Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Cal Turner Extended Care Pavilion
Docket No. A-11-23
Decision No. 2384
June 8, 2011

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Cal Turner Extended Care Pavilion (Cal Turner) appeals the August 10, 2010 decision of Administrative Law Judge (ALJ) Richard J. Smith upholding a determination by the Centers for Medicare & Medicaid Services (CMS) to impose remedies for Cal Turner's noncompliance with requirements for long-term care facilities participating in the Medicare program. *Cal Turner Extended Care Pavilion*, DAB CR2257 (2010) (ALJ Decision). CMS made its determination based on the results of a complaint survey done by the Kentucky state survey agency at Cal Turner. Following an in-person hearing, the ALJ concluded that Cal Turner was not in substantial compliance with the Medicare participation requirements at 42 C.F.R. §§ 483.20(b), 483.20(k)(2) and 483.25(h) and that the facility's noncompliance posed immediate jeopardy to resident health and safety from May 17 through June 3, 2009. The ALJ also found that the civil money penalties (CMPs) imposed by CMS – $4,550 per day for the period of immediate jeopardy and $150 per day for the one day of noncompliance that was not immediate jeopardy (June 4, 2009) – were reasonable. After considering all of Cal Turner's arguments on appeal, we affirm the ALJ Decision.

Applicable Law

Long-term care facilities participating in the Medicare and Medicaid programs are subject to the survey and enforcement procedures set out in 42 C.F.R. Part 488, subpart E, to determine if they are in substantial compliance with the program requirements in 42 C.F.R. Part 483, subpart B. "Substantial compliance" means a level of compliance 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. "Noncompliance," in turn, is defined as "any deficiency that causes a facility to not be in substantial compliance." *Id.* Surveyors report survey findings in a Statement of Deficiencies (SOD). *See* 42 C.F.R. § 488.325 (requiring public disclosure of certain survey information, including SODs). The SOD identifies each "deficiency" under its regulatory requirement, citing both the regulation at issue and the corresponding "tag" number used by surveyors for organizational purposes. "Immediate jeopardy" is defined as "a situation in which the

provider's noncompliance with one or more requirements of participation has caused or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301.

A long-term care facility found not to be in substantial compliance is subject to various enforcement remedies, including CMPs. 42 C.F.R. §§ 488.402(b),(c), 488.406, 488.408. CMS has the option to impose a CMP whenever a facility is not in substantial compliance. 42 C.F.R. §§ 488.402(b), 488.406(a), 488.430. CMS may impose per-instance or per-day CMPs. 42 C.F.R. § 488.408(d)(1)(iii), (iv), (e)(1)(iii),(iv). There are two ranges of per-day CMPs, with the applicable range depending on the scope and severity of the noncompliance. 42 C.F.R. § 488.438(a)(1). The range for noncompliance that constitutes immediate jeopardy is $3,050-$10,000 per day. 42 C.F.R. §§ 488.408(e)(1)(iii), 488.438(a)(1)(i). The range for noncompliance that is not immediate jeopardy is $50-3,000 per day. 42 C.F.R. §§ 488.408(d)(1)(iii), 488.438(a)(1)(ii). When CMS imposes one or more of the alternative remedies in section 488.406 for a facility's noncompliance, those remedies continue until "[t]he facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit . . . ." 42 C.F.R. § 488.454(a)(1).

Standard of Review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence on the record as a whole, and a disputed conclusion of law to determine whether it is erroneous. *Guidelines-Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs*, http://www.hhs.gov/dab/divisions/appellate/guidelnes/prov.html; *Batavia Nursing and Convalescent Inn*, DAB No. 1911, at 7 (2004), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 143 F. App'x 664 (6th Cir. 2005).

Factual Background[1]

The survey and ALJ proceeding

Cal Turner participates in the Medicare program as a skilled nursing facility (SNF) and in Kentucky's Medicaid program as a nursing facility (NF). ALJ Decision at 1. The Kentucky state survey agency (state agency) conducted a complaint survey at Cal Turner that ended on June 4, 2009. *Id.* The SOD for that survey reflects the surveyors' findings that Cal Turner was not in substantial compliance with three Medicare and Medicaid participation requirements: 42 C.F.R. § 483.20(b) (Tag F272 – Comprehensive

[1] The information under this heading is drawn from the ALJ Decision, the record before the ALJ and the parties' submissions on appeal. It is presented to provide a context for the discussion of the issues raised on appeal, and is not intended to replace, modify, or supplement the ALJ's findings of fact or conclusions of law.

Assessments); 42 C.F.R. § 483.20(k)(2) (Tag F280 – Comprehensive Care Plans); 42 C.F.R. § 483.25(h)(Tag F323 – Accidents and Supervision). *Id.* at 1-2, citing CMS Ex. 2. The state agency cited all of the deficiencies at scope and severity level K, which represents a pattern of noncompliance that constitutes immediate jeopardy. 42 C.F.R. § 488.404(b)(1)(iv), (b)(2)(ii); 59 Fed. Reg. 56116, 56183 (1994).

