Department of Health and Human Service

**DEPARTMENTAL APPEALS BOARD**

Civil Remedies Division

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| In the Case of: | ) | Date: September 02, 2009 |
| Community Care Center of Baker (CCN: 19-5571), | ) | Docket No. C-07-624 |
| | ) | Decision No. CR1999 |
| v. | ) | |
| Centers for Medicare & Medicaid Services. | ) | |

## DECISION

Petitioner, Community Care Center of Baker, was not in substantial compliance with program participation requirements due to violations of 42 C.F.R. §§ 483.25(h)(1), 483.25(h)(2), and 483.75,[1] from January 15 through May 31, 2007. Per instance civil money penalties (PICMPs) of $3500, $3500, and $3000 for the respective violations are reasonable.

## I. Background

Petitioner, located in Baker, Louisiana, is authorized to participate in Medicare as a skilled nursing facility (SNF) and in the Medicaid program as a nursing facility (NF). Petitioner was subject to a survey by the Louisiana Department of Health and Hospitals (the state agency) completed on May 3, 2007. The Centers for Medicare & Medicaid Services (CMS) notified Petitioner by letter dated May 31, 2007, that based upon the deficiencies found by the survey of May 3, 2007, CMS was imposing a PICMP of $10,000 ($3500 for the alleged violation of 42 C.F.R. § 483.25(h)(1), $3500 for the alleged violation of 42 C.F.R. § 483.25(h)(2), and $3000 for the alleged violation of 42 C.F.R. § 483.75); a denial of payment for new admissions (DPNA) beginning on June 15,

[1] References are to the version of the Code of Federal Regulations in effect at the time of the survey, unless otherwise indicated.

2007, and continuing until Petitioner returned to substantial compliance; and termination of Petitioner's provider agreement on November 3, 2007, if Petitioner did not return to substantial compliance before that date. CMS advised Petitioner by letter dated August 14, 2007, that Petitioner had returned to substantial compliance on an unspecified date and that the DPNA and termination remedies were rescinded. CMS Exhibit (CMS Ex.) 1; Petitioner Exhibit (P. Ex.) 1.

Petitioner requested a hearing by letter dated July 27, 2007. The request for hearing was docketed as C-07-624 and assigned to me for hearing and decision on August 6, 2007. A Notice of Case Assignment and Prehearing Case Development Order (Prehearing Order) was issued at my direction on August 6, 2007.

A hearing was convened in New Orleans, Louisiana, on February 26 and 27, 2008. CMS offered and I admitted CMS Exs. 1 through 9. Petitioner offered P. Exs. 1 through 15. I admitted P. Exs. 1, 3 through 9, 12, and 14. Petitioner withdrew P. Ex. 10. CMS presented the testimony of surveyors Barbara Van Lieu, R.N. (Transcript (Tr.) 76-159), and Sandra Brown, R.N. (Tr. 160-235). Petitioner called as witnesses, Joyce Elaine Brown, R.N., Petitioner's Director of Nursing (DON) (Tr. 236-96), Joann Brew, L.P.N. (Tr. 296-351), and Claudia Thompson, C.N.A. (Tr. 360-411). The parties filed post-hearing briefs (CMS Br. and P. Br., respectively) and post-hearing reply briefs (CMS Reply and P. Reply, respectively).

## II. Discussion

### A. Issues

The issues in this case are:

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

### B. Applicable Law

The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 (SNF) and 1919 (NF) of the Social Security Act (Act) and at 42 C.F.R. Part 483. Section 1819(h)(2) of the Act vests the Secretary of Health and Human Services (Secretary) with authority to impose enforcement remedies against a SNF for failure to comply substantially with the federal participation requirements

established by sections 1819(b), (c), and (d) of the Act.[2] Pursuant to 1819(h)(2)(C), the Secretary may continue Medicare payments to a SNF not longer than six months after the date the facility is first found not in compliance with participation requirements. Pursuant to 1819(h)(2)(D), if a SNF does not return to compliance with participation requirements within three months, the Secretary must deny payments for all individuals admitted to the facility after that date – commonly referred to as the mandatory or statutory DPNA. In addition to the authority to terminate a noncompliant SNF's participation in Medicare, the Act grants the Secretary authority to impose other enforcement remedies, including a discretionary DPNA, civil money penalties (CMPs), appointment of temporary management, and other remedies such as a directed plan of correction. Act § 1819(h)(2)(B).

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

The regulations specify that CMS may impose a CMP for each day a facility is not in substantial compliance or for each instance of noncompliance. The regulation provides that a CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, $3050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). Pursuant to 42 C.F.R. § 488.301, "*[i]mmediate jeopardy* means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." (Emphasis in original.) The lower range of CMP, $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

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

causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). CMS is authorized to impose PICMP from $1000 to $10,000, whether or not immediate jeopardy is identified. 42 C.F.R. § 488.438(a)(2).

The Act and regulations make a hearing before an administrative law judge (ALJ) available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act § 1128A(c)(2); 1866(h); 42 C.F.R. §§ 488.408(g); 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *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 Pavilion*, 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 the facility's authority to conduct a nurse aide training and competency evaluation program. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i). The CMS determination as to the level of noncompliance "must be upheld unless it is clearly erroneous" (42 C.F.R. § 498.60(c)(2)), including the finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9, 38 (2000), *aff'd*, *Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See e.g., Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Review of a CMP by an ALJ is subject to 42 C.F.R. § 488.438(e).

