Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Carroll County Nursing and Rehabilitation Center
(CCN: 04-5295),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-09-312

Decision No. CR2220

Date: August 13, 2010

DECISION

Petitioner, Carroll County Nursing and Rehabilitation Center, was not in substantial compliance with Medicare program participation requirements from November 3, 2008 through December 30, 2008, due to violations of 42 C.F.R. §§ 483.20(b), 483.25(h) and 483.75, during a November 7, 2008 survey. A civil money penalty (CMP) of $5,050 per day for the period starting November 3, 2008 and continuing through November 5, 2008, for the three immediate jeopardy deficiencies, and a $600 per day CMP for the period of November 6, 2008 and continuing through December 30, 2008, due to Petitioner's continued noncompliance, for a total CMP of $48,150, are reasonable. I do not find reasonable a $5,050 per day CMP being assessed against Petitioner for immediate jeopardy level deficiencies for the period November 6 through 7, 2008.

I. Background

Petitioner is a dually participating nursing care facility located in Berryville, Arkansas. Petitioner participates in the Medicare program. Sections 1819 and 1866 of the Social Security Act (Act) and implementing regulations at 42 C.F.R. Parts 483 and 488, govern

its participation in Medicare. Its hearing rights in this case are governed by 42 C.F.R. Part 498.[1]

The Arkansas Department of Human Services (state survey agency) for compliance with Medicare participation requirements on November 7, 2008 (November survey) and then was resurveyed December 29, 2008 through January 1, 2009 (January survey) to determine whether Petitioner had implemented its plan of correction and achieved substantial compliance. During the November 7 survey, Petitioner was found to not be in substantial compliance with 12 participation requirements – nine non-immediate jeopardy deficiencies and three immediate jeopardy level deficiencies.[2] CMS Exhibit (Ex.) 2. CMS determined to impose sanctions to remedy Petitioner's alleged noncompliance.[3] During the January survey Petitioner was found to still be in substantial noncompliance with participation requirements and additional remedies were imposed by CMS. CMS Ex. 1, at 7. Petitioner requested a hearing by letter dated March 11, 2009, challenging only the findings and related remedies for the immediate jeopardy level deficiency tags F272 (violation of 42 C.F.R. § 483.20(b) (Comprehensive assessment)), F323 (violation of 42 C.F.R. § 483.25(h) (Accidents)), and F490 (violation of 42 C.F.R. § 483.75 (Administration)). The case was assigned to me for a hearing, related proceedings, and a decision.

On June 24, 2009, CMS moved for partial summary disposition on the nine non-immediate jeopardy deficiencies and related remedies that Petitioner did not appeal from both the November and January surveys. Petitioner filed a response on July 14, 2009 to CMS's motion with attachments which included the three CMS notice letters it had received. Petitioner filed its prehearing exchange on August 4, 2009, which included 24 proposed exhibits that it identified as P. Ex. 1 – P. Ex. 24. CMS filed its prehearing exchange on August 4, 2009, which included 34 proposed exhibits that it identified as CMS Ex. 1 – CMS Ex. 34. On August 11, 2009, Petitioner filed a subpoena request. On

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[1] Petitioner is a nursing home facility both under the federal Medicare program (as an SNF) and the state Medicaid program (as an NF) and is referred to as a "dually participating facility." *See* 42 C.F.R. § 488.301. SNFs are governed by section 1819 and 1866 of the Act and NFs are subject to section 1919 of the Act.

[2] The November survey findings include nine deficiency tags at the non-immediate jeopardy level and related remedies which Petitioner is not appealing and which are administratively final (*see* October 7, 2009 Ruling), and three immediate jeopardy level deficiencies alleging violations of 42 C.F.R. §§ 483.20(b) (Tag F272), 483.25(h) (Tag F323), and 483.75 (Tag F490).

[3] The sanctions were set forth in CMS notice letters dated December 8, 2008, January 14, 2009, and January 20, 2009. CMS Ex. 1.

August 24, 2009, Petitioner filed objections to several of CMS's proposed exhibits. On September 15, 2009, the parties each filed their prehearing briefs.

On September 17, 2009, a telephone prehearing conference was convened with the parties to discuss proceedings in this matter and my rulings on (1) CMS's motion for partial summary disposition, and (2) Petitioner's document production and subpoena requests, objected to by CMS, and Petitioner's response to CMS's objections. During the conference Petitioner confirmed that it was not challenging the nine non-immediate jeopardy level findings resulting from the November survey of its facility, and all the deficiency findings from the January survey. On October 7, 2009, I issued a ruling affirming the unchallenged deficiencies and related remedies as administratively final, and addressing Petitioner's objections to CMS's proposed exhibit. I incorporate that ruling into this decision. *See* Ruling issued October 7, 2009; *see also* Petitioner's Response dated July 14, 2009 (where Petitioner concedes that the unchallenged deficiencies and related remedies are administratively final). Having found that Petitioner raised a genuine issue of material fact as to the interpretation of the CMS notice letters pertaining to the CMP of $600 per day for the period from November 8, 2008 through December 30, 2008 which stemmed from the November survey, I directed the parties to present evidence to support their position regarding this factual issue. On October 12, 2009, Petitioner filed an objection to my ruling on its request for document production and, on October 21, 2009, I issued an order overruling Petitioner's objection.

On January 14, 2010, Petitioner notified my office, by electronic correspondence, that it wished to waive its right to an in-person hearing, and requested that the in-person hearing be vacated. It further requested that I decide this matter on the written submissions of the parties. A conference call was convened with the parties on January 15, 2010, to discuss Petitioner's email waiver notification. During the conference call, Petitioner reaffirmed its request to waive an in-person hearing, and both parties advised me that testimony from witnesses would not be necessary. The parties asked that I decide the matter on the written record. The parties' request was granted and Petitioner was directed to file a formal written waiver. 42 C.F.R. § 498.66. An order was issued on January 20, 2010, providing the parties with filing deadlines for the submission of their final briefs and other supporting documents.