The state agency forwarded the survey results to CMS along with recommendations for remedies. *Id.* at 2. In a letter dated June 23, 2009, CMS notified Cal Turner that it was imposing remedies, including a CMP of $4,550 for the period of immediate jeopardy (May 17 through June 3, 2009) and a CMP of $150 per day effective June 4, 2009 until the facility achieved substantial compliance.[2] *Id.*, citing CMS Ex. 4, at 2-3. By letter dated July 21, 2009, CMS notified Cal Turner that a revisit survey conducted on July 15, 2009 found the facility in substantial compliance effective June 5, 2009. *Id*, citing CMS Ex. 4, at 10. By letter dated August 12, 2009, Cal Turner timely requested a hearing. *Id.* The ALJ conducted an in-person hearing on July 1, 2010.

Summary of Undisputed Facts

The noncompliance found by the ALJ relates to the use of chairs, described by the manufacturer as "Power Lift & Recline Chairs" (lift chairs), owned by 16 Cal Turner residents.[3] ALJ Decision at 7, citing CMS Ex. 2, at 2; P. Ex. 5, at 1. The lift chairs are similar in appearance to a typical recliner chair, but the seat and back of the chair can be adjusted with a hand control, attached to the chair, to make it easier to stand up or sit down. *Id.,* citing P. Ex. 5, at 1. The allegations on the SOD extend to all 16 residents who had lift chairs but focus primarily on two residents, identified as Resident 1 (R. 1) and Resident 3 (R. 3), who CMS alleges suffered falls related to the use of their lift chairs. *Id.*; CMS Ex. 2, at 2.

R. 1's care plan states that she has "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." ALJ Decision at 10, quoting CMS Ex. 9, at 7-8; P. Ex. 24, at 1-2. R. 1 also has "impaired ADL abilities d/t weakness, difficulty ambulating, and lack of coordination [and] Parkinson's,' all of which require staff to 'assist x 1 with ambulating, transfers, toileting, dressing, grooming and bathing." *Id.*, quoting CMS Ex. 9, at 11; P.

---

[2] CMS imposed other remedies that would take effect by specified dates if the facility did not achieve substantial compliance but cancelled those remedies in its July 21, 2009 notice letter. CMS Ex. 4, at 10. Cal Turner also lost its authority to offer or conduct nurse aide training and competency evaluation programs (NATCEP). *Id.* at 3. *See* 42 C.F.R. § 483.151(b)(2)(iv)(providing that a state may not approve NATCEP for a facility which in the previous two years has been assessed a CMP of $5,000 or more). Cal Turner does not challenge the loss of NATCEP, and we would be required to uphold that loss in any event since we are affirming a CMP of more than $5,000.

[3] The ALJ noted that Cal Turner's records used the terms "recliner" and "lift chair" interchangeably to refer to the chairs. ALJ Decision at 10, n.1.

Ex. 24, at 4. R. 1's rehabilitation assessment states that 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.'" *Id.* at 11, quoting CMS Ex. 9, at 28.

R. 1's care plan notes a fall on May 17, 2009, and gives instructions to "move [wheelchair] alarm to recliner when in recliner [and] back to [wheelchair] when in [wheelchair]." *Id.* at 10, quoting CMS Ex. 9, at 16; P. Ex. 27, at 1. A 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." *Id.*, quoting CMS Ex. 9, at 20; P. Ex. 12, at 2; P. Ex. 44, at 25-26. Nurses' notes for May 17, 2009 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." *Id.*, quoting CMS Ex. 9, at 81. An investigation report stated that R. 1—

> 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.
>
> *Id.*, quoting P. Ex. 10, at 2. R. 1 was taken to the hospital for examination where radiology reported a left subdural hematoma, the majority of which was consistent with acute hemorrhage. *Id.*, citing CMS Ex. 9, at 45.

R. 3's initial resident assessment protocol summary states that she 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." *Id.* at 11, quoting CMS Ex. 10, at 22. This form also states that R. 3 "continues to be non-ambulatory." *Id.* Cal Turner's records indicate that R. 3 fell on March 7, 2009. The resident fall tracking log states that she "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." *Id.*, quoting CMS Ex. 10, at 27; P. Ex. 40, at 2. Nurses' notes on March 7 state that R. 1 was "sitting up in recliner earlier. SOB + restless. Gave neb tx per MD order and Xanax 25 mg (at 1930). At 2015 [resident] on floor." *Id.*, quoting CMS Ex. 10, at 29; P. Ex. 36, at 1. R. 3 was sent to the emergency room for an x-ray which indicated no fracture. *Id.*, citing CMS Ex. 10, at 31; P. Ex. 36, at 2.

The ALJ Findings

The ALJ made the following findings of fact and conclusions of law (FFCLs):

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

2. When employed as directed in the manual, a "lift chair" is an "assist[ive] device."

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

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

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

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.

7. The imposed remedies are reasonable.

ALJ Decision at 5, 7, 9, 14-17.

Discussion

A. Substantial evidence supports the ALJ's conclusion that Cal Turner was not in substantial compliance with three Medicare requirements.

