Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Wellington Specialty Care & Rehabilitation Center,	)	Date: September 15, 1998
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-97-252
	)	Decision No. CR548
Health Care Financing Administration.	)	
	)	

DECISION

I decide that the Health Care Financing Administration (HCFA) is authorized to impose civil money penalties against Petitioner, Wellington Specialty Care & Rehabilitation Center, in the following amounts: $10,000 per day for the period beginning with February 5, 1997, and running through February 27, 1997; $3,000 per day for the period beginning with February 28, 1997, and running through April 16, 1997; and $1,500 per day for the period beginning with April 17, 1997, and running through May 21, 1997. Briefly summarized, my decision is as follows:

- HCFA established that, for the period beginning February 5, 1997, and running through February 27, 1997, Petitioner was not complying with a federal participation requirement to the extent that residents of Petitioner suffered or were likely to suffer serious injury, harm, impairment or death. Petitioner failed to implement a written policy to protect its residents from neglect. Petitioner's dereliction of care caused a resident to die by strangulation as a consequence of becoming entrapped in the side rails of her bed.

- Petitioner had received written warnings about the dangers to residents posed by unprotected bed side rails. Petitioner's staff had recommended that the resident who was fatally injured be protected from possible entrapment in her bed side

rails. Barely a week before the incident which proved to be fatal, this resident had become entrapped in her bed side rails. Petitioner did essentially nothing to protect the resident from entrapment, despite receiving all of these warnings.

• Petitioner failed to protect other residents from the risk of entrapment in bed side rails. These residents were placed at risk of severe injury or death due to Petitioner's failure to take measures to protect them.

• The egregiousness of Petitioner's noncompliance with participation requirements, coupled with Petitioner's reckless disregard for the welfare of its residents, justifies the imposition of a $10,000 per day civil money penalty against Petitioner for each day of the period which begins on February 5, 1997, and which runs through February 27, 1997.

• HCFA established that Petitioner continued to fail, after February 27, 1997, to implement a policy to prevent neglect of residents, although this continued failure was at a level that was less than the level of immediate jeopardy. Petitioner continued to fail to assure that its residents were protected from the possibility of injury from bed side rails.

• During the period beginning with February 10 - 13, 1997, and continuing through April 16, 1997, Petitioner was deficient in numerous respects, in addition to its failure to implement a policy to prevent neglect of residents. Petitioner provided care of a substandard quality to its residents in four areas. These areas included failures by Petitioner to: provide its residents with necessary social services; prevent the development of or appropriately treat pressure sores; give its residents adequate supervision and assistance devices so as to prevent avoidable accidents; and plan and effectuate adequate nutrition of residents.

• These deficiencies, which persisted after February 27, 1997, are a basis for imposing civil money penalties against Petitioner in addition to the penalties imposed for the period from February 5 - 27, 1997. It is reasonable to impose a $3,000 per day civil money penalty against Petitioner for each day during the period which begins on February 28, 1997, and which ends on April 16, 1997. I base these penalties on, among other factors, the egregiousness of the deficiencies that Petitioner manifested during the period and on its culpability.

• Petitioner continued to be deficient in numerous respects after April 16, 1997. These deficiencies included deficiencies that had been identified previously at the February 10 - 13, 1997 survey of Petitioner, and which Petitioner failed to correct by April 16, 1997. They included also deficiencies not previously identified.

• Petitioner did not prove that it corrected these continuing and additional deficiencies before May 21, 1997. A basis therefore exists to impose a civil money penalty against Petitioner for each day of the period which begins on April 17, 1997, and which runs through May 21, 1997.

• The deficiencies which persisted after April 16, 1997, and which continued through May 21, 1997, are a basis for imposing civil money penalties against Petitioner for each day of the April 17 - May 21, 1997 period. These civil money penalties are in addition to those which I have authorized for the periods which begin on February 5, 1997, and end on February 27, 1997, and which begin on February 28, 1997, and end on April 16, 1997. It is reasonable to impose a civil money penalty against Petitioner of $1,500 per day for each day of the April 17 - May 21, 1997 period. I base this conclusion, in part, on the seriousness of the deficiencies that persisted at Petitioner's facility, the relationship of deficiencies to other deficiencies, and on Petitioner's history of deficiencies.

I. Background

A. Background facts

The background facts which I recite here are not disputed by the parties. Petitioner is a long-term care facility. Petitioner is a participating provider in the Medicare program. It is subject to provisions of the Social Security Act which govern the participation in Medicare of long-term care facilities.

Petitioner was surveyed on February 5, 1997, by surveyors employed by the State of Florida Agency for Health Care Administration (Florida State survey agency). See Tr. at 161. The survey was prompted by an incident which I have summarized briefly above, in which a resident of Petitioner became entrapped in the side rails of her bed, resulting in the resident's death by strangulation. The surveyors who conducted the survey issued a report in which they concluded that Petitioner was not complying substantially with a federal participation requirement. HCFA Ex. 1. The surveyors found Petitioner's noncompliance to be so severe as to pose immediate jeopardy to residents of Petitioner.

The surveyors returned to Petitioner's facility from February 10 - 13, 1997, to conduct a comprehensive survey. The surveyors found Petitioner not to be complying with 26 participation requirements. They found Petitioner to be providing substandard care in four separate areas. HCFA Ex. 8; Tr. 163. The surveyors did not survey Petitioner on this occasion to determine whether Petitioner had removed the immediate jeopardy to its residents which the surveyors had found on February 5, 1997.

The surveyors resurveyed Petitioner on February 28, 1997, to determine whether Petitioner had removed the immediate jeopardy to its residents that the surveyors had found on February 5, 1997. HCFA Ex. 12. The surveyors determined at this visit that the immediate jeopardy had been removed. However, they concluded also that Petitioner's residents remained at risk for harm, albeit at a level of severity that was less than immediate jeopardy, due to Petitioner's failure to rectify completely problems relating to the use of bed side rails. Id.; HCFA Ex. 14.

The surveyors made a fourth visit to Petitioner's facility on April 15 - 17, 1997. On this occasion the surveyors found that Petitioner had not yet attained compliance with 14 participation requirements (11 of which were cited at the survey of February 10 - 13). HCFA Ex. 17. In one area, the level of care that Petitioner was providing to its residents was found by the surveyors to be substandard. Id. Petitioner was found to have attained compliance with all participation requirements effective May 22, 1997.

HCFA accepted the surveyors' findings and, based on these findings, determined to impose civil money penalties against Petitioner as follows:

- For each day of the period beginning with February 5, 1997, and running through February 27, 1997, $10,000 per day, with a total penalty for the period of $230,000.

- For each day of the period beginning with February 28, 1997, and running through April 16, 1997, $3,000 per day, with a total penalty for the period of $144,000.

- For each day of the period beginning with April 17, 1997, and running through May 21, 1997, $1,500 per day, with a total penalty for the period of $52,500.

Petitioner requested a hearing, and the case was assigned to me for a hearing and a decision. I held a hearing in Tampa, Florida, on April 20 - 22, 1998. At this hearing, I received into evidence exhibits from HCFA (HCFA Ex. 1 - HCFA Ex. 29 and HCFA Exs. 31 and 32). I identified HCFA Ex. 30, but did not receive this exhibit into evidence. I also received into evidence exhibits from Petitioner (P. Ex. 1 - P. Ex. 5).

HCFA called the following witnesses to testify at the hearing:

- *Marsha L. Lisk, R.N.* (Tr. at 45 - 159). Ms. Lisk has been a registered nurse for approximately 35 years. She is employed by the Florida State survey agency. Ms. Lisk participated as a surveyor in the February 5, 1997 survey of Petitioner's

facility. She also participated in the February 10 - 13, 1997, February 28, 1997, and April 15 - 17, 1997 surveys of Petitioner's facility.

• *Ann M. Mehaffey, R.N.* (Tr. at 160 - 212). Ms. Mehaffey has been a registered nurse for 30 years. She is employed by the Florida State survey agency. Ms. Mehaffey served as the team leader for the surveyors who conducted the February 10 - 13, 1997 survey of Petitioner. Ms. Mehaffey also served as the team leader for the April 15 - 17, 1997 survey of Petitioner's facility.

• *Susanne Marie Emond* (Tr. at 213 - 241). Ms. Emond is a registered dietician and a licensed dietician with the State of Florida. Ms. Emond is employed by the Florida State survey agency. Ms. Emond participated in the February 10 - 13, 1997 survey of Petitioner. Ms. Emond also participated in the April 15 - 17, 1997 survey of Petitioner's facility.

• *Joanne Stewart* (Tr. at 248 - 329). Ms. Stewart is a social worker who is employed by the Florida State survey agency. Ms. Stewart participated in the February 10 - 13, 1997, and April 15 - 17, 1997 surveys of Petitioner's facility.

