Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Gilman Care Center, LLC,
(CCN: 525674),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-09-603

Decision No. CR2247

Date: September 20, 2010

DECISION

Petitioner, Gilman Care Center (Petitioner or facility), is a long-term care facility, located in Gilman, Wisconsin, that participates in the Medicare program. Over a relatively short period (September 2008 – April 2009), numerous facility residents suffered a multitude of falls, some resulting in serious injuries, yet the facility made little effort to prevent their recurrence. Based on this and other findings, the Centers for Medicare and Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare requirements, and that its deficiencies posed immediate jeopardy to resident health and safety. CMS imposed civil money penalties (CMPs) of $6,800 per day for one day of immediate jeopardy and $400 per day for 35 days of substantial noncompliance that was not immediate jeopardy.

Here, Petitioner challenges CMS's actions.

For the reasons set forth below, I find that the facility was not in substantial compliance with Medicare program requirements; its deficiencies posed immediate jeopardy to resident health and safety; and the penalties imposed are reasonable.

I. Background

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act §1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain 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.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months and more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308.

Here, following a complaint investigation/survey, completed on April 28, 2009,[1] CMS determined that the facility was not in substantial compliance with Medicare participation requirements, specifically:

- 42 C.F.R. § 483.10(b)(11) (Tag F157 – notification of changes);
- 42 C.F.R. § 483.20(k)(1) (Tag F279 – comprehensive care plans);
- 42 C.F.R. § 483.25(h) (Tag F323 – supervision/accident prevention); and
- 42 C.F.R. § 483.30(a) (Tag F353 – sufficiency of staff).

CMS also determined that the deficiencies cited under the supervision/accident prevention regulation (42 C.F.R. § 483.25(h)) posed immediate jeopardy to resident health and safety. CMS Exhibits (Exs.) 1, 3.

CMS subsequently determined that the facility returned to substantial compliance on May 29, 2009. CMS Ex. 4.

CMS has imposed against the facility a CMP of $ 6,800 per day for one day of immediate jeopardy (April 23, 2009), and $400 per day for 35 days of substantial noncompliance

[1] Surveyor Yvonne Breeden initiated the complaint investigation on April 14-15. Based on her findings, CMS decided to extend the survey. Surveyor Lori Metcalfe conducted the more thorough review on April 27-28. Tr. 10-11.

that was not immediate jeopardy (April 23 through May 28, 2009), for a total CMP of $20,800. CMS Ex. 4.

Petitioner timely requested a hearing.

On April 13, 2010, I convened a hearing, via video teleconference, from the offices of the Departmental Appeals Board in Washington, D.C.[2] The parties convened in St. Paul, Minnesota. Mr. Robert M. Hesslink, Jr. appeared on behalf of Petitioner, and Mr. Craig Herkal appeared on behalf of CMS. I have admitted into evidence CMS Exs. 1-45 and P. Exs. 1-17; Tr. 7; Order Summarizing Prehearing Conference at 2-3. The parties filed pre-hearing briefs (CMS Br.; P. Br.), post-hearing briefs (CMS Cl. Br.; P. Cl. Br.) and reply briefs (CMS Reply; P. Reply).

II. Issues

1. From April 23 through May 28, 2009, was the facility in substantial compliance with Medicare program requirements, specifically 42 C.F.R. §§ 483.10(b)(11), 483.20(k)(1), 483.25(h), and 483.30(a);

2. If the facility was not in substantial compliance with 42 C.F.R. § 483.25(h), did its deficiencies pose immediate jeopardy to resident health and safety; and

3. If the facility was not in substantial compliance with program requirements, are the penalties imposed – $6,800 for one day of immediate jeopardy and $400 per day for 35 days of substantial noncompliance that was not immediate jeopardy – reasonable?

Transcript (Tr.) at 5-6; Order Summarizing Prehearing Conference at 1-2.

III. Discussion

A. The facility was not in substantial compliance with 42 C.F.R. §§ 483.25(h) and 483.20(k)(1) because its staff did not take reasonable steps to prevent foreseeable accidents; they did not consistently follow care plan instructions for

[2] Unfortunately, the transcript from this proceeding is riddled with errors. However, by joint stipulation, the parties offered corrections for the most glaring. The transcript, therefore, should be read in conjunction with the parties' list of corrections. Joint Stipulation to Correct Transcript (June 18, 2010).

preventing accidents; and did not review and revise care plans to meet the changing needs of residents.[3]

Regulatory Requirements. The facility must develop a comprehensive care plan for each resident. The plan must include measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the resident's comprehensive assessment. Among other requirements, the plan must describe the services the facility will furnish so that the resident can attain or maintain his/her highest practicable physical, mental and psychosocial well-being as required by the quality of care regulation, 42 C.F.R. § 483.25. 42 C.F.R. § 483.20(k)(1).

Under the statute and the "quality of care" regulation, each resident must receive, and the facility must provide, the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. Act § 1819(b); 42 C.F.R. § 483.25. To achieve this, the facility must, among other requirements, "ensure" that each resident's environment remains as free of accident hazards as possible. 42 C.F.R. § 483.25(h)(1). It must "take reasonable steps to ensure that a resident receives supervision and assistance devices designed to meet his assessed needs and to mitigate foreseeable risks of harm from accidents." *Briarwood Nursing Ctr.*, DAB No. 2115 at 5 (2007); *Guardian Health Care Ctr.*, DAB No. 1943 at 18 (2004) (*citing* 42 C.F.R. § 483.25(h)(2)). The facility must anticipate what accidents might befall a resident and take steps to prevent them. A facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods must constitute an "adequate" level of supervision under all the circumstances. *Briarwood,* DAB No. 2115 at 5; *Windsor Health Care Ctr.*, DAB No. 1902 at 5 (2003); *see Burton Health Care Ctr.*, DAB No. 2051 at 9 (2006) (Whether supervision/assistive devices are adequate for a particular resident "depends on the resident's ability to protect himself from harm.").

As the following discussion shows, in this case, facility residents suffered a disturbing number of falls, and facility staff made little or no meaningful effort to prevent them.

Resident 5 (R5). R5 was admitted to the facility on July 17, 2008. At the time of her admission, she was 76-years old and suffered from dementia, hypertension, and a seizure disorder. CMS Ex. 18 at 1-2, 5. According to her initial assessment, she was able to walk and transfer without assistance. CMS Ex. 18 at 4. Beginning in October 2008, however, R5 fell multiple times, and some of her falls caused serious injury:

[3] My findings of fact/conclusions of law are set forth, in italics and bold, in the discussion captions of this decision.

October 17, 2008. At 5:10 a.m., a nurse aide found R5 lying on her right side in the middle of her room. She apparently fell while walking toward the door. Initially, the facility deliberately opted to take no action to prevent another such incident. Asked what interventions they would implement to prevent a recurrence, staff wrote, "None – had shoes on [and] has been steady when [ambulating]." CMS Ex. 20 at 1-9; P. Ex. 5 at 1-4. But R5 subsequently appeared to be limping "slightly" and complained of pain in her right leg and hip. X-rays revealed a right leg fracture, for which she was hospitalized and underwent surgery. She returned to the facility on October 22. P. Ex. 5 at 6, 49-51; CMS Ex. 17 at 23.

Staff reassessed R5 at the time of her readmission. They deemed her at high risk for falls "due to her dementia." P. Ex. 5 at 56. According to the assessment, she now required a two-person assist with a gait belt for transfers and toileting. She no longer could bear weight on her right leg. Her primary mode of locomotion was with a wheelchair, wheeled by others, although she also walked using a cane or walker. P. Ex. 5 at 52, 56.

October 25, 2008. At midnight, R5's roommate went into the hall and told staff that R5 had fallen. Staff found R5 lying on her back on the floor next to her bed. She had a cut on her temple and an abrasion and bruise on her right elbow. According to the incident report, a tab alarm would be applied to prevent further falls. CMS Ex. 20 at 10-17. Apparently, however, this entry is meaningless. The facility's Director of Nursing (DON), Mary Smieja, testified that the "actual interventions" implemented after a fall are located in: 1) the resident care plans; 2) CNA guide; 3) "24-hour reports," and 4) CNA report book. Tr. 125-26. That an incident report lists an intervention does not mean that it was ever adopted, according to the DON.

An October 25, 2008 assessment reiterated that a wheelchair was R5's primary mode of locomotion, although she also used a cane or walker. CMS Ex. 18 at 15. It said that she required at least a two-person assist to walk or transfer. CMS Ex. 18 at 14; *see* CMS Ex. 17 at 22.