The standard of proof or quantum of evidence required is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a prima facie showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *See Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd, Hillman Rehabilitation Ctr. v. United States Dep't of Health and Human Services, Health Care Fin. Admin.*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999); *Cross Creek Health Care Center*, DAB No. 1665 (1998); *Emerald Oaks*, DAB No. 1800; *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x 181 (6th Cir. 2005); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004).

## C. Analysis

My conclusions of law are set forth in bold followed by a statement of the pertinent facts and my analysis.

### 1. Petitioner timely requested a hearing and I have jurisdiction.

There is no dispute that Petitioner timely requested a hearing. Petitioner requested a hearing as to all deficiencies cited by the survey that ended on May 3, 2007, including alleged violations of 42 C.F.R. §§ 483.20(b), 483.20(d), and 483.20(k). However, CMS imposed no enforcement remedies based upon those alleged violations and they are not before me for hearing and decision. Tr. 19-22; 42 C.F.R. § 498.3(b)(13).

CMS presented no evidence related to the revisit survey or the findings of that survey except that in CMS Ex. 1, at 4 and 5, the CMS notice dated August 14, 2007. The August 14 notice advised Petitioner that a revisit survey found Petitioner back in substantial compliance and that CMS had rescinded the proposed remedies of termination and the DPNA. The August 14, 2007 notice did not specify a date on which CMS found Petitioner in substantial compliance or, even, the date on which the revisit survey was conducted. The date Petitioner was found to have returned to substantial compliance was likely prior to June 15, 2007, the date on which the DPNA was to begin, as that remedy was never effectuated. Petitioner alleged in its plan of correction that it achieved substantial compliance as of May 31, 2007, and there is no conflicting evidence. CMS Ex. 2. I conclude that Petitioner returned to substantial compliance with program participation requirements not later than May 31, 2007. I note, however, that the PICMPs proposed by CMS are unaffected by the specific date on which Petitioner actually returned to substantial compliance.

### 2. Petitioner violated 42 C.F.R. § 483.25(h)(1) and (2) by failing, after April 30, 2007, to ensure that the resident environment was as free of accident hazards as possible and by failing to provide adequate supervision and assistance devices to prevent accidents with regard to resident smoking.

#### a. Facts

Petitioner's Lighthouse Unit (located on Hall 200 in the facility) is a locked psychiatric unit that houses 24 residents who are cognitively impaired, with diagnoses such as dementia or other acute mental disorders, who display poor safety awareness, who are difficult to manage, aggressive, and who are noncompliant with facility rules. Tr. 79-80, 239-40; P. Ex. 4.

Petitioner had a smoking policy that applied to the Lighthouse Unit. Petitioner's smoking policy and regulations state that smoking is a personal matter. However, the policy also states that smoking is a source of possible fires. Therefore, Petitioner developed policies and regulations to ensure the safety of its residents, employees and visitors by: prohibiting residents from smoking in their rooms; prohibiting cigarette lighters and matches in resident rooms; requiring that resident cigarette lighters and matches be kept at the nurses' station; limiting facility personnel to providing matches and lighting cigarettes only in designated areas set aside for smoking; prohibiting visitors from smoking in the facility; and designating specific areas as smoking areas, including the outside patio of the Lighthouse Unit. CMS Ex. 9, at 31.

The surveyors cite examples related to Residents 1 and 2 as the basis for citing violations for 42 C.F.R. § 483.25(h)(1) (Tag F323) and (2) (Tag F324). However, the facts related to Resident 2 are sufficient to establish the violations. CMS Ex. 2, at 9, 17.

Resident 2 was originally admitted to Petitioner's facility on January 13, 2003. P. Ex. 6, at 1; CMS Ex. 2, at 9. Resident 2's diagnoses included schizophrenia, psychogenic disorder, paranoia, obsessive compulsive disorder, depression, and bipolar disorder. P. Ex. 6, at 1; CMS Exs. 2, at 9; 8, at 1, 6, 20. Resident 2 resided on the Lighthouse Unit because his paranoid schizophrenia caused him to be easily agitated throughout the day, to worry about cigarettes, to be verbally abusive, and to engage in socially inappropriate and disruptive behavior. CMS Ex. 8, at 20. On January 13, 2003, the day of his admission to the facility, and on January 13, 2005, Resident 2 signed documents agreeing that he understood the facility's smoking policies and regulations.[3] CMS Ex. 8, at 11, 34; P. Ex. 6, at 11, 34.

On January 13, 2005, staff completed a resident risk factor for smoking safety form for Resident 2 that indicated that: Resident 2 was a regular smoker; he was not at risk of dropping cigarettes; he had not smoked in an inappropriate place for the last 30 days; he was redirected easily; he did not need supervision to smoke; he had a high cognitive level; he smoked a pack a day; and he was a low risk. P. Ex. 6, at 10; CMS Ex. 8, at 10. This is the only assessment in evidence.