On January 28, 2010, Petitioner filed its formal written request waiving its right to an in-person hearing, as well as its objections to 22 of CMS's proposed exhibits. On February 4, 2010, CMS filed a request to present additional evidence but withdrew its request on February 9, 2010. On February 5, 2010, the parties filed their Joint Stipulations of Fact (Jt. Stip.), and on February 9, 2010, CMS filed its brief (CMS Brief), amended list of proposed exhibits and witnesses. In response to Petitioner's objections to CMS's proposed exhibits, CMS withdrew all of the exhibits Petitioner objected to, except for

CMS Exs. 7 and 14.[4] CMS did not file any objections to Petitioner's exhibits. Petitioner filed its brief (P. Brief) on March 31, 2010. CMS's reply (CMS Reply) was filed on May 5, 2010.

I determine that the two exhibits proposed by CMS (CMS Exs. 7 and 14), and objected to by Petitioner, are relevant and will be admitted. CMS Ex. 7 contains records related to Resident 6, and CMS Ex. 14 contains records related to Resident 19's records. Since both of these residents are named in deficiency tags F323 and F490, the documents contained in the exhibits are important for my consideration in reviewing the reasonableness of CMS's determination to impose a $600 per day CMP against Petitioner for continued noncompliance with participation requirements at the non-immediate jeopardy level for the period of November 8, 2008 and running to December 30, 2008. Petitioner's objections are therefore overruled, and I admit into the record CMS Exs. 1-4, 7, 10, 14, 15, 18-22, 33, 34, and P. Exs. 1-24.

CMS's amended witness list, filed February 9, 2010, listed 10 witnesses; however, CMS did not provide sworn affidavits for any of the listed witnesses.[5] Petitioner offered as exhibits nine sworn affidavits.[6]

This decision is based on the complete record, which includes the parties' arguments, written submissions, and exhibits admitted into the record.

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[4] Petitioner objected to CMS proposed exhibits 5-9, 11, 12-14, 16, 17, 19, 20, 22, 23-32. CMS withdrew CMS proposed exhibits 5, 6, 8, 9, 11-13, 16, 17, 23-32.

[5] CMS's amended witness list included Susan LeBlanc, R.N. and Daniel McElroy, R.N., both from CMS's Division of Medicaid and State Operations; surveyors Kathy Mitchell, R.N., Joleen Newsbith, R.N., and Vicky Cummings, R.N.; and, from the state survey office, Johanna Siebert, Shey Mclish, Pharmacist, Pat Ford, Dionne Hayes, R.N., Deborah Crows, R.N., and Linda Van Scotter.

[6] Petitioner offered the affidavits of Shannon Davidson, Director of Nursing (DON) (P. Ex. 11); Anna Fultz, Certified Nurse Aide (CNA) (P. Ex. 12); Debra K. Parton, Licensed Practical Nurse (LPN) (P. Ex. 13); Kathy Reichenberg, LPN (P. Ex. 14); Melody Stephens, LPN (P. Ex. 15); Derrick Williams, CNA (P. Ex. 16); Shannon Shields, CNA (P. Ex. 17); April Chaney, CNA (P. Ex. 19); Sheila McCutcheon, Administrator (P. Ex. 20). Petitioner also presented two documents titled as affidavits, but which were neither signed nor sworn to: (1) affidavit of Vicki Smith, CNA (P. Ex. 18); and (2) John Michael Storm, III, President of Storm Medical Equipment Company, Inc, a distributor of health care equipment (P. Ex. 21).

II. Burden of Proof

The standard of proof or quantum of evidence required is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a prima facie showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *See Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x 181 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800 (2001); *Hillman Rehab. Ctr.,* DAB No. 1611 (1997), *aff'd,* No. 98-3789, 1999 WL 34813783 (D.N.J. May 13, 1999); *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998).

Petitioner challenges the allocation of the burden of proof and relies on the Eight Circuit decision in *Grace Healthcare of Benton v. Dep't of Health & Human Servs.,* 589 F.3d 926 (8th Cir. 2009)*, amended by* 603 F.3d 412 (8th Cir. 2009)*,* to support its claim that placing the burden of proof to show substantial compliance on the facility violates the Administrative Procedure Act (APA). Petitioner asks that I adhere to the requirements of the APA and place the burden of proof on CMS. P. Brief at 1, 2. Petitioner's reliance on the *Grace* decision is misplaced. The Court did not reassign the burden of persuasion and, in fact, expressly stated that the burden of proof issue had not been raised. *Grace Healthcare of Benton*, 589 F.3d at 933 n.7. Although the Court discussed the *Hillman* decision, it declined to address the Departmental Appeals Board's (Board) allocation of the burden of proof. The Court's discussion of Board decisions addressing the burden of proof was confined to a footnote and, as such, constitutes dicta.

I allocate the burden of proof in accordance with the Board's precedent and Petitioner has not advanced any reason for me to allocate the burden in any other way.

III. Issues, Findings of Fact, and Conclusions of Law

A. Issues

The issues in this case are whether:

1. Petitioner was in violation of 42 C.F.R. §§ 483.20(b) (Tag F272), 483.25(h) (Tag F323), and 483.75 (Tag F490) during the November 7, 2008 survey;

2. CMS's determination of noncompliance at the immediate jeopardy level is clearly erroneous; and

3. The remedies imposed were reasonable.

B. Findings of Fact and Conclusions of Law

I make the following findings of fact and conclusions of law (Findings).

