Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Cal Turner Extended Care Pavilion
(CCN: 18-5325),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-09-655

Decision No. CR2257

Date: October 1, 2010

DECISION

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to impose remedies against Cal Turner Extended Care Pavilion (Petitioner or facility). For the reasons that follow, I uphold the civil money penalty (CMP) of $4,550.00 per day effective May 17, 2009 through June 3, 2009, and the CMP of $150 per day effective June 4, 2009. Consequently, the state agency was required to withdraw approval of Petitioner to conduct a nurse aide training and competency evaluation program (NATCEP) for a period of two years.

I. Background

Petitioner is a long-term care facility located in Scottsville, Kentucky. Petitioner is authorized to participate in the federal Medicare program as a skilled nursing facility (SNF) and in the Medicaid program as a nursing facility (NF). On June 4, 2009, the Kentucky State Survey Agency (state agency) conducted a complaint survey of the facility. The state agency determined that Petitioner was not in substantial compliance with the following three Medicare Participation requirements: (1) 42 C.F.R. § 483.20(b), Tag 272 (Comprehensive Assessments) at a "K" level of scope and severity; (2) 42

C.F.R. § 483.20(k)(2), Tag 280 (Comprehensive Care Plans) at a "K" level of scope and severity; and (3) 42 C.F.R. § 483.25(h), Tag 323 (Accidents and Supervision) at a "K" level of scope and severity. CMS Ex. 2.

By letter dated June 18, 2009, the state agency notified Petitioner that it had recommended to CMS that the following remedies be imposed: a CMP of $4,550.00 for June 3, 2009, explaining that immediate jeopardy/substandard quality of care was identified on June 3, 2009, determined to exist on March 7, 2009, and was determined to be removed on June 4, 2009; a CMP of $100 per day effective June 5, 2009, to continue until substantial compliance is achieved or Petitioner's provider agreement is terminated; and denial of payment for new admissions effective as soon as notification requirements can be met. CMS Ex. 4, at 7-8.

By letter dated June 23, 2009, CMS notified Petitioner that the following remedies will be imposed on the dates indicated: a CMP in the amount of $4,550.00 per day effective May 17, 2009 through June 3, 2009, and a CMP of $150.00 per day effective June 4, 2009 will continue until substantial compliance is achieved or Petitioner's provider agreement is terminated; discretionary denial of payment for new admissions (DPNA) effective July 8, 2009, if the facility is still out of compliance on that date; termination of Petitioner's Medicare provider agreement on December 4, 2009 if the facility has not achieved substantial compliance by that date; and loss of NATCEP for two years. CMS Ex. 4, at 2-3.

By letter dated July 21, 2009, CMS notified Petitioner that a revisit survey conducted on July 15, 2009, found the facility to be in substantial compliance with participation requirements effective June 5, 2009. CMS Ex. 4, at 10. CMS advised Petitioner that it was canceling the DPNA and termination actions because compliance was determined prior to the effective dates of those remedies. *Id.*

By letter dated August 12, 2009, Petitioner timely requested a hearing. In its hearing request, Petitioner states:

> The provider challenges the factual basis for concluding that any provision of the applicable regulations was violated by not providing assessment specifically related to the use of lift chairs as opposed to general fall risk assessments. The provider further challenges that injuries to residents identified as Nos. 1 and 3 were in any manner related to the use of lift chair assisted devices. The provider disagrees with the conclusions of law based upon erroneous findings of fact by the State Agency.

I conducted an in-person hearing in Louisville, Kentucky on July 1, 2010. CMS offered exhibits (CMS Exs.) 1 through 18, and Petitioner offered exhibits (P. Exs.) 1 through 44.

I admitted all of the exhibits into evidence. Hearing Transcript (Tr.) 27-28. CMS elicited testimony from Samantha Windsor, Assistant Director of surveyors of state agency. Tr. at 32. Petitioner elicited testimony from Eric Hagan, Petitioner's Administrator, and Sonya McReynolds, Petitioner's Director of Nursing.

Each party received a copy of the hearing transcript, and each party submitted a post-hearing brief (CMS Brief and P. Brief). CMS submitted a post-hearing reply brief, but I have not considered it because the briefing schedule I set out at the conclusion of the hearing (Tr. 113) and in my letter of July 22, 2010 did not permit either side to file such a document.

