Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Golden Living Center - Foley,
(CCN: 01-5032),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-11-467

Decision No. CR2625

Date: September 27, 2012

DECISION

Petitioner, Golden Living Center – Foley, challenges the determination of the Centers for Medicare and Medicaid Services (CMS) that it was not in substantial compliance with program participation requirements. Petitioner also challenges CMS's imposition of a civil money penalty (CMP) of $4050 per day for the period January 30, 2011, through March 4, 2011, and a CMP of $100 per day beginning March 5, 2011, through April 3, 2011. For the reasons discussed below, I sustain CMS's imposition of the CMPs.

I. Background

Petitioner is a long-term care facility located in Foley, Alabama. Petitioner participates in the Medicare and Medicaid programs. The State of Alabama Department of Public Health (state agency) completed a recertification and complaint survey of Petitioner's facility on March 5, 2011. The state agency determined that Petitioner was noncompliant with participation standards beginning January 30, 2011. The surveyors also determined noncompliance at a level of immediate jeopardy and substandard quality of care. The survey team informed the facility of the noncompliance at an immediate jeopardy level of

"J" surrounding a January 30, 2011, incident involving the care of Resident 22 (R22). The immediate jeopardy was relieved on March 5, 2011, when the scope and severity was lowered to a "D" level, to allow the facility time to monitor and revise its corrective actions as needed to establish substantial compliance. CMS Ex. 1, at 1; P. Ex. 1, at 1.

The deficiencies in this case arise from Petitioner's care of Resident 22 (R22). Although the parties characterize them differently, the following facts are not in dispute:

R22 was a long-term resident of Petitioner's facility. At the time of the accident she was 71 years old and her diagnoses included obesity, dementia, status-post stroke, schizophrenia, hypertension, hypothyroidism, and contractures. R22 was non-verbal, bed- and wheelchair-bound, and required extensive assistance with all activities of daily living, including transfers. CMS Ex. 7, at 6-7, 19; CMS Ex. 8, at 1, 34; P. Ex. 4, at 1; P. Exs. 5-8; P. Ex. 9, at 5, 13-16.

On January 30, 2011 a Certified Nursing Assistant (CNA) staff member at the facility was attempting to transfer R22 by using a "Sara" lift device, which requires the resident to stand on a platform. The CNA attempted to do this by herself, and had no assistance. During this process, R22 slipped off of her bed and fell. Then the CNA lifted her in a sitting position back into bed with the Sara lift.

The nursing staff did not assess R22 for injuries after the fall. Petitioner did not notify R22's doctor or family. There are no nursing notes at all for four days following the incident. About five days after her fall, it was eventually discovered that R22 had sustained an impacted fracture of her left femur. The following morning, about nine hours after the radiologist informed the facility of the femur fracture, Petitioner's staff contacted R22's physician with the radiology results. R22 was transferred to the emergency department for further evaluation and treatment.[1]

Based on these events, CMS found Petitioner not in substantial compliance with participation requirements and imposed a $4050 per day CMP from January 30, 2011, through March 4, 2011. CMS also imposed a $100 per day CMP beginning March 5, 2011, until Petitioner returned to substantial compliance and a denial of payment for new admissions (DPNA) beginning April 2, 2011. CMS Ex. 2. On April 4, 2011, the state agency conducted a revisit survey, finding that Petitioner remained out of compliance.

[1] R22 died on March 2, 2011, and although CMS hints that the fall and its *sequelae* contributed to the cause of death, it is impossible to make that connection on this evidence. But the connection is not necessary to support my findings of noncompliance or the appropriateness of the penalties imposed. The fact R22 died, and the cause of her death (i.e., whether it was related to her fall or to her femur fracture), does not affect the posture of this case. This case concerns the care provided to R22 by Petitioner beginning January 30, 2011 and the actions taken by Petitioner afterwards.

Based on this resurvey, CMS continued the $100 per day CMP and the already-imposed April 2, 2011, DPNA until the facility returned to substantial compliance. CMS Ex. 17. Petitioner, however, waived its right to challenge the imposition of the remedies imposed based on the resurvey (the $100 per day CMP and DPNA, beginning the date of the resurvey on April 4, 2012). CMS Ex. 17, at 5. CMS found that Petitioner had returned to substantial compliance on April 22, 2011. P. Ex. 2.

Petitioner requested a hearing by letter dated May 17, 2011.[2] Given Petitioner's waiver, the remaining remedies at issue include a $4050 per day CMP from January 30, 2011, through March 4, 2011, and a $100 per day CMP from March 5, 2011, through April 3, 2011.[3]

I held a hearing in this case in Mobile, Alabama on February 6, 7, and 8, 2012. A 701-page transcript (Tr.) was prepared. Testifying on behalf of CMS were Ellen James, LCSW, MPA, (Surveyor James), Arlinda Vada Cejas, RN, (Surveyor Cejas), and Charlyne White, RN (Surveyor White), surveyors with the state agency. Testifying on behalf of Petitioner were Cynthia Jordan, RN, Petitioner's Assistant Director of Nursing (ADON Jordan), Laura Ford, Nurse Practitioner, Petitioner's Director of Nursing (DON Ford), and Thomas "Tommy" Herndon, LNHA, Petitioner's Nursing Home Administrator (Administrator Herndon). I admitted CMS Exhibits (CMS Exs.) 1 – 9 and 11 – 19 and Petitioner's Exhibits (P. Exs.) 1 – 23. (CMS Ex. 10 was withdrawn. During hearing Petitioner objected to CMS Exs. 5 and 6 for the first time, but the objections were overruled. CMS also proffered CMS Exs. 18 and 19 during the hearing for the first time, but these exhibits were not relevant. P. Exs. 22 and 23 were also offered for the first time at hearing, without objection.) Both parties filed post-hearing briefs (CMS Br. and P. Br.) and post-hearing reply briefs (CMS Reply and P. Reply).[4]

---

[2] In its hearing request, Petitioner makes due process arguments I am without authority to hear. Petitioner's hearing request at 5-6. The arguments are preserved for appeal.

[3] Petitioner states that it "did not admit any new Medicare/Medicaid beneficiaries during the DPNA period, so . . . the DPNA . . . is [not] at issue here." P. Br. at 9. Petitioner also did not specifically challenge the two-year prohibition on its ability to offer a nurse aide training and competency evaluation program (NATCEP). Accordingly, the prohibition is also not at issue here.