1. Petitioner failed to comply substantially with Medicare participation requirements.

For the reasons discussed below, I find that CMS presented evidence sufficient to establish a prima face case that Petitioner was not complying with Medicare participation requirements and that Petitioner's violation of 42 C.F.R. §§ 483.20(b), 483.25(h); and 483.75 was at the immediate jeopardy level for the findings related to use of the Vander-Lift II for resident transfers. Additionally, I find that Petitioner continued to not be in compliance with the participation requirements of 42 C.F.R. §§ 483.25(h) and 483.75 at the non-immediate jeopardy level through December 30, 2008.

a. Petitioner failed to comply substantially with the requirement of 42 C.F.R. § 483.20(b)(Comprehensive assessments, Tag F272), at a scope and severity level of "K".

The regulation at 42 C.F.R. § 483.20(b) states, in pertinent part:

> *Comprehensive assessments* ─ (1) *Resident assessment instrument.* A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. . . . The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

The State Operations Manual (SOM) for tag F272 states that the assessment requirement is an on-going process requiring the facility to identify the resident's functional capacity and health status.[7] CMS maintains that Petitioner was found to not be in compliance with

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[7] State Operations Manual, CMS Pub. 100-07, App. PP – Guidance to Surveyors for Long Term Care Facilities (tag F272) (accessible at http://www.cms.hhs.gov/Manuals/IOM/list.asp). Although the SOM does not have the force and effect of law, the provisions of the Act and regulations interpreted clearly do have such force and effect. *State of Indiana by the Indiana Dep't of Public Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991); *Northwest Tissue Ctr. v. Shalala*, 1 F.3d 522 (7th Cir. 1993). Thus, while the Secretary may not seek to enforce provisions of the SOM, the Secretary may seek to enforce the provisions of the Act or regulations as interpreted by the SOM.

the assessment requirement because it failed to assess the needs of Residents 2 and 9 (R2, R9) as to use of a mechanical lift (also referred to as a Vander-Lift II or Hoyer lift). CMS argues that these failures were cited as immediate jeopardy level deficiencies. Petitioner maintains that R2 and R9 were assessed for suitability for the Hoyer lift and for transfer. P. Brief at 10.

1. Findings related to R2.

The parties do not dispute that on October 8, 2008, during a transfer from the resident's geri-chair to her bed, a Vander-Lift II was used and R2 is reported as having grabbed the lift with her hands and repeatedly shook the lift during the transfer. CMS Ex. 4, at 15. R2 then proceeded to fall, sustaining a fracture of her right hip. *Id.* at 21. During this transfer, one staff person was transferring R2 with the lift, without any assistance. CMS Ex. 4, at 15-16. Petitioner does not dispute that R2 required the assistance of two or more persons for transfer. P. Brief at 10.

CMS asserts that Petitioner failed to produce evidence that it assessed R2's transfer needs which included: (1) suitability for transfer; (2) the proper transfer technique to use with the resident; (3) the appropriate sling size to be used with R2; and (4) the number of staff necessary to transfer the resident using a mechanical lift. CMS Brief at 9. Petitioner disputed this allegation, stating that R2 was assessed for suitability for the Hoyer lift and for transfer. P. Brief at 10.

A review of the evidence before me shows that R2 was admitted to Petitioner's facility in April of 2007, and is noted at the time of the incident at issue to have diagnoses that include Alzheimer's Disease, osteoporosis, and fractures of the left tibia fibula and right hip. CMS Ex. 4, at 1. R2's March 14, 2008 Minimum Data Set assessment (MDS) notes her as having moderately impaired cognitive skills for daily decision-making. She also required assistance of two or more persons for transfers and had to be lifted manually and mechanically for transfers. *Id.* at 42-44. Her April 4, 2007 plan of care (POC), which was updated on September 12, 2008, notes that the resident: had the potential for falls, had decreased physical abilities, had a tendency to move during transfers; and was noncompliant with directions. *Id.* at 67. R2's last activities of daily living (ADL) Functional/Restorative Assessment and Progress (ADL) evaluation, completed September 12, 2008 (prior to her October 8, 2008 fall), notes her as being dependent for transfers, bed mobility, and positioning. I note, however, under the adaptive equipment category, although there is an area where the use of a Hoyer lift with a resident should be checked, R2's assessment does not indicate that a Hoyer lift was to be used for transfers. *Id*. at 63 (*see also* March 14, 2008 and June 13, 2008 ADL assessments (neither document the Hoyer lift or any type of mechanical lift could be used for R2). Although R2's March MDS notes that she was assessed for lifts, and required either manual or mechanical lifts for transfers, there is no indication in R2's ADL evaluation that a Hoyer lift was to be used. Rather, on the ADL evaluation, the section noting that a resident

requires a Hoyer lift for transfers is not checked off. *Id*. at 44. I find that the information in R2's record is inconsistent as to her transfer needs and Petitioner has not provided any argument or evidence to explain this inconsistency.

CMS states that the manufacturer's instructions for the Vander-Lift II, which is the lift Petitioner uses at its facility for mechanical transfers of residents, provide that staff assess residents to determine which are suitable for transfer, the transfer techniques to be used, the appropriate sling size to use when transferring a resident, and the number of staff required for the transfer. CMS Ex. 18, at 22. CMS further states that Petitioner did not have a policy in place addressing mechanical lifts, and CMS did not cite Petitioner solely because it failed to follow the manufacturer's instructions; rather, Petitioner was cited due to a combination of Petitioner's failure to follow the manufacturer's instructions and Petitioner's failure to assess the two residents requiring mechanical transfers, which led to the determination that Petitioner was not in compliance with regulatory requirements. CMS Brief at 10.

Petitioner states it had a facility-wide policy that all transfers using a mechanical lift required the assistance of two staff members. P. Brief at 6. Petitioner claims that a lapse occurred that resulted in the unforeseeable activities by the staff member involved in the transfer of R2 on October 8, 2008, without additional assistance. The thrust of Petitioner's argument is that the staff member acted against facility policy when lifting R2 without additional assistance and that this incident is insufficient to claim a "systemic problem" that justifies an immediate jeopardy level citation. *Id*. At 13-14. I find that the evidence before me does not support Petitioner's assertions. Ms. Fultz, the sole certified nursing assistant (CNA) who was involved with the transfer of R2 on October 8, 2008, admitted in her sworn affidavit, which Petitioner offered as P. Ex. 12, to having observed other CNAs "do a solo lift of Resident 2 using the Vander lift." P. Ex. 12 ¶ 5. Based on this testimony, it would appear that October 8, 2008 was not the first time staff at Petitioner's facility transferred R2 without the use of two or more persons. Moreover, Petitioner failed to offer any evidence of its facility-wide policy in these proceedings.