On October 28, the facility amended R5's care plan to address problems relating to her impaired mobility and recent falls. The plan called for two-person assists and a gait belt for transfers. A call light was to be within her reach. Staff were to check on her every thirty minutes, and to report any attempts to self-transfer. CMS Ex. 17 at 23-24. Inconsistently, the very next page, also dated October 28, 2008, states "she is not on ½ hour checks." CMS. Ex. 17 at 25. Nurses were to monitor her for dizziness when rising.

An alarm was put on her bed to alert staff when she attempted to transfer herself. CMS Ex. 17 at 25.[4]

The facility has produced no evidence to show that staff checked on R5 every thirty minutes as called for in her care plan, and, considering that they later seem to have forgotten that it had been added to her plan, it seems unlikely that staff were performing the checks. *See* CMS Ex. 20 at 19; CMS Ex. 19 at 1.

According to an October 30 assessment, R5 made frequent major position changes *without assistance* and occasionally *walked very short distances during the day, with or without assistance*. P. Ex. 5 at 62. On the other hand, the assessment also says that she: required "one aide assist to transfer to provide balance and support during transfers without bearing weight;" "does not walk in [her] room;" and "requires one aide assist to walk in corridor, only with PT." P. Ex. 5 at 62-63. But then, the assessment "summary" says that she required a two-person assist and a gait belt to ambulate, transfer, and toilet. P. Ex. 5 at 64. The summary also points out that, notwithstanding an infrared alarm on her bed, she has "been caught twice up to the bathroom unassisted." It notes that she "now has a pressure sensor on her bed which will activate the call light when she moves to the edge of the bed." P. Ex. 5 at 64.

From this apparently inconsistent document, I infer that staff recognized that, to be safe, R5 required assistance, although they were obviously (and inexcusably) inconsistent as to how much assistance she required. At the same time, they knew that she regularly acted without any level of assistance. The events of November 9 confirm that inference.

November 9, 2008. At about 3:00 p.m., staff found R5 lying on her right side in the doorway of her room. According to a resident in the room across the hall, who saw the incident, R5 fell when she got out of bed unassisted. The incident report does not mention what was going on with the infrared alarm that was supposed to be on her bed. Staff reported that R5 was "wobbly" and could "easily fall." The incident report confirms that, notwithstanding her assessed needs for assistance, R5 continued her attempts to walk without assistance, and she could reach the bathroom before staff could get to her.[5] CMS Ex. 20 at 19-25.

To prevent additional falls, the incident report called for a personal alarm on R5's wheelchair and checks every 30 minutes. CMS Ex. 20 at 19; P. Ex. 5 at 21. The facility

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[4] Care plans must be prepared by an interdisciplinary team that includes the resident's attending physician. 42 C.F.R. § 483.20(k)(2)(ii). *But see* Tr. at 50-51 (noting physician not part of the facility's interdisciplinary teams).

[5] For reasons that are not explained, most of the staff members were not interviewed until November 26, 2008, over two weeks after the incident. CMS Ex. 20 at 20, 21.

has produced a chart by which staff could document that they checked the resident every thirty minutes. CMS Ex. 19 at 1. I find several problems with the chart. At best, it shows that staff completed 30-minute checks from 3:00 p.m. through 11:30 p.m. on November 9 and, possibly, from 12:00 a.m. through 6:30 a.m., and from 9:00 a.m. through 8:00 p.m. on November 10. No checks were performed between 7:00 a.m. and 9:00 a.m.

In fact, the chart does not persuasively establish that staff performed the required checks on November 10. On November 9, they drew a straight line through the time blocks from 12:00 a.m. through 2:30 p.m. to indicate that *no* checks were performed at those times, the intervention having been implemented effective 3:00 p.m. that day. Then, from 3:00 p.m. through the end of the day, the assigned staff member initialed each 30-minute block to show that he/she checked the resident. On November 10, however, staff drew straight lines from 12:00 a.m. through 6:30 a.m. and from 9:00 a.m. until 8:00 p.m. – the marking used to show that no checks were made from 12:00 a.m. through 2:30 p.m. on November 9. Even DON Smieja conceded that the document is confusing, and that she would "prefer" that staff not document by drawing a straight line through the hours of their shifts. Tr. at 85-86.

In any event, at best, the documentation establishes that staff only began the 30-minute checks on November 9 and ended them on November 10, even though the resident's care plan called for 30-minute checks starting October 28, and that intervention was not changed.

Assessment notes dated November 10 indicate that R5 attempted to ambulate at times, but said that her alarms were in place. These notes say that she required "one aide assist" for bed mobility, transfers, and to walk in her room or the hall, and that she no longer had a wheelchair or needed a walker. Her call light was to be kept within her reach, her light left on, and she was to have non-skid shoes. P. Ex. 5 at 74-75.

A note dated November 11 says that R5 "doesn't understand that she is being noncompliant with doctor's orders for hip precautions, she gets up and walks without assistance, removes pillow/wedge from between her legs and stoops down to pick things up. Staff is constantly reminding her not to do these things." P. Ex. 5 at 75.

On November 11, the facility moved R5 to a room closer to the nurses' station. P. Ex. 5 at 76. According to Petitioner, the move obviated any need for 30-minute checks, although I see no evidence that anyone considered the question or modified the care plan. P. Cl. Br. at 18.

R5's November 18 assessment indicates that she was still in a wheelchair, but requiring less assistance to walk or transfer. It indicates that she performed these functions with minimal physical assistance. CMS Ex. 18 at 31. R5's care plan does not reflect any

significant changes, however, except that, in addition to an infrared alarm on the side of her bed, she was to have a pressure sensitive alarm in her bed. CMS Ex. 17 at 28, 31-32.

December 3, 2008. At about 4:00 p.m., R5 fell while walking down the hall. Her shoes were too big for her, according to the incident report. CMS Ex. 20 at 27-28, 32; P. Ex. 5 at 28-30. She was apparently walking alongside a nurse aide (Barbara P.), on their way to the dining room, "when all of a sudden she fell into the visitor lounge and hit her head on the frame by the door." According to Nurse Aide Barbara P., "she walks around by herself. I was just walking along side of her." CMS Ex. 20 at 28; P. Ex. 5 at 30.

Bone density screening, performed December 4, 2008, showed advanced osteoporosis. CMS Ex. 17 at 11.

Notwithstanding her fall and her diagnosis of osteoporosis, R5's January 18, 2009 assessment indicates that she was once again walking and transferring without assistance. CMS Ex. 18 at 36.

January 19, 2009. At 5:50 p.m., staff found R5 lying on the floor of the dining room, "anxious and complaining of severe pain to left hip." She said that she broke her hip. CMS Ex. 20 at 34. Although she was in a dining room with others, including staff, none seemed to have witnessed the fall until they saw her on the floor. CMS Ex. 20 at 35. The facility speculates that she fell while getting up from her chair. Staff called an ambulance, and she went to the emergency room. She was then transferred to another hospital for surgical repair of a left hip fracture. CMS Ex. 20 at 37; CMS Ex. 17 at 3.[6]

Her January 28 assessment reflects that she was again in a wheelchair, and required assistance to walk and transfer, although the assessment also indicates that she walked in the corridor without assistance. CMS Ex. 18 at 46.

In contrast, R5's February 6 and 21 assessments indicate that she was in a wheelchair and required assistance to transfer and walk. CMS Ex. 18 at 54, 62.

March 15, 2009. At 10:50 p.m., staff found R5 on the floor of the hallway outside her room. According to the incident report, she had been disoriented and, for 24-hours prior to the fall, had exhibited "increased wandering." P. Ex. 5 at 40; CMS Ex. 20 at 38; CMS Ex. 19 at 2. She was sent to the emergency room with a fractured left femur that required surgical repair. CMS Ex. 17 at 4. An emergency room nurse apparently told someone at the facility that R5's hip fracture was in a "very odd place" so "they were questioning if the bone broke and then she fell vs. fall and then broken." CMS Ex. 17 at 4. The entry is ambiguous as to whether it refers to R5's fractured femur or her earlier left hip fracture.

[6] The records inconsistently report the date of the fall as January 18 (CMS Ex. 17 at 3) and January 19 (CMS Ex. 20 at 37).

According to the incident report, R5's order for a bed alarm had been discontinued because it was ineffective. By the time the staff entered the room, she would be across the room to the bathroom. However, following this incident, an alarm was put back on her bed. Petitioner has not explained why staff thought the alarm would be effective this time. CMS Ex. 20 at 38, 43; CMS Ex. 19 at 3.