II. Issues

The issues before me are:

(1) Whether I should take judicial notice of the decision of the Commonwealth of Kentucky Cabinet for Health and Human Services in which Petitioner prevailed;

(2) Whether the "lift chairs" owned and used by several residents of the facility are "assistive devices";

(3) If the lift chairs are assistive devices, whether the facility was in substantial compliance with 42 C.F.R. §§ 483.20(b), 483.20(k)(2), and 483.25(h);

(4) If the facility was not in substantial compliance, whether Petitioner's noncompliance constituted immediate jeopardy; and

(5) If the facility was not in substantial compliance, whether the penalty imposed was reasonable.

III. Applicable Law and Regulations

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

Pursuant to the Act, the Secretary has delegated to CMS the authority to impose various remedies against a long-term care facility that is not complying substantially with federal participation requirements. Facilities that participate in Medicare may be surveyed on

behalf of CMS by State survey agencies to ascertain whether the facilities are complying with participation requirements. 42 C.F.R. §§ 488.10-488.28; 42 C.F.R. §§ 488.300-488.335. Under Part 488, CMS may impose a per instance, or per day, CMP against a long-term care facility when a State survey agency ascertains that the facility is not complying substantially with participation requirements. 42 C.F.R. §§ 488.406, 488.408, 488.430. The regulations in 42 C.F.R. Part 488 also give CMS a number of other remedies that can be imposed if a facility is not in compliance with Medicare requirements.

Pursuant to 42 C.F.R. Part 488, CMS may terminate a long-term care facility's provider agreement when a survey agency concludes that the facility is not complying substantially with federal participation requirements. CMS may also impose a number of alternative enforcement remedies in lieu of, or in addition to, termination. 42 C.F.R. §§ 488.406; 488.408; 488.430. In addition to termination and the alternative remedies that CMS is authorized to impose, pursuant to section 1819(h)(2)(D) of the Act and 42 C.F.R. § 488.417(b), CMS must impose the "mandatory" or "statutory" DPNA. Section 1819(h)(2)(D) requires the Secretary to deny Medicare payments for all new admissions to a SNF, beginning three months after the date on which such facility is determined not to be in substantial compliance with program participation requirements. The Secretary has codified this requirement at 42 C.F.R. § 488.417(b).

The regulations specify that a CMP imposed against a facility can be either a per day CMP for each day the facility is not in substantial compliance, or a per instance CMP for each instance that a facility is not in substantial compliance. 42 C.F.R. § 488.430(a).

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of the CMP, from $3,050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). The lower range of CMP, from $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). There is only a single range of $1,000 to $10,000 for a per instance CMP, which applies whether or not immediate jeopardy is present. 42 C.F.R. §§ 488.408(d)(1)(iv); 488.438(a)(2).

The regulations define the term "substantial compliance" to mean "a level of compliance with the requirements of participation, such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. Non-compliance that is immediate jeopardy is defined as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident."

Id. The Act and regulations make a hearing before an administrative law judge (ALJ) available to a long-term care facility against whom CMS has determined to impose a CMP. Act, section 1128A(c)(2); 42 C.F.R. §§ 488.408(g); 498.3(b)(13). The hearing before an ALJ is a de novo proceeding. *Anesthesiologists Affiliated,* DAB CR65 (1990), *aff'd*, 941 F2d. 678 (8th Cir. 1991).

A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." *See* 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e) and 498.3. However, the choice of remedies by CMS, or the factors CMS considered when choosing remedies, are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge would affect the amount of the CMP that CMS could collect or impact upon the facility's nurse aide training program. 42 C.F.R. §§ 498.3(b)(14)(i) and (ii). CMS's determination as to the level of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate jeopardy. *Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board or DAB) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g.*, *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Review of a CMP by an ALJ is governed by 42 C.F.R. § 488.438(e).

In a CMP case, CMS must make a prima facie case that the facility has failed to comply substantially with participation requirements. To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Hillman Rehab. Center*, DAB No. 1611 (1997), *aff'd*, *Hillman Rehab. Center v. U. S. Dep't of Health & Human Servs.*, No. 98-3789, 1999 WL 34813783 (D.N.J. May 13, 1999).

IV. Findings of Fact, Conclusions of Law, and Discussion

I set forth the findings of fact and conclusions of law to support this decision as separate headings in bold and italics type and then discuss each in detail.