Petitioner also failed to assess R2 as to the appropriate size sling necessary to ensure she was safety transferred. According to the SOD, on November 3, 2008, the Assistant Director of Nursing (ADON) was interviewed. She informed the surveyor that two weeks prior, while she was present at the facility, R2 had slid out of a lift because staff had used too large a sling. CMS Ex. 2, at 15. The SOD also notes that when the Director of Nursing (DON) was interviewed on November 4, 2008, she admitted that the facility did not have assessments documenting the use of the Vander-Lift II. When asked where the documentation was for the CNA to look at to determine the proper sling size, the DON stated that the CNAs could go to CNA 5. The SOD further notes that, when surveyors asked where CNAs could find the information if CNA 5 was not available, the DON responded, "[w]e don't have it documented anywhere, it isn't rocket science." CMS Ex. 2, at 16. Petitioner concedes that there is no documented evidence of what size

sling was to be used by R2. P. Brief at 10. But, Petitioner claims that its CNA staff were trained to determine proper sling size, and Petitioner's restorative aide, April Chaney (CNA 5), was available as a resource. P. Ex. 19. However, according to the SOD, when the surveyor interviewed CNAs 1, 3, 6, and 7 on November 4, 2008, they informed the surveyor that "there was no place they knew to look to know anything about size sling to use, they just used what was there or guessed at the size, and they had not seen assessments or did not know about what was on the Care Plan." CMS Ex. 2, at 16.

Petitioner maintains that the statement of the ADON can not be relied upon because she had no first hand knowledge as to the sling used by R2. In addition, she did not participate in the investigation of the resident's fall. Based on this, Petitioner asserts that the ADON's statement to the surveyors is not reliable. P. Brief at 13. Petitioner relies on the affidavit of Anna Fultz, who was the CNA who transferred R2 on October 8, 2008, stating that Ms. Fultz said that the sling used in R2's transfer was "a little large," and that Ms. Fultz did not state that the sling was the wrong size or unsafe. P. Ex. 12. Petitioner's reliance on Ms. Fultz's affidavit to help establish it was in compliance with the participation requirement at issue here is misguided. A review of the affidavit shows that Ms. Fultz admits that, in the past, she had observed other CNAs do a "solo lift of Resident 2 using the Vander lift." P. Ex. 12 ¶ 5. She further admits that she performed the lift on October 8, 2008, without assistance. *Id.* ¶ 7. She also states "the sling that I used looked a little large, but not too much so." *Id.* ¶ 8. It is clear that Ms. Fultz believed she was using the wrong size sling for R2 when she was transferring the resident on October 8, 2008.

I find that Petitioner has failed to rebut CMS's showing, by a preponderance of the evidence, that Petitioner failed to comprehensively assess R2's transfer needs in order to ensure her safety. Moreover, CMS has shown that R2 sustained actual harm as a result of Petitioner's failure, having sustained a fracture to her right hip resulting from the fall on October 8, 2008. CMS Ex. 4, at 21.

2. Findings related to R9.

Neither party disputes the following facts. On November 4, 2008 at 2:55 PM, a surveyor observed two staff (CNA 1 and CNA 2) perform a lift on R9 using the Vander-Lift II. Jt. Stip. ¶ 5. Following the surveyor's observation, immediate jeopardy was called at 5:20 PM that same day for deficiencies related to the use of the Vander-Lift II. Jt. Stip. ¶ 5, 6.

What is in dispute is whether Petitioner properly assessed the need of R9 as to use of mechanical lifts during transfers; specifically, whether Petitioner properly assessed the proper sling size to be used for R9's transfers.

A review of R9's medical record shows that her July 11, 2008 MDS notes her as being dependent on the physical assistance of two persons for all ADLs. CMS Ex. 10, at 22-27.

Her April 27, 2007 POC, updated October 8, 2008, notes the resident's need for the use of a Hoyer lift for transfers. CMS Ex. 10, at 22. However, the SOD notes that while the surveyor observed the transfer of R9 on November 4, 2008 at 2:55 PM, the staff stated that the sling was too small for the resident. CMS Ex. 2, at 17. According to the SOD, when CNA 1 was interviewed by the surveyor later that day, he stated that he was aware that the sling was too small and admitted that he did not know about her care plan. CMS Ex. 2, at 17.

Although CMS claims R9 was at risk for serious harm or injury, Petitioner insists that the transfer was done successfully and that R9 was not placed in harm. P. Brief at 6. Petitioner claims that the two staff persons who were involved in R9's transfer on November 4, 2008, felt rushed when observed by the surveyor and that the staff reported to Petitioner that the surveyor was "angry or upset." P. Exs. 16 and 17. Petitioner states that "CNA #1 testified that he did not tell the surveyor that the sling was too small, but instead responded that the sling was a size small." P. Brief at 6; P. Ex. 16. I find Petitioner's argument unavailing. Whether the sling was too small, or a size small has the same result, it did not properly fit R9 and clearly placed her at risk for serious harm or injury.

The evidence before me strongly supports the inference that Petitioner's staff who are tasked with doing resident transfers on a daily basis, were not knowledgeable as to how to assess a resident for the proper sling size. Relying on one staff member, CNA 5, is not an answer as it is unlikely that she works 24-hour shifts and would be there at all times. A systemic problem existed at Petitioner's facility, which placed any resident in need of a transfer at great risk of falling. CMS has established R2 sustained actual harm and also risk of harm existed for R9. Any other resident at Petitioner's facility who required a transfer and did not have a properly fitting sling was also at risk of harm.

