Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Senior Care Health & Rehabilitation Center -- Dallas,
(CCN: 67-5417),

Petitioner,

v.

Centers for Medicare & Medicaid Services

Docket No. C-12-1160

Decision No. CR3228

Date: May 12, 2014

DECISION

Petitioner, Senior Care Health & Rehabilitation Center – Dallas, is a long-term care facility located in Dallas, Texas, that participates in the Medicare program. During the facility's annual survey, state surveyors discovered that facility nurses did not safely administer intravenous (IV) medications. Based on this and other findings, the Centers for Medicare & Medicaid Services (CMS) determined that, from March 29 through May 17, 2012, the facility was not in substantial compliance with Medicare program requirements and that, from March 29 through April 28, 2012, its deficiencies posed immediate jeopardy to resident health and safety. CMS imposed civil money penalties (CMPs) of $5,550 per day for 31 days of immediate jeopardy and $150 per day for 19 days of substantial noncompliance that was not immediate jeopardy.

Petitioner admits that it was not in substantial compliance but challenges the immediate jeopardy determination and the reasonableness of the CMPs.

For the reasons set forth below, I find that, from March 29 through April 28, 2012, the facility's deficiencies posed immediate jeopardy to resident health and safety; and that 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, the Texas Department of Aging and Disability Services completed Life Safety Code (LSC) and standard surveys on April 25, 2012 and April 28, 2012, respectively. Based on the survey findings, CMS determined that the facility was not in substantial compliance with multiple program requirements, specifically:

- 42 C.F.R. § 483.20(k)(3)(i) (Tag F281 − comprehensive care plans/professional standards of quality) at scope and severity level K (pattern of noncompliance that poses immediate jeopardy to resident health and safety);

- 42 C.F.R. § 483.25(c) (Tag F314 – quality of care/prevention of pressure sores) at scope and severity level E (pattern of noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.25(i) (Tag F325 – quality of care/nutrition) at scope and severity level D (isolated instance of noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.25(k) (Tag F328 – quality of care/special needs) at scope and severity level K;

- 42 C.F.R. § 483.25(m)(1) (Tag F332 – quality of care/medication error rates) at scope and severity level K;

- 42 C.F.R. § 483.25(m)(2) (Tag F333 – quality of care/significant medication errors) at scope and severity level K;

- 42 C.F.R. § 483.35(i) (Tag F371 – dietary services/sanitary conditions) at scope and severity level F (widespread noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.60(a) and (b) (Tag F425 – pharmacy services/procedures and consultation) at scope and severity level F;

- 42 C.F.R. § 483.60(b), (d) and (e) (Tag F431 – pharmacy services/consultation, labeling, and storage) at scope and severity level F;

- 42 C.F.R. § 483.65 (Tag F441—infection control) at scope and severity level F;

- 42 C.F.R. § 483.75 (Tag F490 – administration) at scope and severity level K;

- 42 C.F.R. § 483.75(f) (Tag F498 – administration/nurse aide proficiency) at scope and severity level E; and

- 42 C.F.R. § 483.70 (a) (LSC) (Tags K025 – smoke barriers, at scope and severity level F; K029 – fire rated construction, at scope and severity level E; and K072 – means of egress, at scope and severity level F).

CMS Exs. 1 at 1-4; CMS Ex. 2.

Based on these findings, CMS imposed CMPs of $5,550 per day from March 29, 2012 through April 28, 2012, and $150 per day beginning April 29, 2012. CMS Ex. 1 at 2. Thereafter, CMS determined that the facility returned to substantial compliance on May 18, 2012. The CMP continued through May 17, 2012. CMS Ex. 1 at 5-6.

Petitioner timely requested a hearing. Petitioner limits its appeal to the immediate jeopardy determination – which is based on the deficiencies cited at 42 C.F.R. §§ 483.20(k)(3)(i), 483.25(k), 483.25(m)(1), 483.25(m)(2), and 483.75 – and the CMPs imposed. CMS's determination that, from March 29 through May 17, 2012, the facility was not in substantial compliance with program requirements is therefore final and binding and provides a sufficient basis for imposing a penalty.