• *Patricia Ryan, R.N.* (Tr. at 329 - 370). Ms. Ryan has been a registered nurse for more than 20 years. She is employed by the Florida State survey agency. Ms. Ryan participated in the April 15 - 17, 1997 survey of Petitioner's facility.

• *Alice Adler* (Tr. at 375 - 395). Ms. Adler is a program administrator for the Tampa office of the Florida State survey agency. She testified in her capacity as the supervisor of the individual surveyors who testified on behalf of HCFA.

• *Richard James* (Tr. at 396 - 406). Mr. James is the chief of the Survey and Certification Operations Branch for HCFA's Atlanta Regional Office.

Petitioner called the following witnesses to testify at the hearing:

• *Roseanne McDonnell, L.P.N.* (Tr. at 437 - 598). Ms. McDonnell is a licensed practical nurse who is employed by Petitioner. She is a unit manager for Petitioner. She manages a wing of Petitioner's facility.

• *Renate N. Hudson* (Tr. at 598 - 632). Ms. Hudson is a consulting dietician who has been a registered dietitian since 1979. She has a master's degree in administration dietetics. Ms. Hudson's consulting duties include consulting as to the management of food service in long-term care facilities. I accepted Ms. Hudson as an expert witness in the field of nutrition.

• *Cheryl F. Thurber, R.N.* (Tr. at 632 - 679). Ms. Thurber has been a registered nurse for 20 years. She currently is a nurse-consultant. Her current duties include assisting long-term care facilities with monitoring resident care; developing systems and assisting in the implementation of those systems; assisting in the hiring and training of staff at long-term care facilities; and miscellaneous consulting concerning nursing, delivery of care, and staffing at long-term care facilities. I accepted Ms. Thurber as an expert witness in the field of long-term care nursing.

• *Theresa S. Vogelpohl, R.N.* (Tr. at 680 - 760). Ms. Vogelpohl is a registered nurse with a master's degree in gerontological rehabilitation. She has six years' experience in caring for people with dementia. She has written several publications which address the care that is given to people with dementia. She has also written a publication on pressure ulcers. I accepted Ms. Vogelpohl as an expert witness in the field of gerontological nursing.

B. Summary of the governing law

Under both the Act and applicable regulations, Petitioner is classified as a long-term care facility. In order to participate in Medicare, a long-term care facility must comply with federal participation requirements. The statutory requirements for participation by a long-term care facility are contained in the Act, at sections 1819 and 1919. Regulations which govern the participation of a long-term care facility are published at 42 C.F.R. Part 483.

Sections 1819 and 1919 of the Act give the Secretary of the United States Department of Health and Human Services (Secretary) authority to impose against a long-term care facility a civil money penalty for failure by the facility to comply substantially with participation requirements. These sections state, in effect, that the Secretary's authority to impose a civil money penalty against a long-term care facility is the same as the civil money penalty authority that is conferred on the Secretary under section 1128A of the Act. Act, sections 1819(h)(2)(B)(ii); 1919(h)(3)(C)(ii). Both sections 1819 and 1919 state that: "The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty . . . [imposed under either section 1819 or 1919] in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a)." Id.

The Secretary has delegated to HCFA and the States the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. 42 C.F.R. Part 488. The Part 488 regulations provide that facilities which participate in Medicare may be surveyed on behalf of HCFA by State

survey agencies in order to ascertain whether the facilities are complying with participation requirements. 42 C.F.R. §§ 488.10 - 488.28. The regulations contain special survey provisions for long-term care facilities. 42 C.F.R. §§ 488.300 - 488.335. Under the Part 488 regulations, a State or HCFA may impose a civil money penalty against a long-term care facility where a State survey agency ascertains that the facility is not complying substantially with participation requirements. 42 C.F.R. §§ 488.406, 488.408, 488.430. The penalty may be imposed for each day that the facility is out of compliance. Id.

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

The terms "substantial compliance" and "immediate jeopardy" are defined terms in the regulations which govern participation of long-term care facilities in Medicare. "Substantial compliance" is defined 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. "Immediate jeopardy" is defined to mean:

> 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.

There are additional factors which the State and HCFA consider in determining where within a range of penalties, once the range is established, the amount of a penalty should be. These include the facility's: (1) history of noncompliance, including repeated deficiencies; (2) financial condition; and (3) culpability for the deficiencies. 42 C.F.R. § 488.438(f). Additionally, the State and HCFA may consider factors specified in 42

C.F.R. § 488.404. These include the relationship that a deficiency may have to other deficiencies, and a facility's prior history of deficiencies.

A civil money penalty which falls within the lower range of penalties may not be increased to the upper range based on the presence or absence of factors described in 42 C.F.R. §§ 488.404 and 488.438(f), unless the deficiency at issue is a repeated deficiency. And, a civil money penalty which falls within the upper range of penalties may not be decreased to the lower range based on the presence or absence of factors described in 42 C.F.R. §§ 488.404 and 488.438(f). However, once the range of a penalty is fixed (either upper or lower) the factors described in 42 C.F.R. §§ 488.404 and 488.438(f) become important in determining where within that range the penalty will be established. And, those factors and only those factors must be considered by an administrative law judge in any case where the amount of a civil money penalty is challenged. 42 C.F.R. § 488.438(e).

A long-term care facility against whom HCFA has determined to impose a civil money penalty is entitled to a hearing before an administrative law judge at which the facility may contest HCFA's determination. Act, section 1128A(c); 42 C.F.R. §§ 488.408(g), 498.3(b)(12),(13); see 42 C.F.R. § 488.438(e). A relevant part of section 1128A of the Act provides that the Secretary shall not impose a civil money penalty against an individual or entity until that individual or entity has been given written notice and an opportunity for the Secretary's determination to be made on the record after a hearing at which the individual or entity is entitled to be represented by counsel, to present witnesses, and to cross-examine adverse witnesses. Act, section 1128A(c)(2). This right to a hearing under section 1128A has been interpreted uniformly to confer on a party against whom the Secretary has determined to impose a civil money penalty a right to a de novo hearing. Anesthesiologists Affiliated, et al., DAB CR65 (1990), aff'd 941 F.2d 678 (8th Cir. 1991); Tommy G. Frazier, DAB CR79 (1990), aff'd 940 F.2d 659 (6th Cir. 1991); Berney R. Keszler, M.D., et al., DAB CR107 (1990).

In a de novo hearing in a case involving a determination to impose a civil money penalty against a party, the party against whom a civil money penalty determination is made is afforded the right to contest both the determination of misconduct which is the basis for the penalty and the amount of the proposed penalty. In such a case, the administrative law judge has authority to impose a penalty that is for an amount which is less than that which the agency determines to impose where the amount that is determined by the agency is not reasonable.

There are potentially two issues to be heard and decided in a case where a long-term care facility requests a hearing before an administrative law judge from a determination by HCFA to impose a civil money penalty against the facility. The first issue is whether the

facility was not complying substantially with federal participation requirements on the date or dates for which HCFA determined to impose a civil money penalty. The second issue is, assuming that noncompliance is established, whether the amount of the penalty imposed by HCFA is reasonable. 42 C.F.R. §§ 488.408(g), 498.3(b)(12), (13); see 42 C.F.R. § 488.438(e). The issue of the reasonableness of the penalty is not reached unless there is a finding of substantial noncompliance on which a penalty may be predicated. Id.

In a civil money penalty case, a long-term care facility has the burden of overcoming, by a preponderance of the evidence, any prima facie case that HCFA might make that the facility is not complying substantially with federal participation requirements. Hillman Rehabilitation Center, DAB No. 1611 (1997). A long-term care facility potentially bears an additional burden of proof where it challenges the level of the deficiency determined by HCFA. The facility must prove that HCFA's determination of the level of noncompliance is clearly erroneous if the record of the case establishes that the facility is not complying substantially with a participation requirement that is the basis for HCFA's civil money penalty determination. 42 C.F.R. § 498.60(c)(2) (this regulation was formerly published as 42 C.F.R. § 498.61(b)). The facility would not have to meet this additional burden in a case where it was able to prove by a preponderance of the evidence that it was complying substantially with the participation requirement or requirements on which HCFA premised its civil money penalty determination.

II. Issues, findings of fact and conclusions of law

A. Issues

The issues in this case are whether:

1. A basis exists to impose civil money penalties against Petitioner.

2. The amounts of the penalties that HCFA determined to impose against Petitioner are reasonable.

B. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I state each Finding, below, as a separate heading. I discuss each Finding in detail.

As I discussed above, at Part I.A. of this decision, HCFA's determinations to impose civil money penalties against Petitioner are based on the findings that Florida State survey agency surveyors made at four compliance surveys of Petitioner. These surveys occurred on the following dates: February 5, 1997; February 10 - 13, 1997; February 28, 1997;

and April 15 - 17, 1997. It was at the February 5, 1997 survey that surveyors found that Petitioner was not complying with participation requirements such as to cause immediate jeopardy to its residents. The February 10 - 13, 1997 survey did not address the question of whether Petitioner had removed the immediate jeopardy to its residents. That survey was a general compliance survey which looked at participation requirements other than those which had been addressed at the February 5, 1997 survey. The question of removal of immediate jeopardy was addressed separately at the February 28, 1997 survey. The April 15 - 17, 1997 survey addressed the question of whether Petitioner had corrected deficiencies that the surveyors identified at the February 10 - 13, 1997 survey.