[4] At the close of the CMS case-in-chief, Petitioner moved for summary disposition arguing that CMS failed to establish a *prima facie* case that Petitioner was not in substantial compliance and a separate motion for summary disposition arguing that CMS did not establish a *prima facie* case for the duration of the non-compliance. Tr. at 360-365. I denied Petitioner's motions. Tr. at 371-372.

II. Issues

1. Whether Petitioner was in substantial compliance with participation requirements in the Medicare and Medicaid programs;

2. Whether CMS' determination of immediate jeopardy was clearly erroneous; and,

3. Whether the remedies imposed are reasonable.

III. Controlling Law

Sections 1819 and 1919 of the Social Security Act (Act) and the regulations at 42 C.F.R. Part 483 govern Petitioner's participation in Medicare and Medicaid. Sections 1819 and 1919 of the Act provide the Secretary of Health and Human Services (Secretary) with authority to impose remedies, including CMPs, against long-term care facilities for failure to comply with participation requirements.

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.

The Secretary has delegated to CMS and the states the authority to impose remedies against long-term care facilities not complying substantially with federal participation requirements. The applicable regulations at 42 C.F.R. Part 488 provide that state survey agencies, on behalf of CMS, may survey facilities participating in Medicare and Medicaid to ascertain whether the facilities are complying with participation requirements. 42 C.F.R. §§ 488.10-488.28. The regulations contain special survey conditions for long-term care facilities. 42 C.F.R. §§ 488.300-488.335. Under Part 488, a state or CMS may impose a CMP against a long-term care facility if a state survey agency ascertains that the facility is not complying substantially with participation requirements. 42 C.F.R. §§ 488.406, 488.408, and 488.430. The CMP may begin to accrue as early as the date that the facility was first substantially out of compliance or may continue to accrue until the date the facility achieves substantial compliance, or until CMS terminates the facility's provider agreement. 42 C.F.R. § 488.440.

The regulations specify that if a CMP is imposed against a facility based on an instance of non-compliance, the CMP will be in the range of $1000 to $10,000 per instance. 42 C.F.R. § 488.438(a)(2). When a CMP is imposed against a facility on a per-day basis,

it must fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, from $3050 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 $3000 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). "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.

Sections 1819(f)(2)(B) and 1919(f)(2)(B) of the Act prohibit approval of a NATCEP if within the last two years the facility has been subject to, among other things, an extended or partial extended survey; imposition of a CMP of not less than $5,000; or imposition of a denial of payment for new admissions.

A facility may challenge the scope and severity that CMS cites only if a successful challenge would affect the range of CMP amounts that CMS imposed or would affect the facility's NATCEP. 42 C.F.R. § 498.3(b)(14), (d)(10)(i). CMS's determination as to the scope and severity of non-compliance "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*, DAB No. 1726, at 9 (2000), *aff'd, Woodstock Care Center v. U.S. Department of Health and Human Services*, 363 F.3d 583 (6th Cir. 2003).

The Departmental Appeals Board (Board) has long held that the net effect of these regulations is that a provider has no right to challenge the scope and severity assigned to a noncompliance finding except in the situation where that finding is the basis for an immediate jeopardy determination. *See, e.g., Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000).

A facility must prove by the preponderance of the evidence that it is in substantial compliance. *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004), *aff'd, Batavia Nursing and Convalescent Center v. Thompson*, 129 F. App'x 181 (6th Cir. 2005). To put the facility to its proof, CMS must initially present a *prima facie* case of noncompliance with Medicare participation requirements, providing evidence on any factual issue that the facility disputes that is "[s]ufficient to establish a fact or raise a presumption unless disproved or rebutted." *Alden Town Manor Rehabilitation and Health Care Center*, DAB No. 2054, at 4 (2006). Once CMS has made such a showing as to any disputed facts, the burden of proof shifts to the facility to show at the hearing

that it is more likely than not that the facility was in substantial compliance. *Alden Town Manor*, DAB No. 2054, at 4-5; *see generally Evergreene Nursing Care Center*, DAB No. 2069 at 7-8 (2007)(discussing the "well-established framework for allocating the burden of proof on the issue of whether [a] SNF was out of substantial compliance"). *Golden Living Center – Riverchase*, DAB No. 2314, at 8 (2010).

IV. Discussion

I make numbered findings of fact and conclusions of law (Findings) to support my decision. I set them forth below as separate headings, in bold and italic type, and discuss each in detail.[5]

1. Petitioner failed to substantially comply with the accidents/hazards and supervision requirement at 42 C.F.R. § 483.25(h) (Tag F-323).[6]

Section 483.25(h) references accidents[7] and states:

---

[5] I have reviewed the entire record, including all the exhibits and testimony. Because the Federal Rules of Evidence do not control the admission of evidence in proceedings of this kind (*see* 42 C.F.R. § 498.61), I may admit evidence and determine later, upon a review of the record as a whole, what weight, if any, I should accord that evidence or testimony. To the extent that any contention, evidence, or testimony is not explicitly addressed or mentioned, it is not because I have not considered the contentions. Rather, it is because I find that the contentions are not supported by the weight of the evidence or by credible evidence or testimony.

[6] The case was originally cited as a violation of section 483.25(h) as F-323, the "accident hazard" regulation. CMS later added section 483.25 as F-309, "failure to provide necessary services to maintain highest practical well-being," and section 483.10(b)(ii) as F-157, "failure to notify physician and family of change in condition." The addition of F-157 and F-309 seems to have been announced to Petitioner on August 29, 2011 (*see* CMS's Pre-Hearing Memorandum, at 13). Petitioner has never objected to this procedure. Petitioner has had the opportunity to address each of the deficiencies. I will address all three deficiencies, and note that the F-309 citation is based on exactly the same facts as F-323, and the F-157 citation follows on the facility's failure promptly to tell R22's doctor and responsible party about the fall and findings thereafter.

[7] The Board references the Medicare State Operations Manual (SOM) in defining an accident as:

> "an unexpected, unintended event that can cause a resident bodily injury," excluding "adverse outcomes associated as a direct consequence of treatment or care (e.g., drug side effects or reactions)." SOM Appendix PP,

> (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.

In *Meridian Nursing Center,* DAB No. 2265, at 3 (2009), the Board described the requirements of this subsection, stating:

> Section 483.25(h)(1) requires that a facility address foreseeable risks of harm from accidents "by identifying and removing hazards, where possible, or where the hazard is unavoidable because of other resident needs, managing the hazard by reducing the risk of accident to the extent possible." *Maine Veterans' Home – Scarborough,* DAB No. 1975, at 10 (2005). Section 483.25(h)(2) requires that a facility take "all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents." *Briarwood Nursing Center,* DAB No. 2115, at 11 (2007), citing *Woodstock Care Center v. Thompson,* DAB No. 1726 (2000) (facility must take "all reasonable precautions against residents' accidents"), *aff'd, Woodstock Care Center v. Thompson,* 363 F.3d 583 (6th Cir. 2003).