Petitioner has not overcome CMS's showing that it was not in compliance with the regulatory requirements at 42 C.F.R. § 483.20(b). R2's assessments as to the need for a Hoyer lift were inconsistently documented, and she was not assessed for the correct size of the sling. With respect to R9, the record showed that she needed a Hoyer lift, but she was not assessed for the correct size of the sling.

b. Petitioner failed to comply substantially with the requirement of 42 C.F.R. § 483.25(h) for R2 and R9 (Accidents, Tag F323), at a scope and severity level of "K".

The regulation at 42 C.F.R. § 483.25(h) requires:

> *Accidents.* The facility must ensure that—
>
> (1) The resident environment remains as free of accident hazards as is possible; and

> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

CMS states that Petitioner was found to not be in compliance with the requirements outlined at 42 C.F.R. § 483.25(h) because it failed to provide R2 and R9 with adequate supervision and assistance devices to prevent accidents during transfers.

1. Findings related to R2.

The CNA involved in the transfer of R2 on October 8, 2008, Ms. Fultz, admitted in a sworn affidavit that the sling "looked a little large." Although Ms. Fultz attempts to qualify her statement by saying "but not too much so," it does nothing to negate the fact that the sling used for the resident was the wrong size. P. Ex. 12 ¶ 8. The sworn affidavit from LPN Melody Stephens confirms that Ms. Fultz was aware that the sling she was using with R2 at the time of the October 8 fall was too large. P. Ex. 15 ¶ 4. And, as discussed earlier, Petitioner concedes that there is no documented evidence of what size sling was to be used by R2. P. Brief at 10. I also note that Petitioner does not dispute that R2 required the assistance of two or more people during transfers, nor does Petitioner dispute that the resident's POC noted that she was known to engage in unpredictable behaviors, i.e. grabbing the bar or sling during transfer. Moreover, several of Petitioner's staff noted, when completing a questionnaire on April 1, 2009, regarding the resident's October 8 incident, that they were aware of R2's grabbing behaviors. CMS Ex. 4, at 67; P. Ex. 9, at 3, 4, 6.

I find that R2's behavior of grabbing the bar or sling during her transfer on October 8, 2008, was foreseeable. I further find that R2 sustained actual harm as a result of Petitioner's failure. Accordingly, I conclude that CMS has established a prima facie case, which Petitioner has failed to overcome by a preponderance of the evidence, that Petitioner's staff did not provide proper care and supervision when only one staff person transferred R2.

2. Findings related to R9.

Petitioner's staff admitted to not following the manufacturer's instructions when they failed to use the correct sling size. CMS Ex. 2, at 17; CMS Ex. 18, at 22. CNA 1 admitted that because he and CNA 3 felt rushed, they used the sling that was already under the resident from a previous shift, thus failing to assess the appropriateness of the sling size for R9. P. Ex. 16 ¶ 7; P. Ex. 17 ¶ 5.

CMS has established that Petitioner's staff did not provide proper care and supervision to R9, when they failed to use the correct sling size to transfer her on November 4, 2008. Thus, they placed R9 at risk of harm. Petitioner has not provided evidence to overcome CMS's showing. Accordingly, I find that Petitioner's failure to assess R9 for the correct

size sling prior to use, contrary to the manufacturer's instructions, was a violation of the participation requirements at 42 C.F.R. § 483.25(h) and placed R9 at risk for harm.

c. Petitioner failed to comply substantially with the requirement of 42 C.F.R. § 483.25(h) for R6 and R19 (Accidents, Tag F323), at a non-immediate jeopardy level of compliance.

Also during the course of the November survey, Petitioner was found to be in violation of 42 C.F.R. §§ 483.25(h) and 483.75 (cited at Tags F323 and F490), for deficiencies related to resident smoking. The parties have agreed that even though the resident smoking-related deficiencies are cited at Tags F323 and F490 which are identified as immediate jeopardy level tags, the allegations related to the resident smoking deficiencies do not constitute immediate jeopardy level deficiencies. Jt. Stip. ¶ 8, 9. In its brief Petitioner addresses tags F323 and F490 regarding the smoking deficiencies, stating that it would not pursue these smoking-related deficiencies if I rule that they were not immediate jeopardy level and did not contribute to the associated CMPs. I therefore undertake a review of the findings related to both R6 and R19 in order to determine if there was a basis for CMS to impose against Petitioner a $600 per day CMP from November 8, 2008 through December 30, 2008, based on Petitioner's continued noncompliance at a non-immediate jeopardy level.

Petitioner's facility had a smoking policy which was effective September 1, 2005. It provided that: residents would be issued cigarettes in the quantity deemed safe for them to handle; staff would stay with the residents who needed supervision while smoking; and that lighters would be kept at the nurse's stations as residents should not have a lighter in their possession. P. Ex. 1, at 2. On September 1, 2007, Petitioner's smoking policy changed, allowing for the issuance of cigarettes to residents in the quantity deemed safe for them to handle. In addition, residents could have possession of a lighter, unless there was a past problem or a problem developed. The requirement that staff would stay with residents who needed supervision while smoking was not changed in the September 1, 2007 smoking policy. CMS Ex. 18, at 3. Petitioner's September 1, 2005 and September 1, 2007 smoking policies both state that admission for a resident who smokes will be contingent upon his or her agreement to abide by Petitioner's smoking policy. P. Ex. 1, at 1; CMS Ex. 18, at 3.

Petitioner presented sworn affidavits from its Administrator, Sheila McCutcheon, and its DON, Shannon Davidson. P. Exs. 4 and 6. According to Petitioner, their testimony shows that the September 1, 2007 smoking policy, allowing residents to keep lighters, was the policy in place at the time of the November 7 survey. Petitioner claims both R6 and R19 were assessed, and then reassessed periodically as to their ability to safely smoke unsupervised. And, if a resident was determined to be unsafe when smoking, then he or she would be provided supervision to prevent injury. P. Brief at 7.

