Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Glenburn Home,	)	Date: October 5, 2009
(CCN: 15-5524),	)	
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-07-321
	)	Decision No. CR2014
Centers for Medicare & Medicaid	)	
Services.	)	
	)	

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose a one-day civil money penalty (CMP) in the amount of $10,000 against Glenburn Home (Petitioner or facility).

I. Background

Petitioner is a Medicare certified skilled nursing facility doing business in Linton, Indiana. Although Petitioner underwent several surveys in a survey cycle from September 2006 through March 2007 where several deficiencies were noted, the only survey at issue for my review is Petitioner's challenge to the immediate jeopardy finding from a survey completed October 17, 2006. The surveyors of the Indiana State Department of Health (Survey agency) determined Petitioner to be out of compliance with several participation requirements, and a Statement of Deficiencies (SOD) dated October 17, 2006, was issued to Petitioner which outlined the survey findings. CMS concurred with the surveyors' findings of noncompliance and, by letter dated January 11, 2007, notified Petitioner of the proposed sanction of a one-day CMP in the amount of $10,000 for October 17, 2006. The CMP is based on alleged noncompliance with three deficiency tags (F221, F224 and F324) at the immediate jeopardy level.

On March 12, 2007, Petitioner timely requested a hearing (Request for Hearing) before an administrative law judge (ALJ). The case was assigned to me on March 22, 2007, for hearing and a decision. In its Request for Hearing, Petitioner states that it is only

contesting the alleged deficiency tags which rise to the level of immediate jeopardy; specifically, tags F221, F224 and F324, as identified in the October 17, 2006 SOD.[1] Petitioner is also not contesting the reasonableness of the amount of the CMP imposed for the three immediate jeopardy level deficiencies identified in the October 17, 2006 SOD. Rather, Petitioner challenges CMS's determination that the alleged noncompliance constituted immediate jeopardy, stating that CMS's determination is clearly erroneous.

The parties filed a *Joint Statement of Issues Presented for Hearing*, dated October 22, 2007 (Jt. Stip.) which further narrowed the issues Petitioner is challenging. Petitioner stipulated that it only wishes to challenge its compliance with F221 (example 1), F224, and F324 (examples A.1 and B.1). *See* Jt. Stip. CMS stipulated that the examples not contested by Petitioner are not part of the immediate jeopardy finding at tags F221 and F324. *Id.*

As a threshold matter, my review is limited to those issues that Petitioner has appealed and over which I have jurisdiction. Inasmuch as Petitioner does not challenge all the deficiencies cited in the October 17, 2006 SOD, those findings and remedies remain uncontested and are, therefore, final and binding against Petitioner. 42 C.F.R. § 498.20(b).

A schedule was established for the parties to file written submissions including proposed witness and exhibit lists and prehearing briefs. On October 22, 2007, Petitioner filed its request for issuance of subpoenas, and, on October 25, 2007, CMS filed its objection to Petitioner's request. I denied Petitioner's request for subpoenas based on: (1) untimely filing; (2) failure to adhere to the requirements outlined in my Order of June 25, 2007; and (3) failure to comply with the requirements of 42 C.F.R. § 498.58.[2]

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[1] In its Request for Hearing Petitioner states that it waives its right to contest any of the other deficiencies and the related remedies imposed by CMS – these include the non-immediate jeopardy CMP, a denial of payment for new admissions (DPNA), and the loss of its nurse aide training and certification program (NATCEP) as outlined in a notice letter from CMS dated February 23, 2007 and which relate to surveys conducted at Petitioners facility on September 12, 2006, December 7, 2006 and December 21, 2007. Therefore, Petitioner has limited its challenge to only the three immediate jeopardy level deficiencies found during the October 17, 2006 survey of its facility. *See* Request for Hearing; *see also* CMS Notices dated January 11, 2007 and February 23, 2007. CMS Exhibits (Exs.) 3, 4; *Joint Statement of Issues Presented for Hearing*, dated October 22, 2007.

[2] *See* discussion of ruling at transcript page (Tr.) 8-10. In its objection to Petitioner's request for subpoenas, CMS agreed to voluntarily produce two of the three surveyors Petitioner requested be subpoenaed for the limited purpose of explaining notations in their surveyor notes relating to two residents, Resident 6 and Resident 20.

An in-person hearing was convened in this matter from November 5 through 9, 2007, in Indianapolis, Indiana. During the course of the hearing, there being no objections, the following exhibits were admitted: CMS Exs. 1 through 46[3], and Petitioner (P.) Exs. 1 and 2. Tr. 7, 8. During testimony, Petitioner proffered P. Ex. 3 which CMS objected to. P. Ex. 3 was not admitted by me into evidence.[4] Tr. 296.

At hearing, CMS called as witnesses three surveyors: Melinda Lewis, Registered Nurse (RN); Marla Potts, R.N.; and Anne Marie Crays, R.N. Petitioner elicited the testimony of witnesses Mandy Moore, Certified Nurse Aide (CNA) and Nancy Anderson, Activities Director.[5]

A transcript of the proceeding was prepared and the parties were given an opportunity to identify any prejudicial errors. CMS filed a list of errors on December 3, 2007, none of which was noted as prejudicial. CMS's list will remain with the record of proceedings. No objections or conflicting statement of errata was filed by Petitioner.

The parties submitted post-hearing briefs and CMS filed a reply brief (CMS Br. and CMS Reply; and P. Br.[6]). Petitioner declined to file a reply brief.

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[3] At hearing Petitioner stated that due to the narrowing of issues in its appeal before me (*See* Jt. Stip.), some of the nursing notes included in CMS Exs. 1-46 no longer apply to the deficiencies before me, however, as CMS chose to include the nursing notes in its proffered exhibits, Petitioner made note of its blanket objection to any hearsay statements in CMS Exs. 1-46. I therefore take judicial note of Petitioner's objection.

[4] Although not admitted, P. Ex. 3 is included in the case record file and marked separate in the event Petitioner wishes to appeal this decision. Tr. 296.

[5] At the hearing, Petitioner requested to have Sharon Reines, R.N., who also served at the facility as the MDS (Minimum Data Set) Coordinator, testify as a witness. CMS objected. Petitioner's amended witness list was not received by either CMS or my office by the hearing date, and as I found grounds for prejudice to CMS, Petitioner's request was denied. *See* discussion and ruling at Tr. 16-17.

[6] I note that Petitioner attached to its post-hearing brief a 28-page document titled *Revised Long-Term Care Facility Resident Assessment Instruction User's Manual Version 2.0*, Chapter 1, at 1-20, Centers for Medicare & Medicaid Services (December 2002, revised January 2008). The document is included in the case record file but not admitted as an exhibit.

This decision is based on the complete record which includes the parties' arguments, written submissions, all exhibits admitted into the record, and the witness testimony adduced during the hearing.

II. Issues

The issues in this case are whether:

1. Petitioner was in substantial compliance with tags F221 (example 1), F224, and F324 (examples A.1 and B.1) during the October 17, 2006 survey; and, if not,

2. CMS's determination that the noncompliance with tags F221 (example 1), F224, and F324 (examples A.1 and B.1) during the October 17, 2006 survey constituted immediate jeopardy was clearly erroneous

III. Applicable Law

Long-term care providers, such as Petitioner, participate in the Medicare program by entering into provider agreements with the Department of Health and Human Services (HHS). Requirements of participation are imposed by statute and regulation. *See* Social Security Act (Act) §§ 1819, 1919; 42 C.F.R. Parts 483, 488, and 489. In order to continue participation in the Medicare program, providers must remain in substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

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, which includes imposing a CMP. Act § 1819(h). CMS may impose a CMP for the number of days that the facility is not in substantial compliance with one or more program requirements, or for each instance that a facility is not in substantial compliance. 42 C.F.R. §§ 488.430(a), 488.440. The presence of a single deficiency cited at the D-level or above is sufficient to establish a facility's noncompliance with applicable regulations and authorize the imposition of remedies. *Beechwood Sanitarium*, DAB No. 1824 (2002).