1. Where CMS and the state disagree, CMS's findings of noncompliance take precedence.

The crux of Petitioner's argument in its post-hearing brief is that the ALJ should take judicial notice of, and be bound by, the decision of the Commonwealth of Kentucky Cabinet for Health and Family Services dated August 12, 2010, for case number AHB OIG 09-568, in which the administrative law judge reversed its decision to issue a Type A Citation to Cal Turner Extended Care Pavilion in regard to Residents 1 and 3. P. Brief

at 4-5, Exhibit 1. That administrative law judge found that the state had not met its burden of proving the alleged state regulatory violations. P. Brief at Exhibit 1.

In support of its argument, Petitioner states that neither 42 C.F.R. § 488.452 nor the holding in *Lake Mary Health Care*, DAB 2081 (2007) is relevant to the instant case because they address only situations in which CMS and state agency determinations are based on the same set of underlying facts. Moreover, now that the state agency has reversed itself, Petitioner argues that there are no facts which support a CMS determination of immediate jeopardy and assessment of civil money penalties. P. Brief at 4-5. Specifically, Petitioner states that the "Cabinet has now determined as a matter of fact that the lift chairs were not assistive devices, were not used as assistive devices, and neither Resident 1 nor Resident 3 fell while using the lift chair as an assistive device." P. Brief at 5.

I disagree with this reasoning. The underlying facts have remained the same. The state administrative law judge reached a conclusion based on the evidence and testimony before her. In this case, testimony from the state proceeding has been submitted into evidence, and, in addition, there is testimony from the hearing before me as well as many exhibits submitted for my consideration. All of the testimony and evidence in both cases are related to the same statement of deficiencies by the state agency.

The purpose of the state proceeding was to determine the facility's compliance with state regulations, but the purpose of this federal proceeding is to determine the facility's compliance with federal regulations. *See* P. Ex. 44, at 5, 8-10. As the Departmental Appeals Board stated in *Lake Mary Health Care*, DAB 2081, at 7 (2007):

> Ultimate responsibility for the interpretation and enforcement of federal participation requirements lies with CMS, not with the state surveyors who conduct surveys under an agreement with CMS. Any greater familiarity that FAHCA may have with practices in Florida nursing homes cannot override the expertise of federal regulators in the nationally-applicable regulations involved in this matter. Federal law makes clear that, in a situation such as that presented here, CMS's finding of noncompliance and imposition of remedies for a determination of immediate jeopardy not only is legally permissible but must take precedence over the state's position. The statute and regulations contemplate the possibility that state and federal findings and choice of remedies may not always be in accord. Thus, section 1919(h)(6)(B) of the Act provides that, in the case where CMS finds noncompliance (but no immediate jeopardy) but the state makes no finding of noncompliance, CMS may nevertheless "impose any remedies specified in paragraph (3)(C)," which include civil money penalties up to $10,000 per day. [FN4] See also §§ 1819(h)(2)(A)

> and 1919(g)(3)(A) of the Act; 42 C.F.R. § 488.452(a)(2) (CMS findings of noncompliance take precedence over state findings of compliance); 59 Fed. Reg. 56,116, at 56,129 (Nov. 10, 1994). Where either CMS or the state finds immediate jeopardy, section 1919(h)(5) of the Act provides that the entity finding immediate jeopardy shall notify the other and take "immediate action to remove the jeopardy and correct the deficiencies" by applying the legal remedies available in immediate jeopardy situations.

For the above reasons, I find no merit in Petitioner's argument that I should take judicial notice of, and be bound by, the state agency findings. Accordingly, I will review the record before me in determining whether Petitioner was in compliance with the federal regulations.

2. When employed as directed in the manual, a "lift chair" is an "assisted device."

Sixteen of the residents of the facility own what is referred to as a "lift chair." CMS Ex. 2, at 2. These chairs are similar in appearance to a typical recliner chair, however, they are different in that they have a hand-held control module, attached to the chair by a cord, by which the chair's occupant can adjust the seat and back of the chair to make it easier to stand up or sit down. The manufacturer refers to the chair as a "Power Lift & Recline Chair." P. Ex. 5, at 1 (owner's manual).