The SOD alleges that Petitioner failed to provide evidence that the two residents had agreed to the facility's 2007 smoking policy or evidence of an assessment of smoking for resident safety. CMS Ex. 2, at 39, 41.

1. Findings related to R6.

The SOD notes that, on the morning of November 5, 2008, a surveyor interviewed R6. R6 told the surveyor that he was allowed to smoke by himself and that he had a Scripto lighter in his possession. CMS Ex. 2, at 36. Later that morning, while on a designated smoker's porch, the surveyor observed R6 take a lighter out of his shirt pocket and light his cigarette. According to the SOD entry, the resident was with R19 and another male resident, but there were no staff present. *Id.* at 36. A few minutes later, the surveyor observed R6 pass his lighter to R19, who then used the lighter to light her own cigarette. The SOD entry notes that no staff was present on the smoker's porch with the residents. *Id*. at 36-37. On November 6, 2008, the surveyor observed R6 enter a designated smoking area and light a cigarette. The SOD entry notes that also on the porch were R19 and another resident, but there were no staff. The surveyor then observed R19 move to a chair near R6 and use R6's lighter to light her own cigarette. *Id*. at 36.

R6 was admitted to Petitioner's facility on February 26, 2007, and signed Petitioner's September 1, 2005 smoking policy (most current at the time), on February 27, 2007. CMS Ex. 7, at 1; P. Ex. 1. At the time of the survey, R6 had diagnoses which included cerebrovascular accident, seizure disorder, left arm and leg weakness, ataxia, depression, and malignant brain tumor with agitation. CMS Ex. 7, at 1. R6's August 14, 2008 MDS notes that he has moderately impaired cognitive skills for daily decision-making, is easily distracted with mental functions that varied over the course of the day, had persistent anger that was easily altered, and required extensive physical assistance of one person for daily living activities with the exception of eating. CMS Ex. 7, at 89-90. The resident's March 2, 2007 POC, updated August 16, 2008, identified R6's risk for injury to self and others, and environment hazards related to his smoking, as a problem. CMS Ex. 7, at 22. The August 16, 2008 POC lists the following approaches: (1) keep lighter at nursing stations, (2) have staff light cigarettes, and (3) ensure that the resident does not smoke alone. *Id*. However, a July 21, 2008 POC, updated August 15, 2008, notes as problems that R6: was hazardous to both himself and others, refused to wear a smoking apron, had lighter fluid; and was a chain smoker at times. The July 21, 2008 POC, as updated on August 15, 2008, lists the following approaches: (1) remove lighter fluid from the resident's possession; (2) a smoking apron should be placed on the resident when he is taken to smoke or has a lit cigarette; (3) involve his family as reinforcement; and (4) have his family remove his lighter fluid and not bring any more into the facility. An added notation stating that as of August 15, 2008, the resident was allowed to keep a lighter. CMS Ex. 7, at 27. It is clear that R6's POC interventions for the same hazardous behavior conflict, i.e., it is not clear whether R6 can: have a lighter in his possession;

even light cigarettes on his own, or can even smoke without staff supervision. *Compare* CMS Ex. 7, at 22 *and* CMS Ex. 7, at 27.

An entry in the nurse's note dated June 28, 2008, states that R6 got very close to setting his mustache on fire while lighting a short cigar, and states that the resident might need supervision with lighters. CMS Ex. 7, at 67. Additionally, from a medical perspective, R6 was at risk for complications related to possible seizure activity. CMS Ex. 7, at 2. Several nurse's note entries state that R6 had seizures lasting from 30 seconds to 1 minute on October 7, 2008, October 29, 2008, and on November 5, 2008. *Id.* at 71, 75, 77. However, as noted above, from my review of the documents presented, it appears that conflicting documentation exists as to whether R6 could smoke with the supervision of staff, or even could carry a lighter.

I also find that CMS has presented evidence sufficient to establish a prima facie showing which Petitioner has not successfully rebutted that R6 was not receiving adequate supervision and assistance devices to prevent accidents, in violation of the participation requirements outlined at 42 C.F.R. § 483.25(h). The evidence before me clearly shows that R6 was in need of supervision when smoking and therefore, pursuant to Petitioner's September 1, 2007 smoking policy, if a resident was determined to be unsafe, as was R6, the resident should be provided supervision to prevent injury. *See* CMS Ex. 18; P. Brief at 7. Based on the evidence before me, Petitioner failed to do so with R6. Petitioner admitted that R6 has a history of noncompliance, but stated that even though it made several interventions to improve his behavior, the resident continued his noncompliant behavior. P. Ex. 4; P. Brief at 11. Petitioner cannot negate its responsibility for the safety of its residents by simply stating that the resident was noncompliant.

Although CMS has indicated that the findings related to R6's smoking were not cited at an immediate jeopardy level of compliance, I note that there is a potential for Petitioner's failure to result in actual harm to R6.

2. Findings related to R19.

R19 was admitted to Petitioner's facility in February 1995. At the time of the survey, R19 had diagnoses which included seizures, schizophrenia with fluid disorder, dementia with anxiety, agitation with aggression, organize brain syndrome, and major depression. CMS Ex. 14, at 1. A October 3, 2008 MDS notes R19 as moderately impaired in cognitive skills for daily decision-making; is easily distracted; exhibits periods of restlessness; had mental function that varied over the course of the day; and had persistent anger that was not easily altered. *Id.* at 12-13. R19's April 27, 2007 POC, updated October 3, 2008, listed as problems: (1) at risk for injury to self and others; (2) environmental hazards related to smoking; and (3) picks up cigarette butts and hides the cigarette butts to smoke later. The POC interventions listed included: (1) R19 was not to have possession of a lighter or matches; and (2) only staff were to light her cigarettes.