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, of from $3050 per day to $10,000 per day, is reserved for deficiencies that 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 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 Act and regulations make a hearing before an ALJ available to a long-term facility against whom CMS has determined to impose a CMP. Act § 1128A(c)(2); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The ALJ's review is generally limited to two general issues, *i.e.*, whether there is a basis for the imposition of enforcement remedies, and whether the remedies CMS proposes are reasonable. 42 C.F.R. §§ 488.408(g), 488.438(e), 489.53(d), 498.3, 498.5(b). The ALJ's review and decision on these issues is *de novo* and the Departmental Appeals Board (the Board) has consistently so ruled. *See, e.g.*, *Emerald Oaks*, DAB No. 1800, at 11 (2001) (ALJ makes no finding regarding how CMS made its determination, but makes an independent determination based upon the evidence of record); *Beechwood Sanitarium*, DAB No. 1906, at 29 (2004) (what CMS knew or how it made it's decision is simply immaterial to the ALJ); *The Residence at Salem Woods*, DAB No. 2052, at 11 n.5 (2006) (ALJ is bound to make an independent determination of reasonableness of remedy based upon evidence developed at hearing); *Cal Turner Extended Care*, DAB No. 2030, at 7 (2006) (ALJ does not conduct a quasi-appellate review of the CMS determination, but makes an independent determination based upon the evidence developed before the ALJ).

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 collected by CMS or impact upon the facility's nurse aide training program. 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 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).

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). Further, "*(s)ubstantial 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." (Emphasis in original).

IV. Burden of Proof

When a penalty is imposed and appealed, CMS must establishe a prima facie case that the facility was not in substantial compliance with federal participation requirements. To prevail, the facility must overcome CMS's showing by a preponderance of evidence. *Emerald Oaks*, DAB No. 1800, at 4 (2001); *Cross Creek Health Care Center*, DAB No. 1665 (1998), applying *Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd Hillman Rehabilitation Center v. HHS*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999). I adopt the burden as set forth in the Board's decision in the *Hillman* case, and as stated and discussed in detail in the *Batavia Nursing and Convalescent Center* and *Batavia Nursing and Convalescent Inn* cases. *See Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004); and *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004).

V. Findings of fact, conclusions of law and discussion.

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I state each Finding, below, as a separate heading. I discuss each Finding in detail.

A. The evidence establishes that as of the October 17, 2006 survey Petitioner did not comply substantially with the requirements of 42 C.F.R. § 483.13(a) - tag F221 - Quality of Care - Physical Restraints.

The regulation that is at issue here governs a facility's use of physical restraints. The regulation provides that a "resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms." 42 C.F.R. § 483.13(a). The regulation at 42 C.F.R. § 483.13(a) prohibits providers from using physical restraints for purposes of discipline or convenience and prohibits using restraints that are not required to treat the resident's medical symptoms.

Petitioner was found to be in violation of this regulation at a scope and severity level of immediate jeopardy. CMS Ex. 1, at 6. The SOD dated October 17, 2006, states that Petitioner failed to ensure the least restrictive physical restraint was used to treat residents' medical symptoms. *Id.* at 6. CMS alleges that: (1) Petitioner failed to assess Resident 20 for use of a thigh belt restraint both prior to implementation of the restraint and after the resident exhibited dangerous behavior while in the restraint; (2) Petitioner failed to review alternatives to restraints prior to implementing use of the thigh belt restraint; and (3)

Petitioner failed to obtain consent for use of the restraint from the resident's legal guardian. CMS Br. at 24, 25.

Resident 20, a 74-year-old male, was admitted to Petitioner's facility on June 9, 2006 following a fall at home where he sustained a head injury. CMS Ex. 19, at 8. A history and physical exam from the transferring hospital indicates that he was admitted to the hospital on June 8 for severe agitation and dementia. *Id.* at 156. Resident 20's diagnoses at the time of his admission to Petitioner's facility included progressive dementia, severe acute agitation and confusion, and coronary artery and small vessel disease. *Id.* at 157. Resident 20 is also noted as having short and long term memory problems and severely impaired cognitive skills for decision making. *Id.* at 8. On June 12, 2006, Resident 20 was assessed as a moderate risk for falls. *Id.* at 4. The resident's family informed facility staff upon admission that at home the resident "wanders to the point of exhaustion," and that Resident 20 had adverse reactions to most chemical restraint medicines used. *Id.* at 8.

Four days following Resident 20's admission to Petitioner's facility, his physician ordered use of a padded Broda chair thigh belt[7] for his unsteady gait and wandering to the point of exhaustion. CMS Ex. 19, at 119. The resident was also placed on Paxil 10 milligrams (mg) for depression and anxiety. *Id.* The physician's order states the resident could be sent to the "behavioral unit if necessary as needed." *Id.* On June 12, a PRN order was processed which provided for use of a thigh belt as a last option. On June 14, 2006, a physician's order was obtained for physical therapy to evaluate the resident's unsteady gait. *Id.* Also, on June 16 the resident's Paxil dosage was increased from 10 mg to 20 mg due to his behaviors and signs of agitation. *Id.* at 120. The resident's record also notes that on June 16 an order was obtained for the resident to be transferred to the Davis County Behavior Unit. On June 22, a physician's order was obtained for Resident 20 to be seen by a psychologist, Dr. Forestor. *Id.*

The parties do not dispute that the thigh belt used for Resident 20 was a physical restraint. Rather, CMS claims that Petitioner did not properly assess Resident 20 to determine the appropriateness of the use of the thigh belt restraint in the Broda chair prior to its implementation. CMS Br. at 24. CMS's State Operations Manual (SOM) requires that the medical symptom which warrants the use of a restraint be documented in the resident's medical record, that there be ongoing assessments, and documentation in the resident's care plans. Pub. 100-07, SOM, Appendix PP - Guidance to Surveyors for Long Term Care Facilities (discussing tag 221). A physician's order alone is not sufficient to warrant

[7] Broda chairs are positioning chairs used for medium to high level care residents. CMS Ex. 44, at 4. A thigh belt is a one-piece position device used for pelvic positioning. It leaves the hips and upper torso unrestrained to minimize a resident sliding under the belt. *Id.* at 44, at 1, 7-8 (picture of Broda chair and thigh belt); *see also* Tr. 30-22.

the use of restraints. A facility is responsible for assessing and care planning restraint use on an ongoing bases and must "engage in a systematic and gradual process toward reducing restraints." *Id.*

Petitioner's physical restraint policy identifies the process staff are to follow when a physical restraint is employed for a resident of the facility. The policy requires that an assessment be undertaken and "[r]esidents at risk for restraint use will be identified through the MDS, At Risk For Falls Assessment and through a multi disciplinary assessment process." CMS Ex. 36, at 1. The policy further requires that the interdisciplinary team "must" [a]ssure that all possible alternative methods have been assessed for appropriateness. This assessment must be documented on the Medical Record." CMS Ex. 36, at 1-2.

1. Petitioner failed to assess Resident 20 before use of a thigh belt restraint.

CMS maintains that Petitioner had no record that an assessment was completed to determine if the restraint used on Resident 20 was necessary. CMS Br. at 11. Petitioner advances several arguments in support of its assertion that Resident 20 was properly assessed prior to the implementation of the thigh belt. I address each of Petitioner's arguments separately.

a. Petitioner contends that the initial restraint assessment was stolen.

Petitioner states that the proper restraint assessment had been completed, but had been removed from Resident 20's chart by a disgruntled nurse. According to Petitioner that individual stole the restraint assessment records in July 2006. P. Br. at 3 As evidence to support this claim, Petitioner provides a copy of the July 31, 2006 discharge notice indicating that the employee "[a]dmitted to taking confidential information home and destroyed part of it, brought part of it back to facility." P. Ex. 1, at 9. Petitioner also provides a copy of a November 26, 2006 letter it filed with the Consumer Protection Division regarding the disgruntled nurse who removed the forms from the facility. P. Ex. 1, at 2. Petitioner claims that it was not until staff looked for the form in question during the survey that facility staff realized that Resident 20's assessment was one of the documents the disgruntled nurse had destroyed. Petitioner's staff was unable to find a consent form and, therefore, immediately completed another consent form which was signed by the resident's son on October 10, 2006. P. Prehearing Br. at 3; CMS Ex. 19, at 53.

CMS argues that even if the restraint assessment had in fact been stolen and destroyed, Petitioner should have reassessed the resident's use of the restraint prior to the October 2006 survey, either as part of the quarterly assessment after the resident tried to stand in the chair while restrained, or after the resident fell while restrained in the Broda chair. CMS Br. at 27. Surveyor Melinda Lewis, R.N. testified that Petitioner should have discovered that the initial restraint assessment was missing because staff should have reviewed the previous assessment when reassessing the use of Resident 20's restraint. Tr. 181; CMS Ex. 19, at 19. CMS asserts that toward the end of June 2006, Resident 20 was in the thigh belt each time he was placed in the Broda chair, and at times also during the middle of the night. *Id*. at 62-71. Thus, Petitioner should have had some documentary evidence supporting the assessment and use of the thigh belt for Resident 20.