Resident 2's care plan dated May 15, 2006 (updated to reflect goal and target dates of December 15, 2006, March 13, 2007, and May 8, 2007), states that Resident 2 is a chronic smoker unable to manage cigarettes appropriately to last throughout the month. The care plan establishes a goal that the resident will have a sufficient number of

[3] The only substantive difference between the policy that Petitioner signed in 2003 and the form he signed in 2005, is that the former prohibits visitors from smoking "in the facility" and the latter states that visitors cannot smoke in a resident's room but allows visitor smoking in designated areas. CMS Ex. 8, at 11, 34; P. Ex. 6, at 11, 34.

cigarettes to last throughout the month. The approach listed is that Resident 2 will be given all cigarettes every morning to last throughout the day and will be encouraged to smoke cigarettes in longer intervals, which I construe to be longer intervals between cigarettes consistent with the stated goal. CMS Ex. 8, at 12; P. Ex. 6, at 12. Resident 2's care plan also reflected that he was delusional and depressed and was concerned about not having enough cigarettes, and that he believed if he had more cigarettes he could write music and not sleep as much. CMS Ex. 8, at 19; P. Ex. 6, at 19.

The Oak Haven Unit, also located in Petitioner's facility in the hall adjacent to the Lighthouse Unit, was a partial-day psychiatric care unit that provided outpatient psychotherapy treatment to patients, including certain Lighthouse Unit residents. P. Ex. 4; P. Ex. 9, at 2. Resident 2 attended the Oak Haven partial-day program. CMS Ex. 8, at 18; P. Ex. 6, at 18. At Oak Haven, Lighthouse Unit residents, such as Resident 2, had contact with other patients who did not reside on the Lighthouse Unit and their smoking materials. P. Ex. 9, at 2.

The first incident involving Resident 2 occurred on January 15, 2007. Prior to January 15, 2007, Lighthouse Unit residents were issued two cigarettes at a time, every two hours to smoke in the outdoor smoking area. Staff would light residents' cigarettes and watch them smoke the cigarettes entirely before allowing them to return to the Lighthouse Unit. Petitioner's smoking policy was posted at the nurses' station and on the door leading to the Lighthouse Unit. Petitioner's staff randomly searched suspected residents returning from Oak Haven or pass by patting down their jackets and pants pockets. Tr. 246-50, 300. Prior to January 15, 2007, Petitioner's nurses would document in nurses' notes problems relating to smoking. P. Ex. 14, at 1; Tr. 267, 365.

On January 15, 2007, at about 8:00 a.m., a smoke detector sounded and Resident 2 was observed standing in his bathroom with a sheet or clothes ablaze on the floor and flames shooting up. L.P.N. Brew extinguished the fire. CMS Ex. 8, at 8, 21, 24; P. Ex. 6, at 8, 21, 24; Tr. 301. Due to the smoke, residents of the Lighthouse Unit were evacuated. Tr. 301. Soon after the fire, Resident 2 was allowed to go to Oak Haven. Tr. 301-02. Later on January 15, 2007, at 1:30 p.m., a smoke detector sounded and Resident 2 was observed smoking in his room. Nurses confiscated a lighter. CMS Ex. 8, at 8, 21; P. Ex. 6, at 8, 21; Tr. 301. L.P.N. Brew completed an incident report regarding the incidents of January 15, 2007, which DON Brown and Administrator Jason Lambert signed on January 16, 2007. CMS Ex. 8, at 21; P. Ex. 12; Tr. 251-56.[4] L.P.N. Brew notified Resident 2's treating psychiatrist at Oak Haven, Dr. Robert Blanche, about the fires, and

[4] Although CMS alleged that DON Brown and Administrator Lambert did not see the report because the copy given to the surveyors was not signed, I accept the facility's explanation that the signed copy was stored elsewhere and that the DON and the Administrator signed the incident report on January 16, 2007. Tr. 253-57.

Dr. Blanche issued a physician emergency certificate (PEC) the same day that resulted in Resident 2's admission to a behavioral or psychiatric hospital for approximately two weeks. Resident 2 returned to Petitioner's facility on January 29, 2007. Tr. 302; P. Ex. 6, at 8, 24; CMS Ex. 8, at 8, 24. Petitioner's care plan does not reflect any revision due to the January 15, 2007 incidents. CMS Ex. 8, at 12-20; P. Ex. 6, at 12-20; P. Ex. 9, at 3; P. Ex. 10, at 2; Tr. 83, 142, 166-67, 295.

The evidence does not show that the incidents on January 15, 2007, were addressed by Petitioner's quality assurance committee as was done after the April 30, 2007 fire. Tr. 277; CMS Ex. 8, at 22; P. Ex. 6, at 22. DON Brown testified that Petitioner took the following actions after the January 15, 2007 fire: a second smoke detector was placed in Resident 2's room near his bed; staff continued to issue cigarettes but a resident had to smoke the first before being issued a second; staff inquired more of residents returning from Oak Haven; staff did a pat search of all residents returning from Oak Haven; staff randomly searched rooms of those suspected of possessing smoking materials;[5] staff limited family visits to stop smoking materials being passed to residents; and staff monitored high risk individuals more closely. Tr. 258-60. L.P.N. Brew testified that Petitioner: installed smoke detectors in every room; staff started issuing one cigarette at a time which the resident had to smoke before being issued another; staff daily questioned and searched residents returning from Oak Haven; placed a sign on the door leading into the Lighthouse Unit that said no cigarettes or lighters beyond that point; and signs were placed inside the door of the Lighthouse Unit and at the nurses' station. L.P.N. Brew testified that she asked Administrator Lambert to talk to Oak Haven staff because the Lighthouse Unit residents were bringing smoking materials into the Lighthouse Unit after being at Oak Haven and she talked to Oak Haven staff herself about the issue. L.P.N. Brew testified that the procedures she described were not written down. Tr. 302-11; P. Ex. 8, at 2-3. C.N.A. Thompson testified that staff: stopped residents returning from pass and Oak Haven and patted their pockets; asked Lighthouse Unit residents at breakfast who had cigarettes and patted them down, checked under hats and in coat pockets, pulled out coat pockets, and felt socks to see if a resident had smoking materials; handed residents only one cigarette at a time and made sure (by watching the residents through a glass door or standing outside with them) that they smoked it outside before coming back into the Lighthouse Unit and patted them as they came inside; stopped