The statement of deficiencies dated June 4, 2009, explains that each deficiency is related to the resident's use of the lift chairs, which were possibly the cause of falls of two residents. CMS Ex. 2. Specifically, the deficiencies cited allege that the facility (1) "failed to conduct an assessment to determine whether the use of the chairs was appropriate for each resident and to ensure that the chairs were not an accident hazard"; (2) "failed to develop a comprehensive care plan regarding the use of remote control lift chairs for two residents . . . in the selected sample of five and eight residents . . . not in the selected sample"; and (3) "failed to assess residents to determine whether the use of the lift chairs were a potential accident hazard." CMS Ex. 2, at 2, 13, 23.

Petitioner argues that "the lift chairs had never been identified as an 'assistive device' on any prior survey . . . and . . . none of the applicable literature consisting of state and federal regulations, manuals, product literature, etc. identify a lift chair as an assistive device." P. Brief at 3.

CMS argues at page 11 of its Brief:

> According to the Owner's Manual for the lift chairs in question, these lift chairs are assistive devices. The manual describes the chairs as "medical equipment designed to help you sit down and

> stand up." (Pet. Ex. at 5) (sic). In addition to equipment constructed for the sole purpose of operating as an "assistive device," common household items can also be "turned into" assistive devices if they are used a (sic) such. (Tr. at 35-36, 43).

The owner's manual reads, in pertinent part: "[t]his power lift and recline chair is a piece of medical equipment designed to help you sit down and stand up. Children should not be allowed to operate it without adult supervision." P. Ex. 5, at 2. The manual further warns:

> Your Golden power lift chair is a piece of medical equipment. Therefore, you are required to exercise caution when operating it to ensure your personal safety and that of others around you. The following are rules for the safe operation of your Golden power lift chair.

P. Ex. 5, at 3.

The manual does not specifically call the chair an assistive device but does refer to it repeatedly as medical equipment, and indicates the purpose of which is to help one sit down and stand up. Several of the manual's "rules for the safe operation of your Golden power lift chair" address, in the most explicit way, the avoidance of physical hazards to the user in getting into and out of the chair, and in the chair's occupancy, placement, and operation. P. Ex. 5, at 3, 8. Helping one sit down and stand up is an act of providing assistance. It follows that a lift chair is an assistive device when used as directed in the manual.

Of note, P. Exs. 1 and 3 are sections of the State Operations Manual that define assistive devices, presumably submitted as guidance for determining whether a lift chair is an assistive device. Specifically, Section V—Guidance to Surveyors, the section relating to Tag F323 states that "'Assistive Device' refers to any item (e.g., fixtures such as handrails, grab bars, and devices/equipment such as transfer lifts, canes, and wheelchairs, etc.) that is used by, or in the care of a resident to promote, supplement, or enhance the resident's function and/or safety." P. Ex. 1, at 2; *see* State Operations Manual, App. PP.

Later in that same section relating to Tag F323, in regard to assistive devices/equipment hazards, it states:

> Assistive devices and equipment can help residents move with increased independence, transfer with greater comfort, and feel physically more secure. However, there are risks associated with the use of such devices and equipment, and these risks need to be balanced with the benefits gained from their use. Training of staff,

> residents, family members and volunteers on the proper use of assistive devices/equipment is crucial to prevent accidents. It is also important to communicate clearly the approaches identified in the care plan to all staff, including temporary staff. It is important to train staff regarding resident assessment, safe transfer techniques, and the proper use of mechanical lifts including device weight limitations.

P. Ex. 3, at 1-2. In regard to assistive devices for transfer, that same section states: "[m]echanical assistive devices for transfer include, but are not limited to, portable total body lifts, sit-to-stand devices, and transfer or gait belts." P. Ex. 3, at 3 (emphasis added).

A lift chair easily fits this broad definition of assistive devices, as the owner's manual itself defines the lift chair as medical equipment with a purpose of helping one sit down and stand up. In other words, a lift chair falls within the category of "sit-to-stand devices."