Her assessments, dated March 27 and April 5, indicate that she no longer walked and that she required extensive assistance to transfer. CMS Ex. 18 at 74, 85.

Severe osteoporosis was finally added to her March 27, 2009 assessment (although it had been diagnosed at least four months earlier). CMS Ex. 18 at 75; *compare* CMS Ex. 18 at 5, 15, 25, 32, 37, 47, 55, 63

As the above discussion shows, from October 2008, the facility knew that R5 was at risk for falls, but it did little to protect her from injury. After her first fall, staff recognized that she was at risk, and eventually determined that she required a two-person assist with a gait belt. P. Ex. 5 at 52, 56. They also knew that she was demented, rendering highly questionable her ability to remember and follow instructions. CMS Ex. 18 at 2, 5. After her second fall, they amended her care plan to call for a two-person assist and a gait belt for transfers. They were to check on her every thirty minutes, and an alarm was supposed to be put on her bed. CMS Ex. 17 at 24-25. They eventually moved her to a room closer to the nurses' station. P. Ex. 5 at 76.

But the evidence establishes that staff did not follow the care plan. They did not implement the 30-minute checks when that intervention was first added to R5's care plan (October 28), but did so only after she had suffered another fall (November 9). Then, they stopped checking after just one day. Whether alarms were consistently in place is questionable, since incident reports do not describe staff responding to the sound of an alarm. Moreover, even if followed, these interventions soon proved inadequate, and staff knew it. They recognized that R5 continued to get out of bed and walk without assistance. She plainly needed more supervision, but the facility did not provide it.

According to her care plan, R5 required a two-person assist with a gait belt. It appears that these instructions were simply not followed, with staff instead claiming that she required only a one-person assist. While disturbing, these inconsistencies ultimately did not matter, since staff provided her with *no* level of assistance, even when they were present and could have done so with relative ease. On December 3, for example, a nurse aide happened to be beside her, but she walked down the hall on her own, *without any assistance*. CMS Ex. 20 at 28. ("[S]he walks around by herself. I was just walking along side of her.") That she was wearing ill-fitting shoes only exacerbates the deficiency. On January 15, she was ostensibly in a dining room with staff present, yet no one witnessed her fall. Notwithstanding the presence of staff and a care plan that called

for two-person assist with gait belt for transfers and ambulation, R5 was able to get out of her chair and to walk (and fall) without staff intervening. No evidence suggests that, after she fell, anyone even recognized that staff had ignored the fall prevention instructions set forth in her care plan.

Petitioner argues that R5's January 19 and March 15 falls were caused by spontaneous fractures. According to Petitioner, R5 did not fall and break a bone on either occasion; rather, she spontaneously broke the bone and fell as a result. P. Cl. Br. at 22. I note that the evidence supporting Petitioner's theory is thin. If, in fact, R5 were so vulnerable to spontaneous fractures that standing up caused them, I would expect to see some assessment of her ability to bear weight safely. But, even if the theory were well-supported, the facility would still have failed to ensure R5's safety. Indeed, R5's osteoporosis only enhanced her risk of suffering a serious injury from falls, and made it all the more critical for the facility to prevent them.

Resident 12 (R12). R12 was a 74-year-old woman whose diagnoses included chronic kidney disease, chronic obstructive pulmonary disease (COPD), hypothyroidism, schizophrenia, Parkinson's disease, seizure disorder, congestive heart failure, and bipolar disorder. CMS Ex. 32 at 7, 16

Although R12's care plan identified as a problem the potential for injury due to falls, it offered few specific interventions to prevent them, instead, generally directing the nurses to encourage her to steady herself when outside completing chores, and to notify her physician and her representative if she fell. Nurse aides were supposed to "report any unsafe conditions or situations to the nurse" and "encourage her to ask for assistance." CMS Ex. 32 at 45.

January 5, 2009. At 1:10 p.m., R12 fell into the nurses' station and hit her head. Staff described her right upper cheek as bruised and swelling, and the swelling continued the following day. She had been walking back to her room after smoking on the patio. "Her gait was very unsteady." Apparently, the facility social worker, who was walking with her, had offered assistance, but the resident refused. Staff wrote that, to prevent a recurrence, they reminded her of the effects of smoking on her balance and gait. CMS Ex. 34 at 1-4, 55-56; P. Ex. 3 at 1-4; P. Ex. 3 at 60.

No evidence suggests that staff made other efforts to prevent additional falls. They simply attributed the incident to R12's refusal to accept help.

January 6, 2009. At 10:15 p.m., staff found R12 sitting on the floor of her room beside her bed. She told staff that she got up to get her coin purse, but elsewhere staff report that she was straightening her blankets. Staff reminded her to use the call light. Staff were instructed to "give her some gripper socks and encourage her to wear them at night." CMS Ex. 34 at 6-10, 56; P. Ex. 3 at 6-9; *see* P. Ex. 15 at 8 (Smieja Decl. ¶ 52).

January 25, 2009. At 8:25 a.m., R12 was found sitting with her back against the outside windows in the entryway to the patio. She had apparently been coming back inside after smoking on the patio; staff were not aware that she had gone out. According to their statements, she needed supervision while smoking. No one saw her leave, and the door alarm did not sound. The incident report calls for reassessment of her smoking privileges and indicates that she should be accompanied by staff until that reassessment was completed. After a subsequent fall, staff noted a bruise on her buttocks, which they attributed to this fall. CMS Ex. 34 at 11-13, 56-57; P. Ex. 3 at 65.

Early in the morning on February 1, 2009, staff reported that R12 had been up most of the night, rearranging the dresser drawers in her bedroom. She repeatedly demanded that staff take her outside to smoke. Her conversations "all night have gone from one sentence of one subject to another subject the next sentence." P. Ex. 3 at 67.

February 2, 2009. At 4:45 a.m., staff found R12 sitting on the floor near the doorway in the hall. She had apparently been to the nurses' station, because she wanted to go out to smoke. Staff told her that she needed to get dressed and put on a coat before going out. Staff then saw her leave her room with her coat in hand. She was in the hall, holding the handrail, but let it go so that she could put her arm through a coat sleeve. She lost her balance, and fell. To prevent recurrence, the incident report says that staff should encourage her to ask for help when putting on her coat to go outside. CMS Ex. 34 at 15-20, 56-57. This intervention was added to her care plan, even though the plan already instructed staff to tell her to ask for assistance. But the intervention supposes that she fell because staff were unaware of her need for assistance. In fact, staff well knew what she was doing, and offered her no help.

I note also that R12 was not wearing gripper socks; she was barefoot. P. Ex. 3 at 18; P. Ex. 3 at 68.

In a smoking assessment, dated February 5, 2009, staff reported that R12 liked to shut off the alarm and go outside on her own but that she "must be accompanied out for all smoking" and "kept in view of staff at all times." Staff also described her as "agitated" because of the smoking limits placed on her and reported that "she decided to walk the full distance of the sidewalk to the dumpster on her own, over ice with potential for falling." CMS Ex. 32 at 49; P. Ex. 3 at 70-71.

From February 7-11, 2009, R12 was hospitalized with an exacerbation of her COPD and pneumonia. P. Ex. 3 at 73-74. She apparently reluctantly agreed that she needed to quit smoking because of the health risks, although she subsequently changed her mind. P. Ex. 3 at 74, 77 (stating R12 complained of the nicotine patch), 78 (noting R12 angry about not being allowed to go outside and smoke; agitated because she wants to go outside to smoke), 81 (observing R12 mad at staff because she can't smoke), 82 (asserting R12

refuses nicotine patch; very upset because she cannot smoke; very agitated and angry because nobody would give her cigarettes; "in and out the patio door many times"), 83 (stating R12 insists that when her pneumonia is resolved, she will continue to smoke).[7] Finally, after R12 repeatedly threatened to go into town on her own to buy cigarettes, her daughter (who had power of attorney) agreed that she should be allowed to smoke. P. Ex. 3 at 84.

On February 18, 2009, R12 and staff amended her smoking agreement. Because she had been up at night "wanting to smoke every ten minutes," she would be allowed to smoke only from 8:00 a.m. to 10:00 p.m. She would also lose her smoking privileges if she continued to barge into the nurses' station, refusing to leave, or if she turned off any door alarms. CMS Ex. 32 at 49.

The agreement soon proved ineffective. Throughout the night of February 19, R12 was up at the nurses' station asking to smoke. She "was not happy when told she could not smoke during the night . . . would walk away mad, only to return later to try to get to smoke . . . ." P. Ex. 3 at 87.