The Board has also held that facilities "have the 'flexibility to choose the methods of supervision' to prevent accidents so long as the methods chosen are adequate in light of the resident's needs and ability to protect himself or herself from a risk." *Briarwood Nursing Center,* DAB No. 2115, at 5, *citing Liberty Commons Nursing and Rehab – Alamance,* DAB No. 2070, at 3 (2007).

The Board stated in *Briarwood Nursing Home,* DAB No. 2115, that:

> [T]he "mere fact that an accident occurred does not, in itself, prove that the supervision or devices provided must have been inadequate to prevent it." *Josephine Sunset Home,* DAB No. 1908, at 13 (2004). On the other hand, it is not a prerequisite to finding noncompliance under section 483.25(h)(2) that any actual accident have occurred or be caused by the inadequate supervision to find noncompliance. *Woodstock* at 17. The occurrence of an accident is relevant to the extent the surrounding circumstances shed light

---

> Guidance to Surveyors, Part 2, SOP 483.25 Quality of Care (Rev. 274, June 1995 (SOM Guidance).

Woodstock Care Center, DAB No. 1726, at 4.

> on the nature of the supervision being provided and its adequacy for the resident's condition. *St. Catherine's Care Center of Findlay, Inc.*, DAB No. 1964, at 12 (2005) (accident circumstances may support an inference that the facility's supervision of a resident was inadequate). The focus is on whether the facility took all reasonable steps to ensure that a resident receives supervision and assistance devices that met his or her assessed needs and mitigate foreseeable risk of harm from accidents. *Woodstock Care Center v. Thompson*, 363 F.3d at 590 (facility must take "all reasonable precautions against residents' accidents").
>
> > The regulation speaks in terms of ensuring that what is "practicable" and "possible" to do is done. What is thus required of facilities is not prescience but reason and professional judgment in assessing what can be done to make residents (given their special needs) safe, through removing accident hazards, providing appropriate devices, and ensuring adequate supervision.
>
> *Josephine Sunset Home*, at 14-15.

Briarwood Nursing Center, DAB No. 2115, at 11-12.

The Board has also held that the regulations permit facilities some flexibility in choosing the methods they use to prevent accidents, so long as the chosen methods constitute an adequate level of supervision. *Windsor Health Care Center*, DAB No. 1902 (2003), *aff'd Windsor Health Center v. Leavitt*, 2005 WL 858069 (6th Cir. April 13, 2005). A facility must anticipate what accidents might befall a resident and take steps — such as increased supervision or the use of assistance devices, for example — to prevent them. *Aase Haugen Homes*, DAB No. 2013 (2006).

There are two different kinds of lifts which Petitioner's facility employed, the Sara lift and the Marissa lift (also called a Hoyer lift). Tr. 381-382. The record indicates that a "Marissa" lift was safer and more appropriate for R22. The Sara lift is used to transfer patients in a standing position whereas the Marissa lift is used to transfer patients in a seated, slightly reclined position. CMS Ex. 11, at 10, 21-24; CMS Ex. 12, at 14. The Sara lift has hand bars that the resident holds on to and requires the resident to be able to stabilize himself or herself in either a sitting or a standing position. Tr. 54, 285. The Sara lift is for "limited-assist, weight bearing individuals" who can grasp a handlebar and are able to follow simple directions. P. Ex. 19, at 1; P. Ex. 20, at 17; Tr. 285; P. Br. at 10. It should not be used for residents who are not able to bear weight. CMS Ex. 12. The Marisa lift provides greater support for such residents. Depending on the circumstances, the lifts can be used with one or two persons and have additional supportive straps or accessories increase safety based on the particular patients needs. Each lift has its

benefits and drawbacks but either way, residents who need support in transfers should be assessed for the most appropriate lift and reassessed as needed.

Petitioner failed to ensure that staff used the appropriate lift for R22.

CMS argues that the staff should have been using the more supportive Marissa (or Hoyer) lift for R22, or should at least have conducted an assessment of R22 to determine the most appropriate lift. Petitioner, on the other hand, argues that there is no evidence that R22 would not have sustained a fall if the staff had used the more restrictive Marissa (or Hoyer) lift.

I find that Petitioner failed to ensure that staff used the appropriate lift for R22. Facility records including lift assessments, nursing notes, care plan, physician notes, as well as testimony vary as to whether the Sara or Marissa lift was the most appropriate lift for R22. Petitioner's care plan for R22 indicated that she should be transferred with a mechanical lift because of her cognitive and physical functional deficits, but did not indicate which lift Petitioner should use. P. Ex. 12, at 32. Petitioner's records are inconsistent as to whether R22 could bear weight or follow simple instructions. The lift assessments conducted yielded varying and at times inconsistent results. For example, the January 7, 2009 lift assessment stated that R22 was unable to bear weight on either leg, unable to follow simple instructions, and unable to assist in any movement. CMS Ex. 8, at 6. However, just two months later a March 18, 2009 lift assessment indicated that R22 could bear weight on both legs and follow simple instructions. CMS Ex. 8, at 9. At the end of August 2009, the nursing notes state that R22 had a "decline of condition." P. Ex. 14, at 6. However, there is no documentation of the nature of the decline and no concurrent lift assessment. The facility did not conduct another lift assessment for R22 until well over a year later, but the nursing notes in November 2009 and January 2010 indicate that the facility switched back to using the Marissa lift again to transfer R22. P. Ex. 14, at 7, 10. An October 6, 2010, assessment stated that R22 was unable to bear weight, indicating that a Marissa lift was appropriate. P. Ex. 7, at 4. However, only twelve days later, on October 18, 2010, a lift assessment stated that R22 could bear weight on at least one leg and that staff should use the Sara lift for transfers. CMS Ex. 8, at 7. Strikingly, there is nothing in the record to support that R22's condition improved or even fluctuated. There is no documentation that the lift assessment differential was even recognized. P. Ex. 8, at 7; P. Ex. 14, at 22-25; Tr. at 411-415. A December 13, 2010 lift assessment again indicated a Sara lift should be utilized. CMS Ex. 8, at 7. However, just a few weeks before R22's fall, an occupational therapist assessed R22 as so significantly lacking in "sitting balance" that R22 required support to keep her from falling out of her wheelchair. Certainly, R22's inability to support herself while seated in a wheelchair should have raised serious concerns about whether a Sara lift could safely be utilized. P. Ex. 10, at 8.