[5] C.N.A. Thompson testified that rooms were searched daily for cigarettes and smoking materials when the rooms were cleaned and that staff would search night stands, closet drawers, and look under mattresses. DON Brown testified that random room searches were conducted when residents were suspected of having smoking materials. However, DON Brown testified that she was not best able to testify how searches were done and that the nurse on the hall, Ms. Brew, would be able to discuss how searches were done or residents questioned. As C.N.A. Thompson worked full-time on the Lighthouse Unit, she also would be more familiar with the activities of that unit. Tr. 259-60, 384.

storing cigarettes on the Lighthouse Unit and left them with the activities coordinator, who brought them to the Lighthouse Unit in the morning; and initiated room searches for smoking materials when resident rooms were cleaned. She testified that the procedures were not written down. Tr. 362-64, 376, 384, 406-07.

After January 15, 2007, if a C.N.A. found (through searches or otherwise) cigarettes or smoking materials, the C.N.A. would bring the discovery to a nurse's attention and it would be documented in the 24-hour nursing report, the jot book (used by C.N.A.s and nurses to communicate between shifts), and/or in nurses' notes. Tr. 311-12, 365; P. Ex. 14, at 5, 8, 10. Nursing staff did not document if they did not find cigarettes or smoking materials following a search. Tr. 267.

The second incident involving Resident 2 occurred on April 30, 2007. On April 28, 2007, Resident 2 returned from being out of the facility on pass with his father. CMS Ex. 8, at 33; P. Ex. 6, at 33. C.N.A. Thompson testified that on April 30, 2007, Resident 2 was observed by C.N.A. Josh Howard on the patio with a pack of matches that C.N.A. Howard confiscated. Resident 2 then went to his room. C.N.A. Howard followed Resident 2 and observed Resident 2 standing in his bathroom. C.N.A. Howard left the room but five minutes later C.N.A. Howard and C.N.A. Thompson smelled something funny, they heard a noise, saw the bathroom door open only a crack, and when they opened the bathroom door they saw a sheet on fire by the sink; C.N.A. Howard put out the fire with water and C.N.A. Thompson reported the fire. Tr. 368-72. Nurses' notes from April 30, 2007, state that Resident 2 set sheets on fire in his room while smoking in bed and that Dr. Blanche and Dr. Dial were notified, as well as Resident 2's father (who stated that he gave Resident 2 a lighter). CMS Ex. 8, at 7; P. Ex. 6, at 7; P. Ex. 11. Facility staff prepared a form titled Continuous Quality Improvement Corrective Action Plan dated April 30, 2007. The document stated that Resident 2 had been smoking in bed; set the sheets on fire; the smoke detector went off; staff was alerted; the fire was extinguished; there were no injuries; an incident report was completed; Dr. Blanche and Dr. Dial were notified and would see the resident; and Resident 2's family was notified. CMS Ex. 8, at 22; P. Ex. 6, at 22. The recommended plan of action on the continuous quality improvement corrective action plan dated April 30, 2007, was that "[a]ll residents returning from pass will be searched before returning to unit, if found with lighter or matches will recommend PEC [physician order for psychiatric hospitalization], family informed not to supply matches or lighters." CMS Ex. 8, at 22; P. Ex. 6, at 22; Tr. 277. After the April 30, 2007 fire, L.P.N. Brew testified that every resident got a pat down after their return from Oak Haven; staff paid closer attention to problem residents; and "Activities" started giving cigarettes to the C.N.A. in the morning and the C.N.A. would keep the cigarettes on her/his person until they were issued to residents one at a time. Tr. 315. Dr. Blanche did not order psychiatric hospitalization for Resident 2 following the fire on April 30, 2007. Tr. 272-73, 282. C.N.A. Thompson testified that after the April 30, 2007 fire, staff searched residents more; watched residents more with cigarettes; emptied residents' pockets and searched them after they finished smoking on the patio, when they returned from pass, and any return to the unit. Tr. 372-73, 383. C.N.A.

Thompson testified that after April 30, 2007, they increased monitoring of Resident 2 by having him sit by the nurses after he returned from the Oak Haven site, and gave him only five to ten minutes alone in his room or bathroom before checking on him. Tr. 373. L.P.N. Brew testified that closer attention was paid to Resident 2 and four or five other residents who had a similar problem. Tr. 316.

The third and final incident involving Resident 2 occurred on May 2, 2007. C.N.A. Thompson testified that in the morning on May 2, she saw Resident 2 on the patio fidgeting with his pockets. When C.N.A. Thompson asked Resident 2 to give her whatever he had in his pockets, Resident 2 threw on the ground a pack of cigarettes of a different brand than that passed out by the facility. Tr. 375-76. C.N.A. Thompson testified that later that day she observed Resident 2 in his room brushing his hair and then going out of and into the room. C.N.A. Thompson testified that she searched the room and found in the closet a butted cigarette that had been smoked. She gave the cigarette butt to L.P.N. Brew. Tr. 316, 376-77. Shortly thereafter, the smoke detector in Resident 2's room alarmed. L.P.N. Brew and C.N.A. Thompson smelled cigarette smoke and searched Resident 2's room, but found nothing. They called the maintenance supervisor to help search, but still found nothing. CMS Ex. 6, at 5; CMS Ex. 8, at 9; P. Ex. 6, at 9; Tr. 316-17; 322-23; 377-78. Approximately five to ten minutes after the search, the smoke detector alarmed again. C.N.A. Thompson and L.P.N. Brew had to push Resident 2's bed away from the door, and when they entered the room they saw flames in one closet. Tr. 316-23, 379-82; CMS Ex. 8, at 9, 23; CMS Ex. 6, at 5; P. Ex. 6, at 9, 23; P. Ex. 13. The fire was extinguished, the fire department was called, and the Lighthouse Unit and facility were safely evacuated. CMS Ex. 6.

