compliance or for each instance that a facility is not in substantial compliance. 42 C.F.R. § 488.430(a). There are two ranges for per day CMPs. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, from $3050 per day to $10,000 per day, is reserved for deficiencies that constitute 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). The upper range may not be used in this case. 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). The $400 per day CMP in this case is at the low end of the lower range.

In determining whether the amount of the CMP is reasonable, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of noncompliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404; and (4) the facility's degree of culpability.

CMS asserts that $400 per day CMP for the period August 5, 2005 through February 1, 2006 is reasonable based upon the eight deficiencies alleged to have resulted in actual harm. CMS Prehearing Brief at 20-22; CMS Brief at 25-26. CMS does not assert that Petitioner had a history of noncompliance and does not reveal whether the reduction in the CMP from $600 per day to $400 per day may have been based upon consideration of Petitioner's financial circumstances, culpability, or both.

Petitioner argues that, while the regulation requires that I consider a facility's financial condition in determining the reasonableness of the proposed CMP, the regulation gives me no guidance as to how to make the determination. Petitioner does not assert it will be forced out of business or that quality of care will suffer if it is required to pay the $72,400

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[17] The period, which began on August 5, 2005 and ran through February 1, 2006, was 181 days. The reduction of the per day CMP from $600 to $400, resulting in a total CMP of $72,400, rather than $108,600.

CMP. P. Brief at 29-30. Rather, Petitioner asserts that the proposed CMP "is beyond what the facility budget can handle" (P. Brief at 30) and is punitive given the facility's financial status (P. Brief at 30-31).

Petitioner submitted the declaration of Ted Morgan (P. Ex. 87). Mr. Morgan attests that he is the managing member or Provider Healthcare Services LLC, the general partner of Provider Healthcare Services of Concho, LP, the operator of Petitioner. He further attests that he is familiar with the financial circumstances of Petitioner. Mr. Morgan attests that occupancy rates were down through May 2006, which he attributed to a November 2005 decision by Petitioner to close its secured unit and its residents were discharged to other facilities. A result of the discharge of the secured unit residents was a reduction in cash flow during the six months from November 2005 to May 2006. Mr. Morgan also advised me that Petitioner accepted a husband and wife for care at a reduced reimbursement rate at the request of the state, which also negatively impacted cash flow. Mr. Morgan advised that Petitioner uses a revolving line of credit for operating needs. Mr. Morgan attests that a large penalty in a lump sum or by monthly payments would be beyond what the current budget could handle. He also indicates that Petitioner had made an offer and amortized payout proposal, apparently to CMS, that he considered manageable that would have no impact upon resident care or services. P. Ex. 87. The amount he thought manageable was not stated. Petitioner also submitted financial data for my consideration including profit and loss statements from balance sheets for 2005 and 2006, and a cash flow statement for 2006. P. Ex. 86.

I note that Mr. Morgan never asserts in his declaration that Petitioner would have to go out of business if required to pay the proposed CMP of $72,400, or that payment of the CMP would negatively impact quality of care. Rather, Mr. Morgan and counsel for Petitioner both carefully couch their argument in terms of the CMP being beyond what the budget can "handle." I have reviewed the limited financial data provided, focusing significantly on the documents mentioned above. I note that the period covered is only approximately 18 months. Further, Petitioner's restricted cash flow the first six months of 2006 was due to a business decision of Petitioner. Mr. Morgan did not explain whether Petitioner would ultimately seek more residents, but my interpretation of his declaration is that the reduced cash flow was temporary. I conclude that Petitioner has not established that requiring it to pay the $72,400 CMP would cause it to close or negatively impact resident care. Petitioner proposes in its brief a per day CMP of $50 to $100 per day. P. Brief at 33. Considering Petitioner's financial condition, I do not consider such a low CMP to be adequate to encourage Petitioner to continue to maintain compliance with program participation requirements. I also do not find the $72,400 CMP to be punitive. *See Batavia Nursing and Convalescent Inn*, DAB No. 1911, n.25; *Fairfax Nursing Home, Inc.*, DAB No. 1794, at 18 (2001), *aff'd*, 300 F.3d 835 (7th Cir. 2002); *Regency Gardens Nursing Center*, DAB No. 1858, at 11 (2002).

Petitioner's regulatory violations caused actual harm. 42 C.F.R. § 488.404(b). The deficiencies were not isolated incidents as Petitioner argues, but occurred over a period of more than six months and affected the quality of life and quality of care of multiple residents. I find that Petitioner was culpable with regard to all the deficiencies discussed in this decision. "Culpability" is defined at 42 C.F.R. § 488.438(f)(4) to include "but is not limited to neglect, indifference or disregard for resident care, comfort or safety."

I also conclude that the state agency was required to prohibit Petitioner from conducting 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.

Based on the arguments and evidence presented by the parties, I have considered what would be a reasonable CMP in this matter. I base my decision on the factors delineated at 42 C.F.R. §§ 488.438(f) and 488.404 (incorporated by reference at 42 C.F.R. § 488.438(f)(3)). I have also considered that CMS reduced the CMP from $600 per day to $400 per day. I conclude that a CMP of $400 per day for the 181-day period from August 5, 2005 through February 1, 2006, totaling $72,400, is reasonable. I have no grounds to disturb the DPNA or withdrawal of Petitioner's authority to conduct a NATCEP.

III. Conclusion

For the reasons discussed above, I conclude that Petitioner was not in substantial compliance with program participation requirements from August 5, 2005 through February 1, 2006. I also conclude that a CMP of $400 per day for 181 days, totaling $72,400, is reasonable and there was a basis for a DPNA effective from October 19, 2005 through February 1, 2006. The state was required withdraw approval of Petitioner's NATCEP for a period of two years, from August 5, 2005 through August 4, 2007.

/s/
Keith W. Sickendick
Administrative Law Judge