On February 26, 2013, I convened a telephone hearing from the offices of the Departmental Appeals Board in Washington, D.C. Jennifer Mendola appeared on behalf of CMS. She and Captain Dan McElroy, the sole witness, were in Dallas, Texas. Glen D. Sanborn appeared from Amarillo, Texas, on behalf of Petitioner. Transcript (Tr.) at 5, 6.

I have admitted into evidence CMS Exhibits (CMS Exs.) 1-47, and Petitioner's Exhibits (P. Exs.) 1-3. Order Establishing Procedures for Hearing at 2 (January 29, 2013); Tr. at 6. The parties have filed pre-hearing briefs (CMS Pre-hrg. Br.; P. Pre-hrg. Br.) and post-hearing briefs (CMS Post-hrg. Br.; P. Post-hrg. Br.).

II. Issues

Based on the uncontested issues, the facility was not in substantial compliance with Medicare program requirements from March 29 through May 17, 2012, and I must affirm a CMP of at least $50 per day for those days. 42 C.F.R. §§ 488.408(d)(1)(iii), 488.438(a)(1)(ii).

The remaining issues are:

1. From March 29 through April 28, 2012, did the facility's deficiencies pose immediate jeopardy to resident health and safety; and

2. Are the CMPs imposed – $5,550 per day from March 29 through April 28, 2012, and $150 per day from April 29 through May 17, 2012 – reasonable?

Tr. at 5-6.

III. Discussion

Program requirements. Services provided or arranged by the facility must meet professional standards of quality. 42 C.F.R. §483.20(k)(3)(i).

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 this end, the facility must (among other requirements) ensure that residents with special needs receive "proper treatment and care" for a variety of special services, including injections. 42 C.F.R. § 483.25(k). The facility must also ensure that its residents are free of any significant medication errors and that medication error rates are no greater than 5%. 42 C.F.R. § 483.25(m).

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

A. CMS's determination that the facility's deficiencies posed immediate jeopardy to resident health and safety is not clearly erroneous.[1]

The underlying facts of this case are not in dispute, and they present a frightening picture of the nursing staff's inability to administer drugs safely, which, as Petitioner concedes, put the facility out of substantial compliance with 42 C.F.R. §§ 483.20(k)(3)(i), 483.25(k), 483.25(m), and 483.75.

Resident 4 (R4). R4 was a 70-year-old woman, suffering from a wide range of disorders, including anemia, heart failure, hypertension, wound infection, diabetes, hyperlipidemia, cerebral vascular accident, and depression. Her leg had been amputated above the knee. CMS Ex. 2 at 6. She was readmitted to the facility on March 29, 2012, following a hospital stay for evaluation and treatment of her multiple pressure sores. CMS Ex. 5 at 3; CMS Ex. 7 at 3; CMS Ex. 8 at 1, 7, 20, 24.

R4 had in place a "central tunneled internal jugular intravenous line," which is a catheter placed under her skin, ending in her jugular vein (the large vein in the neck that returns blood from the head to the heart). CMS Ex. 2 at 4.

Licensed Vocational Nurse "E." On April 26, 2012, at 3:15 p.m., Surveyor Donna Dudley, RN, observed a licensed vocational nurse (LVN), referred to as "LVN E," administer intravenously, through R4's central IV line, the antibiotic, Vancomycin. In preparing to administer the medication, the LVN first injected normal saline into the line, a standard practice designed to verify that the IV is in its proper place. However, LVN E did not take the steps necessary to insure that air could not enter the IV tubing. Surveyor Dudley saw bubbles in the line, which means that air is present. The syringe, pre-filled with medication, also contained one to two milliliters of air, which the LVN did not remove. Instead, she injected the entire contents of the syringe into the IV tubing. Surveyor Dudley put her hand over the LVN's hand and said, "Stop! There is air in the syringe," but the LVN continued to inject its contents – air and all – into the resident's jugular vein. CMS Ex. 2 at 4, 7-8; CMS Ex. 42 at 2 (Dudley Decl.).

Injecting air into someone's veins is extremely dangerous. It can cause a venous air embolism (VAE) and lead to stroke or death. Given the location of R4's catheter, air could travel directly to her heart and into her lungs. CMS Ex. 42 at 2-3 (Dudley Decl.); *see* CMS Ex. 12 (instructing staff to "purge air" from the flow regulator); CMS Ex. 11 at 2 (reporting that "catheter-associated venous air embolism mortality rates have reached 30%).