The SOD notes that on November 6, 2008, the DON was interviewed by a surveyor. The DON is reported to have told the surveyor that R19 had set her bangs on fire while smoking, and that the facility kept her cigarette and lighters locked up. CMS Ex. 2, at 40. However, as noted above, on November 4, 2008, a surveyor reported observing R6 light a cigarette for R19. This same behavior was observed by the surveyor the very next day, on November 5, 2008. CMS Ex. 2, at 36-38.

Petitioner was unable to produce an executed copy for R19 of a signed smoker's policy. Petitioner states that R19 was admitted prior to September 1, 2005, and, therefore, there is no policy signed by her in her file. Petitioner also states that although the SOD alleges that it failed to show assessment of the residents for smoking safety, that both residents had care plans in place addressing smoking and that these plans were assessed regularly. P. Ex. 20 ¶ 14; P. Exs. 4, 6. However, in spite of this, both R6 and R19 were noncompliant with their care plans. P. Brief at 11. According to Petitioner, R19's access to lighters and cigarettes was monitored, but the resident continued to request such items and sometimes gained access when staff were not present. P. Brief at 11; P. Ex. 20 ¶¶15, 16.

R19's behaviors, as recognized and assessed by Petitioner, placed her at risk and also the other residents at Petitioner's facility. R19 had already set her bangs on fire while smoking. Petitioner's smoking policy advises residents who smoke that they will be admitted only if they agree to abide by the facility's smoking policy.

I find that CMS has made a prima facie showing that Petitioner was not in compliance with the regulatory requirements set out at 42 C.F.R. § 483.25(h) based on its failure to provide R19 with supervision while smoking to ensure that residents are kept safe. Although CMS has indicated that the findings related to R6's smoking were not cited at an immediate jeopardy level of compliance, I note that there is a potential for Petitioner's failure to result in actual harm to R19, as evidenced by her already having set her own bangs on fire with a lighter.

d. Petitioner failed to comply substantially with the requirement of 42 C.F.R. § 483.75 (Administration, Tag F490), at a scope and severity level of "K".

The regulation at 42 C.F.R. § 483.75 states:

> A facility must 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.

CMS's allegations that Petitioner's facility was not administered in an efficient and effective manner derive essentially from CMS's allegations of the other deficiencies.

CMS's argument is that responsibility for Petitioner's failure to protect its residents rests with Petitioner's management inasmuch as the management's duties included preventing the kinds of systemic failures that were present at the facility. Specifically,
CMS states that the problems at Petitioner's facility related to here were systemic in nature. CMS Brief at 13. In support of its assertion, CMS states that staff interviews by the surveyors revealed that they were not aware whether assessments had been completed for the residents as to suitability for transfer using a mechanical lift, and they did not know how to measure the sling used in transferring the residents. CMS Ex. 2, at 16-18; CMS Ex.15. The regulation required that Petitioner's management assure that its staff identify and address resident needs and that they follow established procedures and protocols. Petitioner's assertions that staff were trained and that it was not aware of its staff's noncompliance does not relieve it of its obligation under the regulation.

Petitioner claims there was no systemic failure of the administration and, as such, there should be no derivative deficiency at 42 C.F.R. § 483.75. Petitioner's defense to CMS's allegations is to argue that they rest on a flawed premise that Petitioner was not in compliance with the other participation requirements. However, the evidence before me plainly establishes Petitioner's noncompliance.

The evidence supports the finding that the facility administration failed to ensure that staff were following its policies, as well as the manufacturer's guidelines regarding measuring for proper sling size. With R2, the CNA used the wrong sling during a transfer; and, when interviewed, several CNAs reported to the surveyor that they did not know about the care plans for the residents. CMS Ex. 2, at 16, 17-18. Petitioner maintains that staff was provided in-service training reminding them that all lifts performed using the Hoyer lift must be performed by two employees. P. Brief. at 6. But, through a sworn affidavit, April Chaney, CNA 5, who was also the Restorative Aide who provided the in-service training to Petitioner's staff after the October 8, 2008 incident with R2, states that the in-service to staff regarding proper use of the Vander-Lift II and assessing residents for proper size slings was in the form of an informational sheet which apparently "instructed and reminded" staff to use two people to transfer residents when using the Vander-Lift II. CMS Ex. 19 ¶ 6. Ms. Chaney also stated that the in-service "instructed and reminded" staff to use the proper sling size when performing transfers. Moreover, Ms Chaney admitted that a demonstration or follow-up to the training was not provided. The rationale Ms. Chaney provided was that the purpose of the training was "simply informative and did not require a skills evaluation." CMS Ex. 19 ¶¶ 7, 8; *see also* P. Brief at 6. Additionally, CNA 3, who was involved in the two-person transfer of R9 on November 4, 2008, admitted that she had not been trained by Petitioner on how to use a lift; but rather, she relied on the training she had received at her previous job. P. Ex. 17 ¶ 7.
I find no dispute as to whether Petitioner's facility was effectively or efficiently managed.

As for the deficiencies related to R6 and R19's smoking, I find that the evidence CMS relied on provides a strong basis for me to further conclude that the facility was neither

efficiently nor effectively managed. The only inference I can draw from the residents' casual defiance of smoking policies is that Petitioner's management had lost control over the resident population. That is more than enough to support a finding of noncompliance.

The problems identified during the November survey resulted from the fact that facility management was lax in enforcing existing policies or in developing interventions that might protect the residents. Even now, Petitioner's primary response to the deficiencies identified at its facility is, essentially, to blame both staff and residents for their failure to adhere to the policies.

2. CMS's finding of immediate jeopardy is not clearly erroneous.

"Immediate jeopardy" is a situation in which a facility's noncompliance with participation requirements is so egregious as to cause, or to be likely to cause, serious injury, harm, impairment, or death to one or more residents. 42 C.F.R. § 488.301. The level of noncompliance must be upheld unless it is clearly erroneous. 42 C.F.R. § 498.60(c)(2).