There is some overlap of the findings that the surveyors made. The findings of deficiencies that were made at the February 10 - 13, 1997 survey overlap the finding of immediate jeopardy that was made at the February 5, 1997 survey. The surveyors found that the immediate jeopardy was not removed until February 28, 1997. That is 15 days after the completion of the February 10 - 13 survey at which additional deficiencies were found.

I have examined closely all of the evidence which relates to each of the four surveys in order to decide whether and when Petitioner was not complying with participation requirements and to decide whether and in what amount civil money penalties may be imposed against Petitioner. I discuss in my Findings, where it is necessary, the results of the individual surveys, whether the results are supported by the evidence of record, and whether Petitioner has met its burden to overcome the findings that the surveyors made. I do not discuss systematically each conclusion that the surveyors made about Petitioner's compliance at each survey. To do so would overwhelm this decision with unnecessary details. Instead, I have discussed every survey conclusion that affects the outcome of this case. No evidence which I omit to discuss in this decision is such that it would change the outcome of the case.

> ***1. As of February 5, 1997, Petitioner had failed to implement a written policy to prevent the neglect of its residents to the extent that its residents were in immediate jeopardy.***

Residents of Petitioner were at risk of serious injury or death resulting from injuries caused by entrapment in unprotected bed side rails. Petitioner knew about this risk and yet failed to act to protect its residents. As a consequence, residents were left unprotected, and one resident, identified as Resident 1 in the report of the February 5, 1997 survey of Petitioner, died. Petitioner's inaction in the face of known risks to its residents is a failure by it to implement a written policy to prevent the neglect of its residents (P. Ex. 1 at 7) in contravention of the requirements of 42 C.F.R. § 483.13(c).

Petitioner's dereliction of care towards its residents was so egregious as to place residents in immediate jeopardy.

The Hillman decision imposes on Petitioner the burden of proving by a preponderance of the evidence that it was complying substantially with participation requirements, assuming that HCFA establishes a prima facie case of noncompliance. Here, the evidence establishes more than a prima facie case of noncompliance by Petitioner. The preponderance of the evidence – indeed, the overwhelming weight of the evidence – is that, as of February 5, 1997, Petitioner had not implemented a policy to prevent neglect.

Under applicable regulations, once noncompliance is established, it is Petitioner's burden to prove that HCFA's determination of the level of a deficiency – immediate jeopardy in this case – is clearly erroneous. 42 C.F.R. § 498.60(c)(2). Petitioner did not prove to be clearly erroneous HCFA's determination that Petitioner's noncompliance as of February 5, 1997, placed its residents in immediate jeopardy. Indeed, the weight of the evidence plainly shows that Petitioner's residents were in immediate jeopardy as of February 5, 1997, due to Petitioner's failure to implement a policy to prevent neglect.

a. Petitioner's neglect of Resident 1 caused the death of that resident.

Petitioner egregiously neglected Resident 1. Petitioner's failure to provide necessary goods and services to the resident caused the resident's death on February 3, 1997, by strangulation in the side rails of the resident's bed. See 42 C.F.R. § 488.301 (defining "neglect").

Resident 1 was a severely demented individual who manifested restlessness and frequent movement while in bed. HCFA Ex. 29 at 13. Her bed had side rails, as did the beds of many of the residents in Petitioner's facility. See P. Ex. 1 at 11 - 153. I take notice that side rails are frequently used in long-term care facilities as safety devices to prevent residents of the facilities from falling out of their beds.

However, side rails can be dangerous to residents of long-term care facilities. There exists a risk that some residents under certain circumstances may suffer injuries from side rails. HCFA Ex. 29 at 16 - 18. On occasion, individuals have become wedged in the gaps between side rails, resulting in injuries or death to those individuals. Id. The dangers posed by side rails impose on long-term care facilities a duty to assess and address the risks of using side rails. It may be necessary for a facility to pad side rails in an appropriate case in order to reduce the gaps between the side rails so as to eliminate the risk that an individual might be injured by becoming wedged between side rails. Id. at 17.

Petitioner was on notice about the dangers that side rails potentially posed to its residents. On August 21, 1995, the Food and Drug Administration (FDA) sent an "Alert" to hospitals and long-term care facilities which warned them of the dangers that bed side rails posed. HCFA Ex. 29 at 16 - 18. This Alert stated that, since January, 1990, the FDA had received 102 reports of incidents involving entrapment of individuals in hospital bed side rails. Id. at 16. The FDA noted that it had received reports of 68 deaths, 22 injuries, and 12 entrapments without injuries occurring in hospitals, long-term care facilities, and private homes. Id. The Alert made it plain that this was a general warning about the dangers posed by bed side rails and not a warning that focused on a specific manufacturer's bed. Id. It specifically warned users of beds with side rails about the possibility of injuries occurring to individuals who are particularly at risk of entrapment. "Such patients included those with *altered mental status . . . or general restlessness.*" Id. at 17 (emphasis added). In such instances, it was recommended that bed side rail protective barriers be installed according to the manufacturers' instructions for such devices. Id.

I find that Petitioner received this warning and was on notice of its contents at least six months prior to the strangulation death of Resident 1. The credible evidence is that Petitioner was on the FDA's mailing list and that the FDA sent the Alert to Petitioner as part of its general circulation of the Alert. HCFA Ex. 31. Petitioner also was advised about the Alert in May, 1996, by a risk management firm. HCFA Ex. 29 at 15; Tr. at 80, 117. This memorandum included a copy of the FDA Alert. Id. Furthermore, the risk management firm, separately from the FDA, emphasized the need to install protective barriers for side rails in appropriate cases. The cover memorandum from the risk management firm "highly encourage(s)" Petitioner to utilize protective barriers on side rails for residents who might be at risk for entrapment, "particularly Alzheimer's patients, [and] those suffering from some sort of dementia . . . ." HCFA Ex. 29 at 15.

Petitioner argues that the warnings it received from the FDA and from the risk management firm addressed only the dangers that bed side rails posed in *hospital-type* beds and not in the kinds of beds that Petitioner used. Petitioner asserts that it was not put on notice that its beds might be dangerous. I find this argument to be unpersuasive. On its face, the FDA Alert is so broadly worded as to caution the users of any type of bed side rails that the devices might be dangerous. Petitioner has not offered credible or persuasive evidence to show that the type of side rails that its beds utilized were meaningfully different from side rails in "hospital type" beds. Moreover, there is no evidence that, when Petitioner received the warnings about the dangers posed by side rails, Petitioner actually assessed its beds for potential risks and decided that they were not potentially dangerous because they were not "hospital-type" beds.

Petitioner not only had been warned that bed side rails posed a potential for risk to demented residents, but it was aware, months prior to the death of Resident 1, that Resident 1 was at high risk for injury from bed side rails. Petitioner knew that Resident 1, a severely demented and restless individual, was the type of resident whom the FDA had found to be particularly at risk for injury from entrapment in bed side rails. See HCFA Ex. 29 at 17.

Petitioner's staff had assessed the resident's condition and determined that the resident was at risk for injury from side rails. A plan of care for the resident, which the facility developed in May, 1996, noted that the resident was restless in bed. The resident's dementia and agitation created a risk that the resident could unknowingly wedge herself between the bed's side rails. Petitioner planned to deal with this risk by padding the side rails of the resident's bed. HCFA Ex. 29 at 13; Tr. at 56 - 57.

Petitioner failed to pad the side rails on the bed of Resident 1, notwithstanding the warnings it had received about the risks posed to residents by bed side rails and, further, notwithstanding its own staff's conclusion that the resident needed to have her side rails padded. On January 25, 1997, Resident 1 wedged her head between her bed's side rails. HCFA Ex. 29 at 4. On this occasion, the resident was not injured. Notwithstanding, Petitioner failed to take any meaningful action which would prevent the possibility of the event reoccurring in the future.

The nurse who discovered Resident 1's plight on January 25, 1997, removed the resident's head from the side rails. HCFA Ex. 29 at 4. The nurse put pillows next to the side rails. HCFA Ex. 4 at 5. Aside from this action, nothing was done by Petitioner to protect Resident 1. No incident report was prepared detailing what had happened to the resident. No reassessment was made of the resident's condition. Tr. at 55, 59 - 60, 501 - 502. And, the resident's bed side rails remained un-padded.

The unsurprising consequence of this inaction by Petitioner, in the face of a clear threat to the safety of Resident 1, is that on February 3, 1997, the resident again wedged her head between the side rails of her bed. HCFA Ex. 29 at 5 - 6. This time, the event had fatal consequences.