As stated above, the ALJ concluded that Cal Turner was not in substantial compliance with three Medicare requirements: 42 C.F.R. §§ 483.20(h), 483.20(k)(2) and 483.25(h). Section 483.20(b) requires facilities to conduct initial and periodic assessments of each resident's functional capacity that are comprehensive, accurate, standardized and reproducible. The ALJ found that Cal Turner had not assessed whether the use of lift chairs was appropriate for 16 residents who had them, including R. 1 and R. 3, or whether the chairs posed a safety hazard. ALJ Decision at 10-13. The ALJ noted that R. 1 and R. 3, and eight of the other residents with lift chairs, had been identified as cognitively impaired with reduced safety awareness. *Id.* at 14, citing CMS Ex. 2, at 23. The facility failed to do these assessments, the ALJ found, even after R. 1 and R. 3 fell under circumstances that implicated the residents' use of the chairs. *Id.* at 10, citing, e.g., CMS Ex. 9, at 20; P. Ex. 12, at 2; P. Ex. 44, at 25-26 (Resident Fall Tracking Log stating R. 1 "was in recliner and had raised chair up as high as it would go and tried to walk [without] help and fell"); *id.* at 11, citing CMS Ex. 10, at 17; P. Ex. 40, at 2 (Resident Fall Tracking Log stating R. 3 "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").

Section 483.20(k)(2) requires facilities to develop a comprehensive care plan for each resident within 7 days after completion of the comprehensive assessment and to

periodically review and revise the plan. The care plan must include include measurable objectives and timetables to meet the medical, nursing and mental and psychosocial needs that are identified in the resident's assessment and must be developed by an interdisciplinary team. 42 C.F.R. § 483.20(k)(1), (2). The ALJ found that Cal Turner failed to develop a comprehensive care plan regarding the use of remote control lift chairs for ten cognitively impaired residents who had lift chairs, including R. 1 and R. 3, even after R. 1 and R. 3 fell. *Id.* at 14, citing CMS Ex. 2, at 13-14. In making this finding, the ALJ took into consideration the fact that on May 19, 2009, two days after R. 1's fall, the facility added to her fall prevention care plan instructions to "keep chair unplugged – staff to plug in to assist" and to use a chair alarm when the resident was in the recliner. *Id.*, citing CMS Ex. 9, at 5. Similarly, he recognized that after R. 3's fall on March 7, 2009, staff added to her fall prevention care plan the instruction " Do not leave . . . in recliner when . . . anxious or restless." *Id.* at 15, citing CMS Ex. 10, at 3; P. Ex. 39, at 4, 11. However, the ALJ concluded that these instructions "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 . . . [a]nd they were not prepared by an interdisciplinary team." *Id.*

Section 483.25(h) requires a facility to ensure that "(1) [t]he resident environment remains as free of accident hazards as is possible; and (2) [e]ach resident receives adequate supervision and assistance devices to prevent accidents." The ALJ found that the facility failed to comply with this requirement because it did not identify the lift chairs as a safety hazard in the environments of R. 1, R. 3 and other cognitively impaired residents and did not adequately supervise R. 1 and R. 3's use of their chairs, as evidenced by these residents' falls. *Id.* at 15, citing CMS Ex. 2, at 23.

On appeal to the Board, Cal Turner argues that the imposition of CMPs "is fundamentally unfair and is without evidentiary support." Request for Review (RR) at 7. However, Cal Turner does not specifically challenge any of the ALJ's noncompliance conclusions or the record facts he relied on for those conclusions.[4] Instead, Cal Turner makes the following arguments:

I. There is no evidence to support the allegation that either Resident 1 or 3 fell as the result of using the lift feature of their chairs.

II. There is no evidence to support the finding that the lift chairs were used as assistive devices at Turner.

III. There is no basis for a finding that Resident 1 or Resident 3 were injured by their lift chairs.

[4] We note that in its opening statement at the ALJ hearing, Cal Turner effectively conceded that its appeal was limited to the immediate jeopardy determination and the remedies imposed for that determination. Tr. at 82 ("We're here on appeal of the immediate jeopardy, not something else, and the penalties imposed for immediate jeopardy.") .

RR at 5-6.

For the reasons discussed below, we conclude that Cal Turner's arguments are neither supported by the record nor material to our decision.

1. The ALJ's inference that at least R. 1's fall was caused by her seat lift chair is reasonable, but noncompliance exists regardless of whether the seat lift chair caused her fall.

Cal Turner does not dispute that it permitted 16 residents, ten of whom had cognitive deficits with reduced safety awareness, to use lift chairs without first assessing the chairs, or the residents' use of them, to determine whether they were appropriate or posed safety hazards and without developing comprehensive care plans addressing use of the chairs. Cal Turner also does not dispute that R. 1 and R. 3 fell in their rooms after having been last observed by staff sitting in their chairs. Nor does Cal Turner dispute the accuracy and reliability of its Resident Fall Tracking Logs for R. 1 and R. 3. As previously noted, the fall tracking log for R. 1 states as follows: "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." ALJ Decision at 10. The tracking log for R. 3's fall summarized the fall as follows: "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." *Id.* at 11. The ALJ found that these tracking log entries supported a reasonable inference "that the lift chars were the cause of the fall for at least one resident." *Id.* at 14. (It is clear from the ALJ's discussion that he is referring to R. 1.) The ALJ further found, "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. . . . 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." *Id.* at 12-13.