The *Revised Long-Term Care Facility Resident Assessment Instrument User's Manual* provides that subsequent reassessments "should focus on recorded information from earlier MDS assessments and Quarterly assessments, written information from the previous three-month period, and notes made during the prior 30-day period." *See Revised Long-Term Care Facility Resident Assessment Instrument User's* Manual, CMS RAI Version 2.0 Manual, at 1-20. Even if the initial assessment was stolen from Petitioner's facility prior to the survey, I agree with CMS's argument that the initial assessment should have been reviewed during the quarterly MDS assessment. That review would have led to the discovery that the initial assessment was missing and it would have prompted a subsequent assessment to justify Resident 20's restraint.

b. Petitioner argues that I should consider a Functional Assessment Reassessment Form (FARF) as meeting the initial restraint assessment requirement.

Petitioner claims that staff did evaluate Resident 20 prior to employing the physical restraint. As the initial assessment was not available, Petitioner argues that I consider a *Functional Assessment Reassessment Form* (FARF) in lieu of the initial assessment. Petitioner maintains that the FARF was part of the data gathered on June 9, 2006 to complete the admission MDS for Resident 20. Petitioner further asserts that the FARF aided staff in determining the types of assistive devices or restraints that would be appropriate for Resident 20. P. Br. 1-2; CMS Ex. 19, at 4, 8.

A review of the FARF indicates that the assessment was initially completed on June 9, with updates on June 12, September 6, and September 27, 2006. CMS Ex. 19, at 4. The FARF which Petitioner claims to be an assessment for Resident 20, recommends a Broda chair and padded thigh belt intervention for a resident who is considered high risk for falls. To be considered a high risk for falls, a resident must score at least 16 points or higher on the assessment. Resident 20 scored 6 points during the June 9 assessment which, based on the assessment risk legend, made him a mild risk for falls. According to

the FARF, a lap buddy and sit-in-place interventions are recommended at this level of risk. *Id*. at 4. During the June 12 reassessment, Resident 20 scored 10 points, classifying him as a moderate risk for falls. *Id.* At a moderate risk the FARF recommends a self-release seat belt, a lap buddy, sit-in-place, safety alarm(s), an optic sensor, and a low bed and mat. *Id.* On September 6, staff reassessed Resident 20 and at that time he scored 11 points which classified him within the moderate risk category. On September 27, Resident 20 was again reassessed and scored 12 points which was also within the moderate risk category. The record is clear that the highest score Resident 20 was assigned during all of the FARF assessments was 12 points, which placed him in the mid-range for the moderate risk category (score range 9-15). *Id*. Thus, Petitioner's reliance on the FARF as an assessment that justifies its use of the thigh belt is not supported by the record or the facts.

c. Petitioner argues that the resident's record provides a medical reason for implementation of the thigh belt restraint.

Petitioner contends that Resident 20's record clearly establishes a medical reason for the thigh belt restraint as well as the alternative to restraints considered or tried. P. Br. at 5. Petitioner cites to the social service assessment, initially completed on June 9 and updated on June 20. Although the assessment provides information as to the resident's support network, it does not address any medical symptom warranting the use of the thigh belt restraint, or the alternatives to restraints tried by staff, nor does that record reveal the reason why less restrictive alternatives were not successful. CMS Ex. 19, at 8. Thus, Petitioner's argument on this point is not persuasive and is without support in the resident's medical record.

d. Petitioner asserts that the RAP Trigger Worksheet meets the initial restraint assessment requirement.

On June 22, 2006, staff completed a Resident Assessment Protocol (RAP) Worksheet for Physical Restraints as part of Resident 20's MDS assessment. CMS Ex. 19, at 49-50. Petitioner's reliance on the June 22, 2006 RAP Worksheet to substantiate its implementation of a physical restraint with Resident 20 is misguided. *Id.* at 45, 49-50. The RAP Worksheet does not justify use of a thigh belt restraint for Resident 20. The RAP Worksheet was completed 10 days after the thigh belt restraint was implemented and, further, does not document that alternatives were tried. The document indicates that the restraint was employed due to the resident's fall risk, aggressive behaviors, or wandering. Moreover, the worksheet indicates that the restraint is not needed. *Id*. at 50. The RAP Worksheet notes Resident 20 was not able to get up from the Broda chair with the thigh belt in place. *Id.* The record also indicates that the resident was being restrained to control behavioral symptoms and repetitive physical movements attributed to the

resident's cognitive loss/dementia, acute confusional state, impaired communication, sad or anxious mood, and psycho tropic drug side effects. *Id.* at 49. It further notes that use of the restraint was part of a behavioral management program, and attempts had not been made to control Resident 20's behavioral symptoms without the use of restraints. CMS Ex. 19, at 49-50. Contrary to Petitioner assertion, the RAP Worksheet for Resident 20 does not justify the initial use of a restraint or the continued use of the restraint. *Id*. at 50.

Lastly, Petitioner's own witness, Nancy Anderson, who served as the activity director at the facility, testified that the RAP Worksheet contained inaccurate information and she would not consider the worksheet to be an assessment. Tr. 324.

2. Petitioner failed to review alternatives to physical restraint prior to implementing the thigh belt restraint.

CMS asserts that Petitioner failed to document whether alternatives to restraints had been tried before implementing use of a thigh belt. CMS Br. at 11.

Petitioner's physical restraint policy requires that "[i]f alternative methods (lower beds, padding on floor, increased activity programming, better seating arrangements, removal of obstacles in immediate environment, closer staff observation with reminders and cueing, [sic] etc.) have proven inadequate, the Interdisciplinary Team must document their recommendation for the least restrictive restraint." CMS Ex. 36, at 2.

Petitioner maintains that facility staff did evaluate less restrictive alternatives. Petitioner claims that an alarm had already been placed on a recliner in the resident's room, a low bed and mat had been placed in his room, and a bed sensor had been added to his bed due to his risk for falls. P. Br. at 2, 5; CMS Ex. 19, at 59. Petitioner claims that a recliner was tried before use of the Broda chair, but it was not successful in preventing Resident 20 from rising. Tr. 133; CMS Ex. 19, at 60. At hearing, Ms. Anderson testified for Petitioner that alternatives were reviewed by the interdisciplinary team. Tr. 163-66, 273- 77, 317-18. Ms. Anderson also testified that after the June 10 fall, the interdisciplinary team decided to try a Broda chair with a thigh belt as Resident 20's "freedom of movement had to be curtailed to keep him from attempting to constantly ambulate so that he would not fall after becoming exhausted." Tr. 273. Ms. Anderson also testified that the thigh belt restraint was the facility's "first step" in responding to Resident 20's fall risk due to wandering. Tr. 273. She further asserted that the facility had tried to get Resident 20 involved in activities prior to implementing the thigh belt. Tr. 317.

Petitioner has not provided any corroborating evidence to support Ms. Anderson's assertions that less restrictive alternatives and the resident's involvement in activities were attempted, nor do I find documentation in the resident's record establishing which, if any, alleged activities were attempted. Rather, the record supports CMS's claim that the lower

bed, padding on floor, low bed, and bed alarm implemented before or shortly after the use of restraints were directed to address Resident 20's risk of falls from bed, not his wandering to the point of exhaustion.

3. Petitioner failed to assess Resident 20 after the implementation of a thigh belt.

Petitioner's physical restraint policy requires there be a medical reason for the use of a physical restraint and that the interdisciplinary team assure that all possible alternative methods are assessed for appropriateness. Furthermore, the policy requires that the assessment *must* be documented in the resident's medical record. P. Ex. 36, at 1-2.