Petitioner also argues that the facility decided not to use the Marissa (or Hoyer) lift because R22 was fearful of the sling in that lift. Tr. at 397-399, 410-414; P. Br. at 13. There is no compelling evidence in the record, however, to support Petitioner's assertion that its decision was based on the resident's fear or preference. If R22's fear of the Marissa lift was the basis for Petitioner's staff to use the Sara lift, it seems reasonable to expect that rationale to be well-documented in the Resident's medical record, especially because the Marissa lift was more appropriate on most occasions. However, even if I accept Petitioner's assertion as true, that does not absolve or release Petitioner from the requirement that it provide R22 adequate supervision. If, under the circumstances, the facility substituted one device for another, the facility is obligated to institute additional interventions to compensate for the diminished effectiveness of the alternative device, or to tailor the alternative method better to the resident's specific needs. In this case, a second nursing assistant and leg straps would have been the minimum interventions provided to aid in assuring R22's safety. All reasonable steps should have been put into place to ensure that R22 received supervision and assistance devices that met her assessed needs and mitigated foreseeable risks of harm from accidents.

Petitioner failed to timely reassess R22 for lifts

There is additional evidence that before the accident, some of Petitioner's staff expressed concerns about the use of the Sara lift with R22. Tr. at 137, 169; CMS Ex. 9, at 55, 59, 73-75. Nursing staff had noticed that R22 had begun to decline about three weeks prior to R22's accident. R22 was no longer able to follow directions, balance herself, and would stiffen during transfers. Tr. at 137, 169; CMS Ex. 9, at 55, 59, 73-75. Despite caregiver concerns, their superiors failed to act immediately or reassess R22 until well after the accident and R22 returned from the hospital. CMS Ex. 9, at 55, 59.

Petitioner failed to ensure the appropriate number of staff were utilized for transfers

Even if the Sara lift was appropriately utilized for R22's transfers at the time of the accident, it is abundantly evident that additional safeguards should have been, but were not, in place. R22's medical records, including her Minimum Data Set, nursing notes, occupational therapy evaluation, and other assessments, along with caregiver interviews and witness testimony, make it clear that R22 was not stable during surface to surface transfers and was only able to stabilize with human assistance. P. Ex. 9, at 3-14, 19; P. Ex. 10, at 8. CNA Dominico Floyd, LPN Cynthia Dorris, LPN Susan Campbell, LPN Mildred Carroll, and Nurse Cyndee Hamilton, all informed surveyors that R22 required two people during transfers, because she was stiff or would stiffen-up, was hard to handle, and difficult to move. CMS Ex. 9, at 5, 7, 33-36, 49, 51.

Additionally, the record shows that if a resident lacks "sitting balance" a second staff person should be used to support the resident. P. Ex. 20, at 8, 11; P. Ex. 21, at 7 (Stating

in the introductory section of the Sara Lift 3000 Operations Manual, that all "instructions are described as if lifting a patient from a chair. The same operations can be performed effectively when lifting a patient from a wheelchair or sitting position on a bed, although a second attendant should support the patient if the patient lacks sitting balance," and later in that Exhibit, at page15, is this note: "! Caution: If the patient lacks sitting balance and has been returned to sit on the side of the bed a second attendant may be needed to support the patient while the sling is being removed." The record shows that R22 did not have sitting balance or trunk stability. P. Ex. 10, at 8. In fact, shortly before the January 30, 2011 accident, R22 was referred for an occupational therapy evaluation. On January 6, 2011, the occupational therapist diagnosed R22 as demonstrating "abnormal posture," with right trunk lateral flexion. P. Ex. 10, at 8. The therapist observed that while seated in her wheelchair, R22 "demonstrate[d] lateral leaning to [the right] side" and recommended to order and fit R22 with a "positioning device in order to reduce risk for falls," and educate nursing staff. P. Ex. 10, at 9. The occupational therapist further recommended therapy for neuromuscular re-education and wheelchair management among other skills as a focus for therapy provided two times a week for three weeks. P. Ex. 10, at 8. The evaluation was signed by the occupational therapist on January 6, 2011 and contains R22's physician's undated signature.[8] P. Ex. 10, at 8. Despite that clear evidence that R22 did not posses trunk stability, on January 30, 2011, R22 was left without a second staff member to provide direct support while the CNA left R22 to operate the device. The presence of a second CNA or other caregiver was undoubtedly required to provide even minimum support for obvious foreseeable risks to R22.

Petitioner failed to ensure that staff used leg straps

Another tool that Petitioner could have used, but failed to use, to reduce the risks to R22 were leg straps. Again, CNA Floyd, CNA Coutu, LPN Stivers, LPN Carroll, and Nurse Hamilton, all informed surveyors that the leg straps were important to use in order to help keep R22 safe during transfers. CMS Ex. 9, at 33-36, 49, 51, 53, 57, 59-60, 73, 75. The manufacturer's training check list also advises that leg support straps should be fastened "if added security is desired or needed." P. Ex. 19, at 1. Yet on January 30, 2011, R22's caregiver did not use this additional safety mechanism. In support of its position, Petitioner simply stated that the leg straps were not mandatory to use with the Sara lift, and opined without more that the leg straps could have made her injuries worse. P. Br.

[8] After two occupational therapy treatments, the therapist discharged R22 from therapy on January 24, 2011, noting that R22's positioning devices for her wheelchair had arrived, were applied, and the nursing staff had been educated on wheelchair positioning. The note is focused on the successful addition of the positioning device as providing proper postural alignment for R22 while she was seated in her wheelchair. The summary makes no mention of improved trunk stability, strengthening, or sitting balance, nor does it otherwise indicate that any was achieved. *See* P. Ex. 10, at 9.

at 18 n.9. I find the evidence once again shows that the facility failed to take another reasonable step to ensure R22's safety.

Petitioner failed to reassess R22 for lifts after the January 30, 2011 accident

The record is clear that on January 30, 2011, Petitioner's staff should have exercised greater care in transferring R22 through using a Marissa lift rather than a Sara lift, or a Sara lift with an additional staff person and the use of leg straps, despite the obvious foreseeability of the risks specific to R22. Petitioner's staff chose to use the less-safe method of transferring R22, leaving the unstable and rigid Resident (who needed special positioning devices to prevent her falling out of her wheelchair) unattended at the side of her bed. After R22's foreseeable fall on January 30, 2011, Petitioner's staff once again failed to ensure R22's safety when they did not promptly reassess R22 for appropriate transfer mechanisms.