On May 2, 2007, Resident 2 was discharged to a psychiatric hospital by order of his treating physician. Tr. 327; CMS Ex. 8, at 9, 23; CMS Ex. 2, at 1; P. Ex. 6, at 9, 23; P. Ex. 13.

b. Analysis

The general quality of care regulation at 42 C.F.R. § 483.25 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 developed by the resident's care planning team pursuant to 42 C.F.R. § 483.20. The general quality of care regulation includes two specific requirements pertaining to accident hazards and providing supervision and assistance devices to residents to avoid accidents – both are at issue in this case.

A participating facility must ensure that the resident environment remains as free of accident hazards as is possible. 42 C.F.R. § 483.25(h)(1). The Board has provided some guidance for adjudicating alleged violations of the section:

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

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

A participating facility is also required to 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); *Century Care of Crystal Coast*, DAB No. 2076 (2007), *aff'd*, *Century Care of the Crystal Coast*, 281 F. App'x 180 (4th Cir. 2008); *Golden Age Skilled Nursing & 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 (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). CMS Publication 100-07, State Operations Manual (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)(1) because Petitioner failed to "ensure that the resident environment remains as free of accident hazards as is possible by failing to ensure that residents on the locked psychiatric unit did not possess lighters, lit cigarettes or matches. . . ." CMS Ex. 2, at 8-9. The surveyors alleged that immediate jeopardy began on January 15, 2007, when Resident 2 started a fire and that immediate jeopardy was abated on May 2, 2007, when Resident 2 was sent to a psychiatric hospital. The surveyors alleged that, even after Resident 2's transfer, the deficiency continued. CMS Ex. 2, at 9. The surveyors alleged that Petitioner violated 42 C.F.R. § 483.25(h)(2) because Petitioner "failed to increase supervision of residents after dsicovering (sic) the residents with matches, lit cigarettes or lighters in their rooms. . . ." CMS Ex. 2, at 17. The surveyors alleged that the deficiency posed immediate jeopardy beginning on January 15, 2007, and that immediate jeopardy was abated on May 2, 2007 with Resident 2's transfer. The surveyors alleged that, even after Resident 2's transfer, the deficiency continued. CMS Ex. 2, at 17.

CMS alleges that Petitioner did not implement reasonable interventions to minimize accident hazards, specifically with regard to resident smoking, and Petitioner failed to provide adequate supervision to avoid risk of harm to the residents of Petitioner's facility, specifically the Lighthouse Unit. Petitioner argues, generally, that it did all it could reasonably do, given the difficult nature of its resident population and their rights to smoke and for privacy.

Petitioner's interventions following the January 15, 2007 fire include: placing more smoke detectors; having residents smoke a cigarette before being issued a second; querying residents more about smoking materials and pat searching residents coming back from Oak Haven and at breakfast; searching rooms; limiting family visiting; monitoring high risk individuals more closely; placing signs on doors to prevent smoking materials from coming into the Lighthouse Unit; communicating with Oak Haven Unit staff to enlist their aid in preventing smoking materials from being given to Lighthouse Unit residents when they were on the Oak Haven Unit for treatment; and moving cigarettes off the Lighthouse Unit to be kept with the activities director who would hand out the cigarettes.

Petitioner implemented the following interventions following the April 30, 2007 fire: a continuous quality improvement action plan was prepared requiring that all residents returning from pass would be searched before returning to the Lighthouse Unit and, if found with a lighter or matches, a psychiatric hospital admission would be recommended and the family would be advised of this policy and would be informed not to supply

matches or lighters; residents were more thoroughly searched and watched when they smoked; and Resident 2's monitoring was increased by having him sit by the nurses after he returned from Oak Haven and staff was to give him only five or ten minutes alone in his room before checking on him.[6]

CMS notes that, despite the interventions of Petitioner's staff, fires continued to occur, which put residents, staff, and visitors at risk. As Petitioner pointed out at the hearing, however, this is not the end of the inquiry. Rather, it is necessary to consider whether Petitioner's interventions were reasonable and sufficient in light of the known risk of accidents and whether its residents were adequately supervised to prevent accidents.

In fact, there is no question and no real dispute that Resident 2 was the accident hazard at Petitioner's facility. The fact that he was an accident hazard was clearly known to Petitioner as of the January 15, 2007 fire. On that date, a smoke detector sounded and Resident 2 was observed standing in his bathroom with a sheet or clothes ablaze on the floor and flames shooting up. The fire was apparently ignited by Resident 2 in his room with a cigarette or a lighter or matches he secreted to his room. Later the same day it was discovered that he was smoking in his room. Both parties focus primarily in this case on the availability of smoking materials and matches or lighters and Petitioner's efforts to control access to these materials on the Lighthouse Unit in order to prevent the hazards associated with smoking and smoking materials. The evidence does not support a finding that Resident 2 or any other resident in Petitioner's facility, including Resident 1, was a pyromaniac, and the real risk seems to have been Resident 2's careless smoking and his need to hide his smoking materials from Petitioner's staff.