On June 10, 2006, Resident 20 was involved in two falls, one from his bed at 4:15AM and one in the hallway at 4:25 PM. CMS Ex. 19, at 3. The first incident occurred after the resident bolted from his wheelchair and ran down the hall. *Id.* at 60. The resident's record notes the resident as being agitated, having hit a wall with his fists when staff attempted to sit him in a recliner. *Id*. at 59-60. A few days later, on June 12, 2006, staff reported restraining Resident 20 in a Broda chair with a padded thigh belt. *Id.* at 119; CMS Ex. 44, at 1, 7-8. On June 12, 2006, a nurse noted that Resident 20 became very agitated when the padded thigh belt restraint was applied to his Broda chair. CMS Ex. 19, at 62. On June 15, 2006, the resident is reported as yelling "mother" loudly, banging his chair into the wall, and trying to tip it over. *Id.* at 64. Although the resident had been placed in a different chair, a heavier one, he was reported as nearly tipping the chair over. *Id.* On June 19, 2006, the resident is reported as trying to walk while the Broda chair was still attached to him by way of the thigh belt restraint. *Id*. at 66. When staff attempted to talk to him he tried to physically strike out at them. *Id.* Two staff were required to sit him back down in order for staff to unhook him from the chair. *Id*. at 21. On June 20, 2006, staff developed a care plan for the padded thigh belt in the Broda chair. CMS Ex. 19, at 19. On June 22, 2006, staff completed the RAP Worksheet as part of Resident 20's MDS assessment. CMS Ex. 19, at 49-50. On June 23, 2006, Resident 20 is reported as being agitated, yelling while in the Broda chair, and the following day he tore one side of his Broda belt and removed the inner padding from it. CMS Ex. 19 at 68, 69. Use of the thigh belt restraint in the Broda chair continued to be used in July, August, and September 2006. CMS Ex. 19, at 72-102. Resident 20's clinical record reveals he was exhibiting restless behavior, being aggressive with staff, racing up and down the hall in his Broda chair at high rates of speed, and often entering other resident rooms. During this time he is reported running over other residents' feet or running into them at least eight times.

CMS Ex. 19, at 25, 27, 30, 32, 33, 78-84, 88-100. Additionally, he is reported as "unable to comprehend [the] danger he is causing other residents." CMS Ex. 19, at 92.

On September 25, 2006, the resident was placed in a stationary Broda rocker/glider. CMS Ex. 19, at 17; CMS Ex. 13, at 11. However, the resident was noted as being agitated, and rocking the chair back and forth swiftly nearly tipping it sideways. CMS Ex. 19, at 109. Staff brought this to the safety risk manager's attention who then spoke with the Director of Nursing (DON) and, later that evening, a decision was made for the resident to be placed in a stationary chair. *Id.* A few hours later on September 26, 2006, while restrained with the thigh belt in the Broda chair, Resident 20 attempted to stand and as the CNA walked toward him, he tipped the chair forward and fell, causing the Broda chair to fall on top of him. CMS Ex. 19, at 103. He sustained a 1 centimeter (cm) abrasion to the right side of his forehead and a 2 c.m. abrasion to his right knee. Staff reported the incident to the safety risk manager who instructed staff to update the care plan and to initiate one-to-one while the resident is in the Broda chair; that the Broda rocker was to be used if the resident was up; and the resident was to be on one-on-one care. The updated care plan specifically provided for: "(1) one-on-one when up in the Broda chair; (2) monitor every shift for injuries; and (3) redirect with a snack, walk, or back rubs. *Id.*

The resident's care plan for use of the thigh belt restraint directed that staff assess Resident 20 for reduction or possible removal of the restraint. CMS Ex. 19, at 19. However, after the September 26 incident where Resident 20 tipped his Broda chair forward, Petitioner did not assess the resident's continued use of the thigh belt restraint in the rocking Broda chair.

Resident 20 was placed in a stationary rocking on September 25 and he tipped it a few hours later at 1:30 AM on September 26, hitting his head and knee during the fall. The resident continued to exhibit reckless behavior while in the Broda chair with the thigh belt restraint. Even after the resident's fall on October 8, 2006 – when he leaned forward and tipped the Broda chair over landing head first – staff continued to use the thigh belt restraint.

From July 2006 through September 2006 staff routinely placed this resident in the Broda chair contrary to physician orders. Even though during this time the resident continued to exhibit restless behaviors while in his chair, no assessment was conducted to determine the appropriateness of restraining the resident in the Broda chair with the thigh belt. Additionally, Resident 20's plan of care and the faculty's own policy required staff to assess Resident 20 for reduction or possible removal of the restraint. CMS Ex. 19, at 19; CMS Ex. 36, at 2.

The evidence establishes that Petitioner failed to assess Resident 20 to evaluate the continued effectiveness and need of the restraint after implementation of a thigh belt.

4. Petitioner did not obtain a consent form from a responsible family member for the implementation of a restraint for Resident 20.

A facility must obtain the consent from a family member of a cognitively impaired resident who is incapable of decision making. *Milpitas Care Ctr. v. CMS*, CR932 (2002), *aff'd*, DAB No. 1864 (2004). CMS alleges that no consent was obtained from the resident's legal guardian for use of the restraint. CMS Br. at 11.

Petitioner claims the original consent form was stolen and facility staff had the resident's son sign another form on October 1, 2006. Petitioner asserts that entries in Resident 20's chart show that the resident's son was at the facility the night his father bolted from the chair and fell on June 10, and he was also present and notified on June 12 when the physician ordered the use of the Broda chair. P. Br. at 5; CMS Ex. 19, at 60-62; Tr. 177-78.

A review of the resident's record shows that Resident 20's son did spend the night at the facility on June 10 and June 12, 2006. CMS Ex. 19, at 60, 62. The progress notes indicate that he was made aware of Resident 20's new physician orders. CMS Ex. 19, at 60, 62.

CMS argues that because Resident 20's son was made aware of the orders does not conclusively establish that the facility obtained informed consent from Resident 20's responsible family member for use of a restraint. CMS Reply at 7. CMS is correct, consent requires more than "mere knowledge of the order." *Id.* Consent requires that the legal guardian be aware of the benefits and risks associated with the use of the restraint as well as the alternative to restraint use. SOM § 221. Petitioner was required to inform the family of the different options to address the resident's behavior as well as the risks and benefits of using the thigh belt restraint. Petitioner has failed to produce evidence that this was done prior to implementing use of the thigh belt restraint.

5. Analysis

Prior to implementation of a restraint on a resident a facility must complete a restraint assessment which clearly establishes that the restraint is medically warranted. There must be a medical reason for the use of a restraint and assurance that the least restrictive device is being employed. When employing the use of restraints a facility has an "obligation to continue to assess the impact of the use of a restraint and to consult with the doctor if the nursing facility finds that use of the restraint no longer meets the criteria of the regulation." *Lakeridge Villas Health Care Ct. v. CMS*, DAB No. 1988 (2005), *aff'd*, *Lakeridge Villa Health Care Ctr. v. Leavitt*, 202 F. App'x 903 (6th Cir. 2006). The

continued use of the restraint must be reassessed and a resident must be supervised while in the restraint.

In addition, reassessments should be completed in response to any incident or accident involving the use of the restraint, and at least quarterly as a minium. Notations in a resident's record to continue use of the restraint do not qualify as a reassessment. *Golden Sate Manor Nursing & Rehab. Ctr. v. HCFA*, CR412 (1996), *aff'd*, DAB No. 1597 (1996).

Petitioner was cited for failing to comply with this requirement because it failed to assess Resident 20 for the use of a thigh belt restraint both prior to implementation of the restraint and after Resident 20 exhibited dangerous behaviors while in the restraint. As such, Petitioner failed to ensure that Resident 20 had the least restrictive restraint used to treat his medical symptoms. The facility's failure placed Resident 20 at risk for serious injury and harm. Absent an assessment, Petitioner could not ensure that the restraint was warranted by Resident 20's medical symptoms, or that the least restrictive device was being used to address the resident's medical symptoms rather than for staff convenience.

Petitioner has been unable to submit evidence that it performed an assessment before using the thigh belt restraint on Resident 20. In addition, Petitioner has been unable to establish that it had: (1) medical symptoms warranting use of the restraint; (2) that alternatives had been tried; and (3) sufficient documentation as to why alternatives were not successful. *See Golden State Manor Nursing & Rehab Ctr*. DAB No. 1597. As such, I determine that the pertinent documentation to show the restraint was necessary has not been provided. *See Wisteria Care Ctr. v. CMS*, DAB No. 1892 (2003). Moreover, staff failed to obtain a physician's order for use of the thigh belt restraint in the Broda chair on a routine basis instead of "as needed", as originally ordered; and also failed to renew the order at least every thirty days as required by Petitioner's own policy. CMS Ex. 36, at 2.