Petitioner did not reassess R22 after she fell on January 30, 2011, or over a period of the next several days even though multiple staff members observed swelling and bruising around R22's knee and inner thigh. P. Ex. 15. By failing to do so, Petitioner's staff continued to transfer R22 using the Sara lift, and required R22 to put pressure on her fractured leg. Only after R22's fractured hip was diagnosed and she was readmitted to Petitioner's facility on February 12, 2011 did the facility conduct a mobility or lift assessment. CMS Ex. 8, at 53. However, even this lift assessment was not completed and remains even now unsigned. The form directions indicate that R22 is not a candidate for the Sara lift, but it is unclear as to whether the Marisa lift could be an alternative. Rather, the form directions indicate that R22 is unable to be in a semi-reclined position and directs to "consult care plan team." CMS Ex. 8, at 53. There are no additional notations that one would normally expect, which is particularly surprising given these specific circumstances. CMS Ex. 8, at 53. Petitioner has not supplied a lift assessment or other documentation on the issue by the care plan team other than a notation on the immediate plan of care. The immediate plan of care indicates to use the Marissa lift for transfers with a licensed nurse to support R22's left leg. CMS Ex. 8, at 29, 58. There are no accompanying notes or assessments that clarify how this decision was reached or how R22 could safely be transferred using the Marissa if she is not able to be in a semi-reclined position, or whether the facility utilized a special purpose sling for R22's Marissa transfers. CMS Ex. 8; CMS Ex. 11, at 18-23; P. Ex. 10; P. Ex. 13-14.

Petitioner supplied evidence as to what techniques or processes the CNA employed during the transfer; however, there is no evidence that the CNA employed techniques or processes that were reasonable in light of the resident's assessed needs. It is not disputed that R22 was an obese and "stiff" resident with a very unstable trunk, who was at high risk for falls and required a mechanical lift for transfers. However, Petitioner argues that the techniques or processes employed on January 30, 2011 and thereafter were reasonable in light of R22's needs. I believe that the evidence shows otherwise. It is clear that by

using the less-supportive Sara lift, without a second staff member to aid in R22's safety, and also without the additional support of the leg straps to reduce the risk of an accident, Petitioner failed to ensure that R22's environment remained as free of accidents and hazards as possible and failed to employ supervision that was reasonable in light of R22's needs, in violation of 42 C.F.R. § 483.25(h).

CMS has established that Petitioner violated the accidents/hazards regulation in five specific areas: (1) Petitioner failed to ensure that staff used the appropriate lift for R22, (2) Petitioner failed timely to reassess R22 for lifts, (3) Petitioner failed to ensure the appropriate number of staff were utilized for transfers, (4) Petitioner failed to ensure that staff used leg straps, (5) Petitioner failed to reassess R22 for lifts after the January 30 2011 accident. CMS Ex. 9, at 5, 7, 10, 13, 15, 17, 33-36, 49, 51, 53, 55, 57, 59-60, 73-75; CMS Ex. 11; CMS Ex. 12; Tr. at 54, 168, 183, 187-189, 278-281, 283-285, 291-293, 309, 382.

2. Petitioner failed to comply substantially with the requirement to consult immediately with the resident's physician and notify the resident's interested family member as required by 42 C.F.R. § 483.10(b)(11) (Tag F-157).

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

In this case, Petitioner failed to consult with R22's physician or notify R22's family immediately after R22 fell, after R22 developed bruising and swelling, and again after the facility received R22's x-ray results indicating that she had sustained multiple fractures.

In *Georgian Court Nursing Center*, DAB No. 1866 (2003), the Board upheld the ALJ's finding of noncompliance when the nursing aide knew that he had tried an improper one-person transfer of the resident, when substantial evidence supported the ALJ's finding that the aide had injured the resident in the attempted transfer, and when the resident, who was paralyzed on her left side, complained to the charge nurse that her upper left arm hurt and that the aide had hurt her arm. The charge nurse did not investigate the resident's allegation about the improper transfer or inform the resident's physician or family about the injury until the following morning, when the resident's shoulder was bruised and swollen. The Board stated that there was no dispute that the potential for an

injury as serious as a broken arm necessitated treatment by a physician. *Georgian Court Nursing Center*, DAB No. 1866.

Here, the nursing staff first erred in not immediately notifying R22's doctor and family member of the fall. Petitioner's argument that R22 was not displaying any changes in signs or symptoms in condition and no notification was required is unconvincing. The regulation plainly requires notice if the Resident was in an accident that might need her physician's care. Clearly a fall involving a resident as vulnerable to injury as R22 may have needed physician care and the facility was required to notify the physician promptly. Moreover, Petitioner's nursing staff knew or should have known about Petitioner's January 30 fall. Thereafter, they failed to conduct a proper assessment of R22 or consult with her doctor for treatment orders. Petitioner's suggestion that R22's fracture could have been a spontaneous fracture due to her severe osteoporosis and unrelated to her fall appears disingenuous. If R22 did in fact have bones so brittle that her fractures "could have been caused by a sneeze," then it follows that the fall would clearly cause severe trauma to R22 including multiple fractures, such as those sustained. See P. Ex. 15, at 3. It is not a defense that her osteoporosis was yet to be diagnosed because standards of practice dictate that nearly any nursing facility resident would be in serious danger of sustaining a fracture from any kind of a fall. Petitioner's staff knew that R22's doctor and family should have been immediately contacted after her fall on January 30, 2011. P. Ex. 15, at 3; P. Ex. 16, at 5; Tr. at 424-425, 429, 491, 565.

Petitioner next failed to consult immediately with R22's doctor and family when the staff noticed R22's bruising and swelling. CMS Ex. 9, at 65-66, 71, 73, 75; Tr. at 590. In fact, even Petitioner's DON testified that when the nursing staff first became aware of R22's bruise, they should have notified both her physician and her responsible party. Tr. at 590. Petitioner argues that nursing staff assessed R22's bruising and swelling and determined that it was the result of R22's arthritis or ongoing edema, and therefore notification was not necessary. However, there is no corresponding documentation or even nursing note of either Nurse Kattleman's or Nurse Hamilton's assessment. Even if the nursing staff attributed R22's "swollen and warm to touch" leg with "old bruising noted below and lateral to [R22's] left knee," to an arthritis flare-up, the standard of nursing care is to report such findings to the appropriate parties. P. Ex. 15, at 2, 6-8; Tr. at 275, 280-281. On the other hand, had Petitioner's nursing staff been aware of R22's fall, it seems reasonable to expect that they would have better understood the significance of the swelling and bruising. Once again, however, it is basic nursing practice and reasonable for the nursing staff to be aware of R22's fall and Petitioner's failure to understand the magnitude of such symptoms only add to Petitioner's culpability.