Petitioner's interventions following the January 15, 2007 fire and smoking incident were apparently successful, as no other fire is reported between January 15, 2007 and April 30, 2007. The success of Petitioner's surveillance is demonstrated by the fact that staff continued to find and seize contraband smoking materials, matches, and lighters, including those seized from Resident 1. P. Ex. 14. Although Petitioner's interventions were mostly not documented, there is no requirement that a smoking monitoring policy

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[6] I note there is an inconsistency between the affidavit of Administrator Lambert and the testimony of C.N.A. Thompson and L.P.N. Brew regarding the interventions instituted. Administrator Lambert states only that residents were questioned when coming back from Oak Haven and states that Resident 2 was subjected to a higher level of monitoring and more intensive questioning only upon his return from Oak Haven. Administrator Lambert did not mention pat downs or other preventive interventions. P. Ex. 9; *see* CMS Br. at 11. However, I give the testimony of C.N.A. Thompson and L.P.N. Brew, who were on the Lighthouse Unit each day and testified subject to cross-examination, greater probative value than the affidavit of the Administrator.

be documented, as acknowledged by Surveyors Van Lieu and Brown (Tr. 132, 212). I find the testimony of C.N.A. Thompson and L.P.N. Brew credible.[7] I conclude that their testimony; the nurses' notes and other documents presented reflecting Petitioner's actions following the January 15, 2007 fire; and the fact that no fires occurred from January 15, 2007 to April 30, 2007, demonstrate substantial compliance with the participation requirements at 42 C.F.R. § 483.25(h)(1) and (2).

On April 30, 2007, Resident 2 started another fire. Resident 2 was apparently smoking in bed, as staff found a sheet on fire by the sink in his bathroom. There is no dispute that Resident 2 had been out on furlough with his father and that his father gave him the lighter used to set the fire. CMS legitimately questions how, with increased monitoring after the January 15, 2007 fire, Petitioner's staff failed to find the lighter before Resident 2 used it to light smoking material that ignited his sheet. Resident 2's return from pass with a lighter in his possession, whether or not he used the lighter to start the fire on April 30, 2007, shows that Petitioner's interventions were not effective on April 30, 2007. Although the testimony of C.N.A. Thompson and L.P.N. Brew was that they increased their monitoring of Resident 2 following the April 30, 2007 fire, the monitoring implemented was clearly insufficient for on May 2, 2007, Resident 2 caused another fire that required evacuation of the facility, a call to the fire department, and substantial damage to Resident 2's room. It is self-evident that any fire poses significant risk of great harm or death to Resident 2, other residents, staff, and visitors.

I conclude that Petitioner's interventions following the April 30, 2007 fire were not reasonable to mitigate the foreseeable risk of harm posed by Resident 2. Petitioner's interventions after April 30, 2007, were not reasonable as that fire demonstrated that Resident 2 could set another fire despite staff's supervision and that staff's supervision

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[7] I accept staff's testimony as credible and sufficient to establish that interventions were implemented as they testified. Although Petitioner is correct that the regulations do not specify what supervision is required and the regulations do not specifically require documentation that supervision was provided, being correct on this point represents no victory for Petitioner. While no specific documentation is required, the absence of documentation would normally support an inference that no interventions were devised or implemented. Thus, when it is necessary for Petitioner to prove what it did to eliminate or mitigate a foreseeable risk to its residents, the absence of documentation makes it difficult at best for Petitioner to establish what reasonable steps it took to mitigate the risk. Further, even with credible testimony from staff, the absence of documentation makes it difficult, for example, for Petitioner to prove the level, consistency, and quality of supervision provided to Resident 2 given the limitations of human memories. Petitioner was not charged by the surveyors under 42 C.F.R. § 483.25(h) with inadequate documentation; rather, Petitioner loses in this case due to the inadequacy of its interventions after the April 30, 2007 fire.

was inadequate to mitigate the foreseeable risk. The fact that Resident 2's physician did not order admission to a psychiatric hospital following the April 30, 2007 fire, as he did following the January 15, 2007 fire, is no defense for Petitioner. P. Brief at 28; P. Reply at 2-4. The physician's decision, or lack thereof, left Resident 2 in Petitioner's supervision and Petitioner remained responsible for the safety of Resident 2 and its other residents. The evidence shows that, after the April 30, 2007 fire, Resident 2 needed constant supervision until such time as other interventions or his transfer to a more appropriate facility could be accomplished. After two fires, Resident 2 should not have been permitted to go to his room and close a door unsupervised, given the foreseeable risk that Resident 2's illicit smoking could accidentally cause a fire.