B. The evidence establishes that as of the October 17, 2006 survey Petitioner was not in substantial compliance with the requirements of 42 C.F.R. § 483.13(c) - tag F224 - Staff Treatment of Residents.

The regulation requires that each facility develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. 42 C.F.R. § 483.13(c).

Petitioner was found to be in violation of this regulation at a scope and severity level of immediate jeopardy. CMS Ex. 1, at 30. The SOD alleges that Petitioner failed to prevent Resident 6, who resided on a locked dementia unit, from verbally abusing and physically threatening other residents who also resided on the unit. *Id*; CMS Br. at 33, 43-44.

At the time of the survey, Resident 6 was a 41-year-old male who had been admitted to Petitioner's facility on June 1, 2006, subsequent to a major auto accident in which he sustained head trauma.[8] CMS Ex. 17, at 4, 60. Resident 6 was recommended by the hospital discharge planner and approved by the State Medicaid agency for admission to Petitioner's SCU. The SCU is a locked unit where residents diagnosed with Alzheimers, dementia, and other related conditions reside due to concerns about their own safety. CMS Ex. 17, at 60, 61; CMS Ex. 40, at 5. Resident 6 was reported to be six-feet tall and weighed 255 pounds. CMS Ex. 17, at 68. Resident 6's physician's report dated September 28, 2005, notes diagnoses including partial paralysis of the right side, post closed head trauma, depression, short-term memory problems, that he was oppositional but not physical, and he had a developmental age of a 12 to13- year-old. CMS Ex. 17, at 4. An initial social service assessment completed on June 1, 2006 indicates that Resident 6 was placed at Petitioner's facility due to "dementia/wandering", and he reportedly felt good about the placement. CMS Ex.17, at 5. Resident 6's behavior plan dated June 29, 2006, indicates "Resident voices sexually explicit comments" and "Resident uses verbally aggressive language." CMS Ex. 17, at 7-8. Between October 4 through 11, 2006, Resident 6's care plan was updated to include a third behavior: "Resident becomes angry and hits doors and wall with his fist." CMS Ex. 7, at 10.

CMS asserts that Petitioner failed to protect other residents on the Alzheimer's unit from Resident 6's verbally abusive and physically threatening behavior. CMS Br. at 33. Petitioner maintains that it appropriately care planned for Resident 6's behaviors and intervened to manage Resident 6's behaviors. P. Br. at 9, 10; see also P. Prehearing Br. at 3-4.

A review of the resident's clinical record reveals the following incidents and intervention by facility staff:

> 1. June 28, 2006 - Resident 6 became upset at a female resident who bumped him when she sat down beside him on the transport bus. This incident resulted in the resident's coffee spilling onto his lap at which he became upset, using verbally aggressive language. CMS Ex. 17, at 34. Staff verbally directed Resident 6 to calm down, this is reported as effective and Resident 6 then proceeded on to the activity, sitting next to the same female resident. *Id.* In response to this incident, facility staff developed a behavior care plan on June 29, 2006 addressing Resident 6's behaviors to include verbally aggressive language. The behavior plan directed staff to tell the resident to refrain from voicing sexually explicit or verbally aggressive language; redirect him with an activity such as cards; engage him in

[8] Resident 6 also sustained head injuries resulting from auto accidents in 1980 and again in 1998. CMS Ex. 12, at 8; CMS Ex. 13, at 6.

appropriate conversation; to discuss his behaviors with him in private after the incident; to also strongly reinforce compliance with the rules; and lastly, to encourage him to vent to staff. *Id.* at 7.

2. June 30, 2006 - Resident 6 became upset and used profanity at a female resident who took his coffee off the table while he was playing cards with other residents. CMS Ex. 17, at 33. Facility staff responded by moving Resident 6 to Yoder Hall, a higher functioning unit in the facility. Resident 6 was placed in a room next to Resident 20, a 74- year-old, 136 pound man who suffered from dementia. CMS Ex. 17, at 58. Petitioner then developed a second care plan, dated July 3, 2006, which addressed a concern of emotional outburst secondary to his head injury. CMS Ex. 17, at 19. The care plan directed staff to: observe the resident for mood changes; observe his body language; allow him his personal space; redirect him with an activity; and, that staff were to know that he loves to play cards. *Id.* Residents in Yoder Hall were at that time higher functioning residents who were more likely to invade Resident 6's personal space. Tr. 108.

3. July 28, 2006 - Resident 6 became agitated at another resident who was calling out "help me, ma'am." CMS Ex. 17, at 37. Resident 6 proceeded to place his fist close to the resident's face stating: "What the F- do you want?" *Id.* Staff are reported to have intervened and redirected Resident 6 to his room to calm down and listen to music which was reported as effective. *Id.* All staff were then in-serviced on the resident's behavior plans and directed to notify nursing and social services of further occurrences of agitation by Resident 6 towards other residents. *Id.*

4. August 13, 2006 - a CNA observed Resident 6 with his fist drawn back while he was physically on top of Resident 20 as Resident 20 sat in his Broda chair. Resident 6 was heard cursing Resident 20. CMS Ex. 17, at 24. The CNA told Resident 6 to refrain from cursing whereupon he went to his room. The CNA reports that on his way to his room he continued to curse. *Id.* No new interventions were added to Resident 6's behavior plan to address his physically threatening behavior.

5. September 4, 2006 - Resident 6 became upset with Resident 20 because Resident 20 was sitting in a Broda chair outside Resident 6's room. Resident 6 is reported to have punched his fist in the air towards the other resident. CMS Ex. 17, at 24. Staff redirected Resident 20 down the hall and Resident 6 went into his room. *Id.* at 42-43.

6. September 17, 2006 - Resident 6 was overheard by staff yelling out obscenities, punching his fist, and cursing at Resident 20, stating: "I am going to kill you." CMS Ex. 17, at 27; CMS Ex. 19, at 98. Within a half hour later when Resident 20 came by Resident 6's room, staff noted that Resident 6 began cussing at Resident 20 and pounding his fist. CMS Ex. 17, at 44. Staff redirected Resident 6 into his room. *Id*. No new interventions were added to Resident 6's behavior plan after these incidents.

7. September 18, 2006 - while sitting at a table in the dining room, a female resident became agitated about a window being open. Resident 6 stood up and slammed his chair against the table and then cursed at the female resident. CMS Ex. 17, at 45. Staff removed the female resident from the table while a nurse explained to Resident 6 that his language was inappropriate. Resident 6 responded to the staff stating: "What are you going to do, wash my mouth out with soap, don't give a damn." *Id*. The resident then walked back to his room. *Id*. Following this incident Resident 6's behavior plan was updated with the only one new intervention of instructing staff to have Resident 6's mother speak to him. *Id.* at 7, 45. Resident 6's mother was informed by staff that if the resident's behavior continued, other arrangements would have to be made for Resident 6 for the safety of other resident safety. *Id.* at 45. Later that evening, social services was notified that Resident 6 continued to cuss and show anger toward the female resident. *Id*. at 46. The resident was placed on one-on-one supervision, and staff were instructed not to let him near the female resident. *Id.*

8. September 19, 2006 - upon being asked a question by a female resident while in the dining room, Resident 6 yelled "I don't know" and gave the female resident a dirty look. CMS Ex. 17, at 45. Staff redirected the resident to his room. *Id*. The resident stated "I don't care" and is reported to have mumbled words while he walked to his room. The resident was reported as calm and cooperative for the remainder of the evening. *Id.*

9. September 21, 2006 - Resident 6 was reported to have come up behind Resident 20 and physically threaten him by making a punching motion. CMS Ex. 17, at 27. Staff told the resident that his behavior was inappropriate. He then went to his room and when a staff member followed him it is reported that the resident shared his frustration by stating: "these old folks." *Id.*

10. September 27, 2006 - when a female resident attempted to grab jelly off of Resident 6's tray, he became angry and started cursing at her. CMS Ex. 17, at 28. Later that day, while finishing his lunch in the dining room, the table was pushed by another resident when moving a chair which in turn resulted in Resident 6 cursing at the resident. *Id.* When a female resident at the same table told the

resident to "shut the hell up" and not to use that kind of language at the table in a room full of women, the resident is reported as having stood up fast, causing the table and surrounding chairs to move across the dinning room, resulting in the resident's pants getting wet. *Id.* When staff redirected the resident back to the room to change his pants he cursed at them stating: "F---- you I don't care if my pants are wet or not." *Id.* Again, no new interventions were added to Resident 6's care plan to address his physically and verbally threatening behavior.