Finally, Petitioner violated the notification requirement once again when it failed to immediately notify R22's doctor and family of her x-ray results showing R22 suffered an impacted supracondylar fracture of the femur. Instead, the facility failed R22 again when it waited for about nine hours before acting to contact the doctor and family. Petitioner's

records indicate that the charge nurse "had several things going on" Thursday evening and "didn't call the [doctor or responsible party] with the x-ray results until early [the next] morning." P. Ex. 15, at 7. Petitioner attempts to minimize this infraction and again attempts to argue that it was a nursing decision to refrain from notifying the physician and family.

As asserted by Petitioner, the preamble to the final rule states: "We recognize that judgment must be used in determining whether a change in the resident's condition is significant enough to warrant notification, and accept the comment that only those injuries which have the potential for needing physician intervention must be reported to the physician." 56 Fed. Reg. 48,826, 48,833 (Sept. 26, 1991). However, Petitioner attempts to hide behind what it calls its staff's "nursing judgment" in deciding not to contact R22's physician at 10 p.m. because the physician may have been sleeping. The sleeping patterns of R22's physician is not professional nursing judgment. Moreover, Petitioner's related argument that nothing could be done to treat R22 at the hospital anyway is likewise unavailing. This analysis is supported by the Board's finding in *NHC Healthcare Athens*, DAB No. 2258, at 6-7 (2009). Similarly, when Petitioner's staff contacted R22's physician the following day, her physician did order the transfer of R22 to the hospital. In *NHC Healthcare Athens*, the physician's assertion that she would not have ordered an intervention on the evening of June 5 (five days after the Resident fell and the evening she began showing signs of pain) did not excuse the nursing home's failure to notify her, since the requirement that the facility contact (and consult with) the physician is not contingent on how the physician might respond, but on the existence of facts requiring notification. Here, it is clear that the fact that R22 had indeed suffered a serious fracture of her left femur likewise required immediate physician consultation. *See Georgian Court Nursing Center*, DAB No. 1866.

Finally, the facility recognized that it failed to immediately notify R22's physician and family. Though its internal investigation, Petitioner determined that both general and one-on-one training was necessary for its licensed nursing staff on the topic of physician and responsible-party timely notification. P. Ex. 15, at 2; *see* P. Ex. 16; P. Br. at 24-25; Tr. at 652-653. This training provided the notification guidelines and a form to aid in effective communication between licensed staff and resident physicians. P. Ex. 16, at 11, 13. This form requires the nurses to conduct an assessment prior to contacting the physician and reminders to document specific details in the nursing notes. It also includes a section to document when the family was notified. P. Ex. 16, at 13. This training was completed on February 18, 2011. Because Petitioner recognized this deficiency on its own, and took proactive steps to remedy, this violation appears to have subsided by February 18. Unfortunately, however, as discussed later, Petitioner was not able effectively to correct the other two deficiencies until late April.

3. Petitioner failed to comply substantially with the quality of care regulation at 42 C.F.R. § 483.25 (Tag F-309).

42 C.F.R. § 483.25 requires that:

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Although "practicable" is not defined in the regulations, in *Ridge Terrace*, DAB No. 1834, the Board explained that "practicable" in section 483.25 refers to the resident's condition, not to the care and services that the facility must provide.[9] In *Crestview Parke Care Center v. Thompson*, 373 F.3d 743 (6th Cir. 2004), the court concluded that the general quality of care regulation is not a "strict liability" regulation. The court explained that the word "practicable" suggests that a "'reasonableness' standard inheres in the regulation" and that it would be possible for a facility to show "a justifiable reason for the violation of § 483.25."

The preamble to the final rule implementing this provision (*see, e.g.*, 54 Fed. Reg. 5316, 5332) states that the wording reflects an approach that emphasizes resident care outcomes, rather than procedural and structural requirements.

> We recognize that a facility cannot ensure that the treatment and services will result in a positive outcome since outcomes can depend on many factors, including a resident's cooperation (i.e., the right to refuse treatment), and disease processes. However, we believe it is reasonable to require the facility to ensure that 'treatment and services' are provided, since the basic purpose for residents being in the facility is for 'treatment and services' and that is why the Medicare or Medicaid program makes payment on the residents' behalf.

Fed. Reg. 5316, 5332. Furthermore, the facility could "direct surveyor attention to any evidence (the resident [sic] or the resident's clinical record) in order to show that a negative resident care outcome was unavoidable." *Id.* at 5332.

---

[9] The Board noted in *Woodstock*, DAB No. 1726, that "while the concept of practicability is relevant in examining what duty a long-term care facility has to prevent accidents, the regulation requires that the facility 'ensure' that each resident receive adequate supervision." *Id.* at 25.

Here, it is clear that Petitioner failed to provide R22 with the necessary care and services to maintain her highest practicable well-being.

After R22's fall, nursing should have assessed R22 before the staff moved her. It is basic standard of practice for a nurse to immediately assess a resident after a fall, before the resident is moved. Tr. at 190, 192, 294, 425, 429. Moreover, it is against Petitioner's own policy to move a resident after a fall, even if the resident has not fallen directly onto the floor. CMS Ex. 9, at 37; P. Ex. 16, at 6-10. It is not disputed that a licensed nurse did not assess R22 after she fell. P. Br. at 18. The CNA should have called for a licensed nurse before she moved the Resident. The licensed nurse could have conducted a head-to-toe assessment of R22 to determine if there were any injuries, and to assure that R22's health was not further compromised or her injuries exacerbated. CMS Ex. 9, at 56, 59, 74, 75; Tr. at 189-190, 196-197, 427-428. This nursing assessment would have included checking for any raised areas of the body, abnormal rotation, abrasions, or bruising. Also important for R22 would be assessing her for pain — particularly because R22 was nonverbal. In that circumstance the licensed nurse would look not only at R22's facial expressions, but would be alert for any possible grimacing, pulling away, and would have checked R22's vital signs including blood pressure and pulse. Tr. at 201, 425-427, 490. Instead, the CNA "assessed [R22] enough to satisfy herself that the Resident had not been injured . . . ." P. Br. at 18. A CNA is not qualified to conduct a nursing assessment of the quality or nature that was required in this situation. What examination the CNA performed at the time did not meet the standard of care. *See* P. Br. at 24.