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

Nor did LVN E administer the correct dosage of Vancomycin. R4's physician ordered 250 milliliters (ml) infused over a 90-minute period. CMS Ex. 2 at 9; CMS Ex. 8 at 12, 18, 20, 22. In administering IV medications, the facility used a "mechanical flow regulator" (Control-a-Flo) to control the rate at which the medication was administered. To infuse 250 ml over 90 minutes, the nurse set the drip factor at 10, resulting in a flow rate of 28 drops per minute (10 drops equal 1 ml). CMS Ex. 2 at 9; *see* CMS Ex. 10 at 11. But mechanical flow regulators can be inaccurate, so nursing staff must also count the drops actually administered. CMS Ex. 42 at 3-4 (Dudley Decl.). The facility's written policy instructed staff to "**CONFIRM RATE BY COUNTING DROPS**." CMS Ex. 10 at 10 (emphasis in original). Similarly, the regulator's instructions caution that "[f]low rate markings are approximate" so staff must "verify flow rate by observing drip rate." CMS Ex. 12. But LVN E did not count the drops. One of the surveyors did so and reported that the flow rate was 36 drops per minute. CMS Ex. 2 at 9.

Further, LVN E could not accurately read the numbers on the regulator dial. She pointed to the number "100" (ml/hr) and told the surveyors that it read "10." She pointed to the number "125" (ml/hr) and said that it read "30." She subsequently admitted that she could not read the dial without her glasses, which she was not wearing. CMS Ex. 2 at 10; CMS Ex. 43 at 2 (Santoro Decl.).

Assistant Director of Nursing (ADON). Nor was the facility's ADON able to administer IV medication to R4 safely. When the ADON connected a new bag of medication, the drip chamber on the tubing was empty, which allowed air to enter, and Surveyor Dudley saw air enter the tubing. The ADON attached the tubing – air and all – to R4's central line, which would have allowed the air to go directly into the line and thus R4's body. Surveyor Dudley stopped the infusion by clamping off the tubing. She asked that the Director of Nursing (DON) come to the room. Together, Surveyor Dudley and the DON measured the amount of air in the tubing and agreed that 3.1 centimeters of air were in the line. CMS Ex. 2 at 11; CMS Ex. 42 at 3 (Dudley Decl.).

Inadequate training. According to the facility's policy for setting up a primary infusion, only a professional nurse "with documented IV education" may set up a primary infusion. CMS Ex. 10 at 8. Yet, with few exceptions, nursing staff had not been trained to administer IV medications. According to the facility's DON and its human resources director, the facility last conducted in-service training on administering IV medications in 2007. CMS Ex. 42 at 4 (Dudley Decl.); CMS Ex. 36 at 29. Surveyor Dudley consulted one of the nurses in the corporate offices, who provided personnel files for 10 of the facility's LVNs (he could not locate all of the files). Of those 10, only 3 LVNs had any classroom training on administering IVs, and, of those, 2 training certificates dated back to 2006 and 2007. Significantly, the ADON, who was responsible for training the other LVNs in proper IV techniques, had no documented classroom training, only a "skills check-off" list from the DON. CMS Ex. 42 at 4-5 (Dudley Decl.).

Medication error rate. R4 was not the only resident whose medications were not properly administered.[2] The survey team observed 10 medication errors out of 48 opportunities for error. Including R4, 7 of the 16 residents they observed did not receive their medications as ordered, and the errors were made by a variety of staff – four LVNs, one registered nurse (RN), and two medication aides. CMS Ex. 2 at 58; CMS Ex. 35 at 2-5; CMS Ex. 36 at 3-6; CMS Ex. 37 at 25; CMS Ex. 38 at 1-2.

Specifically:

- On April 26, 2012, Surveyor Minika Ekpenyong, M.S., R.N., observed "LVN G" administer 20 units of insulin to R20. A physician's telephone order, dated April 11, discontinued prior insulin orders and called for 25 units of insulin every evening. CMS Ex. 16 at 6. LVN G told Surveyor Ekpenyong that she did not know that the order had been changed. CMS Ex. 16 at 16; CMS Ex. 44 at 3 (Ekpenyong Decl.). It seems that staff erred in filling out R20's medication administration record (MAR). The MAR accurately says to discontinue the previous order – 20 units every evening. But staff did not write in the newly-ordered number of units (25); they rewrote 20 and continued to administer that amount. CMS Ex. 17 at 9. When Surveyor Ekpenyoung brought the April 11 order to LVN G's attention, she said "oh." CMS Ex. 2 at 74.