The death of Resident 1 was the direct consequence of Petitioner's failure to attend to the resident's need to have her bed side rails protected. The resident would not have died had Petitioner taken seriously the warnings it received about the dangers to demented patients and residents that are posed by bed side rails. Nor would the resident have died had Petitioner followed through on its staff's assessment of the resident's needs. And, the resident would certainly not have died had Petitioner reacted appropriately to the first episode in which Resident 1 wedged her head between her bed's side rails.

Petitioner makes several arguments about its care of Resident 1 in an effort to show that it did not neglect the needs of the resident. I find these arguments not to be persuasive. First, Petitioner asserts that its May, 1996 care plan for Resident 1, in which Petitioner determined that padding the resident's side rails was necessary, was out of date. Petitioner's posthearing brief at 3; Tr. at 443. Petitioner asserts that padding the side rails was not necessary and that using pillows as a barrier against entrapment was a more effective strategy. Petitioner's posthearing brief at 3 - 4. I find that this argument is refuted by the weight of the evidence. There is no evidence to suggest that the resident's condition had changed since May, 1996, when Petitioner's staff had determined that padding the side rails was necessary. Furthermore, padding the bed's side rails was precisely the corrective action that both the FDA and the risk management firm had advised Petitioner to be necessary in the cases of demented and agitated residents such as Resident 1. And, obviously, placing pillows against the resident's side rails did not prevent the resident from entrapment and death by strangulation.

Petitioner argues that there is no evidence that Resident 1's overall care was of less than acceptable quality. Petitioner's posthearing brief at 4 - 5. That may be true but it is irrelevant. The overall quality of care that the resident may have received begs the question of whether Petitioner neglected to protect the resident from the hazard posed by side rails.

Petitioner argues additionally that bed side rails pose only negligible risks to residents. Petitioner's posthearing brief at 5. But, this assertion is belied by the weight of the evidence in this case which establishes that bed side rails pose a hazard to demented and restless residents. The strangulation of Resident 1 was not a freak occurrence. It was a reasonably predictable consequence of the resident's dementia and restlessness coupled with Petitioner's exposure of the resident to unprotected bed side rails. See HCFA Ex. 29 at 16 - 18.

b. Petitioner's neglect of Resident 1 is an example of Petitioner's overall failure to assure that its residents were protected from the risks posed by bed side rails.

Petitioner's failure to recognize that Resident 1 was at risk for injury or death due to the use of unprotected bed side rails is an example of Petitioner's failure in general to recognize and to address the risks that bed side rails posed to the health and safety of its residents. The death of Resident 1 was not a unique episode so much as it was a culmination of Petitioner's overall failure to assure that its residents were protected from the risks posed by bed side rails. Petitioner neglected to consider the risks which bed side rails posed to residents other than Resident 1. None of these other residents suffered injuries as a consequence of Petitioner's neglect of their needs. But, it is evident that at

least some of these residents faced hazards that were similar or identical to those which caused the demise of Resident 1.

I note Petitioner's argument that the surveyors scoped the immediate jeopardy as an isolated deficiency and not as a pattern of deficiencies or widespread deficiencies. Petitioner's posthearing brief at 9 - 10. I do not accept Petitioner's conclusion that this categorization is consistent with a determination that the immediate jeopardy situation existed only with respect to Resident 1, or its inference that I should not consider any risk to the other residents cited in the HCFA form 2567. HCFA Ex. 1. This hearing is de novo, and I am authorized to evaluate the scope of the deficiency. 42 C.F.R. § § 488.404, 488.438(e)(3) and (f). Thus, I am authorized to make my own determination as to the scope of the deficiency as it affects residents other than Resident 1. However, it is also apparent from the record that Petitioner has not been prejudiced here. Petitioner had notice that the surveyors intended the immediate jeopardy determination to apply to residents other than Resident 1. The surveyors considered that immediate jeopardy existed with respect to other residents in Petitioner's facility, as was detailed early on in the initial HCFA form 2567 that was received by Petitioner. HCFA Exs. 1, 5. Further, HCFA put Petitioner on notice during the deposition of Ms. Lisk that it intended the scope to be greater than that initially recorded in the HCFA form 2567. P. Ex. 5 at 49 - 50.

The surveyors who visited Petitioner's facility on February 5, 1997, determined that there were two other residents who were at risk because of gaps between their bed side rails and their beds. HCFA Ex. 1. These residents were identified in the report of the February 5, 1997 survey as Residents 10 and 20. HCFA Ex. 1; 4 at 28; Tr. at 77.

Furthermore, by Petitioner's own admission, by February 5, 1997, it had identified 16 additional residents who were at risk for entrapment in their bed side rails. HCFA Ex. 4 at 7; Tr. at 51 - 54. The criteria which Petitioner used to make these identifications were quite similar to those identified in the FDA Alert as putting residents and patients at risk. See HCFA Ex. 29 at 16 - 18. Petitioner identified residents who had diminished mental capacity, were restless, and were small in size, as being those who were at risk for entrapment in bed side rails. HCFA Ex. 4 at 7; Tr. at 51 - 54. Petitioner decided to undertake measures to protect these residents from entrapment. Tr. at 53. However, these measures had not been accomplished by the time the Florida State survey agency surveyors left Petitioner's facility on February 5, 1997. Tr. at 74 - 76.

Petitioner argues that it had, in fact, assessed all of its residents to determine their need for side rails. Petitioner's posthearing brief at 5. But, the fact that residents had been assessed to determine whether they may have needed side rails begs the question whether

Petitioner assessed these residents for the possibility that any of them might be injured by side rails. In fact, Petitioner concedes that it did not conduct such assessments prior to February 5, 1997. Id.; Tr. at 440, 643, 689.

Petitioner argues strenuously that adverse inferences should not be drawn against it from the fact that it assessed its residents for possible risk of harm from entrapment in bed side rails. Petitioner's reply brief at 1 - 5. Petitioner asserts that, under the Federal Rules of Evidence, evidence of corrective actions taken by a party after an event may not be used to prove culpability for the event. Id. at 2. Furthermore, according to Petitioner, the fact that it conducted assessments is proof that it showed an unusual degree of concern for the welfare of its residents and is not evidence that suggests dereliction of care by Petitioner.

I am not persuaded that rules of evidence would bar this evidence from consideration. The "culpability" which is demonstrated by the evidence which relates to the risk assessments performed by Petitioner after the strangulation death of Resident 1 is Petitioner's culpability for a risk of harm to residents other than Resident 1. The evidence relates to a broader issue than Petitioner's culpability for the death of Resident 1. The evidence is relevant to the question of whether circumstances prevailed at Petitioner's facility which put residents other than Resident 1 at risk. And, as I discuss below at Finding 2, it is relevant to the question of whether Petitioner took remedial actions prior to February 27, 1997, to eliminate the immediate jeopardy which prevailed at its facility.

Nor am I persuaded that the fact that Petitioner assessed residents other than Resident 1 shows that Petitioner was demonstrating an extraordinary degree of concern for the welfare of its residents. Petitioner was on notice prior to conducting the assessments of residents other than Resident 1 that there might be other residents who were at risk for entrapment injuries. The fact that Petitioner did perform the assessments evidences no extraordinary concern by Petitioner for its residents' welfare. Under the circumstances, failure by Petitioner to perform the assessments would have constituted a total abdication by Petitioner of responsibility for its residents' safety and welfare.

Between February 7 and February 10, 1997, Petitioner's staff assessed over 140 residents to determine whether any of these residents were at risk for injury from bed side rails. P. Ex. 1 at 11 - 153. It is not clear whether any of these residents are in addition to or include the 16 residents whom Petitioner had identified as of February 5, 1997, as being at risk for entrapment. See Tr. at 518 - 519. The assessments which Petitioner's staff performed showed that several of these residents were at a risk for harm from unprotected side rails. The fact that several of Petitioner's residents were found to be exposed to the same risk as was Resident 1 establishes that, in the period of time leading up to and including February 5, 1997, there was a general failure by Petitioner to

recognize the risk posed to residents by bed side rails and to take corrective action to protect these residents. Examples of residents found by Petitioner's staff to be at risk for harm from unprotected bed side rails include: the resident in Room 11A of Petitioner's facility (P. Ex. 1 at 31); the resident in Room 28B of Petitioner's facility (Id. at 66); the resident in Room 40A of Petitioner's facility (Id. at 86); the resident in Room 40B of Petitioner's facility (Id. at 87); the resident in Room 46A of Petitioner's facility (Id. at 94); the resident in Room 47B of Petitioner's facility (Id. at 95); and, the resident in Room 87A of Petitioner's facility (Id. at 149).

c. Petitioner's failure to assure that its residents were protected from the risks posed by bed side rails was noncompliance with the requirement that it implement a written policy to prevent the neglect of its residents.