We are not persuaded by Cal Turner's arguments for rejecting the ALJ's inferences and, indeed, conclude that the inferences are reasonable. Cal Turner does not dispute the principal facts on which the ALJ reasonably relied, the fact that the chair seat was raised as high as it would go and that R. 1, since she was alone in the room, was the only person who could have operated the remote control to raise the seat. Cal Turner argues that R. 1 "could have fallen while *approaching* the chair to sit down . . . or simply moving about the room." RR at 3, citing P. Ex. 44 at 104-105 (emphasis in original); *see also* Reply at 8-9, citing Tr. at 105-106 (Director of Nursing (DON) testifies based on her investigation and review of the records she did not see the lift chairs as causing the fall in either case). Cal Turner points to the fact that no one actually observed R. 1 fall, and to a diagram drawn by a nurse indicating, Cal Turner asserts, that R. 1 "was found some distance from and to the side of the chair, not immediately in front of it." RR at 3, citing P. Ex. 44, at 104;

RR at 4, citing P. Ex. 11. The fact that no one observed the fall is undisputed but, if anything, supports the ALJ's inference that R. 1 operated the remote control herself. There is conflicting evidence as to just where R. 1 was found in relationship to her chair. The same person who drew the diagram (which is not dated or done to scale) indicating that R. 1 was found "to the side of the chair" stated in the facility's investigation report that she was found "in front of her recliner," albeit "some length away from" it. P. Ex. 10, at 2. The surveyors interviewed three certified nurse aides who "all stated they observed Resident #1 lying on the floor in front of the recliner[.]" CMS Ex. 2, at 30. However, the exact location of where R. 1 fell is not material; neither is the fact that she apparently tried to walk without assistance. Whether R. 1 fell immediately after getting out of her chair or after getting out of her chair and trying to walk without assistance is irrelevant. Either way, the chair's seat lift mechanism contributed to R. 1's fall since facility records show that R. 1 used that mechanism to get out of her chair and begin walking.

Cal Turner itself appears to indirectly concede that R. 1's fall was caused by use of her lift chair. Although Cal Turner denies that the chair was the proximate cause of the fall, it acknowledges that the fall was preceded by R. 1's having succeeded in leaving her chair. *See* RR at 6 (stating that the lift chairs were not used as assistive devices "with the exception of the one occasion when Resident 1 raised her chair and *after doing so* fell while walking without assistance") (emphasis in original); *see also* Reply at 3 (stating that "unrebutted evidence establishes that Resident 1 . . . fell while she was walking *after successfully leaving her chair*") (emphasis added). We conclude that the tracking log summary, which is undisputed evidence, constitutes substantial evidence supporting the ALJ's inference that R. 1's fall was caused by her use of the chair.

Although we have concluded that substantial evidence supports the ALJ's inference that R. 1's use of her lift chair caused her fall, our decision does not depend on the lift chair's having caused R. 1's fall. It is enough to conclude, as the ALJ did in the alternative, that at the very least, the circumstances surrounding R. 1's fall indicated that the lift chair could have caused the fall and put Cal Turner on notice that the lift chair was a safety hazard for R. 1.

> 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.

ALJ Decision at 12 (emphasis added). While Cal Turner disputes the ALJ's conclusion that R. 1's use of her chair was the actual cause of her fall, Cal Turner

does not specifically dispute the ALJ's alternative conclusion that R. 1's fall put the facility on notice that use of her lift chair "may be the cause of [her] fall." *Id.* Nor does Cal Turner dispute the ALJ's finding that R. 1's fall at the very least put Cal Turner on notice that it needed to assess the use of the chair. *Id.* Cal Turner also does not dispute the ALJ's broader conclusion that given the notice provided by R. 1's fall, "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." *Id.* at 14. We agree with the ALJ that "[a]t a minimum, Residents 1 and 3 in particular, as well as those [other eight] cognitively-impaired residents with lift chairs should have been care-planned for the usage of lift chairs." *Id.*[5]

In summary, we find reasonable the ALJ's inference that at least one resident's fall (R. 1) was caused by the use of a lift chair. We also conclude that even if the lift chair was not the cause of R. 1's fall, the ALJ correctly found that her fall put Cal Turner on notice of the hazards posed by the chair and imposed on the facility obligations to assess, care plan and ensure the safety of all sixteen residents with lift chairs, especially the ten residents with reduced safety awareness. Cal Turner does not dispute it did not do the comprehensive assessments, care planning or safety hazard evaluation required to meet these obligations.

2. *The ALJ did not err in finding that the lift chairs were assistive devices when used as directed in the owner's manual, but noncompliance exists regardless of whether the chairs were used as assistive devices by either Cal Turner staff or the facility's residents.*

a. The ALJ correctly concluded that he was not bound by the state judge's determination that the lift chairs are not assistive devices.