February 20, 2009. At 1:55 a.m., staff found R12 sitting on the floor of her bathroom. She had been to the nurses' station a few minutes earlier, asking for a cigarette. Staff told her that it wasn't time, and gave her a glass with ice. She returned to her room, unsupervised, to fill the glass with water from the bathroom tap. According to the incident report, "no intervention" was called for because the resident was "very independent with ambulation." CMS Ex. 34 at 21-24, 58. She was bleeding a small amount from her mouth, having bit her tongue. Her knee was bruised and slightly swollen and warm to the touch. She also had bruising on her right arm from hitting the door casing. CMS Ex. 34 at 26, 57-58.

R12 also began to exhibit "unusual behavior." She required a two-person assist with bathing; her gait was unsteady; she was talking to herself; and she had a mildly elevated temperature. P. Ex. 3 at 89. Staff called her doctor and suggested that she might have a urinary tract infection (UTI), since she had previously exhibited similar symptoms when suffering from a UTI. P. Ex. 3 at 89; CMS Ex. 34 at 21.

Staff also sent the February 20 incident report to R12's physician, who faxed back an order for "fall precautions." CMS Ex. 32 at 25. I see no evidence that staff implemented any changes in their treatment of R12 in response to the physician's order.

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[7] R12 was plainly addicted to cigarettes, and no one could have seriously thought that she would give them up easily. Yet, I see no evidence of any care planning related to R12's smoking cessation. They simply gave her a nicotine patch and told her she could no longer smoke.

February 22, 2009. At 4:30 a.m., staff again found R12 lying on her bathroom floor, apparently attempting to use the toilet. The proposed intervention was to remind her to use her call light. Staff also noted that she suffered from lack of sleep, and had earlier been "falling asleep standing up" but refused to go to bed. CMS Ex. 34 at 28-31, 58-59.

Petitioner questions whether the resident actually fell, pointing out that no one witnessed the incident, and that she told staff conflicting stories. She was found sleeping on the bathroom floor, with her pants down. P. Ex. 3 at 33. According to the incident report, staff last saw her at 4:00 a.m. when someone walked her back to her room, hoping that the plainly exhausted resident would go to bed, but she was unwilling to do so. P. Ex. 3 at 32. Staff obviously left her, because no one saw her again until she was found on the bathroom floor half an hour later. She told staff three stories: that she lay down on the bathroom floor (which would not explain why her pants were down); that she slid off the toilet onto the floor; and that she fell. P. Ex. 3 at 32.

February 23, 2009. Shortly after midnight, staff responded to R12's call light and found her on the floor next to her bed. According to the incident report, the resident said that she lowered the bed, unlocking the wheels. When she then tried to sit on the bed, it rolled away; she slid off and hit her head. To prevent a recurrence, staff told her not to unlock her bed wheels, and noted that the care plan team was "in the process of developing interventions designed for resident safety." They also suggested that the medical director be consulted. CMS Ex. 34 at 33-36.

A February 24 addition to the incident report mentions contacting R12's physician to determine whether her high blood pressure was causing her falls. CMS Ex. 34 at 33; P. Ex. 3 at 93.[8] Her physician re-ordered anti-hypertensive medication, which had been stopped during her December hospital stay. P. Ex. 3 at 93, 94.

February 24, 2009. At 1:35 a.m., staff responded to the sound of an alarm, and found R1 on the floor of her room. She said that she had come out of the bathroom, planned to sit on a big chair, but landed on the floor. After her fall, she made her way over to the alarm and set it off. Staff told her to stay in bed and sleep. CMS Ex. 34 at 38-41, 43, 59-60; P. Ex. 3 at 93.

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[8] Although the relationship between R12's falls and her hypertension is questionable, something was definitely going on with her blood pressure that called for physician involvement. On the dates of her falls, for example, she had the following blood pressure readings: Jan. 5 – 143/78 (P. Ex. 3 at 61); Jan. 6 – 140/90 (P. Ex. 3 at 62); Jan. 25 – 158/82 (P. Ex. 3 at 65); Feb. 2 – 160/100, 172/90 (P. Ex. 3 at 68); Feb. 20 – 150/90 (P. Ex. 3 at 88); Feb. 22 – ***220/118*** (P. Ex. 3 at 91); Feb. 23 – 170/76 (P. Ex. 3 at 92); and Feb. 14 – 176/98 (P. Ex. 3 at 93).

At 11:40 that night, a nurse aide answered R12's call light and found her on the floor. She said that she had been asleep, sitting at the edge of her bed with her head on the side table, and she fell off. According to the incident report, an infrared alarm was on the bed, but the resident had turned it off. CMS Ex. 34 at 44-47, 49, 60; P. Ex. 3 at 93.

February 25, 2009. Notes indicate that R12 fell again during the night shift on February 25 (in addition to the two falls on February 24), but the record contains no additional information about that incident. P. Ex. 3 at 95.

An addition to her care plan, dated February 26, 2009, says that she is to wear shoes at all times when up. CMS Ex. 32 at 45.

A therapy screen for falls, dated February 27, 2009, indicates that R12 wore slippers that were too large. Even though the facility had already documented at least eight falls in seven weeks, the therapy screen recommended only that nursing staff continue to monitor, with follow-up by the physical therapist if the falls continued. CMS Ex. 32 at 29.

March 7, 2009. It seems that R12's smoking privileges had been revoked and she spent much of the night of March 6-7 pestering the nurses so that they would allow her to smoke. She repeatedly set off the alarms on the patio doors; she followed staff around, asking for a cigarette. They told her that they were busy and did not have time to keep checking on the alarms. She eventually left them alone, and went into the dining room. CMS Ex. 33 at 9-10. At 5:15 a.m., staff found R12 lying on the floor of the dining room, having suffered another fall. She told staff that she had been setting out napkins and clothing protectors, walking from table to table, when she found herself on the floor. Staff hypothesized that R12 had fallen asleep, since she had only slept for 30 minutes that night. Thereafter, her physician, Dr. Dickson, increased her medication (Trazadone) to see if it would stabilize her mood and allow her to sleep. CMS Ex. 34 at 50-54, 61.

The facility's consulting pharmacist, Robert B. Greifenhagen, reviewed R12's drug regimen and, in a March 24, 2009 memo, advised Dr. Dickson about possible medication changes to prevent additional falls. CMS Ex. 32 at 38.

On April 8, 2009, the facility allowed R12 a three-day trial period of unsupervised smoking. On April 13, they continued the unsupervised smoking "as long as she is seated." CMS Ex. 32 at 49.

April 26, 2009. At 7:35 a.m., R12 fell again. She was on the patio, getting up from a chair. P. Ex. 3 at 113-14. On April 27, 2009, the facility put a temporary hold on R12's unsupervised smoking because of her fall the day before. CMS Ex. 32 at 49; P. Ex. 3 at 114.

R12 was seriously mentally ill, and I have no doubt that she regularly harassed and irritated the staff. Unfortunately, it seems that staff did not appreciate the relationship between her illness and her behavior. Even though she acknowledged that R12 "was in a manic stage at this point" (Tr. 89), DON Smieja characterized R12 as "a stubborn, obstinate person who is going to do what she wants to do when she wants to do it." Tr. 92. She denied that R12 lacked control over her behaviors because of her mental illness. Tr. at 92-93.

Unlike the facility's other residents who were vulnerable to falls, R12 did not generally engage in risky behaviors without staff knowledge. To the contrary, when she became agitated and was unwilling or unable to sleep, she was more likely to harass the staff. Her agitation and exhaustion made her more vulnerable to accidents and injury, and thus called for closer staff supervision. But staff plainly wanted her to go away when she was in this state. Thus, as the above discussion shows, they either sent her away or watched her engaging in risky behavior without intervening. These were not reasonable steps to ensure that the resident received supervision and assistance devices that would meet her needs and mitigate the plainly foreseeable risks of harm from accidents.

Resident 7 (R7). Resident 7 was a 94-year-old woman suffering from macular degeneration, dementia and other ailments. She had a history of falling. CMS Ex. 24 at 2, 10, 12, 15, 17. The facility recognized that she had difficulty getting to the bathroom "in a timely manner due to her impaired mobility, potential for falls and need for assist of one to get to and from the bathroom." CMS Ex. 24 at 14. The facility also identified her prescribed medications, six of which are known to cause dizziness, as potential problems, so, according to her care plan, they would contact her physician about medication changes or deletions. Her plan also called for one-person assistance with a walker and a gait belt to prevent falling and an infrared alarm on her bed to alert staff that she was attempting to transfer herself. CMS Ex. 24 at 15.