When R22 fell, she landed on the lift footrest in a seated position. Rather than alerting a licensed nurse to assess and protect R22 from further harm, the CNA lowered R22's bed and used the Sara lift, designed to be used with standing residents, to lift R22 back to her bed. CMS Ex. 9, at 21-22, 81-83, 89. The CNA admittedly used this lift incorrectly when she moved R22 from the lift platform and transferring R22 back to her bed. CMS Ex. 9, at 89; CMS Exs. 11-12; P. Br. at 17-18.

After wrongly and single-handedly transferring R22 back to her bed, rather than obtaining the assistance of a licensed nurse, the CNA obtained the help of a second CNA. Together, the two CNA's used the Sara lift *again*, requiring R22 to stand, to transfer R22 to her wheelchair. P. Br. at 18; P. Ex. 15, at 2, 4, 9-10; CMS Ex. 9, at 89.

After a resident suffers a fall, it is standard practice for the nursing staff to monitor that resident closely for signs or symptoms of injury and for pain. Tr. at 200, 299, 491. This careful monitoring should be documented in the resident's medical record. Tr. at 429-430. I find absolutely no credible evidence that Petitioner's staff conducted such monitoring of R22 during that critical period following her fall. There is not a single nursing note regarding R22 for January 30, January 31, February 1, or February 2. CMS Ex. 8, at 16-17. There are absolutely no nursing notes, assessments, nurse/physician communication reports, physician progress notes or orders, or other written evidence that

R22 was monitored at all, let alone closely. CMS Ex. 8; P. Exs. 13-14. I find that Petitioner's failure to closely monitor R22 after her fall was another violation of this regulatory standard.

Despite being aware of R22's bruising and swelling of her leg, Petitioner continued to transfer R22 using the Sara lift, requiring R22 to stand on her inflamed leg during transfers. Petitioner failed to evaluate R22 for lifts after becoming aware of her injury and inflammation. Continuing to transfer R22 in such a manner created a serious risk of additional injury and was certainly below the professional standards of care. CMS Ex. 9, at 56, 59, 74-75; Tr. at 189-190, 196-197, 224, 427-428, 504-505.

Petitioner's nursing staff should have investigated R22's bruises and swelling. Further, either the staff knew of R22's recent fall and conducted inadequate assessments or the assessments that were conducted were indeed flawed because the nursing staff was not aware of R22's recent fall. The CNA involved in the January 30 incident states that she reported it to Nurse Stivers. However, the record is unclear as to whether or not the CNA truly reported the fall. If the CNA did notify the LPN, then the LPN did nothing in response. The record is replete with evidence that thereafter several of Petitioner's CNAs brought R22's bruising and swelling to the attention of their superiors. In fact it is Petitioner's own investigation summary that shows that on February 2, CNA Davis reported the swelling to the nurse on duty. That nurse states that she examined R22's knee and found it "swollen and warm to touch with old bruising noted below and lateral to [R22's] left knee." P. Ex. 15 at 2. The nurse attributed her findings to R22's "history of arthritis." P. Ex. 15, at 2. Although it is unclear how the nurse arrived at her conclusion, her findings are even more confusing because she failed to document her assessment. Presumably, CNA Davis's concerns were not alleviated, because she again reported her concerns to the evening nurse. The second nurse did not notice any bruising and unfortunately concluded that R22's "knee was swollen consistent [with] her arthritis . . . ." P. Ex. 15, at 2. Again, the evening nurse failed to document or make any notes regarding her assessment, findings and conclusion. The following morning, two more CNAs reported their concern regarding R22's bruising to the charge nurse, Nurse Campbell. Nurse Campbell did not assess R22's bruising, but simply reported the bruising to the oncoming p.m. nurse, Nurse Dorris. Again, the p.m. nurse failed to promptly or effectively assess R22. It was not until the following morning, February 3, 2011 that Nurse Dorris assessed R22. She found bruising but did not document or act on her findings, and only reported back to Nurse Campbell with her observations. Finally, Nurse Campbell reported her concern to the ADON who advised her to contact the responsible party.

The DON finally contacted R22's doctor the afternoon of February 3, 2011. The doctor ordered an x-ray of R22's left femur and knee. CMS Ex. 8, at 11, 17. The results were faxed to Petitioner at 9:57 p.m. that evening. The report indicated that R22 had an "impacted supracondylar fracture of the femur." CMS Ex. 8, at 5. However, Petitioner

waited about nine hours before acting at all. Petitioner did not immediately contact R22's physician, address pain issues, or otherwise tend to R22's condition. It was not until about 6:38 the following morning that the staff contacted R22's doctor with the results. CMS Ex. 8, at 17. R22's doctor ordered that the facility transfer R22 to the emergency room for evaluation and treatment. CMS Ex. 8, at 17. As previously stated, Petitioner attempts to argue that this was somehow a valid nursing judgment not to contact R22's physician, because the staff would not want to wake the doctor. Despite that patently-absurd argument, Petitioner's investigation reported the charge nurse stating: "On Thursday night, I had several things going on and didn't call the [doctor or responsible party] wit [the] x-ray results until early [the next] morning." P. Ex. 15, at 7. According to the surveyor's interview of that nurse, the "several things going on" entailed being busy working on a school assignment. Tr. at 155.

The record is replete with evidence that Petitioner failed to provide R22 with the necessary care and services to maintain her highest practicable well-being.

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

Immediate jeopardy exists if a facility's noncompliance has caused, or is likely to cause, "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance (which includes an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a heavy burden to show no immediate jeopardy and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1962, at 11 (2005); *Florence Park Care Center*, DAB No. 1931, at 27-28 (2004), *citing Koester Pavilion*, DAB No. 1750.

The "clearly erroneous" standard, the Board has explained, is highly deferential and places a heavy burden on the facility to upset CMS's finding regarding the level of noncompliance. *See, e.g., Claiborne-Hughes Health Center*, DAB No. 2179, at 20, (2008), *aff'd, Claiborne-Hughes Health Center v. Sebelius*, 609 F.3d 839 (6th Cir. 2010), *quoting Liberty Commons Nursing & Rehab Center*, DAB No. 2031 at 18 (2006), *aff'd, Liberty Commons Nursing & Rehab Center—Johnston v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007). When CMS issued the nursing facility survey, certification and enforcement regulations, it acknowledged that "distinctions between different levels of noncompliance . . . do not represent mathematical judgments for which there are clear or objectively measured boundaries." 59 Fed. Reg. 56,116, 56,179 (1994). "This inherent imprecision is precisely why CMS's immediate jeopardy determination, a matter of professional judgment and expertise, is entitled to deference." *Daughters of Miriam Center*, DAB No. 2067, at 15 (2007).