Cal Turner argues that it was not required to do the assessment or care planning or ensure that the chairs did not pose a safety hazard or supervise their use because the lift chairs had not been identified by CMS as assistive devices, and facility staff did not use them as "assistive devices to raise residents from a sitting to a standing position at Turner."[6] RR at 6. Cal Turner made the same assertion before the ALJ, as part of its argument that the ALJ was bound by a state administrative law judge's (state judge) decision to reverse a Type A Citation imposed under state law for the incidents involving R. 1 and R. 3. The

[5] The ALJ did not make any finding as to whether R. 3's fall was due to use of her chair, and we need not reach this issue since such a finding would merely be cumulative. We note, however, that although Cal Turner claims R. 3 was incapable of operating the remote control for her chair, it does not explain how else she could have gotten out of the chair since she was alone in her room at the time. The entry on R. 3's care plan after her fall, instructing staff to not leave her in the chair when she was anxious or restless, also suggests that Cal Turner thought the chair played some role in her fall.

[6] We note, as did the ALJ, that this is the only argument Cal Turner makes with respect to the findings of noncompliance with section 483.25(h)(2). *See* ALJ Decision at 15-16.

state judge "found that the state had not met its evidentiary burden of proving the alleged state regulatory violations." ALJ Decision at 6, citing P. Brief at Ex. 1 (transcript of state hearing – admitted to the Civil Remedies Division record as P. Ex. 44). Cal Turner argued to the ALJ that the state's reversal of the Type A Citation was a binding factual determination that the lift chairs were not assistive devices and were not used as assistive devices, and that neither R. 1 nor R. 3 fell while using the chair as an assistive device. *Id.*, citing P. Brief at 5. Relying on 42 C.F.R. § 488.452 and *Lake Mary Health Care*, DAB No. 2081 (2007), the ALJ held that he was not bound by the state judge's decision because "[w]here CMS and the state disagree, CMS's findings of noncompliance take precedence," ALJ Decision at 5, and because 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," *id.* at 6, citing P. Ex. 44, at 5, 8-10.

Although Cal Turner cites here the state's determination in its administrative proceeding that Cal Turner did not use the chairs as assistive devices, RR at 4-5, Cal Turner does not specifically appeal FFCL 1, under which ALJ Smith correctly concluded that he was not bound by the state judge's decision for the reasons summarized above. Accordingly, we summarily affirm FFCL 1 for the reasons stated in the ALJ Decision. We note that in *Britthaven of Chapel Hill*, DAB No. 2284 (2009), the Board reaffirmed the holding in *Lake Mary* on which the ALJ relied and applied it to CMS's rejection of changes the state made to findings of noncompliance on the statement of deficiencies as a result of informal dispute resolution.

b. Substantial evidence supports the ALJ's finding that the lift chairs are assistive devices when used by facility staff or residents themselves to assist residents to sit down or stand up.

After concluding that he was not bound by the state judge's finding, the ALJ found that "[w]hen employed as directed in the [owner's] manual, a lift chair is an assist[ive] device." ALJ Decision at 7. Substantial evidence supports the ALJ's finding. As the ALJ discussed, the owner's manual provided by the chair manufacturer describes the lift chairs as "medical equipment designed to help you sit down and stand up" and explicitly addresses how to avoid physical hazards associated with getting into and out of the chairs and the chairs' occupancy, placement and operation. P. Ex. 5, at 2, 3, cited in ALJ Decision at 8. The ALJ reasonably concluded, based on this description and instruction that "[h]elping one sit down and stand up is an act of providing assistance[;] [i]t follows that a lift chair is an assistive device when used as directed in the manual." *Id.* We also find reasonable the ALJ's conclusion that although CMS's State Operations Manual (SOM) (CMS Pub. 100-07, App. PP – Interpretive Guidelines for Long-Term Care Facilities (available at http://www.cms.hhs.gov/Manuals/IOM/list.asp)) does not specifically identify lift chairs as "assistive devices," the SOM's description of "assistive devices" is sufficiently broad to encompass lift chairs, at least to the extent of the seat lift function that helps residents rise to a standing position. *See* ALJ Decision at 8-9. More

specifically, the SOM states that the term encompasses any "devices/equipment . . . used by, or in the care of a resident to promote, supplement, or enhance the resident's function . . ." and that such devices "can help residents move with increased independence, transfer with greater comfort, and feel physically more secure." *Id.*, citing P. Ex. 1, at 2; P. Ex. 3, at 1-2. The SOM also states with regard to mechanical assistive devices for transfer that these "include, but are not limited to . . . sit-to-stand devices . . . ." *Id.* at 9, citing P. Ex. 3, at 3. To the extent the seat lift function of the chairs helps the person sitting in the chair to get out of the chair, without staff assistance in some cases, we agree with the ALJ that the chair assists with transfer to a standing position and fosters greater functional independence.[7]

In its Request for Review, Cal Turner argues that the ALJ's reliance on the owner's manual is misplaced because the "manual is obviously addressed to individuals who purchase lift chairs for use in their home, not residents of a nursing facility where staff are available to assist residents in sitting and standing." RR at 6. We find no merit to this argument. As the ALJ noted, the owner's manual describes how the chairs function and warns about hazards associated with their use, mentioning in particular those associated with "getting into and out of the chair." ALJ Decision at 8, citing P. Ex. 5, at 3, 8. Cal Turner points to nothing in the manual that supports a distinction based on whether the chairs are used at home or in a nursing facility. If anything, the manual's rules for safe operation of the chairs would be even more pertinent in a nursing home setting, at least when the chairs are owned by, or accessible to, facility residents with the type of cognitive impairments and poor safety awareness identified for ten of Cal Turner's residents who had lift chairs.