3. Petitioner failed to comply substantially with the requirement at 42 C.F.R. § 483.20(b) (Tag F272).

The regulation at 42 C.F.R. § 483.20(b) provides:

> The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.
>
> * * *
>
> (b) *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 must include at least the following:
>
> * * *
>
> (xviii) Documentation of participation in assessment.
>
> 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 statement of deficiencies (SOD) stated that Petitioner did not meet this requirement when two of the residents (Resident 1 and Resident 3) fell from their lift chairs. CMS Ex. 2, at 2-3. Specifically, the facility failed to conduct an assessment to determine whether the use of the chairs was appropriate for each resident, especially Residents 1 and 3 after their falls, and to ensure that the chairs were not an accident hazard. CMS Ex. 2, at 2.

In the case of Resident 1, on May 17, 2009, Resident 1's care plan indicates a fall, with instructions to "move [wheelchair] alarm to recliner when in recliner [and] back to [wheelchair] when in [wheelchair]."[1] CMS Ex. 9, at 16; P. Ex. 27, at 1. A summary of the fall in the Resident Fall Tracking Log states: "Resident was in recliner and had raised chair up as high as it would go and tried to walk [without] help and fell. Family of resident across the hall . . . saw her on the floor." CMS Ex. 9, at 20; P. Ex. 12, at 2; P. Ex. 44, at 25-26. The nurses' notes dated May 17, 2009 at 2:00 PM state: "Was called to residents room via visitor, found in floor lying on [left] side eye glasses off of head lying in front of her with one lens out. Blood coming from head. States my head is the only thing hurting." CMS Ex. 9, at 81.

An investigation report form was filled out reporting the fall, a summary of one of the staff interviews states:

> She was found lying on her left side in front of her recliner some length away from the recliner. The assessment was completed and she had an area to her left temporal with some swelling and a small cut in the center. Her pupils were reactive but sluggish and her b/p was elevated.

P. Ex. 10, at 2.

Resident 1 was taken to the hospital for examination. The radiology report indicates a left subdural hematoma with the majority of it hyperdense, consistent with acute hemorrhage. CMS Ex. 9, at 45.

In regard to Resident 1's overall state of health, her care plan indicates "cognitive loss r/t: age related dementia AEB: alert & oriented to self and family with short & long-term memory difficulties" as well as "[p]oor potential for discharge r/t: self-care deficit, cognitive loss, decision-making, risk of falls/injury." CMS Ex. 9, at 7-8; P. Ex. 24, at 1-2. Resident 1 has "impaired ADL abilities d/t weakness, difficulty ambulating, and lack of coordination. Also has Parkinson's," all of which require staff to "assist x 1 with ambulating, transfers, toileting, dressing, grooming, and bathing." CMS Ex. 9, at 11; P. Ex. 24, at 4.

[1] "Recliner" and "lift chair" are used interchangeably throughout.

Resident 1's rehabilitation assessment states that the she "requires limited assistance with bed mobility, ambulating, and bathing, extensive assistance with dressing and transfers due to difficulty ambulating, weakness, and lack of coordination related to Parkinson's disease." CMS Ex. 9, at 28.

In regard to Resident 3's fall on March 7, 2009, the Resident Fall Tracking Log provides a summary of the event: "[resident] was sitting in recliner prior to being found on . . . floor lying on [right] side . . . . [u]nable to say how she got on the floor, from recliner." CMS Ex. 10, at 27; P. Ex. 40, at 2.

The nurses' notes for the day of the fall state: "[resident] sitting up in recliner earlier. SOB + restless. Gave neb tx per MD order and Xanax 25 mg (at 1930). At 2015 [resident] on floor." CMS Ex. 10, at 29; P. Ex. 36, at 1. Resident 3 was sent to the emergency room for xray, which was negative for fracture. CMS Ex. 10, at 31; P. Ex. 36, at 2.

In regard to Resident 3's overall state of health, her initial resident assessment protocol summary states that the resident is "at risk of injury due to falls due to short-term memory loss, impaired communication, hemiplegia, takes psychotropic medications, recently admitted to facility and history of fall while hospitalized." CMS Ex. 10, at 22. The form notes that Resident 3 "continues to be non-ambulatory." CMS Ex. 10, at 22.

Petitioner argues that the state agency surveyor who conducted an abbreviated survey of facility on June 2, 2009, based her findings that Residents 1 and 3 had fallen while attempting to utilize their lift chairs to move from a sitting to a standing position solely on her own assumptions. P. Brief at 2. Petitioner states that the surveyor's testimony at the state hearing indicates "(1) no one saw either Resident 1 or Resident 3 fall . . . and (2) there was no proof these two residents actually fell from the chair – the two residents in question could have fallen while *approaching* the chair to sit down . . ., or simply moving about the room." P. Brief at 2-3 (citing P. Ex. 44, at 26-27).