The Florida State survey agency surveyors concluded, at Tag 224 of the report of the February 5, 1997 survey of Petitioner, that Petitioner had failed substantially to comply with the requirements of 42 C.F.R. § 483.13(c). This regulation requires a long-term care facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. Petitioner's neglect of its residents, as is demonstrated by its failure to assure that its residents were protected from the risks posed by bed side rails, establishes that Petitioner was not complying with the requirements of the regulation as of February 5, 1997.

Petitioner had a written policy to prevent neglect of its residents. P. Ex. 1 at 7 - 8. But, it is manifest from the evidence that this policy was not implemented by Petitioner, because Petitioner failed to protect its residents from possible injuries from bed side rails. Petitioner tolerated a series of neglectful acts, beginning with the failure by Petitioner to apply to Resident 1 the advice that Petitioner had received in the FDA Alert, continuing with the failure of Petitioner to implement its own staff's plan of care for the resident, and culminating with the resident's death due to Petitioner's neglect. Even after the death of Resident 1, other residents were found to have been at the same or similar risk of injury from unprotected bed side rails as was Resident 1.

d. Petitioner's failure to implement its written policy to prevent neglect of its residents placed residents in immediate jeopardy.

The degree of actual or potential harm caused to residents of Petitioner by Petitioner's failure to implement its policy to prevent neglect was at the level of immediate jeopardy to those residents. Petitioner's noncompliance caused, or was likely to cause, residents to suffer serious injury, harm, impairment, or death. See 42 C.F.R. § 488.301. That is evident from the death of Resident 1, which was due directly to the neglect of that

resident by Petitioner. It is also evident from Petitioner's disregard of the warnings that it received concerning the potential for harm due to the utilization of unprotected bed side rails. Finally, it is evident from the fact that residents other than Resident 1 were also at risk of harm and were neglected by Petitioner.

Petitioner argues that, as a matter of policy, HCFA does not make a finding that immediate jeopardy exists unless a deficiency has either caused harm or unless there is a high probability that such harm is likely to occur in the very near future. Petitioner's posthearing brief at 9. Petitioner bases this assertion on language that is present in the State Operations Manual, a policy guide, which HCFA sends to State survey agencies. Petitioner contends that there could not be a legitimate finding of immediate jeopardy in this case because there allegedly is no credible evidence that there was a high probability of serious harm occurring to other residents after February 3, 1997, when Petitioner discovered the death of Resident 1 and addressed the circumstances which caused the resident's death. Id.

I disagree with this assertion. There is overwhelming evidence that Petitioner's neglect of Resident 1 caused the death of that resident. And, as I discuss below at Finding 2, Petitioner has not shown that it addressed adequately the derelictions of care which caused Resident 1's death, either by February 5, 1997, or in the weeks that ensued leading up to and including February 27, 1997.

> ***2. Petitioner's failure to implement its policy to prevent neglect of residents continued at a level of immediate jeopardy through February 27, 1997.***

The Florida State survey agency surveyors resurveyed Petitioner on February 28, 1997, to determine whether Petitioner had eliminated the immediate jeopardy to its residents which resulted from Petitioner's failure to implement its policy to prevent neglect of residents. See HCFA Ex. 12. The surveyors concluded that immediate jeopardy no longer existed as of February 27, 1997. HCFA Ex. 12. But, they concluded that after February 27, 1997, Petitioner continued to fail to implement a policy to prevent neglect, albeit at a level that was less than immediate jeopardy, in that Petitioner continued to fail to address adequately the risks posed to its residents from bed side rails. Id.

A provider has the ultimate burden of proving by a preponderance of the evidence that it is not failing to comply with a participation requirement where HCFA first establishes a prima facie case of noncompliance by that provider. It follows from that rule that the burden is on the provider to prove by a preponderance of the evidence that it has rectified its noncompliance where a finding of noncompliance is made by HCFA against the provider. I find at Finding 1 in this decision that Petitioner was not complying with the

requirement that it implement a written policy to prevent neglect of its residents effective February 5, 1997. I find additionally at Finding 1 that Petitioner's noncompliance as of February 5, 1997, was at the immediate jeopardy level. Petitioner therefore is presumed to remain noncompliant with the requirement that it implement its policy to prevent neglect at the immediate jeopardy level for each day after February 5, 1997, until it proves otherwise or until HCFA determines that immediate jeopardy no longer is present.

Petitioner asserts that it undertook "extraordinary measures" immediately after February 5, 1997, to assure that its residents were protected adequately from any risks that might be posed by bed side rails. Petitioner's posthearing brief at 7. According to Petitioner, these allegedly extraordinary measures consisted of the following actions:

- All of Petitioner's residents were reassessed concerning the extent that they were at risk from side rails.

- Padding was put on a large number of residents' side rails.

- The staff on all shifts of employees at Petitioner's facility were immediately given in-service training concerning side rail use.

- A single employee on each shift was assigned exclusively to make rounds to check on the status of residents for whom side rails were employed.

I am not satisfied that Petitioner removed the immediate jeopardy to its residents prior to February 28, 1997, notwithstanding Petitioner's assertion that it took extraordinary measures to protect its residents. The finding of immediate jeopardy in this case is a finding that at least some of Petitioner's residents were at risk for serious harm or death from bed side rail entrapment as of February 5, 1997. It was incumbent on Petitioner, as a prerequisite to eliminating that risk, to identify those residents. Petitioner did that. But, Petitioner was obligated to do more than to identify those residents who were at risk. In order to eliminate the risk, Petitioner had to carry out the remedial actions that were necessary to protect those residents who were in jeopardy. These necessary actions included padding the bed side rails of all of the residents whom Petitioner had identified as being at risk from possible entrapment in bed side rails. Petitioner did not prove that it did that prior to February 28, 1997.

As HCFA notes in its posthearing brief, I held an on-the-record colloquy with counsel for Petitioner during the hearing of this case in which I expressed concern that Petitioner needed either to prove that it had completed the remedial actions suggested by the post-February 5, 1997 survey assessments, or that it prove that remedial actions were unnecessary. HCFA's posthearing brief at 23 - 25; Tr. at 527 - 529. Counsel for

Petitioner represented then that Petitioner's witnesses would establish through their testimony when such remedial actions were taken. Tr. at 529. However, the testimony of Petitioner's witnesses did not address the issue of whether the remedial actions were taken with respect to the specific residents who were identified in Petitioner's post-February 5, 1997 assessments as needing corrective measures to prevent against injury from bed side rails. See P. Ex. 1 at 11 - 153.

Petitioner relies on Ms. Thurber's testimony to support its assertion that residents who needed to be protected had their bed side rails padded. Tr. at 639. Ms. Thurber attested to seeing "numerous numbers of bumper pads in use in the facility" when she first visited Petitioner's facility on February 6, 1997. Id. However, Ms. Thurber did not aver that all of the residents who were assessed by Petitioner as needing to have side rails padded actually received padding. See Id. Indeed, Ms. Thurber testified that, as of February 6, 1997, there was a shortage of padding at Petitioner's facility. Id.

Nor is Petitioner's assertion that it implemented all necessary corrections on or before February 5, 1997, supported by the testimony of Petitioner's other witnesses. Ms. McDonnell was unable to state when, if at all, any of the residents whom Petitioner identified as needing protection from possible entrapment received such protection. Tr. at 516 - 530, 592 - 593.

> ***3. HCFA established a basis to impose a civil money penalty against Petitioner in the range of civil money penalties that is imposed to remedy noncompliance at the immediate jeopardy level for each day of the period beginning on February 5, 1997, and running through February 27, 1997.***

There is a basis to impose a civil money penalty against Petitioner in the immediate jeopardy range for the period which begins on February 5, 1997, and which runs through February 27, 1997. HCFA satisfied the three prerequisites for imposing such a penalty. First, HCFA established a prima facie case, which Petitioner did not rebut, that as of February 5, 1997, Petitioner was not complying substantially with a participation requirement. As I describe above, at Finding 1, Petitioner had failed to implement a policy to prevent neglect of its residents. Indeed, there is not only a prima facie case of noncompliance here, but, in fact, the preponderance of the evidence is that Petitioner was not complying with this requirement. Second, Petitioner failed to show that HCFA's determination that Petitioner's noncompliance with this requirement was at the immediate jeopardy level was clearly erroneous. In fact, the preponderance of the evidence establishes that Petitioner's deficiency was at the immediate jeopardy level. Third, Petitioner did not prove by a preponderance of the evidence that it had eliminated the immediate jeopardy to its residents on any date prior to February 28, 1997.

4. A civil money penalty of $10,000 per day for each day of the period which begins on February 5, 1997, and which runs through February 27, 1997, is reasonable.