Nor does Cal Turner explain why the mere fact that a nursing home has staff available to assist residents to stand and sit would preclude either staff or residents using the chairs – rather than other methods or equipment – for that assistance. Cal Turner asserts that the ALJ "ignored the unrebutted testimony that the lift chairs provided by residents' families were not used as assistive devices to raise residents from a sitting to a standing position at Turner." RR at 6. Cal Turner quotes testimony by its administrator responding to a question as to whether the facility used them for that purpose. "I don't believe anybody used them for that purpose. They were recliners in the room." Reply at 7, citing Tr. at 93-94. The administrator also responded "No" when asked whether to his knowledge, any of the residents actually used lift chairs to help themselves lift out of the chair." *Id.* Cal Turner also quotes testimony by the DON that she was not aware of or had no knowledge that either R. 1 or R. 3 used lift chairs to elevate themselves and that she was not aware of any other resident that used them for this purpose. *Id.* at 7-8. The testimony Cal Turner cites does not establish that no staff or no residents ever used the seat lift feature, only that the administrator and DON had no knowledge that this occurred. The

[7] The ALJ specifically found that the lift chair "falls within the category of 'sit-to-stand devices.'" ALJ Decision at 9. Since Cal Turner does not dispute this specific finding, we need not decide whether the particular category of "sit-to-stand devices" mentioned in the SOM encompasses seat lift chairs. However, we agree with the ALJ that functionally the chairs operate to assist a resident to transfer from a sitting to standing position.

testimony also is irrelevant because the ALJ made no finding that Cal Turner staff or residents generally used the chairs as assistive devices, only that the chairs were capable of being used as such and that the evidence supported an inference that R. 1, at least, used the seat lift mechanism to exit the chair on the day she fell. Cal Turner itself admits that "the chairs in question undoubtedly were capable of being so used," and, in fact, were so used on the "one occasion when Resident 1 raised her chair and *after doing so* fell while walking without assistance." RR at 6 (emphasis in original). Cal Turner also concedes that "[m]any appliances may be considered 'assistive devices' or not depending on the manner of their use." *Id.*

Moreover, Cal Turner's assertion that staff did not use the chairs to assist residents is undercut by the entry on R. 1's care plan after her fall: "Keep chair unplugged – staff to plug in to assist." CMS Ex. 9, at 5; P. Ex. 24, at 7. The reference to "staff to plug in to assist" has no purpose in the plan unless the facility intended staff to use the seat lift function to assist residents. Cal Turner's assertion is also undercut by testimony from a Cal Turner nurse at the state hearing, cited by the ALJ, that "she personally observed facility residents use the lift function of their chairs." ALJ Decision at 13, citing CMS Brief at 7; P. Ex. 44, at 38-39. Cal Turner did not dispute this testimony in its request for review but argues in its Reply that the nurse only testified that she observed residents using some function of the chairs – which operate as recliners also – not necessarily the lift function. Reply at 4. This is not a reasonable reading of the nurse's testimony. The transcript clearly shows that the nurse was testifying about having observed residents using the seat lift function. She testified that R. 1 had a seat lift chair. The questioner then asked her to describe how the seat lift feature functions. After giving the answer Cal Turner quotes in its Reply, the nurse then said, "The best I can tell you they've got a remote and they push it, and it slowly elevates them to into kind of like a standing position and then goes back down." P. Ex. 44, at 38. When asked whether she had ever seen one lift before, she responded "Yes, I have" and identified a lift chair owned by a prior resident, now deceased. *Id.* at 39. Finally, when asked whether the chairs were functional in the sense that "anybody could use the remote control to lift the chairs," the nurse responded "As far as I know, they did." *Id.*

c. Noncompliance exists regardless of whether the chairs were used as assistive devices by either Cal Turner staff or the facility's residents.

Having found that the lift chairs were assistive devices, the ALJ found noncompliance with the regulations based on Cal Turner's undisputed failure to assess whether the chairs were appropriate for each resident, develop care plans for their use, ensure that the chairs did not pose a safety hazard in each resident's environment and supervise each resident's use of the chairs. The ALJ did not go on to consider whether he could find noncompliance with the applicable regulations regardless of whether the lift chairs were assistive devices, presumably because, as the ALJ stated, Cal Turner's whole argument before him was that "because the chairs were not used as assistive devices, there is no basis for a citation." ALJ Decision at 16. However, we find nothing in any of the

regulations at issue here that makes a violation dependent on finding the lift chairs to be assistive devices. Section 483.20(b) requires initial and periodic assessments of each resident's needs, including "physical functioning . . . ." 42 C.F.R. § 483.20(b) (1)(viii). The SOM guidance for surveyors pertaining to section 483.20(b) includes assessing whether each resident's functional abilities would be improved by the use of assistive devices. SOM, App. PP, F272, §483.20(b) Guidelines. Section 483.25(h)(2) requires facilities to ensure that each resident "receives adequate supervision and assistance devices to prevent accidents."[8] Thus, the regulations and the SOM address a facility's affirmative duty to assess whether assistive devices would help to improve each resident's functional capacity or to prevent accidents and, if so, to provide those devices. There is nothing in the regulations that would support a conclusion that the duties to assess, care plan and prevent accidents do not pertain to equipment or devices present in the facility unless the equipment or devices are found to be assistance devices. CMS states in its Response, and we agree, that --