The testimony to which Petitioner refers reads:

> Q. . . . [D]id anybody tell you they saw these things happen other than what they saw was the resident in the floor?
>
> A. No.
>
> Q. Okay. So in all fairness, the resident could have . . . gotten out of the chair, walked someplace, walked back to the front of the chair and fallen?
>
> A. Anything's possible. Yes.

Q. Okay. So with regard to her, other than the fact that the people stated that where both these . . . residents were found was in proximity to their chair, their recliner/lift chair, and to their bed, that's all that you were able to determine?

A. Yes. I didn't have proof that they actually saw them fall from the chair.

P. Ex. 44, at 26-27 (direct examination). Before the above testimony, the following colloquy occurred on direct examination:

Q. . . . [W]hat information did you have to indicate that the lift chairs were in some manner the cause of their falls?

A. The CNA . . . had told me that the lift chair when she went in the room after the resident was, they were gotten by the visitor and [the resident] was on the floor, the lift chair was raised as high as it would go and [the resident] was laying on the floor with her head bleeding.

P. Ex. 44, at 26. This testimony is consistent with the notes in the Resident Fall Tracking Log, which states: "Resident was in recliner and had raised chair up as high as it would go and tried to walk [without] help and fell. Family of resident across the hall . . . saw her on the floor." CMS Ex. 9, at 20; P. Ex. 12, at 2.

The fact that the nurses who first arrived on the scene reported the cause of the fall to be the chair is sufficient information for the facility to be on notice that the lift chair may be the cause of the fall. Regardless of whether the lift chair was in fact the cause of the fall, that information alone should have prompted an assessment of the use of the chair as an assistive device in transferring the resident from sitting to a standing position.

Petitioner also argues that the undisputed testimony of the facility's staff was that the lift chairs were not used to assist the residents in rising from the chair, either by the staff or the residents. P. Brief at 3. Citing both the state hearing and the hearing before me, Petitioner further states that the chairs were merely used as recliners furnished by the residents' families to provide additional comfort. P. Brief at 4.

The problem with this argument is that the Resident Fall Tracking Log states that the recliner chair was raised as high as it would go at the time they found Resident 1 fallen on the floor. CMS Ex. 9, at 20; P. Ex. 12, at 2. It is reasonable to infer that Resident 1 herself used the remote control to raise the chair because she was the only person in the room when found fallen on the floor. It is also reasonable to infer that the chair was the cause of the fall in this instance given the fact that the chair was in the raised position and

the resident was on the floor in close proximity to the chair. Further, the facility floor nurse testified at the state hearing that she personally observed facility residents use the lift function of their chairs. CMS Brief at 7; P. Ex. 44, at 38-39.

Petitioner argues that the resident's family provided the residents with the lift chairs, not the facility. However, the family's wishes do not — as a matter of settled law — absolve the facility of its responsibility for compliance with the regulations and thereby providing the care needed by its residents. *Koester Pavilion*, DAB No. 1750, at 34 (2000).

As mentioned above, the lift chair owner's manual characterizes the lift chair as an item of medical equipment and explicitly sets out cautionary information consistent with its use as an item of medical equipment. And as Petitioner's Administrator, Eric Hagan, testified, whether provided by the facility or the resident's family, an assessment should be carried out on all medical equipment. Specifically, Mr. Hagan testified the following on cross examination at the state hearing:

> Q. Okay. So people are allowed to supply their own medical equipment?
>
> A. Well, let me back up. If it's medical equipment then that has to – we have to make sure we go through, get that checked out. All medical has to make sure it's appropriate, we have a physician order for it and it's appropriate to use and then if there's any other parties – respiratory therapy, whoever that helps maintain that or make sure they're receiving whatever they're supposed to get, then yes.
>
> Q. Okay. A policy on whether or not residents can operate their own medical equipment?
>
> A. It would be similar. They would have to have a physician order. They'd have to have a need. It would have to be coordinated through our medical staff and a team of individuals to make sure it's safe.
>
> Q. Okay. So in other words, an assessment?
>
> A. Yes.