- R23 had orders for two doses of the anti-seizure medication, Dilantin, one for 100 milligrams (mg) and a second for 50 mg of Infatab (a chewable tablet usually prescribed to children), each tablet to be administered three times a day. At 6:10 p.m. on April 26, "Medication Aide H" reported that the resident's Dilantin was not in the drug cart. The ADON reported that the facility was out of the Dilantin, but it would be delivered later that evening. CMS Ex. 2 at 74; CMS Ex. 21 at 2; CMS Ex. 41 at 2-3 (Hobson Decl.). But the medication was not delivered, and staff gave R23 a 100 mg tablet only, which they took from the facility's emergency supply. They did not administer the additional 50 mg. This posed a potentially serious problem for R23. Dilantin has a narrow range of effectiveness, and the resident's blood levels for the medication were already low. Immediately prior to the time of the survey, they measured between 6.7 and 8.4 micrograms per ml. The desired range is 10 to 20 micrograms. CMS Ex. 2 at 77-78; CMS Ex. 23; CMS Ex. 41 at 5-6 (Hobson Decl.).

- Surveyor Coralea Hobson, R.N., M.Ed., observed Medication Aide H administer eye medications to R21. R21's physician ordered Travatan Z eye drops for each eye, to treat the resident's glaucoma, followed by artificial tears to the left eye

[2] Of the multiple medication errors, CMS relies only on those attributable to R4's care to establish immediate jeopardy.

- *only*, to be administered five minute after the Travatan. The medication aide administered the second medication after just three minutes and administered the drops to both eyes. CMS Ex. 2 at 79; CMS Ex. 44 at 4 (Ekpenyong Decl.).

- R22's physician ordered the laxative Senna, 8.6 mg twice daily, but the medication aide did not administer the medication. CMS Ex. 2 at 80; CMS Ex. 20 at 2; CMS Ex. 41 at 5 (Hobson Decl.).

- R15's physician ordered 200 mg of Nitrofurantoin, which treats urinary tract infections. "Medication Aide D" administered 100 mg instead. CMS Ex. 2 at 59.

- Finally, R19's physician prescribed a multivitamin. Medication Aide D administered Vitamin B complex instead. CMS Ex. 2 at 60.

Petitioner challenges none of this. P. Post-hrg. Br. at 11.

Because the services provided to R4 did not meet professional standards of quality, the facility was not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(i). R4 did not receive "proper treatment and care" with respect to her injections, which put it out of substantial compliance with 42 C.F.R. § 483.25(k). Staff medication errors were significant and the rate of error far exceeded 5%, which put the facility out of substantial compliance with 42 C.F.R. § 483.25(m)(1) and (2). Finally, the sheer volume of deficiencies cited, including those not appealed, suggests a systemic problem here, for which the facility's administration should be accountable. *See Stone County Nursing & Rehab. Ctr.*, DAB No. 2276 at 15-16 (2009) (holding that a deficiency citation alleging noncompliance with section 483.75 may be derived from findings of noncompliance with other participation requirements). Moreover, the facility failed to administer its own policies regarding medication administration and staff training, for which its administrators are directly responsible. The facility was therefore not in substantial compliance with 42 C.F.R. § 483.75.

Immediate jeopardy. 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 Departmental Appeals 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. 1962 at 11 (2005) (citing *Florence Park Care Ctr.*, DAB No. 1931, at 27-38 (2004)); *Daughters of Miriam Ctr.*, DAB No. 2067 at 7, 9 (2007).

I need not find that the facility's noncompliance actually caused serious harm, injury, or death. So long as the deficiencies are likely to cause serious injury or harm, they pose immediate jeopardy.

Petitioner complains that CMS imposed the immediate jeopardy finding, effective March 29, the day R4 was readmitted to the facility. According to Petitioner, "[w]e do not know whether the actions of LVN E, [the] ADON . . . and the DON were isolated occurrences of April 26, 2012 or the norm." P. Post-hrg. Br. at 13. In fact, we know that when R4 was readmitted to the facility on March 29, she had in place the IV line that connected to her jugular vein. We know that nurses were required to administer medications through that line. We also know that nursing staff, including the ADON, had not been trained to do so, did not know how to do so, and performed in a way that jeopardized the resident's safety.