> the facility was responsible for conducting an assessment regardless of whether the lift chair was classified as an assistive device or not. If it was determined that the lift chair had no medical or occupational therapy purpose – but it could still push residents from a sitting position to a standing-tilting position, an assessment would still have been necessary. Even if the lift chair did not have a propensity to help, it still had a great propensity to cause harm – especially to cognitively and physically impaired residents.

Response at 11 (citation omitted). [9]

Nor do we see any language in the regulations that would support Cal Turner's argument that noncompliance should not be found because the residents' families, not the facility, provided the chairs. *See, e.g.,* RR at 2. The ALJ correctly held that "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." ALJ Decision at 13, citing *Koester Pavilion*, DAB No. 1750, at 34 (2000). Cal Turner permitted residents to bring the lift chairs into the facility. Having done so, Cal Turner

---

[8] We use the terms "assistance devices" and "assistive devices" interchangeably throughout this decision. The SOM states that, although section 483.25(h)(1) (the accidents regulation) uses the term "assistance devices," the "currently accepted nomenclature refers to 'assistive devices'." SOM, App. PP, F323.

[9] Cal Turner cites an alleged "admission" by surveyor Samantha Windsor on cross-examination that "if the lift feature of the chairs in question were not used, then [the chairs] would not be considered assistive devices and, therefore, Turner was not in non-compliance for failing to assess patients for their use." Reply at 10. If Cal Turner is suggesting an admission by the surveyor that it had no duty to assess the lift chairs absent a finding that the lift chair feature was used, we do not find that to be an accurate characterization of Ms. Windsor's answer, which we note, occurred in the context of a confusing line of questioning. Tr. at 56-59. Ms. Windsor clearly testified that the facility has a duty to assess any assistive device being used and, as the questioner noted, that the chair was an assistive device. Tr. at 59. She also testified that "it is not necessary for there to be an assistive device for there to be a deficiency under [section 483.25(h)]." Tr. at 42; *see also* Tr. at 51.

had a duty to assess whether those chairs were appropriate for each resident, based on each residents' assessed needs and functional capacity, and if it concluded that they were, to develop care plans for their use. Cal Turner also had a duty to assess whether the chairs posed a safety hazard for any of the residents who had them and to provide supervision during their use, particularly for residents identified as fall risks and/or having reduced safety awareness.

We note in this regard that Cal Turner's administrator testified during the state hearing that the facility did not prohibit residents from supplying and operating their own medical equipment but that the facility required a physician order for such equipment and permission was subject to Cal Turner's assessment of the equipment "to make sure it's safe." P. Ex. 44, at 45, cited in ALJ Decision at 13. The administrator also testified that the facility did not see the lift chairs as medical equipment. P. Ex. 46, cited in ALJ Decision at 13. Nonetheless, the administrator's testimony supports the ALJ's finding that the facility's obligation to assess the chairs – assuming they were medical equipment – did not depend on whether the facility or the families provided them for the residents. In addition, Cal Turner has not explained why the warnings in the owner's manual would not impose on the facility a duty to assess the chairs as medical equipment regardless of whether the facility would have independently viewed or employed them as such.

In summary, we find substantial evidence supporting the ALJ's conclusion that the seat lift chairs were assistive devices but uphold the ALJ's conclusion that Cal Turner failed to comply with the three federal regulations regardless of whether the lift chairs were assistive devices.

B. The ALJ did not err in concluding that CMS's immediate jeopardy determination was not clearly erroneous.

As the ALJ held, and Cal Turner does not dispute, CMS's determination of the level of noncompliance, including immediate jeopardy, must be upheld unless it is shown to be clearly erroneous. ALJ Decision at 16, citing 42 C.F.R. § 498.60(c). 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.*, citing 42 C.F.R. § 488.301. Under that standard, CMS's determination of immediate jeopardy is presumed to be correct, and the nursing facility has a heavy burden to demonstrate clear error in that determination. *Brian Center Health and Rehabilitation/Goldsboro,* at 9, citing *Barbourville Nursing Home*, DAB No. 1962, at 11 (2005), *aff'd, Barbourville Nursing Home v. U.S. Dep't of Health & Human Servs.*, 174 F. App'x 932 (6th Cir. 2006); *Liberty Commons Nursing and Rehab Center – Johnston,* DAB No. 2031, at 18-19 (2006), *aff'd, Liberty Commons Nursing & Rehab Ctr. – Johnston v. Leavitt*, 241 F. App'x. 76 (4th Cir. 2007); *Maysville Nursing and Rehabilitation Facility*, DAB No. 2317, at 11 (2010). Once CMS presents evidence supporting a finding of noncompliance, CMS does not need to offer evidence to support its determination that the noncompliance constitutes immediate jeopardy; rather, the