March 7, 2009. At 3:15 a.m., staff found R7 sitting on the floor, having fallen on her way to the bathroom. She had bumped her head on the door, but appeared uninjured. Her infrared alarm had apparently gone off, but had stopped ringing, and staff responded to her roommate's alarm. Staff put a personal alarm on her while in her wheelchair. CMS Ex. 26 at 1-5, 51; P. Ex. 6 at 1-4, 91. According to Petitioner, R7's physician ordered a Life Watch monitor in response to R7's fall. P. Cl. Br. at 27; *see* P. Ex. 6 at 37.

March 16, 2009. At 2:00 a.m., a nurse aide heard R7 calling for help and found her lying on the floor. She was on her back with her head resting on the leg of her roommate's over-the-bed table. She had a small lump on the top of her head. Again, she had fallen on her way to the bathroom. She complained that she hit her head. According the Nurse Aide Stacy Preston, her infrared alarm was on, "but never sounds." To prevent additional falls, staff changed her alarm and replaced her regular socks with "gripper socks." CMS Ex. 26 at 6-8, 11, 51-52.

On March 18, staff were instructed to take R7 to the bathroom at midnight and 4:00 a.m. CMS Ex. 26 at 6; P. Ex. 6 at 6; Tr. at 95.

March 22, 2009. At 10:40 p.m., staff found R7 sitting on the floor of her room, having fallen on her way to the bathroom. She had a scrape, bruising, and pain on the back of her left thigh. CMS Ex. 26 at 12-15, 52-53; P. Ex. 6 at 105. The incident report says that the facility would replace her mattress with a "raised edge mattress." CMS Ex. 26 at 12; P. Ex. 6 at 12. In addition to her infrared bed alarm, a personal alarm would be attached to her clothing. P. Ex. 6 at 105.

March 23, 2009. At 10:45 p.m., staff again found R7 on the floor of her room, having fallen on her way to the bathroom. They reminded her to use her call light. CMS Ex. 26 at 17-20, 53.

March 24, 2009. At 3:45 a.m., R7 was yet again found lying on the floor of her room, next to her bed. She said that she had been attempting to get out of bed by herself. The infrared alarm sounded. Staff thereafter applied a pressure alarm to her bed and put a non-skid rug next to her bed. CMS Ex. 26 at 22-27, 53-54; P. Ex. 6 at 107-08.

A March 24 report from the facility's consulting pharmacist points out medications that could be causing dizziness. CMS Ex. 24 at 3.

A nursing assessment, dated March 30, 2009, reiterates that, to prevent falls, R7 requires assistance in toileting. It directs staff to offer to toilet *every hour* while she is awake and at midnight and 4:00 a.m. CMS Ex. 24 at 17. No documentation or other reliable evidence establishes that staff did so.

April 8, 2009. At 1:35 a.m., Nurse Aide Stacy Preston responded to the sound of R7's pressure alarm. She found the resident on the floor on her knees next to her bed. The infrared alarm had not sounded, and the pressure alarm sounded very softly. Staff changed the alarm batteries. The resident had been attempting to get out of bed by herself. According to staff, she had been taken to the toilet five times between 10:30 p.m. and 1:35 a.m. The incident report indicates that all medications causing dizziness would be discontinued. CMS Ex. 26 at 28-31, 33, 54.

Two hours later (3:25 a.m.) staff again heard the pressure alarm sounding, and found R7 sitting on the floor by the side of her bed. She was wrapped in blankets. She had again attempted to get out of bed when she fell. At this point, she had been to the bathroom eight times between 11 p.m. and 3 a.m. Once again, the infrared alarm did not sound. Staff were to begin checking her every 15 minutes during the night. They also advised R7 to call them for assistance. CMS Ex. 26 at 34-37, 39, 54-55. Petitioner offers no evidence that staff, in fact, checked on R7 every 15 minutes. *See* Tr. 100.

April 12, 2009. At 1:15 p.m., RN Jane Toro heard R7 yelling for help. She found her on the floor of her bathroom, her unlocked wheelchair in the doorway. The resident had attempted to take herself to the bathroom. She had removed both the wheelchair alarm and her shoes. CMS Ex. 26 at 40-43, 55. The facility expanded the 15-minute checks, making them around-the-clock. P. Ex. 6 at 72. Again, no evidence establishes that staff performed these checks.

April 13, 2009. At 2:05 a.m., a nurse aide entered R7's room to pass out towels and check on the resident. She found the resident lying flat on her back on the floor near her bathroom door. She was wearing gripper socks. No alarms had sounded, although staff checked them and found that they were working. The resident said that she had been returning from the bathroom. Staff noted that she had been incontinent, and had wet her bed. A bladder scan was scheduled. CMS Ex. 26 at 45-48, 50, 55.

DON Smieja could not explain why R7's alarms failed so often. She opined that the nurse aides might not have turned them on, even though they charted that they were on. She could not remember whether she ever asked them about it. Tr. at 99. In any event, an alarm may be a useful tool, but it is no substitute for adequate supervision.

Petitioner points out that staff appropriately consulted R7's physician, who ordered tests to determine an underlying cause of her falls. But such consultation does not relieve the facility of its obligation to keep her safe, knowing that – for whatever reason – she could not be left unsupervised without putting her at risk for unsafe behavior leading to falls.

Resident 2 (R2). R2 was an 86-year old man who suffered from severe COPD, rheumatoid arthritis, depression, hypertension, and Alzheimer's disease. CMS Ex. 14 at 7. He had a history of falls, and required at least a one-person assist with gait belt for walking and transferring. CMS Ex. 14 at 56.

September 10, 2008. At 2:00 in the afternoon, a staff member was walking past R2's room and saw him on the floor on his knees. He said that he had been trying to go to bed, transferring out of his wheelchair, when he fell. According to the incident report, no one saw or heard anything. CMS Ex. 14 at 1-4.

September 26, 2008. At 11:30 p.m., staff again found R2 on the floor of his room, his underwear pulled down around his knees. He was wet. He suffered bruises, skin tears and a head injury. According to the incident report, he had been transferring himself. To prevent recurrence, staff put an infrared alarm at the side of his bed. CMS Ex. 14 at 8-11, 14-15.

November 17, 2008. Responding to R2's call light at 10:05 p.m., Nurse Aide Barbara Pennoyer found the resident lying on his back on the floor in front of his recliner. To

prevent such falls, the incident report says to put no-skid padding on the recliner and to encourage the resident to wait for assistance. CMS Ex. 14 at 16-19.

November 26, 2008. At 1:30 a.m., Nurse Aide Stacy Preston was checking on residents as part of her scheduled rounds, when she found R2 lying face down on the floor in front of his recliner chair. He had last been observed two hours earlier, sitting in his recliner. Staff again told him to use his call light and to wait for assistance. CMS Ex. 14 at 24-27, 29. A note written late that night says "increase frequency of monitoring at night when up in recliner," although it is silent as to the frequency of such monitoring. P. Ex. 4 at 46. DON Smieja was not able to explain the meaning of "increase frequency." Tr. at 104. Nor does Petitioner identify what system, if any, it had in place to assure more frequent monitoring.

January 20, 2009. At 4:00 a.m., Nurse Aide Preston heard a noise and went to investigate. She found R2 on the floor at the entrance to his bathroom. He said that he had forgotten to use his call light. She noted that he refused to sleep in his bed and suggested that a pressure alarm be attached to his recliner. He suffered a small skin tear on his left elbow. CMS Ex. 14 at 34-36, 39.[9]

In a February 4, 2009 care plan instruction addressing the resident's incontinence, the nurse aides were directed to toilet the resident every hour when he is awake. The entry also says that the resident is "not reliable with use of call light." CMS Ex. 12 at 3. The care plan says nothing about toileting at night, but other instructions say to toilet hourly when he is awake and every two hours during the night shift. P. Ex. 4 at 61. One problem with this, of course, is that R2 was regularly awake during the night shift, so the instructions are ambiguous. In any event, no evidence shows that staff carried them out.