P. Ex. 44, at 45. Mr. Hagan also testified that the facility did not see the lift chairs as medical equipment, and that the lift chairs did not cause the residents' falls. P. Ex. 44, at 46. There is no evidence that an assessment was carried out for the lift chairs.

4. Petitioner failed to comply substantially with the requirement at 42 C.F.R. § 483.20(k)(2) (Tag F280).

The regulation at 42 C.F.R. § 483.20(k)(2) provides that:

> (2) A comprehensive care plan must be—
>
> (i) Developed within 7 days after completion of the comprehensive assessment;
>
> (ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and
>
> (iii) Periodically reviewed and revised by a team of qualified persons after each assessment.

The statement of deficiencies (SOD) stated that Petitioner did not meet this requirement when two of the residents (Resident 1 and Resident 3) fell from their lift chairs. CMS Ex. 2, at 13-14. Specifically, the facility failed to develop a comprehensive care plan regarding the use of remote control lift chairs for Residents 1 and 3, or for the ten residents who have lift chairs and who are cognitively impaired. CMS Ex. 2, at 13-14.

There are fifteen other residents who also have lift chairs. P. Ex. 14. In addition to Residents 1 and 3, eight of these residents were identified by the surveyors as cognitively impaired with decreased safety awareness. CMS Ex. 2, at 23.

As stated above, it is reasonable to infer that the lift chairs were the cause of the fall for at least one resident. At that time, all residents with lift chairs should have been assessed and their respective care plans updated as needed to address the usage of the lift chairs. At a minimum, Residents 1 and 3 in particular, as well as those cognitively-impaired residents with lift chairs should have been care-planned for the usage of lift chairs.

Resident 1's care plan lists as a "problem" that "resident has potential for injury due to falls d/t unsteady gait, weakness, Parkinson's." CMS Ex. 9, at 5. On this same page, the care plan has an entry dated May 19, 2009, with instructions to "keep chair unplugged – staff to plug in to assist." CMS Ex. 9, at 5. An entry dated April 3, states that a "chair alarm [is] to be used when ↑ in wheelchair" and added to this entry, on May 19, was instructions to also use chair alarm when in recliner. CMS Ex. 9, at 5.

Resident 3's care plan states: "resident has potential for injury to due to falls d/t hemiplegia, non-ambulatory, weakness, impaired communication." CMS Ex. 10, at 3; P. Ex. 39, at 4. Instructions to prevent falls include: "Do not leave [resident] in recliner when [resident] is anxious or restless." CMS Ex. 10, at 3; P. Ex. 39, at 4, 11.

These instructions in the care plans do not meet the requirements of the regulation. They were not based on a comprehensive assessment because, as established above, no assessment was carried out. And, they were not prepared by an interdisciplinary team.

5. Petitioner failed to comply substantially with the requirement at 42 C.F.R. § 483.25(h) (Tag F323).

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

> (h) *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.

The Board has stated with regard to subsection (h)(1),

> The standard in section 483.25(h)(1) itself – that a facility "ensure that the resident environment is as free of accident hazards as possible" in order to meet the quality of care goal in section 483.25 – places a continuum of affirmative duties on a facility. A facility must determine whether any condition exists in the environment that could endanger a resident's safety. If so, the facility must remove that condition if possible, and, when not possible, it must take action to protect residents from the danger posed by that condition.

Laurelwood Care Center, DAB No. 2229, at 8 (2009) (quoting *Me. Veterans' Home – Scarborough*, DAB No. 1975, at 5 (2005)).

The statement of deficiencies (SOD) stated that Petitioner did not meet this requirement when Residents 1 and 3 fell from their lift chairs. CMS Ex. 2, at 23-24. Specifically, the facility failed to ensure the resident's environment remained as free from accident hazards as possible; failed to ensure each resident received adequate supervision and failed to identify potential hazards to prevent accidents for Residents 1 and 3, as well as eight other residents with lift chairs who are cognitively impaired with decreased safety awareness. CMS Ex. 2, at 23.

Petitioner has come forward with no evidence to dispute this assertion but instead relies on the state findings that the lift chairs were not assistive devices, were not used as assistive devices, and that neither Resident 1 nor Resident 3 fell while using the lift chair as an assistive device. P. Brief at 5. Petitioner argues that because the chairs were not used as assistive devices, there is no basis for a citation. *Id.*

As noted above, I conclude that the lift chairs are assistive devices, and the facility should have recognized them as such. The facility failed to identify potential hazards to prevent accidents and thus failed to provide adequate supervision to prevent accidents.