I find that CMS's finding of immediate jeopardy was not clearly erroneous, and, in fact, CMS has established a causal link between Petitioner's act or omission and the asserted harm or potential for harm. Petitioner failed to ensure that residents who required mechanical assistance with transfers and who were assessed to need the assistance of two or more people for a transfer, were provided with the necessary services while being transferred for their safety. The evidence shows that R2's fall, in which she sustained a right hip fracture, resulted from Petitioner's staff's failure to follow both facility policy and the resident's plan of care. Petitioner's failure to assess residents' needs for transfer when using the Vander-Lift II, its failure to ensure that each resident received adequate supervision and assistance devices to prevent accidents (i.e. proper fitting sling), and the facility's administration's failure to administer the facility in a manner that enabled it to use its resources effectively and efficiently were causal factors in the harm sustained by R2 and the potential for harm R9 was subjected to. I further find that these failures constituted a finding of immediate jeopardy.

Petitioner contends that its failure to assign each resident a sling size did not create an immediate jeopardy situation. P. Brief at 13. I find that Petitioner's assertions are unsupported by the evidence. R2 was transferred by staff using a Vander-Lift II with just one single staff person in spite of the resident's MDS which stated she required the assistance of two or more persons for transfers. R2 sustained a serious injury. Moreover, Petitioner failed to have systems in place to assess and supervise residents being transferred. Lastly, Petitioner fails to explain the inconsistency between R2's March 2008 MDS which notes the need for manual or mechanical lift to be used to transfer R2, and the absence of such notation in the resident's September 12, 2008 ADL evaluation, thus bringing into question the comprehensiveness of Petitioner's assessment of the resident's transfer needs.

CMS presented facts which provide ample support for the conclusion that Petitioner's noncompliance was at the immediate jeopardy level. Petitioner argues that CMS has failed to establish a causal connection between its noncompliance and either the actual or potential harm to the residents at issue. However, this argument fails. The regulations do not require any finding of actual harm to justify a determination that immediate jeopardy to residents existed. For these reasons, I conclude that CMS's finding of immediate jeopardy was not clearly erroneous.

3. *CMS's remedy determinations were reasonable.*

Regulations provide that CMS may impose either a per-diem or per-instance CMP to remedy a nursing facility's deficiencies. 42 C.F.R. § 488.438(a)(1)-(2). CMS may impose penalties in the range of $3,050 to $10,000 per day for deficiencies constituting immediate jeopardy, and $50 to $3,000 per day for non-immediate jeopardy deficiencies. 42 C.F.R. § 488.438(a)(2). In this case, CMS determined to impose a per day CMP of $5,050 from November 3, 2008 through November 7, 2008 for the immediate jeopardy deficiencies and a $600 per day CMP from November 8, 2008 through December 30, 2008, for a total CMP of $57,050.

In determining whether the amount of the CMPs 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.

With respect to facility history, Petitioner has a history of noncompliance as identified in prior survey cycles. CMS Ex. 33, at 2; P. Ex. 23.

Petitioner maintains that its financial condition precludes it from paying the proposed CMPs. Petitioner submitted copies of profit and loss sheets for a nine-month period only, covering October 2008 through June 2009, and its balance sheet as of June 30, 2009, which does not identify the beginning time period of the evaluation period. P. Ex. 24, at 1-2, 3-4. I find that Petitioner has not presented sufficient documentation to show that it is unable to pay the CMPs imposed.

As for culpability, the deficiencies in this case were serious and Petitioner must be considered culpable. Given the seriousness of injury or harm to the residents, the imposed CMPs are reasonable. Petitioner knew of R2's behaviors which placed her at risk for serious injury during transfers.

The $5,050 CMP that CMS proposed to impose is at the mid-range of the range for per diem CMPs for immediate jeopardy deficiencies, and the $600 per day CMP for deficiencies at the non-immediate jeopardy level are fully supported by the evidence in

this case which establishes that Petitioner was not in substantial compliance with the requirements of 42 C.F.R. § 483.20(b), 483.25(h), and 483.75.

What remains to be determined is the issue of duration. CMS conceded that the immediate jeopardy was removed on November 5, 2008, for the three immediate jeopardy tags F272, F323, and F490. CMS Reply at 3 n.1. The parties agree that immediate jeopardy was removed on November 5, 2008, resulting in the deficiencies being lowered to a "G" level, and a $600 per day CMP being imposed until substantial compliance was achieved. Jt. Stip. ¶ 5, 6, 7; CMS Reply at 3 n.1. Consequently, on January 1, 2009, Petitioner was re-surveyed and although the conditions that represented immediate jeopardy had been abated, CMS determined that Petitioner continued to be not in substantial compliance which included 42 C.F.R. §§ 483.25(h) (Accidents) and 483.75 (Administration) which had been previously cited. Therefore, the $600 per day CMP was continued through December 30, 2008.

Given that Petitioner abated immediate jeopardy on November 5, 2008, as CMS conceded, I find that imposing against Petitioner a $5,050 per day CMP for immediate jeopardy level deficiencies for November 6 and 7, 2008, is not reasonable. Rather, I find that a $5,050 per day CMP for the period of November 3, 2008 through November 5, 2008, and a $600 per day CMP for the period of November 6, 2008 through December 30, 2008, are reasonable.

IV. Conclusion

For the foregoing reasons, I conclude that Petitioner was not in substantial compliance with the Medicare program participation requirements at the immediate jeopardy level during the November survey. I find as reasonable a $5,050 per day CMP for the period starting November 3, 2008 and continuing through November 5, 2008, for the immediate jeopardy level deficiencies, and a continuing CMP of $600 per day for the period of November 6, 2008 and running through December 30, 2008.

/s/

Alfonso J. Montaño
Administrative Law Judge