11. September 28, 2006 - while in the hallway with another resident, Resident 6 was given a cup of coffee by the CNA. He then is reported to have turned around and started growling as he walked down the hallway because another resident was trying to speak with him. CMS Ex. 17, at 29, 48. Later the same day, another resident was in the restroom acting agitated and behaving loudly when a CNA walked by Resident 6 to help the resident in the bathroom. Resident 6 is reported to have stated loudly that someone ought to hit the other resident hard enough to shut him up. *Id.* at 29, 48. In response to this comment, staff contacted Resident 6's physician noting "Res is becoming increasingly aggressive . . . may we have an order for Res to see Dr. Forester? . . . We are concerned because of res behavior we are worried he is going to hurt someone [and] this will be state reportable. . . . Please advise . . ." *Id*. at 54. Resident 6 was evaluated that same day by a mental health professional for a psychological evaluation. It was recommended that the resident be started on Depokate 500 mg. *Id*. at 55-57. The psychological evaluation indicated that Resident 6 had long standing mood, behavior, and reality contact problems. *Id*. at 56.

12. October 4, 2006 - Resident 6 is reported to have become agitated when another resident was in the hall bathroom, resulting in his punching the door. That same day staff updated the resident's care plan for his behaviors of voicing sexually explicit comments, using verbally aggressive language, and hitting doors and walls with his fists. CMS Ex. 17, at 10. To assist Resident 6 in addressing these behaviors, staff were directed to request him to refrain from using either sexually explicit comments; to re-direct him with an activity, specifically "cards"; engage him in appropriate conversation; if angry approach him one staff member at a time and in a quiet area allow the resident to vent his feelings; offer the resident a snack or drink, speaking to him in a calm, non-threatening tone; and lastly, staff were to call the resident's mother for intervention. *Id.*

On October 5, 2006, Surveyor Marla Potts, R.N., interviewed Dr. Forester, the mental health professional who assessed Resident 6 on September 28, 2006. Surveyor Potts testified that she was advised that Resident 6 was described as brain impaired, that he did not have dementia, and that his behaviors were "highly unpredictable." Tr. 52-53; *see also* CMS Ex. 12, at 8. According to Surveyor Potts, she was told by Dr. Forester that when

Resident 6 was doing well, he was not a threat, but when he was doing bad, the resident made him very nervous. Tr. 53; CMS Ex. 12, at 8. On October 5, 2006, following Surveyor Pott's interview with Dr. Forester, immediate jeopardy was called by the survey team. That afternoon the resident was transferred from Petitioner's facility to a local hospital due to physical and verbal aggression. CMS Ex. 17, at 62. The discharge document prepared by Petitioner states the reason for the transfer is that Resident 6 was placed on the dementia unit with no diagnosis of dementia or Alzheimers and that he had exhibited verbal aggression to dementia residents. CMS Ex. 17, at 64.

Petitioner argues that Surveyor Melinda Lewis' testimony is flawed in that during the hearing, according to Petitioner, Surveyor Lewis testified that residents in the SCU had behaviors that annoyed Resident 6; that she did not ask any resident in the SCU if they were scared of Resident 6; and none of the residents on SCU had told her they were scared of Resident 6. P. Br. at 11, citing Tr. 73-74. Other than attacking the surveyor for what she did not do, Petitioner provided no testimony or evidence to contradict Dr. Forester's statement to Surveyor Potts that Resident 6 posed a threat to residents on the unit.

CMS is not required to show that abuse has occurred in order to establish that a facility failed to protect and promote a resident's right to be free from abuse. *Western Care Management Corp. v. CMS*, DAB No. 1921 (2004). A facility's duty to protect residents from abuse includes abuse from other residents. *Id*. Here, CMS contends that Petitioner failed to protect the other residents on the SCU from Resident 6's verbally abusive and physically threatening behavior. CMS further claims that Petitioner should have reevaluated Resident 6's care plan when his behaviors were noted to be more physically threatening in order to determine alternative interventions. It was not until Resident 6 slammed his chair against a table and cursed a female resident that Resident 6's care plan was updated on September 18, 2006. This change was implemented after Resident 6 had already exhibited physically threatening behavior in July, August and September of 2006. The resident's abusive behavior increased in frequency in September 2006 (i.e. yelling, punching his fist, pounding his fist and threatening to kill Resident 20, and slamming his chair against the table and cursing at a female resident, physically threatening Resident 20.) *See* CMS Ex. 17, at 20, 27, 42, 44. CMS maintains that the resident's abusive behavior placed Petitioner on notice that the interventions it had tried were not effective and that Petitioner owed other residents a duty to take additional and necessary measures to protect them, including discharging the abusive resident.

CMS argues that Petitioner should have developed a proactive intervention to try to address Resident 6's abusive behavior before it occurred by identifying potential triggers for Resident 6's outburst. Surveyor Lewis testified that her review of Resident 6's medical record indicated that Resident 6's behavior appeared to be triggered by other residents entering Resident 6's personal space, making noise or engaging in other behavior which annoyed Resident 6. CMS Reply at 15, citing to Tr. 51, 74. However, there is no

assessment in the clinical record which indicates that Petitioner assessed or identified potential triggers for the abusive behavior by Resident 6.

Moreover, CMS states that Petitioner did not remove Resident 6 from the SCU until October 5 when Petitioner was notified that the resident's presence on the unit placed other residents in immediate jeopardy. Petitioner's SCU policy lists as criteria for discharge: "[a] behavioral problem that cannot be managed to provide a safe environment for all individuals on unit as evidenced by violent, aggressive, threatening behavior placing other residents at harm." CMS Ex. 40, at 6. Petitioner's policy on resident abuse defines verbal abuse as "the use of oral, written or gestured language that willfully includes disparaging or derogatory terms to a resident or their families, or within the resident's hearing distance, regardless of their age, ability to comprehend, or disability." CMS Ex. 38, at 1. The policy further provides that "[r]esidents accused of abuse allegations will be removed from the facility if at all possible, and placed in an appropriate environment. If removal from the facility is not possible, the offending resident will be removed from the source of abuse and monitored at all times until appropriate placement can occur." CMS Ex. 38, at 4. CMS states that contrary to its own policy, Petitioner kept Resident 6 on the SCU in spite of his verbal abuse and threatening behavior to other residents.

Petitioner maintains that its staff had identified Resident 6's demeanor towards other residents prior to the survey, recognizing that it had the potential to make other residents feel threatened. Staff had developed a care plan with interventions to prevent encounters by Resident 6 with other residents to avoid the resident becoming abusive, and staff were closely monitoring Resident 6's behaviors and had reassessed and revised the interventions regularly. Petitioner argues that most, if not all, of the outbursts cited by CMS were not the product of a change in Resident 6's mood, but were caused other residents. As examples, Petitioner cites that on one occasion Resident 6 did not become upset until hot coffee was poured on this lap. In another instance, it was not until another resident took his coffee while he was playing cards. P. Br. at 9

In response to CMS's allegation that Petitioner failed to add new interventions to Resident 6's care plan to address threatening behavior, Petitioner maintains that the interventions it had in place were effective in curtailing abusive language and threatening behavior prior to the threatening behavior by Resident 6 on July 28 and August 13 when Resident 6 displayed his fist to Resident 20 while agitated. CMS. Br. at 34. Petitioner further argues that CMS ignores the fact that after the July 28 incident Petitioner's staff intervened and redirected Resident 6 to his room to listen to music which calmed him down. Petitioner maintains that all staff was immediately in-serviced on Resident 6's behavior plan and instructed to notify nursing administration, and social services of further occurrences.

Based on my review of the evidence in this case I find that Petitioner was not in compliance with tag F224. Surveyor Lewis testified that the standard of practice for addressing a resident's verbal or physically threatening behavior is to first separate the abuser from other residents, then assess the abuser by looking at the resident's environment to determine what triggered the abusive behavior. Once potential triggers for the behavior are identified, the facility can develop a plan of care to try to prevent the behaviors from occurring. Tr. 49,73. Petitioner does not dispute that the standard annunciated by Surveyor Lewis was the correct standard, nor does Petitioner argue that it complied with that standard.