February 7, 2009. At 11:05 a.m., R2 stood up from his wheelchair and attempted to walk out of his room. Nurse Aide Peggy Meiners found him on the floor with the alarm sounding. Although he bumped his head, he was not injured. CMS Ex. 14 at 39-43. According to the incident report, an alarm would be added to his wheelchair. Staff were to "check on him" when they walked by, and remind him to use his call light when he

[9] It appears that, at the time of the survey, someone inserted an additional intervention into the documentation of the January 20 fall. An entry dated April 24, 2009, says "family demands he be in recliner, even though they were informed that he cannot manage the footrest." P. Ex. 4 at 49. I find inherently unreliable such after-the-fact documentation, particularly when it is generated at the time of the survey. In any event, as shown by the narratives describing his multiple falls, the recliner was not R2's problem. His problem was that he could not safely stand and walk without assistance. He fell after getting out of bed, after getting up from his recliner, and after getting up from his wheelchair.

needed help. CMS Ex. 14 at 39. As CMS pointed out, and DON Smieja agreed, staff's checking on a resident when they happened to walk by his room would not be a "measurable intervention." Tr. at 106. Moreover, DON Smieja also admitted that staff were not trained or otherwise instructed to check on residents when walking by their rooms, although DON Smieja considered it "common sense" to do so. Tr. at 107.

February 24, 2009. At 1:00 p.m., Nurse Aides Diane Krizan and Peggy Meiners were toileting R2, when one of his knees gave way, and he "went down on one knee." CMS Ex. 14 at 45-48, 58.

March 17, 2009. At 2:40 p.m., the assistant activities coordinator was pushing the resident in his wheelchair, when the chair hit a carpet strip, and the resident fell out, hitting his face on the floor. He sustained a cut, bruising and swelling above his nose, and he scraped his forehead. He complained of pain to his nose and left arm. On March 25, the occupational therapy (OT) department assessed his wheelchair positioning, and, on March 27, the facility replaced his wheelchair. CMS Ex. 12 at 18; CMS Ex. 14 at 50-52, 58-59.

A nursing assessment, dated March 25, 2009, recognized that R2 no longer understood how to ask for assistance. An accompanying "plan" called for hourly toileting while he was awake, and checks every two hours during the night. CMS Ex. 12 at 25. The assessment and plan do not seem to recognize that these instructions were supposed to have been implemented on February 4, as part of the resident's toileting plan. CMS Ex. 12 at 3; P. Ex. 4 at 61.

In a March 27 fall summary, staff reported that R2 experienced "numerous falls, with the fall pattern being during the night." He refused to stay in bed, preferring his recliner, but would get up from the recliner and walk. One of his medications was identified as a possible cause of his insomnia, and was changed. He had a personal alarm on his wheelchair, and an infrared alarm on his bed. His call light was to be kept within reach, although he rarely used it. Upon waking, he was to have a one-person assist, wheelchair to follow, and use of a gait belt. An OT evaluation assured the fit of the wheelchair. He was on an aggressive toileting program: every hour when awake and every two hours at night, according to the summary. CMS Ex. 14 at 56-57.

On April 14, 2009, R2's care plan was finally amended to address his risk of injury from falls. Staff were to encourage him to ask for assistance (even though his March 25 assessment says that he no longer understood how to ask for assistance). He was to be walked twice daily, "document why if he does not." His bed was to have an infrared alarm, his recliner/wheelchair a pull tab alarm. Staff were to check on him each time they passed his room, and remind him to use his call light. CMS Ex. 12 at 5.

April 24, 2009. Nurse Aide Diane Krizan was walking past R2's room at 10:40 a.m., and she saw him on the floor, his back against his recliner. He said that he had been getting up and complained that he had bumped his head. His tab alarm had not sounded. Staff opined that his clothing was too slippery for the alarm to adhere properly and were instructed to add "gripping material" to the alarm clip to secure it to the resident's clothing. They were also instructed to institute 15-minute checks, but again no systems were in place to assure the frequent checks. P. Ex. 4 at 30-33.

On April 28, 2009, however, R2 was in the facility's main dining room before breakfast. No alarm was attached to his clothing. CMS Ex. 1 at 29; Tr. at 32-33.

Thus, R2 fell repeatedly, and the facility persisted in offering interventions that were ineffective (e.g. encourage him to use his call light), poorly implemented (alarms) or ignored (frequent checks).

Resident 15 (R15). R15 was a 73-year-old mentally-retarded man who suffered from manic-depressive psychosis. He had a club foot and a history of falls. CMS Ex. 36 at 1, 9.

A February 17, 2009 note wrongly states that R15 had no history of falls. P. Ex. 2 at 19. His cumulative diagnosis list says otherwise; an entry, dated October 20, 2008, says (in capital letters) "HISTORY OF FALL," and multiple, ill-defined closed fractures of his lower limbs. The listing is repeated in a March 3, 2009 entry. CMS Ex. 36 at 1.

In a December 12, 2008 entry, his care plan identifies as a problem "potential for falling." The plan instructs staff to monitor his blankets to prevent tripping when he gets out of bed, to keep a urinal at his bedside, not to use a slippery blanket, and to remind him to keep the back of his legs close to the bed when transferring himself. CMS Ex. 36 at 9-10.

February 19, 2009. At 8:30 in the morning, staff heard R15 crying in his room. They found him sitting on the floor in front of his bed. He said that he had slipped off when trying to get into bed. He complained that his back hurt. Staff reminded him to keep a walker nearby when transferring himself. CMS Ex. 37 at 1-4, 16.

February 22, 2009. At 5:30 a.m., staff heard R15 crying. They found him lying on his back on the floor of his room, complaining that he had fallen and that his back hurt. Staff reminded him to use his call light. Some staff opined that he had staged the fall to get attention, but agreed that he might have fallen and then lay on his side, because he was unable to get up without assistance. CMS Ex. 37 at 6-8, 17.

March 1, 2009. At 12:40 p.m., a nurse aide found R15 on the floor of his room, crying. He had apparently attempted to take himself to the bathroom, but was incontinent, had an

accident, and slipped on urine and feces. Staff told him to ask for assistance. CMS Ex. 37 at 11-14, 17-18.

Petitioner acknowledges that the resident fell on March 1, but characterizes that incident as a "fluke accident." P. Cl. Br. at 35. On the other hand, according to Petitioner, the February incidents were not falls, but events staged by an attention-seeking R15. P. Cl Br. at 35. Support for this position is weak. First, no one witnessed the incidents. Second, if R2 had started to stage accidents, I would expect to see this new and problematic behavior identified and addressed in his care plan. The plan mentions no such behaviors, but it does address his risk of falling, particularly when getting out of bed. Finally, a therapy screen, dated March 4, 2009, cites "numerous falls while toileting." CMS Ex. 36 at 6.

Resident 10 (R10). R10 was a 77-year-old woman who was admitted to the facility because she suffered a hemorrhagic stroke, and was no longer able to care for herself at home. She had cancer of the pancreas and Alzheimer's disease, among other ailments. CMS Ex. 28 at 6; CMS Ex. 29 at 13.

February 24, 2009. At 1:55 a.m., a nurse aide assisted R10 onto her bedside commode, but then the aide went to fetch wipes from the bathroom, leaving the resident unassisted. The resident leaned forward to pull up her pants, and fell, sustaining a laceration, bruise and lump on her head. CMS Ex. 30 at 1-6, 23-24. I do not agree with Petitioner's contention that the nurse aide "sufficiently" supervised the resident when this fall occurred (*see* P. Cl. Br. at 36), nor did DON Smieja, who testified that the nurse aide's conduct was not acceptable. Tr. at 112. The standard of care requires that staff have in place all the materials needed before attempting to toilet a resident. Tr. at 111-12.

March 9, 2009. At 11:20 p.m., a nurse aide found R10 lying on the floor next to her bed. She had earlier been wheeling herself around in a wheelchair with a pressure alarm attached. She removed the alarm and transferred herself to her bed. Sitting on the edge of her bed, she reached for her walker, and fell. She was wearing slippery socks. Staff replaced them with gripper socks, and reminded her to call staff if she needed help. CMS Ex. 30 at 7-9, 12, 24-25.

It appears that, on March 9, staff amended R10's care plan to identify falls as a problem. However, no interventions were added until March 20, and, even then, the approaches were non-specific: "observe, record, and report all unsafe conditions and situations" (which staff would presumably do whether or not part of any care plan); "encourage to ask for assistance; instruct resident in use of [unspecified adaptive] equipment;" and report falls to physician for follow-up (again a requirement independent of any care planning). CMS Ex. 28 at 13. Finally, on April 10, they added a few less general interventions to the care plan: bed in low position; encourage to ask for assistance; call light in reach; transfer with one-person assist; walk with two-person assist – one

following with wheelchair; gripper socks when in bed; pull tab and infrared alarms; and wedge pillow in wheelchair for positioning. CMS Ex. 28 at 13.