The nursing staff's techniques were not safe, because introducing air into a vein can cause a VAE, which has "the potential for severe morbidity and mortality." Many cases of VAE are subclinical, without an adverse outcome, and symptoms are often nonspecific. CMS Ex. 11 at 1. However, a VAE may be fatal and frequently carries "high neurologic, respiratory, and cardiovascular morbidity." CMS Ex. 11 at 2. Where, as here, a majority of the nurses do not know how to administer medications to a resident without introducing air into her jugular vein, they are likely to cause serious injury, harm, or even death. CMS's determination that the facility's deficiencies posed immediate jeopardy is therefore not clearly erroneous.

B. The penalties imposed are reasonable.

To determine whether a CMP is reasonable, I apply 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.

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 section 488.438(f) 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 22-26 (2002); *Emerald Oaks*, DAB No. 1800 at 9-10 (2001); *CarePlex of Silver Spring*, DAB No. 1683 at 8 (1999).

CMS imposes a penalty of $5,550 per day for the days of immediate jeopardy, which is at the low end of the penalty range for deficiencies posing immediate jeopardy ($3,050 to $10,000 per day). 42 C.F.R. §§ 488.408(e)(iii); 488.438(a)(1)(i). For the period of substantial noncompliance that was not immediate jeopardy, CMS imposes a penalty – $150 per day – that is at the very low end of the applicable penalty range ($50 to $3,000). 42 C.F.R. §§ 488.408(d)(1)(iii); 488.438(a)(1)(ii). Considering the relevant factors, these penalties are modest.

Except for alluding to an "enforcement action" that it took in May 2008, CMS says little about the facility's history. CMS Ex. 47 at 6 (McElroy Decl.). Petitioner, on the other hand, acknowledges that it has not consistently maintained substantial compliance, but claims that its prior deficiencies caused no actual harm and did not pose immediate jeopardy. P. Post-hrg. Br. at 19; P. Br. at 21; P. Ex. 3. According to a "health inspection summary" submitted by Petitioner, in March 2011 and April 2010, the facility had lower-level deficiencies in areas that included pharmacy and quality-of-care. P. Ex. 3. A history of substantial noncompliance is, by itself, sufficient to justify imposing penalties above the minimum, so the deficiencies cited need not have caused actual harm or posed immediate jeopardy. But here, the summary Petitioner submits is ambiguous about the levels of noncompliance. They are described as "minimal harm or the potential for actual harm." If a deficiency poses the potential for *more* than minimal harm, the facility is not in substantial compliance. If the deficiency causes minimal harm, the facility may still be in substantial compliance. I therefore do not consider the facility's history a significant factor in determining whether the CMPs are reasonable.

With respect to the facility's financial condition, the facility has the burden of proving, by a preponderance of the evidence, that paying the CMP would render it insolvent or would compromise the health and safety of its residents. *Van Duyn Home & Hosp.*, DAB No. 2368 at 18 (2011); *Gilman Care Ctr.*, DAB No. 2357 at 6-7 (2010). Here, Petitioner points out that it has a large Medicaid population and operates at a loss because of low reimbursement rates, although other entities within the corporation make up the short-fall. If required to pay the CMP, the facility will freeze employee wages and delay non-essential facility upgrades. For example, plans for a beauty shop will likely be put on hold. P. Ex. 1at 1-2 (Kerr Decl. ¶¶ 3, 4, 6); P. Ex. 1 at 3-4 (Tappan Decl. ¶¶ 3, 6); P. Br. at 17-19; P. Post-hrg. Br. at 16-18. Such claims, which, in any event, are not supported by compelling financial documentation, fall short of the standard for lowering a CMP based on financial condition. In *Guardian Care Nursing & Rehab. Ctr.*, DAB No. 2260 (2009), for example, the facility could not even afford to represent itself on appeal. Its Medicaid census was 90%; its annual shortfall was $250,000; and it relied on charitable contributions for its continuing viability. The Departmental Appeals Board criticized the absence of financial documentation and concluded that the facility had not established

that additional resources would not be available. DAB No. 2260, at 9; *but see Columbus Nursing & Rehab. Ctr.*, DAB No. 2505 at 17-18 (2013) (finding that the absence of documentation regarding the facility's financial condition did not preclude ALJ from concluding, based on witness testimony, that financial condition justified reducing the CMP).