burden is on the facility to show that that determination is clearly erroneous. *Liberty Commons Nursing & Rehab Ctr. – Johnston v. Leavitt*, 241 F. App'x. 76, at **3–**4. The ALJ concluded based on the evidence discussed above that Cal Turner had not shown CMS's immediate jeopardy determination to be clearly erroneous, and after reviewing Cal Turner's arguments to the Board, we agree.

The ALJ correctly noted that under the plain language of the regulation, he did not need to find that Cal Turner's noncompliance had caused actual serious injury or harm in order to uphold CMS's immediate jeopardy determination. ALJ Decision at 16. However, the ALJ found that "[h]ere, there was actual harm when Resident 1 fell and suffered a subdural hematoma." *Id.*, citing CMS Ex. 9, at 45. Cal Turner does not dispute that R. 1 sustained actual injury or harm in the form of a subdural hematoma as a result of her fall. Nor does Cal Turner claim that the hematoma was not serious. We note in this respect that an undisputed radiology report indicated a hematoma "consistent with acute hemorrhage." ALJ Decision at 10 (emphasis added). Cal Turner's only argument for overturning the immediate jeopardy determination is that the "facts demonstrate that neither Resident 1 nor Resident 3 were injured *as the result of using their lift chairs*." RR at 6 (emphasis added) ; *see also* Reply at 12 (stating that there is no proof that the lift chairs caused any injury to a Cal Turner resident). We have already upheld the ALJ's rejection of this argument, concluding that substantial evidence supports the ALJ's reasonable inference that use of the lift chairs caused the fall, and injuries, of at least one resident, R. 1. We have also concluded that noncompliance was present regardless of whether the chairs actually directly caused R. 1's fall. Accordingly, we uphold the ALJ's conclusion that CMS's immediate jeopardy citation was not clearly erroneous because Cal Turner's noncompliance with Medicare requirements caused actual serious injury or harm.

Having upheld CMS's immediate jeopardy determination based on actual serious injury or harm, the ALJ did not discuss whether, alternatively, Cal Turner's noncompliance presented a likelihood of serious injury or harm, which, as the ALJ correctly stated would be sufficient to uphold the immediate jeopardy determination. *See* ALJ Decision at 16. The ALJ committed no error since he did not need to reach this issue. Moreover, as the ALJ noted, "[t]he other residents who were cognitively impaired and had a lift chair in their room were at risk for harm." *Id.* Cal Turner asserts that a mere possibility of harm, as opposed to a likelihood of harm, is not enough to sustain an immediate jeopardy determination that is not based on a finding of serious actual harm. That is correct, but meaningless, since the ALJ did find actual serious harm here. However, we would have no hesitancy in finding under the undisputed facts of this case that Cal Turner's noncompliance posed a likelihood of harm to R. 1 and all cognitively impaired residents with lift chairs. Even without the hematoma, the circumstances surrounding R. 1's fall, as reported in the facility's own records, made it foreseeable that her continued use of the seat lift chair without proper assessment, care planning or supervision presented a likelihood that she would fall again. This likelihood was enhanced by the fact that Cal Turner knew from its own assessments that R. 1 was weak and had difficulty ambulating

likelihood that she would fall again. This likelihood was enhanced by the fact that Cal Turner knew from its own assessments that R. 1 was weak and had difficulty ambulating and lack of coordination because of her Parkinson's disease and needed staff assistance with ambulating and transfers. A likelihood of serious harm (such as hematomas and broken limbs) is inherent in a fall for frail, elderly residents with compromised health such as R. 1 or other residents with seat lift chairs who were cognitively impaired and had reduced safety awareness. Cal Turner makes no argument and cites no evidence about R. 1's health condition or the health conditions of any of the other cognitively impaired residents of its facility that would support a finding that a determination of immediate jeopardy based on the likelihood of serious injury or harm was clearly erroneous.

In summary, we uphold the ALJ's conclusion that CMS's immediate jeopardy determination was not clearly erroneous.

C. Cal Turner does not appeal the ALJ's conclusions that the CMP amounts imposed by CMS are reasonable; thus, those conclusions are final.

The ALJ concluded that the CMPs imposed by CMS for Cal Turner's noncompliance – $4,550 per day from May 17 through June 3, 2009 and $150 per day for June 4, 2009 – were reasonable. ALJ Decision at 17, 18. Cal Turner does not challenge these conclusions in its appeal to the Board. Accordingly, the ALJ's conclusions that the CMP amounts are reasonable, for the reasons stated in his decision, are final, and we need not discuss them.

Conclusion

For the reasons stated above, we affirm the ALJ Decision.

/s/
Constance B. Tobias

/s/
Leslie A. Sussan

/s/
Sheila Ann Hegy
Presiding Board Member