The April 30, 2007 fire showed that Petitioner was not able to control Resident 2 without an intervention such as constant supervision. Petitioner argues that such supervision is not reasonable. However, whether an intervention is reasonable must be judged by weighing Petitioner's duty to protect its residents and staff from harm against the cost of staff constantly monitoring Resident 2. Petitioner argues that the situation in this case is similar to that in *Northeast Center for Special Care*, DAB CR1237 (2004 WL 2378302) (2004). P. Brief at 20-21, 27. However, Petitioner's reliance on my prior decision is misplaced because, unlike Petitioner, the Northeast Center for Special Care had imposed close visual observation for each of the three residents in that case. *Id.* at 55-56 (2004 WL 2378302, at 35). Petitioner's argument that one-on-one constant supervision would violate Resident 2's privacy rights is also not persuasive. P. Brief at 27. Both the regulations and the Louisiana Bill of Rights alluded to by Petitioner subject a resident's privacy rights to limitations based on medial contraindication and consideration of resident safety. 42 C.F.R. § 483.15(e)(1); La. Rev. Stat. § 40:2010.8(8).[8] The risk of fire

[8] The Louisiana statute requires each resident will be assured of the following:

> The right to have privacy in treatment and in caring for personal needs; to have closed room doors, and to have facility personnel knock before entering the room, except in case of an emergency or unless medically contraindicated; to have confidentiality in the treatment of personal and medical records; and to be secure in storing and using personal possessions, subject to applicable state and federal health and safety regulations and the rights of other residents. Privacy of the resident's body shall be maintained during but not limited to toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance.

La. Rev. Stat. § 40:2010.8(8).

in a long-term care facility is self-evident, as was the danger to Resident 2, other residents, facility staff, and visitors given Resident 2's behaviors.

Resident 2 was the foreseeable accident hazard that Petitioner did not take reasonable steps to mitigate by adequate supervision after April 30, 2007. Thus, violations of both 42 C.F.R. § 483.25(h)(1) and (2) are well-founded in this case.[9]

**3. Petitioner violated 42 C.F.R. § 483.75 because management failed to ensure that interventions to protect Petitioner's residents were devised, implemented, reassessed, and monitored.**

a. Facts

Reference is made to the forgoing statement of facts related to Resident 2 under Conclusion of Law 2. The following additional facts related to Resident 1 are also pertinent to the violation of 42 C.F.R. § 483.75.

Resident 1 resided in the Lighthouse Unit, and his diagnoses included brain injury and anxiety. CMS Ex. 2, at 15; CMS Ex. 7, at 1; P. Ex. 5, at 1. Resident 1's cognitive status was documented on his quarterly assessment as moderately impaired. CMS Ex. 2, at 15; CMS Ex. 7, at 3; P. Ex. 5. Resident 1's care plan showed he was anxious on a daily basis and worried about, among other things, cigarettes. CMS Ex. 7, at 8; P. Ex. 5, at 8. Resident 1's care plan notes as a behavior problem that he smokes and is frequently found with a lighter he refuses to relinquish. Approaches listed on the care plan to deal with the problem included: resident to smoke in designated areas only; discourage smoking outside of designated areas; confiscate personal lighters as able and discourage personal lighters; lighters to be kept by staff and provided at smoking time; and cigarettes to be passed out every two hours as the resident can afford. CMS Ex. 7, at 9; P. Ex. 5, at

[9] Petitioner also argues that the survey was flawed with the surveyors misconstruing both the facts and the law. P. Brief at 9-18. I am not bound by the surveyors' findings and conclusions but rather conduct a de novo review to determine whether there exists a basis for imposition of an enforcement remedy. Whether the surveyors misconstrued the facts and law, is not an issue I need to resolve in this case. My review of the SOD (CMS Ex. 2) reveals that it was sufficient to place Petitioner on notice as to the alleged deficiencies and Petitioner has had an adequate opportunity to present its defenses for my consideration. Petitioner does not allege that the SOD did not provide adequate notice. Petitioner points to no evidence that the surveyors were personally biased against Petitioner or its management officials. Even if I concluded that the surveyors' performance was inadequate in some respect, inadequate survey performance would not relieve Petitioner of its duty to meet program participation requirements or invalidate adequately documented deficiencies. 42 C.F.R. § 488.318(b).

9. Resident 1's care plan also identified him as a chronic smoker, unable to manage his cigarettes to last through the month, and that he tended to dig in ashtrays for butts. The stated goal was to manage his cigarettes to last through the month. Approaches were that Resident 1 was to be given two cigarettes every two hours by the activities director and he was to be monitored for digging in the ashtrays and redirected if he tried. CMS Ex. 7, at 13; P. Ex. 5, at 13. Resident 1 signed the form that sets forth Petitioner's smoking policy on May 30, 2002. CMS Ex. 7, at 14; P. Ex. 5, at 14. He was assessed on January 13, 2005, as being a regular smoker with no risk of dropping cigarettes, as not smoking in an inappropriate place within the past 30 days, as being easily redirected, as not requiring supervision for smoking, as having a medium cognitive level, and as being at "low risk." CMS Ex. 7, at 16; P. Ex. 5, at 16.

Resident 1 was found smoking in his room on January 15, 2007, the same day that Resident 2 started a fire. The incident was reported to the nurse at Oak Haven, where Dr. Blanche was on site. CMS Ex. 7, at 5; P. Ex. 5, at 5. On January 16, 2007, a lighter was confiscated from Resident 1. CMS Ex. 7, at 5; P. Ex. 5, at 5. On April 13, 2007, a pack of cigarettes and a lighter were confiscated from Resident 1, who stated that his family gave them to him. P. Ex. 14, at 10. On May 1, 2007, a cigarette lighter was confiscated from the pocket of Resident 1's shirt. P. Ex. 14, at 10.

b. Analysis

The regulation requires that "[a] facility be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." 42 C.F.R. § 483.75.