6. Petitioner's noncompliance with 42 C.F.R. §§ 483.20(b) (Tag F272); 483.20(k)(2) (Tag F280); and 483.25(h) (Tag F323) constituted immediate jeopardy to its residents.

The regulations define "immediate jeopardy" as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination about the level of noncompliance must be upheld unless it is clearly erroneous. 42 C.F.R. § 498.60(c).

The surveyors concluded that --

> On 06/03/09 Immediate Jeopardy (IJ) was identified at 483.20 at F272 and F280 at a S/S of "K" and IJ and Substandard Quality of Care at 483.25 at F-323 at a S/S of a "K". The Immediate Jeopardy was determined to exist on 03/07/09 and was ongoing. The facility was notified on 06/03/09 and a partial extended survey was conducted on 06/03-04/09.

CMS Ex. 2, at 3, 14, 24.

According to the plain language of the regulation, a finding of immediate jeopardy only requires that a nursing facility's noncompliance is <u>likely</u> to cause harm to a resident. 42 C.F.R. § 488.301 (emphasis added). The purpose of the regulation, 42 C.F.R. § 483.25(h)(2), is to prevent not only actual harm, but also likely harm to a resident. *Woodstock Care Center*, DAB No. 1726, at 39 (2000), *aff'd*, *Woodstock Care Center v. Thompson*, 363 F.3d 583, 590 (6th Cir. 2003).

Here, there was actual harm when Resident 1 fell and suffered a subdural hematoma. CMS Ex. 9, at 45. As stated above, it is reasonable to infer the lift chair was the cause of Resident 1's fall. The other residents who were cognitively impaired and had a lift chair in their room were at risk for harm. Accordingly, CMS's determination of immediate jeopardy was not clearly erroneous and must be upheld.

7. The imposed remedies are reasonable.

a. The imposed CMP of $4,550 per day from May 17, 2009 through June 3, 2009 is reasonable.

In determining the amount of the CMP, 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.

The upper range of CMP, from $3,050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2).

CMS seeks to impose an upper-range CMP of $4,550 per day from May 17, 2009 through June 3, 2009.

Petitioner has presented no evidence to show that the facility's financial condition would preclude it from paying the proposed penalty. The facility administrator testified that the facility has had "a couple of" deficiency-free surveys, including a Joint Commission survey. T. at 85.

CMS argues that:

> [t]he facility was culpable since it was aware that its residents possessed lift chair provided by their families and, in fact, used the lift features of the lift chairs. At a minimum, the facility failed to take any actions (i.e., assess, care plan, implement interventions, monitor, etc.) to prevent the residents from using the lift features. In addition, the facility was further culpable in regards to Resident Nos. 1 and 3 since it had prior information of the residents' propensity for falls.

CMS Brief at 21.

At $4,550 per day, the imposed penalty is at the low end of the range for an immediate jeopardy level penalty. The seriousness of Petitioner's noncompliance and Petitioner's culpability for failing to provide assessments, care plans, and a hazard-free environment justify the penalty imposed.

b. The imposed CMP of $150 per day effective June 4, 2009 is reasonable.

The lower range of CMP, from $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii).

CMS seeks to impose a lower-range CMP of $150 per day effective June 4, 2009. This penalty was due to the remaining noncompliance after the removal of immediate jeopardy at a scope and severity of "E," "based on the facility's need to monitor for the ongoing effectiveness of its' policies and procedures and to ensure the evaluation by the facility's Quality Assurance process." CMS Ex. 2, at 1.

At $150 per day, this imposed penalty is also at the low end of the range for a non-immediate jeopardy level penalty. For the same reasons cited for the immediate jeopardy penalty, I find that the penalty imposed is reasonable.

V. Conclusion

As I have found Petitioner out of substantial compliance with participation requirements at 42 C.F.R. §§ 483.20(b), 483.20(k)(2), and 483.25(h), at a level of immediate jeopardy, and out of compliance with participation requirements at a non-immediate jeopardy level, I sustain the remedies that CMS imposed.

/s/
Richard J. Smith
Administrative Law Judge