The civil money penalty that may be imposed against Petitioner for each day of the period which begins on February 5, 1997, and which runs through February 27, 1997, must fall within the range of penalties of between $3,050 and $10,000 per day which may be imposed to remedy noncompliance at the immediate jeopardy level. 42 C.F.R. §§ 488.408(e)(2)(ii); 488.438(a)(1). I have examined the evidence in the context of the factors that are established at 42 C.F.R. §§ 488.438(f) and 488.404 (which is incorporated by reference into 42 C.F.R. § 488.438(f)) in deciding the reasonable amount of the penalty within the $3,050 - $10,000 per day range. I conclude, based on the evidence and the factors specified in the regulations, that a penalty of $10,000 per day is reasonable for each day of the period which begins on February 5, 1997, and which runs through February 27, 1997.

The factors that are specified in 42 C.F.R. § 488.438(f) as being relevant to the amount of a civil money penalty include a facility's: (1) history of compliance with participation requirements; (2) financial condition; and (3) culpability for the noncompliance which is the basis for the penalty. The factors that are specified in 42 C.F.R. § 488.404 include the seriousness of deficiencies. They also include the relationship of one deficiency to other deficiencies and a facility's prior history of compliance (I note that, in this respect, the factors duplicate those stated in 42 C.F.R. § 488.438(f)).

I base my conclusion that a $10,000 per day civil money penalty is warranted here primarily on evidence relating to two of these factors. First, Petitioner's failure to protect its residents against the potential for entrapment in bed side rails was an extraordinarily serious deficiency which had fatal consequences for one resident and which placed others at risk of serious injury or death. Second, Petitioner manifests a very high degree of culpability for its noncompliance.

Petitioner's culpability for its noncompliance amounts to a reckless disregard of the dangers to demented and agitated residents posed by unprotected bed side rails. Petitioner had ample and repeated warnings of the danger that unprotected bed side rails posed for Resident 1 (as identified in the report of the February 5, 1997 survey of Petitioner) and did nothing to address those warnings. It failed to implement protective measures for the resident notwithstanding the recommendations that its own staff made in planning the resident's care that such measures be undertaken. Indeed, Petitioner essentially did nothing to protect the resident, even after it had evidence that no reasonable person could ignore, consisting of the January 25, 1997 episode of entrapment, that the resident was at risk for a potentially fatal injury.

The existence of additional deficiencies in Petitioner's operation, besides that which was identified by the surveyors on February 5, 1997, and which I have found to have continued until February 27, 1997, is relevant to the issue of the amount of the civil money penalty that is reasonable for each day of the February 5 - 27, 1997 period. 42 C.F.R. § 488.404(c)(1). The surveyors found numerous additional deficiencies at the February 10 - 13, 1997 survey of Petitioner. Some of these were identified as evidence of Petitioner providing substandard care. I have opted not to discuss these additional deficiencies here. It is unnecessary for me to do so inasmuch as I have concluded that a maximum civil money penalty of $10,000 per day is reasonable based on the severity of the deficiency that was identified on February 5, 1997, and Petitioner's culpability for that deficiency. I may not increase the civil money penalty to a sum of more than $10,000 per day even if I find that Petitioner was deficient in other areas besides that which was identified on February 5, 1997.

I have also considered the issue of whether Petitioner's financial situation is such that Petitioner would not be able to pay these civil money penalties and the other civil money penalties which I sustain below. I conclude that Petitioner has not demonstrated that it is in such financial straits as to be unable to pay the penalties. Petitioner offered some evidence at the hearing to show that it has suffered financial losses as a consequence of the findings that the surveyors made at the various surveys of Petitioner. However, financial losses, even if they are severe, are not enough by themselves to establish an inability of a provider to pay a civil money penalty.

> ***5. As of the February 28, 1997 survey, Petitioner was still not complying with the requirement that it implement a policy to prevent its residents from becoming injured by bed side rails due to its neglect of the residents.***

The Florida State survey agency surveyors resurveyed Petitioner on February 28, 1997, in order to determine whether Petitioner had removed the immediate jeopardy to its residents. The surveyors found that, as of that date, Petitioner continued to fail to implement a policy to prevent neglect of its residents, although at a level of severity that was less than the immediate jeopardy level. HCFA Ex. 12.

The surveyors found that Petitioner had failed to assess the risks of injury from side rails for two of its residents (identified in the report of the February 28, 1997 survey as Residents 5 and 10). Id. at 1. The surveyors additionally found that Petitioner had failed to follow an effective system to prevent possible injury from side rails for ten additional residents. Id. The specific allegation that the surveyors made concerning these residents was that Petitioner had failed to complete cards which instructed certified nurses' assistants (CNAs) concerning the appropriate use of side rails for the residents. Id. at 1 - 2. Finally, the surveyors found that, in the case of one resident (identified in the report of

the February 28, 1997 survey as Resident 16), the resident's side rails were not being utilized properly, thereby allowing a gap to exist between the resident's mattress and the side rails. Id. at 2.

Petitioner asserts that the allegations which the surveyors made in their report of the February 28, 1997 survey are either irrelevant or are refuted by the credible evidence that Petitioner offered in response to those allegations. Although I do not completely accept all of the surveyors' allegations, I find them to be substantiated or not refuted to the extent that they establish the surveyors' overall assertion of noncompliance.

HCFA established a prima facie case that Petitioner had not properly assessed Residents 5 and 10 for the possibility that they might be injured as a consequence of the use of side rails. The surveyors found that these residents had padded side rails placed on their beds. In the case of Resident 10, an interview with the resident's roommate established that Resident 10 had been observed frequently scooting down to the end of the bed and trying to get out of bed, thereby putting the resident at risk for injury from falls. HCFA Ex. 12 at 2. In the case of Resident 5, direct observation of the resident and an interview with Petitioner's staff established that the resident scooted down to the end of her bed in order to get out of bed. Id. at 2 - 3. The surveyors concluded that, in both instances, the residents were at risk for injury as a consequence of their being able to evade the restraining effect of the bed side rails. The surveyors found that Petitioner failed to assess these risks and to plan appropriate countermeasures.

Petitioner asserts that the roommate of Resident 10 had impaired cognition and that there was no evidence that the resident attempted to evade the restraining effect of bed side rails. Petitioner's posthearing brief at 12 - 13; Petitioner's reply brief at 8. However, the evidence cited by Petitioner in its reply brief does not support the assertion that no evidence existed that Resident 10 attempted to evade the restraining effect of the side rails. Petitioner's reply brief at 8, citing P. Ex. 3 at 5 - 11. The surveyors noted that Petitioner's staff had told them that Resident 10's friends had also notified them of the same concerns that Resident 10's roommate had voiced, i.e. that Resident 10 was attempting to evade the restraining effect of the side rails by scooting down to the foot of the bed and trying to get up, thus putting the resident at risk for falls. HCFA Ex. 12 at 2. Moreover, on a February 26, 1997 physical restraint assessment, it is noted that Resident 10 "slides out of bed/chair . . . ." P. Ex. 3 at 6.

As for Resident 5, Petitioner acknowledged that the resident had gotten out of bed. However, Petitioner argued that the resident had been thoroughly reassessed and that the resident had a physician's order for the use of side rails. Additionally, Petitioner avers that the resident's side rails were padded.

Petitioner failed to rebut by the preponderance of the evidence the prima facie case of neglect that HCFA established in the cases of Residents 5 and 10. Petitioner's assertions that the residents' side rails were padded begs the question of whether there were unaddressed risks in utilizing side rails in particular cases. Padding of bed side rails for Resident 5 and Resident 10 may have addressed the risk that either of these residents could be injured by entrapment in side rails. However, there were other risks associated with the use of side rails that Petitioner did not address adequately.

Furthermore, it is apparent from the evidence that, at least in the case of Resident 5, the use of bed side rails put the resident at risk for injury from falls. Petitioner failed to assess the resident for this possibility and failed to implement countermeasures to assure that the resident did not fall out of bed. The documentation which Petitioner introduced concerning Resident 5 establishes that the resident was a demented individual who was at a high risk for sustaining falls. P. Ex. 3 at 16 - 17. Asserting, as Petitioner does, that the resident had been assessed thoroughly does not address the issue of whether the resident had been assessed to determine whether more needed to be done to protect the resident from falling out of bed due to the resident's efforts to evade the restraining influence of side rails. There is no evidence that Petitioner even considered giving the resident additional protection.

HCFA established a prima facie case that Resident 16 was at risk of injury for entrapment from bed side rails. The surveyors observed the resident to be lying in a bed with the head of the bed elevated to an angle of 45 degrees. HCFA Ex. 12 at 3. There was a large gap observed between the bed's mattress and the bottom of the side rail. Id. The surveyors noted that a hole had been drilled into the side rail so that the side rail could be adjusted to eliminate the gap. However, the side rail had not been adjusted. The surveyors noted also that written instructions for care of the resident failed to specify that the side rail be adjusted to address the problem caused by the gap between the side rail and the resident's mattress. Id.