The parties agreed at hearing that the alleged violation of 42 C.F.R. § 483.75 (Tag F490) was derivative of the alleged violations of 42 C.F.R. § 483.25(h). Tr. 13-14. However, my review of the allegations under Tag F490 reveals that the alleged violation is not truly derivative, at least not in the sense that if I find 42 C.F.R. § 483.25(h) was violated, then I should also find that 42 C.F.R. § 483.75 was violated. The surveyors allege in the SOD that the violation occurred because: (1) Administrator Lambert failed to have a system in place to ensure that approaches were implemented, once the facility identified an accident hazard; (2) the Administrator and DON failed to ensure that Resident 2 was supervised and monitored; (3) Resident 2 was not immediately reassessed following the fire on January 15, 2007; and (4) even after Resident 2 was transferred on May 2, 2007, Petitioner remained deficient, albeit not at the level of immediate jeopardy, as management had not implemented a system to immediately reassess and increase monitoring of residents who exhibited inappropriate behavior. CMS Ex. 2, at 26. I find that the surveyors' allegations are well-founded.

The evidence clearly establishes that Petitioner had undertaken a difficult task of housing, serving, treating, and safeguarding the residents of the Lighthouse Unit. Petitioner's records and the testimony of the staff show that Petitioner had a significant problem controlling the smoking behaviors of the residents on the Lighthouse Unit, and Residents 1 and 2 exemplify the problem. As of January 15, 2007, Petitioner was clearly on notice that it had the additional problem that Resident 2 had started a fire inside the facility with his smoking and, absent evidence to the contrary such as improvement in his condition evidenced, for example, by a proper assessment, he could potentially cause another fire. A fire in a facility is a significant event and one should expect that management would undertake efforts to learn the cause of the fire and identify steps to avoid future fires. Even when the cause of the fire is known, as it was in this case, management should take steps to ensure that the threat of future fires is minimized, if not eliminated.

Petitioner may rightly claim that there is no specific requirement for a documented investigation and analysis of cause, or documentation of the interventions devised and adopted to minimize the threat or prevent future fires. However, the absence of documentation makes it difficult for Petitioner to establish that management acted responsibly to ensure that the facility is able to "use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." 42 C.F.R. § 483.75. In this case, there is no evidence that management ensured that Residents 1 and 2 were reassessed on or after January 15, 2007, in an effort to determine the magnitude of the risk they posed to themselves and the population of the Lighthouse Unit. Staff credibly testified to implementing many interventions, though it is admitted by Petitioner that the interventions were largely not documented. The evidence does not show that management was involved in assessing risk or devising and adopting interventions to safeguard its residents, staff, and facilities. The evidence does not show that management was involved in assessing the effectiveness of interventions, including the consistency of their implementation. The evidence does not show that after the April 30, 2007 fire management assessed the effectiveness of prior interventions or made a determination that simply doing the prior interventions more aggressively or intensely was adequate. The evidence does not reflect a management decision that Resident 2 did not need close observation or one-on-one supervision after the fire on April 30, 2007. The evidence does not show that management supervised the implementation of interventions at anytime. The evidence does not show that management intervened with the physician on April 30, 2007, when the physician failed to order psychiatric hospitalization. Unfortunately, the evidence does not show that management recognized Resident 2 as a risk or that management ever engaged in the decision-making necessary to safeguard Resident 2 and other facility residents. A significant risk for serious injury or death existed due to management's lack of action throughout the period January 15, 2007 to Resident 2's transfer on May 2, 2007.

Accordingly, I conclude that Petitioner violated 42 C.F.R. § 483.75 (Tag F490).

**4. The alleged scope and severity of the deficiencies is not subject to my review, as the scope and severity of the deficiencies has no effect on the range of the PICMPs that may be imposed. 42 C.F.R. §§ 488.438(a)(2), 488.438(e), 498.3(b)(14), 498.3(d)(10)(ii).**

**5. Petitioner's regulatory violations provide a basis for the imposition of three PICMPs, and the PICMPs imposed, totaling $10,000, are reasonable.**

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 imposing a DPNA and a CMP. CMS may impose a CMP for the number of days that the facility is not in compliance or for each instance that a facility is not in substantial compliance. 42 C.F.R. § 488.430(a). In this case, CMS has imposed PICMPs totaling $10,000, consisting of $3500 each for the violations of 42 C.F.R. § 483.25(h)(1) and (2) and $3000 for the violation of 42 C.F.R. § 483.75.

In determining whether the amount of the PICMP 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, i.e., neglect, indifference, or disregard for resident care, comfort, or safety. The CMS decision regarding the scope and severity of the deficiencies is not subject to my review, as the scope and severity of a deficiency has no effect on the range of PICMP which may be imposed. 42 C.F.R. §§ 498.3(b)(14), 488.438(a)(2); *see* 42 C.F.R. §§ 498.3(d)(10)(ii), 488.438(e).

I have no evidence concerning the facility's history of noncompliance or its financial condition. However, the deficiencies are serious, because a resident who is able to set a fire seriously endangers all residents, him or herself, staff, and visitors. In light of the potential for harm, the PICMPs imposed are reasonable. I further conclude that the absence of evidence that management actively undertook to mitigate or eliminate the risk of fire, indicates at least indifference or disregard for resident safety.

## III. Conclusion

For the foregoing reasons I conclude that Petitioner violated 42 C.F.R. §§ 483.25(h)(1) and (2) and 483.75 and that PICMPs totaling $10,000 are reasonable.

/s/
Keith W. Sickendick
Administrative Law Judge