I find that because the staff incorrectly transferred R22 she suffered a fall that resulted in her femur fracture. That is actual serious harm. The facility then failed to take any action in response, and did not even assess or treat the injury compounding the seriousness of the harm to R22 and risking others similarly situation. Even if the fall did not cause R22's fracture, it certainly had the likelihood to cause serious injury, and the staff did nothing about it. Furthermore, once Petitioner's staff was informed of R22's femur fracture, they did absolutely nothing about it for about nine hours. Once the facility contacted R22's physician, he ordered her transferred to the emergency department, indicating that this fracture was a serious medical injury. The fact that they did not report this emergency for about nine hours constitutes a situation of immediate jeopardy to R22's health and safety.

5. Petitioner's noncompliance at a level of immediate jeopardy extended from January 30 through March 4, 2011, and substantial noncompliance that was not immediate jeopardy from March 5, through April 3, 2011.

Once the period of noncompliance is shown to have opened, it becomes Petitioner's obligation, under most circumstances, to show when it closed.

The Board in *Cary Health and Rehabilitation Center*, DAB No. 1771 (2001) explained that noncompliance is presumed to continue until the facility demonstrates that it has achieved substantial compliance. In *Taos Living Center*, DAB No. 2293, (2009) however, the Board clarified that it has never held that the presumption of continued noncompliance is unrebuttable (or that findings of continuing noncompliance are an exception to the regulatory provision of hearing rights on findings of noncompliance resulting in enforcement actions). In *Brian Center*, DAB No. 2336, (2010) the Board explained that the facility's burden extends to overcoming CMS's determination as to when the immediate jeopardy was removed. CMS's judgment that corrective measures were insufficient to abate the immediate jeopardy prior to the date CMS determined "is, in essence, a determination that the level of noncompliance continued to present immediate jeopardy" to residents. Thus, a "determination by CMS that a SNF's ongoing compliance remains at the level of immediate jeopardy during a given period constitutes a determination about the 'level of noncompliance' and, therefore, is subject to the clearly erroneous standard . . . ." *Id*. at 7-8.

Petitioner argues that if there is any noncompliance, the period ended when the facility completed its internal investigation and staff retraining the second week of February, 2011. P. Br. at 37. CMS argues that Petitioner continued to pose immediate jeopardy to the residents until at least March 4, 2011. CMS Reply at 5- 9. I find that the CMS finding of immediate jeopardy from January 30 through March 4, 2011 is not clearly erroneous. The record shows that on March 5, 2011:

> . . . after verifying in-services records and interviewing nursing staff, the survey tem concluded the facility implemented corrective measures as described in their Allegation of Credible Compliance provided to the survey team on 03/05/2011 at 9:00 AM, to prevent any future reoccurrence.

CMS Ex. 1, at 30. The survey team removed the immediate jeopardy on March 5, 2011 and lowered the scope and severity to a level "D" to allow for revised corrective actions as needed to establish substantial compliance with F-323. *Id*. Importantly, the Allegation of Credible Compliance included monitoring fall interventions and care provided beginning on March 4, 2011 by the Executive Director, DON, or designee. CMS Ex. 1, at 29-30. The senior staff would monitor to ensure implementation of the interventions every shift for seven days then slowly taper down for about a four-month period. *Id.* I find it absolutely not clearly erroneous that CMS found this monitoring vital to the alleviation of the immediate jeopardy finding.

The evidence further supports that Petitioner remained out of substantial compliance from March 5 through at least April 3, 2011. When CMS conducted its revisit survey on April 4, 2011, the surveyors observed a CNA transferring a resident while using the incorrect lift and with an insufficient number of staff present to assist. CMS Reply at 5; Tr. at 634-635. It is clear that Petitioner's corrective actions were not sufficient to establish substantial compliance with the same regulatory requirements previously cited. I find that CMS was not clearly erroneous in finding that substantial compliance, not amounting to immediate jeopardy, continued after the March 5 survey concluded.

6. The CMP imposed for the period of immediate jeopardy, $4,050 per day from January 30 through March 4, 2011, and $100 per day for the period of substantial noncompliance from March 5 through April 3, 2011, is reasonable.

To determine whether the CMP imposed is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f), which are: (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 circumstance in reducing the amount of the penalty. The factors listed in 42 C.F.R. § 488.404 include: (1) the scope and severity of the deficiency; (2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and (3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

In reaching a decision on the reasonableness of the CMP, I must 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 Petitioner with the kind of deficiency found, in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor

free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Center*, DAB No. 1848, at 21 (2002).

In evaluating the regulatory factors, I find that Petitioner has not submitted evidence regarding its financial condition. These deficiencies are serious and Petitioner is culpable in that Petitioner's actions had a serious negative effect on R22's care, comfort, and safety. Petitioner failed to provide R22 with the correct mode of transfer and with the correct number of staff to assist, creating the unsafe situation where R22 fell and fractured her femur. Petitioner's substandard care continued from that moment forward, where rather than attempting to mediate harm it not only failed to act but continued to put R22 at risk and further exacerbate her injuries. Then, once R22's serious injury was overtly communicated to the facility, nursing staff did nothing with the information for almost nine hours before contacting R22's physician who immediately sent her to the emergency room. Throughout this case, the circumstances surrounding the violations fall on the range of neglect or indifference at the very least: the CNA who allowed R22 to fall did not ask a second CNA for assistance because she was unable to locate another assistant, the charge nurse who did not communicate the radiology results immediately because she was busy with homework, and nearly identical violations witnessed during the resurvey that were far more than simply the result of the CNA's nervousness. The CMP range for immediate-jeopardy level noncompliance is from $3,050 to $10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). The lower range of CMP, from $50 per day to $3000 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). Here CMS imposed a penalty of $4,050 per day, during the immediate jeopardy findings and $100 per day, during the period of substantial noncompliance- both are at the lower end of the allowable ranges. Given that the noncompliance was very serious, and that those violations continued, the $4,050 and $100 per day CMP's are reasonable.

V. Conclusion

For the reasons discussed above, I find that Petitioner's facility was not in substantial compliance with Medicare participation requirements and that its noncompliance posed immediate jeopardy to resident health and safety. I find that a $4,050 per day CMP, from January 30 through March 4, 2011, and a $100 per day CMP, from March 5 through April 3, 2011, is reasonable.

/s/
Richard J. Smith
Administrative Law Judge