I do not find that Petitioner offered evidence sufficient to rebut HCFA's prima facie case concerning neglect of Resident 16. Petitioner's response to the surveyors' findings is to argue that it had drilled holes in the bed side rails of all beds. Petitioner's posthearing brief at 13. From this, Petitioner argues that the fact that there were holes drilled in the bed side rails of Resident 16's bed does not mean that the bed side rails needed to be adjusted for this resident. Petitioner asserts also that there was no risk of entrapment for the resident. It relies on the testimony of Ms. McDonnell, who averred that the gap between the resident's mattress and the bed side rail was only seven or eight inches (Tr. at 462 - 463), and on its photograph of the alleged bed in question purporting to show a gap of only four and a half inches. P. Ex. 3 at 30.

A gap of between four and a half and eight inches between a mattress and a bed side rail certainly is a large enough opening within which an individual could inadvertently wedge a body part, including, possibly, that individual's head. P. Ex. 3 at 30. Moreover, Petitioner has not explained why it did not simply adjust the bed side rail for Resident 16 -- or augment the padding of the side rail -- to avoid the creation of any significant gap. By February 28, 1997, Petitioner ought to have been highly sensitized to the risks to residents posed by gaps between side rails and mattresses. Yet, the evidence shows that Petitioner still, as of that date, was not attentive to the risks of injury from entrapment that its residents faced.

HCFA established a prima facie case of neglect in the cases of those residents for whom CNA care cards had not been completed. HCFA Ex. 12 at 1, 3. These cards were intended to form part of a system which would assure that all of Petitioner's staff received appropriate instruction concerning the use of bed side rails for individual residents. Tr. at 93 - 94. Failure by Petitioner to complete these cards supports the inference that it was not providing adequate instructions to its CNAs.

Petitioner does not deny that, in some instances, it failed to complete CNA care cards for its residents. However, it contends that this failure was immaterial to the question of whether the residents were protected adequately. According to Petitioner, in eight of the ten instances cited by HCFA (Residents 8, 9, 14, 15, 17, 22, 24, and 26), the residents' bed side rails were, in fact, padded. HCFA Ex. 12 at 3. Furthermore, according to Petitioner, there were other systems in place at Petitioner's facility which provided adequate assurance that those residents who needed padded side rails received padding. Petitioner's posthearing brief at 13 -14. Petitioner cites to the testimony of Ms. Thurber as support for this contention. Tr. at 650 - 651.

I am not persuaded that the presence of other safeguards besides CNA cards adequately protected Petitioner's residents from the risks posed by bed side rails. Petitioner's own plan of correction to address the deficiency that was identified on February 5, 1997, included updating CNA cards to assure that all of Petitioner's staff were aware of residents' needs concerning bed side rails. HCFA Ex. 7 at 2. Further, the fatal entrapment of Resident 1, as identified at the February 5, 1997 survey of Petitioner, is graphic evidence of what may happen where staff of a facility is not fully apprised of the needs of a resident. And, finally, I note that one of the residents whose CNA card had not been updated was Resident 16. As I find above, this resident's bed had a potentially dangerous gap between the mattress and side rails due to the staff's failure to adjust the side rails. Moreover, there is no evidence to show that this resident's bed side rails were padded. The failure to protect the resident might have been averted had the resident's CNA card been completed.

6. As of February 10 - 13, 1997, Petitioner was not complying substantially with numerous participation requirements in addition to the requirement that it implement a policy to prevent the neglect of its residents. Some of these additional failures by Petitioner to comply with participation requirements were of a scope and severity such that Petitioner was providing a substandard quality of care to its residents.

The surveyors who conducted the February 10 - 13, 1997 survey found Petitioner not to be complying with 26 participation requirements. HCFA Ex. 8 at 1 - 71. The deficiencies that the surveyors identified encompassed four areas in which Petitioner was found to be providing a substandard quality of care to residents.

A "substandard quality of care" deficiency is an extremely serious deficiency which either meets or approaches the definition of immediate jeopardy. The regulations which govern participation of long-term care facilities in Medicare define "substandard quality of care" to be:

> one or more deficiencies related to participation requirements under [42 C.F.R.] § 483.13, Resident behavior and facility practices, § 483.15, Quality of life, or § 483.25, Quality of care . . . , which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

42 C.F.R. § 488.301.

The record of this case substantiates the findings of deficiencies that the surveyors made at the February 10 - 13, 1997 survey. This evidence also substantiates the surveyors' findings of scope and severity, including their findings that Petitioner provided care of a substandard quality in four separate areas.

The most serious deficiencies that the surveyors identified at the February 10 - 13, 1997 survey included instances of substandard care in the areas of both quality of life and care. The deficiencies included a failure by Petitioner to provide social services to maintain or attain the highest practicable physical, mental, and psychosocial well-being of each resident. HCFA Ex. 8 at 14 - 25; 42 C.F.R. § 483.15(g). They included also a failure by Petitioner to assure that its residents not develop avoidable pressure sores and a failure to provide necessary treatment for pressure sores. HCFA Ex. 8 at 36 - 40; 42 C.F.R. § 483.25(c). The findings of substandard quality of care also included the finding that Petitioner failed to assure that each of its residents received adequate supervision and

assistance devices to prevent the resident from experiencing accidents. HCFA Ex. 8 at 42 - 48; 42 C.F.R. § 483.25(h)(2). Finally, the findings of substandard quality of care included the finding that Petitioner failed to assure that its residents received assessments or interventions to assure that the residents maintained acceptable parameters of nutritional status, such as body weight and protein levels. HCFA Ex. 8 at 48 - 54; 42 C.F.R. § 483.25(i)(1).

Petitioner concedes the presence of the deficiencies that the surveyors identified at the February 10 - 13, 1997 survey of Petitioner. Petitioner's posthearing brief at 15. It argues, however, that the deficiencies were not so significant as were found by the Florida State survey agency surveyors. Id.

I have reviewed carefully Petitioner's argument that the deficiencies that the surveyors identified were less significant than is asserted by the surveyors. The evidence which Petitioner recites relates to the care that Petitioner provided to two residents as identified in the report of the February 10 - 13, 1997 survey, Residents 6 and 22. These residents are cited by the surveyors as examples of substandard quality of care provided by Petitioner under only one finding, the finding which addresses Petitioner's failure to provide social services. HCFA Ex. 8 at 14 - 25. The evidence does not relate to the other three findings that Petitioner provided substandard quality of care.

Moreover, the evidence cited by Petitioner as allegedly detracting from the surveyors' findings of scope and severity relates to only two of the 14 examples that the surveyors cited as evidence that Petitioner failed adequately to provide acceptable social services to its residents. I conclude that Petitioner's characterization of the evidence as it relates to Residents 6 and 22, even were I to agree with it, does not detract substantially from the surveyors' findings of an overall deficiency amounting to substandard care.

Having said that, however, I am not persuaded by Petitioner's characterization of the evidence, as it relates to Residents 6 and 22, that the evidence negates the prima facie case of deficient care that HCFA established with respect to the two residents. In the case of Resident 22, the surveyors found failures by Petitioner to provide necessary social services to the resident in, among other things, the following respects: (1) the November 19, 1996 quarterly assessment of the resident was not completed by Petitioner's social services staff in the areas of mood, behavior and cognition; (2) there was no care plan developed in these areas to assist the resident; (3) social services staff was observed to ignore the resident despite the resident's deteriorated emotional state. HCFA Ex. 8 at 15 - 17. The surveyors concluded that Resident 22 continued to manifest mood and behavior problems due to Petitioner's failure to intervene appropriately to provide social services

for the resident. Id. at 17. The surveyors concluded that, as a consequence, the resident was unable to attain her highest practicable level of psychosocial and mental well-being and in that respect suffered actual harm. Id.

Petitioner's response to these findings is to assert that there is no evidence that the resident did not receive appropriate medically related social services. Petitioner's posthearing brief at 17. Petitioner argues that it is undisputed that the resident was receiving therapy, had psychiatric consults, and was being treated for depression. Id.

I am not persuaded from this response that Petitioner rebutted HCFA's allegations of failure by Petitioner to provide Resident 22 with needed social services. The fact that Resident 22 may have been receiving psychiatric care does not respond to the evidence that the resident was not receiving appropriate social services. The unchallenged evidence that Petitioner's social services staff failed to give the resident needed services includes evidence that the resident was, essentially, ignored by Petitioner's social services staff during episodes of emotional distress.

In the case of Resident 6, the surveyors noted that the resident had been identified upon admission to Petitioner's facility as having problems with behavior, cognitive, mood, and with psychotropic medications. HCFA Ex. 8 at 18. Resident 6 needed a health care decision maker appointed to make decisions for her, given her obvious mental incapacity. The surveyors ascertained that it was the obligation of Petitioner's social services staff to obtain the requisite document. However, staff had failed to do so. Id.

The surveyors found additionally that the resident exhibited signs of mental and emotional distress. However, they found no interventions on the part of Petitioner's social services staff to help the resident. HCFA Ex. 8 at 19. The surveyors concluded that a decline in the resident's functioning could be attributed to the failure of Petitioner's social services staff to undertake necessary interventions on behalf of Resident 6. Id.