Applying the remaining factors, I find that the facility's deficiencies in administering medication to R4, by themselves, justify the penalties imposed. Petitioner well knew that its nursing staff had not been properly trained in administering IV medications. As evidenced by the facility's own policy, it recognized how critical such training is for anyone charged with administering IV medications. Yet, it provided no such training. When, on March 29, R4 was readmitted to the facility with the jugular IV line in place, staff did not administer her medications in a safe manner, disregarding her safety.

Moreover, in determining whether the CMPs are reasonable, I consider *all* of the facility's deficiencies, including those that Petitioner does not contest. The sheer number of deficiencies cited justifies penalties significantly above the minimum, and they include multiple E and F-level deficiencies. But the scope and severity designations tell only part of the story. Even a cursory review of the facts underlying these citations shows how serious the facility's problems were. Although not cited at the immediate jeopardy or actual harm levels, they had real consequences and posed the potential for significantly compromising resident health and safety. Among other problems:

- 42 C.F.R. § 483.25(c). Based on a resident's comprehensive assessments, the facility must ensure that she does not develop pressure sores unless her condition renders them unavoidable. If she has pressure sores, the facility must provide necessary treatment and services to promote healing, prevent infections, and prevent new sores from developing. R4 suffered from serious pressure sores, which had led to a bone infection. Although her physician ordered a pressure-relieving device, for use with her wheel chair, the facility did not provide the device or a reasonable substitute for it until months later.

  Surveyors observed a nurse aide providing R4's wound care without first washing her hands.

  Surveyors also watched an LVN transfer supplies to a table in the resident's room without first cleaning the table top.

  The same LVN "forgot" to treat the significant (4 cm X 3 cm) pressure sore on the resident's right heel. CMS Ex. 2 at 24-32.

- 483.25(i) . Based on a resident's comprehensive assessment, the facility must ensure that the resident maintains "acceptable parameters of nutritional status,"

such as weight and protein levels, and receives a therapeutic diet when there is a nutritional problem. R10 was an 80-year-old woman who was fed through an enteral tube and by mouth. In January 2012, the facility's dietician recommended that her tube feeding be reduced, because she was over her ideal body weight. Thereafter, facility staff provided 49% of her caloric needs and 55% of her protein needs. More significant, they did not then monitor her weight and nutrition intake. When she did not eat, or ate little, they failed to offer her alternate meals, snacks, or shakes. Between March 1 and April 25, 2012, she lost 6% of her body weight. The facility's dietician was not aware of her weight loss. CMS Ex. 2 at 32-38.

- 42 C.F.R. § 483.35(i). The facility must store, prepare, distribute, and serve food under sanitary conditions. Surveyors reported pooling water, food spills, and a putrid odor in the walk-in refrigerator. They saw plugged drains, oven filters covered in grease and dust, appliances and serving bowls covered in food debris, and food stored in containers without tight-fitting lids.

  Staff did not wear hair restraints.

  Staff wore single-use gloves for multiple tasks.

  Unpasteurized eggs were used to prepare dishes that had soft or runny egg yolks.

  Hot foods were not kept at a safe temperature.

  The surveyors observed cracked food carts. "Sanitizing buckets" lacked sanitizer.

  At 9:18 a.m., Surveyor Ann Wedgwood pointed out caked-on food in the microwave. When she returned to the kitchen at 3:50 p.m., it had not been cleaned. CMS Ex. 2 at 105-111; CMS Ex. 45 (Wedgwood Decl.).

I find these and the immediate jeopardy deficiencies extremely serious and the staff culpable. The penalties imposed are therefore reasonable.

IV. Conclusion

Petitioner has conceded that, from March 29 through May 17, 2012, it was not in substantial compliance with Medicare program requirements. For the reasons discussed above, I find that, from March 29 through April 28, 2012, its deficiencies posed immediate jeopardy to resident health and safety. I affirm as reasonable the penalties imposed –$5,550 per day for the period of immediate jeopardy and $150 per day for period of substantial noncompliance that was not immediate jeopardy.

/s/
Carolyn Cozad Hughes
Administrative Law Judge