An assessment note, dated March 25, 2009, indicates that the resident says that she does not ask for staff assistance "because I do not want to be a bother," although staff surmised that she did not remember to use her call light at night. CMS Ex. 29 at 13.

April 2, 2009. At 10:30 p.m., a nurse aide heard R10's chair alarm going off, and found her on the floor of the T.V. room. She had apparently been setting off the alarm all evening. CMS Ex. 30 at 13-16, 25. In this instance, she said that she was "walking toward her recliner," when her "feet and legs got tired so she had to sit down." P. Ex. 7 at 14. To prevent recurrence, staff were instructed to check her every 15 minutes. P. Ex. 7 at 16.[10] Petitioner argues that this was not a fall, because the resident put herself on the floor. But, even assuming that this incident was not technically a fall, R10 was still unsupervised and engaging in a behavior that put her at risk of injury. The facility should have protected her.

I also find it highly unlikely to impossible that facility staff thereafter checked on R10 every fifteen minutes. The facility offers no documentation establishing that the checks were performed. Tr. at 119, 123. Even more compelling, as the following discussion shows, *no* nurse aides were working the shift night on April 2. P. Ex. 8 at 29; *see* discussion, ¶ B, i*nfra*.

An assessment, dated April 3, 2009, notes that R10's gait is unsteady; she is at high risk for falls; and staff must remind her to ask for and wait for assistance. It says that she has a personal alarm on her wheelchair and an infrared and bed sensor on her bed to alert staff when she needs assistance. CMS Ex. 29 at 16.

April 6, 2009. At 6:50 p.m., staff heard an alarm going off, and found R10 in another resident's room, on the floor, between her wheelchair and a recliner. The incident report says that staff should offer to put her in her recliner after meals and calls for "frequent visual checks." CMS Ex. 30 at 18-21, 25.

An assessment dated April 8, 2009, identifies her as at high risk for falls "due to lack of safety awareness related to [stroke] and cognitive impairment." It notes that she has an alarm on her chair and bed, since she does not use her call light and does not wait for staff to arrive to assist her. CMS Ex. 29 at 18. Thus, as with so many of the other

[10] Again, on April 22, someone inserted an additional entry "not transcribed into the computer" and, apparently, not mentioned in the incident report nor added to the care plan. The entry reads: "offer to put in recliner after meals and complete frequent visual checks." P. Ex. 7 at 35. In fact, these instructions were added after her fall on April 6, not after her April 2 fall.

residents, R10 fell repeatedly, and the facility addressed the problem by proposing ineffective interventions.

Based on these examples, Petitioner has not established that it provided its vulnerable residents with supervision adequate to prevent accidents. Petitioner cites *Willow Creek Nursing Ctr.*, DAB 2040 (2006) for the proposition that it was not required to document its supervision of residents. But, in *Willow Creek*, whenever the vulnerable resident, an elopement risk, set off an alarm, he was immediately surrounded by multiple staff members who prevented him from leaving the facility. From this, one could reasonably infer that he was well-supervised. Here, in contrast, alarms went off repeatedly, but no staff member arrived in time to prevent an accident. From this, I can reasonably infer that the vulnerable residents were not adequately supervised, and Petitioner has come forth with no documentation or other reliable evidence to refute that reasonable inference.

I therefore conclude that the facility was not in substantial compliance with 42 C.F.R. § 483.25(h) because it did not take reasonable steps to prevent foreseeable accidents. It also was not in compliance with 42 C.F.R. § 483.30(k)(1) because its care plans did not always include measurable objectives to meet the resident's needs; staff did not revise plans to meet the resident's changing needs; and staff often failed to follow the instructions in those plans.

B. The facility was not in substantial compliance with 42 C.F.R. § 483.30(a) because it did not consistently have on duty the number of staff sufficient to provide necessary care to all residents.

Regulatory requirement. The facility must have in place, on a 24-hour basis, a sufficient number of licensed nurses and other nursing personnel to provide care to all residents in accordance with their care plans. 42 C.F.R. § 483.30(a).

As the above discussion shows, numerous facility residents were at risk for falls. In response, resident care plans called upon staff to check frequently on vulnerable residents, and to respond immediately to alarms. Some residents required frequent toileting, some required one to two-person assists for transfers and ambulation. These interventions are obviously labor-intensive, but it seems that no managers ever considered whether the facility was adequately staffed to implement them. Tr. at 132. Certainly, no additional staff were added to the roster to meet the added demands.

The staffing was minimal, particularly on the night shift. Generally, just one nurse and two nurse aides were on duty then, which seems barely adequate, particularly since nurse aides were expected to perform other duties, such as laundry and general clean-up. P. Ex. 16 at 4-5 (McMurry Decl. ¶¶ 22-28). More troublesome, if an employee did not appear for work, the facility did not have an adequate plan for finding a replacement. As a

result, it was not unusual to find only one nurse and one nurse aide on duty for the night shift. More alarming, according the facility's staffing sheet, on April 2, 2009, no nurse aide was on duty. *See* P. Ex. 8 at 29 (showing one aide on night shift on April 1, 3, 4, 5, 6, 14, 15, and no aides on duty April 2); Tr. 54-57; *see also* CMS Ex. 39 at 1, 2.

Failing to have more than one nurse aide on duty, particularly where so many residents required close supervision, meant that the facility was not be able to meet basic resident needs, and was not in substantial compliance with 42 C.F.R. § 483.30(a).

C. The facility was not in substantial compliance with § 483.10(b)(11), because staff did not immediately consult its residents' attending physicians about significant changes in their conditions.

Regulatory requirement. The facility must protect and promote the rights of each resident. In this regard, it must immediately inform the resident, consult the resident's physician, and (if known) notify the resident's legal representative or interested family member when there is a significant change in the resident's physical, mental or psychosocial status (i.e., a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications); or a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment). 42 C.F.R. § 483.10(b)(11).

CMS cites two instances in which the facility failed to consult immediately a resident's physician about a significant change in the resident's physical status or need to alter treatment significantly.

Resident 6 (R6). R6 was an 84-year-old man with diagnoses that included diabetes and chronic atrial fibrillation. CMS Ex. 21 at 11.

Nursing notes dated January 26, 2009, describe decreased lung sounds with crackles. When asked to breathe deeply and cough, he was able to give only a weak cough. His oxygen saturation level was 97% on room air. CMS Ex. 22 at 4. The following day, his oxygen saturation level had dropped to 90% on room air. CMS Ex. 22 at 5. At about 5:00 or 6:00 a.m. on January 28, he complained of dizziness or vertigo. CMS Ex. 22 at 5. His visiting family expressed concern that he was "feeling dizzy when getting up." CMS Ex. 22 at 6. Staff said they would monitor his pulse and blood pressure and update his physician "as needed." They did not then notify his physician, however.

Nor did they tell the nurse aides that R6 had been experiencing dizziness. At least, the aides on duty claimed that they did not know about it (although they knew he had a history of falls). At 3:45 p.m. on January 28, a nurse aide left the resident alone, sitting on the edge of his bed, waiting to be transferred to a chair. The resident fell and hit his

head on the floor. Staff found him lying on his side. He told them that he was trying to move from his bed to his chair, but became dizzy. CMS Ex. 22 at 6; CMS Ex. 23 at 21.

According to the incident report, R6 would require a two-person assist with a gait belt and wheelchair for mobility "until acute illness/weakness" resolves. CMS Ex. 23 at 19.

At 6:00 p.m. – more than twelve hours after his symptoms began and more than two hours after his fall – staff sent a fax to the office of R6's attending physician, Dr. Ricardo Almonte, saying that R6 complained of dizziness with position change, that he complained of a headache with nasal congestion, and that his blood pressure went up when he changed positions. But the fax said nothing about the resident's fall. CMS Ex. 21 at 8; CMS Ex. 23 at 19; Tr. at 69.

Notwithstanding the instruction for a two-person assist, at 7:05 p.m., one nurse aide attempted to take R6 to the bathroom, using a gait belt, when the resident became weak and dizzy, and could no longer stand. The nurse aide lowered him to the floor. CMS Ex. 23 at 24-25. Staff did not contact R6's physician about this incident, but noted that they were "awaiting return response from MD in regards to resident change in status with recent fall." CMS Ex. 22 at 7. According to the incident report, at noon the following day, staff reported this second incident to Diane Anderson, Dr. Almonte's nurse practitioner. CMS Ex. 23 at 24.