Petitioner's SCU policy provides that "[r]esidents accused of abuse allegations will be removed from the facility if at all possible, and placed in an appropriate environment. If removal from the facility is not possible, the offending resident will be removed from the source of abuse and monitored at all times until appropriate placement can occur." CMS Ex. 38, at 4. In the case before me Petitioner moved Resident 6 from one section of the SCU to a higher functioning wing on the SCU after Resident 6 twice used profanity when upset with a special care resident. P. Br. at 10. Petitioner moved Resident 6 into a room next to Resident 20, a 74-year-old man with severe dementia. Thereafter, Resident 6 began to exhibit physically threatening behavior as well as verbal abuse.

While Petitioner moved the resident to a higher functioning unit of the SCU and had a care plan and interventions to address Resident 6's behavior, the record is clear that the care plan and interventions did not prevent Resident 6's abusive behavior from continuing and from escalating into physically threatening behavior. As CMS aptly states, simply redirecting Resident 6 after his abusive or physically threatening behavior occurs is not an adequate or effective response. Furthermore, as CMS points out, both the nursing standard of practice and the regulations required that Petitioner identify possible triggers for Resident 6's verbally abusive and physically threatening behavior, and implement interventions to try to prevent the behavior from occurring. Here, there is no record that Petitioner conducted any assessment to determine the potential triggers for Resident 6's behaviors. The clinical records in this case support the testimony of Surveyor Lewis that Resident 6's behavior appears to have been triggered by the other residents on the unit when entering Resident 6's personal space, by exhibiting behaviors or simply making noise which annoyed Resident 6. This triggered his abusive behavior. Petitioner's transfer of Resident 6 to a higher functioning wing only served to escalate Resident 6's behavior from verbal abuse to physically threatening behavior because the resident in the higher functioning wing were, as Surveyor Lewis testified, were active and more likely to invade Resident 6's space. Petitioner did not assess the apparent triggers to Resident 6's abusive and physically threatening behavior as required by nursing standards and the regulations nor did it care plan or develop intervention to address the triggers for Resident 6's behaviors. Thus, based on my review of all of the evidence relative to this tag, I find

that Petitioner was not in substantial compliance with the requirements of 42 C.F.R. § 483.13(c) - tag F224.

C. The evidence establishes that as of the October 17, 2006 survey Petitioner was not in substantial compliance with the requirements of 42 C.F.R. § 483.25.(h)(2) - tag F324 - Accidents.

The regulation at 42 C.F.R. § 483.25(h)(2) requires that each resident be provided with adequate supervision and assistance devices in order to prevent accidents. In interpreting and applying this regulation, the Board has been consistent in the opinion that providers are not strictly liable as insurers or unconditional guarantors of good outcomes in the delivery of services to facility residents. Rather, the quality of care provisions of section 483.25 impose an affirmative duty upon providers to deliver services designed to achieve the best possible outcomes to the highest practicable degree. *Woodstock Care Center*, DAB No. 1726, at 25 (2000), *aff'd*, *Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). This interpretation is based upon the legislative history of the Act and regulations which reflect that Congress and the Secretary chose to focus upon the desired ends or results of care, thus allowing facilities to meet the requirements for individual care in a variety of ways. *See* Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203 (Dec. 22, 1987); 54 Fed. Reg. 5316 (Feb. 2, 1989).

The specific manner by which facilities are to deliver care and services is not prescribed by 42 C.F.R. § 483.25(h)(2). A facility is permitted to determine the means to achieve the regulatory end which is the prevention of accidental injury of facility residents. Therefore, in order to evaluate Petitioner's compliance with section 483.25(h)(2), it is necessary to examine whether the facility provided adequate supervision designed to meet the residents' assessed needs and to mitigate foreseeable risks of harm to them. *Northeastern Ohio Alzheimer's Research Center*, DAB No. 1935 (2004); *Tri-County Extended Care Center*, DAB No. 1936 (2004).

The level and kind of supervision provided to the residents is reviewed in order to determine whether it was sufficient to prevent any untoward events. The regulation at 42 C.F.R. § 483.25(h)(2) requires that a facility provide *both* "assistance devices" *and* "adequate supervision" to prevent accidents. Whether the supervision or assistance devices are adequate depends on what kind of measures would be determined to prevent potential accidents from occurring given the known or reasonably foreseeable risks. For instance, in *Woodstock*, the Board considered whether the facility had notice of, or should reasonably have anticipated, the risk of the types of events that occurred and whether any reasonable means were available to prevent them without violating the residents' rights. *Woodstock*, DAB No. 1726, at 26-27. In the case before me, the question has to be answered as to whether the facility did "everything in its power to prevent accidents." *Odd Fellow and Rebekah Health Care Facility*, DAB No. 1839, at 6-7 (2002), quoting *Asbury Center at*

Johnson City, DAB No. 1815, at 12 (2002) and *Koester Pavilion*, DAB No. 1750, at 25-26 (2000).

Based on the regulation and the cases addressing this provision, CMS will meet its burden in establishing a prima facie case if it: (1) presents evidence that an accident occurred (with or without harm to a resident); or (2) shows that Petitioner failed to do what it could to supervise residents or provide assistance devices to minimize risks that could lead to accidents. If CMS makes a prima facie case, the burden shifts to Petitioner and the record will then be considered in terms of where the preponderance of the evidence lay.

Petitioner was found to be in violation of this regulation at a scope and severity level of immediate jeopardy. CMS Ex. 1, at 30. CMS alleges that Petitioner was found out of compliance with tag F324 for two reasons: first for its failure to adequately supervise Resident 20 while he was restrained in a Broda chair; and, second, for its failure to

adequately supervise Resident 6 to prevent him from verbally abusing and physically threatening other residents in the unit. CMS Br. at 43-44. Both Resident 6 and Resident 20 were residents on the facility's SCU.

Resident 20

On October 8, in the AM, Resident 20 was in the Broda chair with the thigh belt restraint in place, the resident leaned forward and tipped the chair forward, landing on his head. CMS Ex. 19, at 110. As a result of this fall, the resident sustained a 1 cm x 2 cm circular rug burn on the left side of his forehead. CMS Ex. 19, at 110. CMS contends that Petitioner failed to provide Resident 20 with adequate supervision to prevent him from tipping over his Broda chair while restrained in the chair. CMS Br. at 38. CMS further alleges that Petitioner was on notice as early as June 15, 2006, that the resident was at risk for tipping his Broda chair.

CMS points to the testimony of Petitioner's witness, Mandy Moore, CNA, to support its contentions. Ms. Moore was on duty the morning of October 8 when the resident tipped his Broda chair by leaning it forward. Tr. 262. Ms. Moore observed that the staff person assigned to watch Resident 20 was about four steps ahead of him and her back was turned momentarily as she was crossing the hall with a cup to fill at the sink in the dining room. Tr. 263. Ms. Moore testified that the resident leaned forward tipping the chair in 2-3 seconds. Tr. 264. Ms. Moore pointed out that the Broda chair weighs about 40-50 pounds and the resident weights 90-100 pounds. Tr. 264. Ms. Moore stated that she observed a staff member approximately four steps ahead of the resident with their back to the resident while walking to the sink in the dining room with a cup in their hand. Tr. 263. According to Ms. Moore, given the size of the Broda chair, it would take a lot of force and time for a resident to tip the chair over. Tr. 267-68.

Petitioner relies on the Board's decision in *Burton Health Care Center v. CMS*, DAB 2051 (2006) where the Board agreed with the ALJ that adequate supervision had been provided where an aide providing one-on-one supervision "momentarily" turned her back to get a brief while a resident was sitting in his wheelchair next to the toilet. The resident attempted to transfer himself to the toilet and fell, causing abrasion to his head and hip. *Id*. at 12. The Board agreed with the ALJ that it was not foreseeable, given that the resident was coherent and capable of following instructions, that during the short period that the aide turned to retrieved a brief, the resident did not ask for assistance but rather attempted a self-transfer. *Id.* at 11-12. Petitioner here states that "it was not foreseeable Resident 20 could tip his stationary Broda chair by attempting to stand wearing the thigh belt until this first occurred on September 26th." P. Br. at 6. Petitioner claims that the first time Resident 20 did this was September 26, and Petitioner assigned one-on-one staffing and then eye contact supervision after the one-on-one was removed. Petitioner reports that on October 6, the resident is noted as almost tipping the Broda chair forward by reaching out at a passerby but the aide on the unit was able to stop him, and one-on-one was immediately reinstated. P. Br. at 7. Petitioner argues that because eye contact supervision had been sufficient to stop a near-tipping episode on October 6, it was not foreseeable that Resident 20 would be able to tip his chair on October 8 by leaning forwarding during the brief moment that an aide turned her back momentarily to get a cup of water for the resident. Petitioner further claims that even if it was foreseeable that Resident 20 would be able to tip his chair by leaning forward, that the relevant inquiry is whether the supervision provided was adequate under the circumstances. *Id.*