In the meantime, on the morning of January 29, Nurse Practitioner Anderson responded to the previous day's fax, directing that the resident be evaluated "in the clinic." CMS Ex. 21 at 8. That afternoon, Dr. Almonte examined R6. According to his report, the resident had fallen three times the night before. Dr. Almonte opined that R6 should stop taking his anticoagulant medication because he risked head injury or internal bleeding due to falls. The doctor ordered a Holter monitor to test for arrhythmia and a carotid ultrasound to rule out carotid disease. He directed the facility to monitor the resident's blood sugar and restricted the resident to a wheelchair until his dizziness resolved. CMS Ex. 21 at 11-12.

Resident 2 (R2). Resident 2 was the 86-year-old man with COPD and Alzheimer's disease who, as described above, experienced multiple falls. He also became acutely ill with a respiratory infection in December 2008.

According to nursing notes, on December 20, 2008, his breathing became labored. Staff documented wheezing and diminished breath sounds. His cough was weak. CMS Ex. 13 at 1. By December 27, he was experiencing shortness of breath. His breathing had become fast and shallow. He was congested. Notes describe "white frothy mucous." CMS Ex. 13 at 3. On December 28, the resident's family told staff that, although they did not want him treated aggressively, they agreed to oral antibiotic therapy so long as R2 was able to swallow the medication. CMS Ex. 13 at 4. The nursing note says that,

among the resident, his wife, and son (who had power of attorney), they agreed to change his code status to "do not resuscitate" (DNR).[11] At about 2:00 p.m., they signed a new consent and advance directive form, which the facility faxed to his primary physician with an update, assessment and statement of their wishes with respect to treatment. CMS Ex. 13 at 4; CMS Ex. 12 at 15. But this was a Sunday, so no one was in the physician's office.

On Monday, R2's physician returned the fax with a DNR order and a prescription for an oral antibiotic to relieve his symptoms. CMS Ex. 12 at 15; Tr. 77 ("It would be a comfort measures."). R2 was able to take the antibiotics, and he recovered. CMS Ex. 13 at 5-7.

For each of these residents, the facility was bound to consult immediately the resident's attending physician, but impermissibly waited hours or days before even sending notice to the physician.

"Significant" does not mean "life-threatening." Nor does the regulation require a medical emergency. Drafters of the regulation emphasized that "in all cases, whether or not there is a medical emergency," the facility must immediately consult the attending physician. 56 Fed. Reg. 48,826, 48,833 (Sept. 26, 1991). "Immediately" means "as soon as the change . . . is detected, without any intervening interval of time." *Magnolia Estates Skilled Care*, DAB No. 2228 at 8 (2009); *The Laurels at Forest Glen*, DAB No. 2182 at 13 (2008).

R6's complaints of dizziness and the resulting falls represented a significant change in his physical status, presenting a need to alter his treatment. Yet, staff waited almost the entire day before sending a fax to his physician, and, in that fax, they failed to mention that the resident had fallen as a result his new symptoms. Moreover, because they waited until after regular business hours, neither his physician nor the physician's assistant learned of the change until the next day. In the meantime, the resident fell as the result of his dizziness. As his physician recognized, the resident required an immediate evaluation. To keep him safe, he also needed to stop taking anticoagulant medication, and had to be restricted to a wheelchair.

R2 had an acute upper respiratory infection that was serious but treatable. Yet his condition deteriorated for days before the facility finally notified his physician. Even then, they sent a fax to the physician's office on a Sunday, further delaying the physician notification.

[11] Puzzling since, according to the physician orders in his chart, as of August 2008, R2 had DNR orders in place. CMS Ex. 12 at 2; Tr. at 74-76.

Nor was it adequate merely to send a fax to the physician's office. Simply communicating information does not satisfy the regulatory requirement to "consult" the attending physician. As the Departmental Appeals Board (Board) ruled in *Magnolia Estates*, consultation requires more than just informing or notifying the physician.

> Consultation . . . requires a dialogue with and a responsive directive from the resident's physician as to what actions are needed; it is not enough to merely notify the physician of the resident's change in condition. Nor is it enough to leave just a message for the physician.

Magnolia Estates, DAB No. 2228 at 8. Thus, sending a fax to the physician's office, particularly after regular business hours, does not satisfy the requirement to consult.

Thus, on these occasions, the facility did not immediately consult the resident's attending physician following a change in condition and need to alter treatment. The facility was therefore not in substantial compliance with 42 C.F.R. § 483.10(b)(11).

D. CMS's determination that the facility's deficiencies posed immediate jeopardy to resident health and safety is not clearly erroneous.

Immediate jeopardy exists if a facility's noncompliance has caused or is likely to cause "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy, and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1931 at 27-28 (2004) (*citing Koester Pavilion*, DAB No. 1750 (2000)); *Daughters of Miriam Ctr.*, DAB No. 2067 at 7, 9 (2007).

The elderly are particularly susceptible to serious injury as the result of a fall. Tr. at 37. In this case, falling was not simply a remote possibility; it was a frequent occurrence. Multiple residents suffered falls on multiple occasions, any one of which was likely to cause serious injury, harm, impairment or even death. R5 fractured both of her hips and her femur. Even accepting Petitioner's argument that one or two of those fractures were spontaneous, and not the result of a fall, her falls were likely to result in broken bones because of her severe osteoporosis.

Moreover, R5 was not the only resident injured. Over the course of her falls, R12 hit her head, bit her tongue, suffered a bruised and swollen knee, and a bruised arm. R7 fell and

hit her head, and bruised and scraped her thigh. R2 hit his head on more than one occasion and suffered bruises and skin tears. R10 suffered head injury, bruising and skin tears. Based on the residents' vulnerability to serious injury and these actual injuries, one could reasonably conclude that the facility's failure to prevent these accidents posed immediate jeopardy to the resident health and safety. CMS's immediate jeopardy determination is therefore not clearly erroneous.

E. The penalties imposed are reasonable.

I next consider whether the CMPs are reasonable by applying the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating factor. The factors in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

In reaching a decision on the reasonableness of the CMP, I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848 at 21 (2002); *Cmty. Nursing Home*, DAB No. 1807 at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800 at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638 at 8 (1999).

CMS has imposed penalties of $6,800 per day for the one day of immediate jeopardy, which is in the mid-range ($3,050-$10,000), and $400 per day for 35 days, which is at the low end of the penalty range for per-day CMPs ($50-$3,000). 42 C.F.R. §§ 488.408(d), 488.438(a)(1).

The facility has a history of substantial noncompliance. Surveys completed in December 2006, January 2008, and October 2008 cited multiple deficiencies. CMS Ex. 43. During the survey completed in October 2008, just six months prior to the survey before me, the facility was not in substantial compliance with 42 C.F.R. § 483.10(b)(11) (tag F157 – notification of change), 42 C.F.R. § 483.20(k)(1) (tag F279 – comprehensive care plans) and 42 C.F.R. § 483.25(h) (tag F323 – supervision/accident prevention), among other deficiencies. CMS Ex. 43 at 3. In January 2008, the facility was also not in substantial compliance with 42 C.F.R. § 483.10(b)(11), and the surveyors found a pattern of substantial noncompliance with 42 C.F.R. § 483.25(h). CMS Ex. 43 at 2. Based on this

history, CMS could reasonably justify a very substantial CMP as necessary to produce corrective action.

Petitioner complains that the penalty imposed has greater financial impact on it than it would others because the facility is small. However, Petitioner does not claim that its financial condition prevents it from paying the CMP. P. Cl. Br. at 43.

With respect to the remaining deficiencies, particularly those that presented immediate jeopardy, I find that the sheer number of vulnerable and unprotected residents suffering injuries justifies a substantial penalty. Further, I find that staff were particularly culpable in their treatment of R5 and R12. Without regard to her care plan's instructions (she was supposed to have a one to two-person assist with a gait belt), staff knowingly allowed R5 to walk unassisted and to stand up from her chair without intervening. After she fell, no one seems even to have recognized that they had ignored the fall prevention instructions in her care plan. Staff also knew that R12 was particularly vulnerable to falls when she was exhausted and agitated. Yet, rather than intervening when they witnessed her engaging in risky behavior, they sent her away. I recognize that staff may not have been able to supervise as needed because the facility was insufficiently staffed. If so, the facility's management is culpable.

I therefore find that the facility's history, the number, scope and severity of the deficiencies cited, and the staff's culpability, justify the penalties imposed.

IV. Conclusion

For the reasons discussed above, I find that the facility was not in substantial compliance with the Medicare requirements. I also find that its deficiencies posed immediate jeopardy to resident health and safety, and I affirm as reasonable the penalty imposed.

/s/
Carolyn Cozad Hughes
Administrative Law Judge