Petitioner's reliance on *Burton* to support its assertions is misplaced as the facts in the matter before me differ from what the ALJ in *Burton* was presented with. Unlike in *Burton*, the staff here did not remain in the same room as the resident and so the staff's actions can not be described as turning away only "momentarily." In *Burton* the resident was not in motion, and not in his chair walking down the hallway as in this case. Petitioner argues that there was only a "momentary lapse in visual supervision by an aide who was within 4 steps of the resident." P. Br. at 8. However, here, Resident 20 was left in an alcove outside of the dining room while the staff person went into the dining room to fill a cup of water, the staff person's back was turned from the resident at the time even though the staff was four steps away from Resident 20. Tr. 263, 266. While her back was turned, Resident 20 succeeded in tipping his Broda chair over. Again, on September 26, the resident had succeeded in tipping his Broda chair over (CMS Ex. 19, at 103), and the record shows that the resident continuously exhibited this behavior. *See* CMS Ex. 19, at 21, 66, 68, 102. Resident 20's clinical record notes that he suffers from severe dementia and acute agitation and confusion. I find that it was foreseeable that he would try to tip his Broda chair over again if left unattended.

Although Petitioner claims that one-on-one supervision was resumed on October 6, after the resident nearly tipped his rocker forward while reaching out toward other residents (P. Br. at 3), there is no record indicating that one-on-one supervision was implemented as a permanent intervention following the incident. CMS Ex. 19, at 108. The DON, the Safety Risk Manager, and the staff person assigned to the resident on October 8 told Surveyor Lewis that Resident 20 was receiving only eye sight supervision on October 8, not one-on-one. CMS Ex. 13, at 8; CMS Ex. 19, at 162, 162; Tr. 43-44. Petitioner's own witness, Ms. Moore, who had witnessed the fall on October 8, never testified that Resident 20 was receiving one-on-one supervision at the time of the fall. Tr. 261-69. Rather, when Ms. Moore first observed Resident 20, he was already on his feet with the chair coming forward. Tr. 263.

There was consistency among the witnesses (Surveyors Lewis, Potts, and Crays; Ms. Moore; and Ms. Anderson) that one-on-one supervision required that one staff member be within arms reach of Resident 20 at all times, ready to assist with his needs. Tr. 43, 190, 193, 231, 243, 247-48, 262, 320. Thus, as the evidentiary and testimonial evidence establishes, Resident 20 was not provided with one-on-one supervision as such that a staff member was within arm's reach of him at all times.

CMS has established that on October 8, 2006, Resident 20 tipped his Broda chair over attempting to stand while restrained, that the resident sustained an injury, and that the supervision being provided to the resident at the time did not meet the level required by the resident's care plan. Resident 20's care plan, dated September 26, 2006, appropriately called for one-on-one supervision while the resident was in the Broda chair with the goal of no falls for 30 days. CMS Ex. 19, at 13. Petitioner has not provided justification for Resident 20 to not be on one-on-one supervision subsequent to September 26, 2006. Moreover, the resident record further notes that on October 8, 2006, apparently after Resident 20 tipped the Broda chair over again, staff recorded as a problem "Res tipped chair over causing injury to head" and an intervention, one-on-one supervision was again listed. *Id.* at 14.

Resident 6

As a matter of judicial economy I do not address CMS's allegation of noncompliance related to Resident 6 under tag F324 as I find the evidence as to Resident 20 as outlined above, sufficient to sustain CMS's determination of noncompliance at the immediate jeopardy level under this citation.

Accordingly, I find that Petitioner has failed to provide evidence to successfully rebut that as of the October 17, 2006 survey Petitioner did not comply substantially with the requirements of 42 C.F.R. § 483.25.(h)(2).

D. CMS's determination that Petitioner's noncompliance at tags F221, F224, and F324 constituted immediate jeopardy was not clearly erroneous.

As previously noted, *immediate jeopardy* is defined as a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. 42 C.F.R. § 488.301 Further, *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." *Id.*

Petitioner challenges CMS's determination that the alleged noncompliance for tags F221, F224, and F324 constituted immediate jeopardy, stating that CMS's determination is clearly erroneous. I note that CMS stipulated that the examples not contested by Petitioner are not part of the immediate jeopardy findings at tags F221 and F324. Tr. 2.

Petitioner's failure to assess Resident 20 for use of the thigh belt restraint both before implementing use of the restraint and after the resident exhibited dangerous behavior while retrained in the Broda chair placed the resident in immediate jeopardy. The resident's record is replete with documented incidents where the resident was agitated and continuously attempted to move or tip the Broda chair over. The resident's record shows that he was successful in tipping his Broda chair over twice, both times hitting his head. Therefore, I sustain CMS's determination that Petitioner's noncompliance at tags F221 and F324 did place Resident 20 in immediate jeopardy.

The clinical records relative to tag F224 establish that Resident 6 was verbally abusive and physically threatening to other residents in the SCU. The medical records clearly indicate that staff were concerned that Resident 6 posed a threat to other residents as demonstrated by the entry which indicates: "Res is becoming increasingly aggressive . . . may we have an order for Res to see Dr. Forester? . . . We are concerned because of res behavior we are worried he is going to hurt someone [and] this will be state reportable. . . . Please advise . . .". CMS Ex. 17 at 54. During an interview with Surveyor Potts, Dr. Forester described Resident 6's behavior as "highly unpredictable." Tr. 52-53; *see also* CMS Ex. 12, at 8. According to Surveyor Potts, she was told by Dr. Forster that when Resident 6 was doing well, he was not a threat, but when he was doing bad, the resident made him very nervous. Tr. 53; CMS Ex. 12, at 8. Based on the evidence, I sustain CMS determination that Petitioner's noncompliance with tag F224 placed the residents of the facility in immediate jeopardy. I further find that Petitioner has not sustained its burden of proving that CMS's determination of immediate jeopardy relative to these tags was clearly erroneous.

E. The alleged violation of 42 C.F.R. § 483.25 (Tag F309).

Petitioner advised me at hearing that it does not dispute the violation of 42 C.F.R. § 483.25 (tag F309), nor does Petitioner challenge the imposition of a CMP of $50 per day for the duration of that violation. Tr. 24-25.

As a threshold matter, my review is limited to those issues that Petitioner has appealed and over which I have jurisdiction. Inasmuch as Petitioner did not challenge the quality of care deficiency citation of 42 C.F.R. § 483.25 (tag F309), that finding remains uncontested. 42 C.F.R. § 498.20(b).

F. A CMP of $10,000 per day for one day beginning and ending October 17, 2006 is reasonable.

Petitioner has not contested the reasonableness of the $10,000 per day CMP imposed by CMS for the three immediate jeopardy level deficiencies identified in the October 17, 2006 SOD. *See* Request for Hearing; Jt. Stip. However, even if Petitioner had challenged the CMP, since I have affirmed CMS's determination of immediate jeopardy for deficiency tags F221 and F324 is not clearly erroneous, I must also affirm the CMP imposed against Petitioner. In doing so, I take into consideration the factors specified in 42 C.F.R. § 488.438(f). Therefore, given the seriousness of the deficiencies cited, Petitioner's culpability, its history of noncompliance[9], and the fact that Petitioner has not raised the issue of its financial condition, I conclude that a $10,000 per day CMP imposed by CMS was reasonable. I also note that according to CMS, the $10,000 per day CMP imposed on October 17 was a result of both the three immediate jeopardy findings litigated and the nine non-immediate jeopardy findings not appealed by Petitioner. CMS Br. at 44.

VI. Conclusion

Based on my review of all of the evidence and testimony presented in this case, I sustain the determination of CMS to impose a CMP against Petitioner beginning and ending October 17, 2006. I further find that the $10,000 CMP imposed in this case is reasonable.

/s/
Alfonso J. Montaño
Administrative Law Judge

[9] During a September 12, 2006 survey, as well as other surveys dating back to 2003, Petitioner was found out of substantial compliance with 12 federal participation requirements which included the same tags cited in this case. CMS Br. at 45-46; CMS Ex. 3, at 1.