Petitioner's response to the surveyors' findings is to challenge details in those findings but not the overall thrust of the findings. Petitioner's posthearing brief at 16. Petitioner did not rebut the surveyors' findings that Petitioner's social services staff had failed to obtain a document appointing a health care decision maker for Resident 6. Nor did they rebut the surveyors' findings that Petitioner's staff failed to intervene on the resident's behalf.

7. Petitioner continued to be deficient, until April 16, 1997, in complying with the participation requirements cited by the surveyors in their report of the February 10 - 13, 1997 survey.

It is Petitioner's burden to prove that on a date or dates earlier than that which was determined by the surveyors it corrected or at least reduced the scope and severity of the deficiencies established at the February 10 - 13, 1997 survey. See Finding 2. Petitioner failed to meet its burden to do so.

Petitioner asserts variously that the deficiencies that were established at the February 10 - 13, 1997 survey were corrected quickly and that they were corrected by no later than February 21, 1997. Petitioner's posthearing brief at 15, 41. It cites P. Ex. 2 as support for this assertion. The exhibit on which Petitioner relies is a massive document which totals 655 pages. Id. Petitioner has not pointed to anything within that exhibit which arguably would substantiate its assertion that it corrected deficiencies quickly. It has made no effort to show how this exhibit addresses the specific findings of deficiencies that the surveyors made in their report of the February 10 - 13, 1997 survey. I find Petitioner's tactic of asserting that proof that it eliminated deficiencies is somewhere within P. Ex. 2 – without explaining where that proof is or what it consists of – not to be persuasive.

There is persuasive evidence which refutes Petitioner's assertion that it corrected quickly, or by February 21, 1997, the deficiencies that were identified at the February 10 - 13, 1997 survey. That evidence, in part, consists of the plan of correction that Petitioner submitted to show how and when it would correct the deficiencies that the surveyors identified. HCFA Ex. 11. That plan states that most corrections would be completed by March 13, 1997, a full month after the completion of the February 10 - 13, 1997 survey of Petitioner. Id. The plan of correction contains a disclaimer in which Petitioner denies that it is admitting the truth of the findings of deficiencies that the surveyors made at the February 10 - 13, 1997 survey. Notwithstanding, the corrective action dates that are stated in the plan are Petitioner's own estimates of how long it would take it to implement the corrections that it listed in the plan of correction. Petitioner's estimates are an admission by it that it would not correct quickly, or by February 21, 1997, the deficiencies identified at the February 10 - 13, 1997 survey, as Petitioner now avers that it did.

The evidence that Petitioner did not correct the deficiencies that were identified at the February 10 - 13, 1997 survey of Petitioner prior to April 16, 1997, consists also of the findings that the surveyors made at the April 15 - 17, 1997 revisit to Petitioner's facility. As I discuss below, at Finding 10, many of the findings of deficiencies that the surveyors made at the April 15 - 17, 1997 revisit are sustained. These findings are, in large

measure, findings that preexisting deficiencies continued. The fact that the deficiencies continued to exist as of April 15 - 17, 1997, refutes Petitioner's argument that they were corrected at an earlier date.

> ***8. HCFA established a basis to impose a civil money penalty against Petitioner in the range of civil money penalties that is imposed to remedy noncompliance at a level of less than immediate jeopardy for each day of the period beginning on February 28, 1997, and running through April 16, 1997.***

Petitioner was deficient in complying with participation requirements for the period beginning on February 28, 1997, and running through April 16, 1997. Findings 6, 7. The level of the noncompliance during this period was at a level that is less than immediate jeopardy. Therefore, a basis exists to impose a civil money penalty against Petitioner for each day of the February 28 - April 16, 1997 period in the range of civil money penalties that is imposed to remedy noncompliance at a level of less than immediate jeopardy.

This Finding takes into account the overlap between the surveyors' findings at the February 10 - 13, 1997 compliance survey of Petitioner and their findings at the February 28, 1997 survey. The findings of the February 10 - 13, 1997 survey, that Petitioner was deficient at a level that is less than immediate jeopardy, are superseded, through February 27, 1997, by the continuing immediate jeopardy situation that prevailed at Petitioner's facility. As I discuss above, at Finding 2, the immediate jeopardy situation prevailed until February 27, 1997. Thus, the findings of the February 10 - 13, 1997 survey become a meaningful basis for imposing civil money penalties against Petitioner only beginning with February 28, 1997, when the superseding immediate jeopardy situation was found to have been removed.

> ***9. A civil money penalty of $3,000 per day for each day of the period which begins on February 28, 1997, and which runs through April 16, 1997, is reasonable.***

I sustain a civil money penalty of $3,000 per day against Petitioner for each day of the period which begins on February 28, 1997, and which runs through April 16, 1997. A penalty of this amount is the maximum which is permitted to be imposed for deficiencies that are at less than the immediate jeopardy level of scope and severity. 42 C.F.R. § 488.438(a)(2). I base my decision to sustain a penalty of $3,000 per day on factors which include: the seriousness of several of Petitioner's deficiencies during the period (42 C.F.R. § 488.404(b)); the culpability of Petitioner for its deficiencies (42 C.F.R. § 488.438(f)(4)); and what is made evident by the relationship of Petitioner's deficiencies

to each other (42 C.F.R. §488.404(c)(1)). As I explain above, I do not find Petitioner's financial condition to be an impediment to its ability to pay the penalties which I impose against it.

The seriousness of Petitioner's deficiencies in and of itself merits the imposition of substantial civil money penalties. As I discuss above, at Finding 6, as of February 10 - 13, 1997, Petitioner was providing substandard quality of care in four areas. This means that Petitioner was providing care that was of such poor quality as to approach the degree of seriousness that constitutes immediate jeopardy to residents. These findings must also be considered in light of the fact that, after February 28, 1997, Petitioner continued to fail to implement its policy against neglect of residents in order to prevent residents from suffering injury due to inappropriate use of bed side rails. That failure continued, notwithstanding the death of a resident on February 3, 1997, due to entrapment, and, notwithstanding also, the surveyors' findings of immediate jeopardy on February 5, 1997.

Petitioner manifests a high degree of culpability for its deficiencies. The failure of Petitioner's staff to provide necessary goods and services to residents, or to provide care of a reasonable quality, evidences an indifference on the part of staff to the residents' welfare and safety. This, in turn, establishes Petitioner's facility to be one in which the quality of care that was provided to residents did not enjoy a high priority.

This conclusion is reinforced by the relationship of the deficiencies to each other. There is a common theme to these deficiencies, which is a generalized indifference on the part of Petitioner's staff to the welfare and safety of Petitioner's residents. There is a connection, for example, between Petitioner's failure to assure that each resident was appropriately protected from possible injury from bed side rails and the failure of Petitioner's social service staff to provide necessary services to residents. Such failures, which were repeated throughout Petitioner's facility, are proof of an operation that, in significant respects, did not care about the well-being of the residents in its charge.

10. Petitioner remained noncompliant with participation requirements at the April 15 - 17, 1997 survey of Petitioner.

The Florida State survey agency surveyors found that Petitioner continued to be noncompliant with numerous participation requirements at the revisit survey which was conducted at Petitioner's facility on April 15 - 17, 1997. HCFA Ex. 17. Many of the deficiencies that the surveyors identified were deficiencies that had been identified previously at the February 10 - 13, 1997 survey. Id. Petitioner denies the surveyors' findings. It asserts that, in fact, it was complying substantially with all participation requirements as of the April 15 - 17, 1997 survey. Petitioner's posthearing brief at 18.

I conclude, after having reviewed closely the findings that the surveyors made at the April 15 - 17, 1997 survey of Petitioner, that Petitioner was not complying substantially with participation requirements as of the dates of the April 15 - 17, 1997 survey of Petitioner. Below, I discuss some of the examples of noncompliance that were established by the surveyors. Some of these examples constitute deficiencies for which Petitioner was cited previously in the report of the February 10 - 13, 1997 survey of Petitioner.

It is not necessary for me to discuss every conclusion that the surveyors made at the April 15 - 17, 1997 survey to find that the surveyors' overall findings of noncompliance are sustained. A basis to impose a civil money penalty against a long-term care facility exists where there is a showing that the facility is not complying substantially with even one participation requirement at a level of deficiency that justifies imposition of a civil money penalty. For that reason, I limit my discussion of the April 15 - 17, 1997 survey to several of the areas where Petitioner failed to overcome HCFA's prima facie showing of noncompliance. Even if Petitioner were to prove that, in all other areas that I have not discussed, it was complying fully with participation requirements as of the April 15 - 17, 1997 survey, it would not change my Finding that Petitioner was not complying with participation requirements as of the dates of the survey.

a. Petitioner did not comply substantially with the participation requirement governing the rights of residents.

The surveyors found that Petitioner was not complying with the requirements in 42 C.F.R. § 483.10(a)(3) and (4) which govern the rights of residents in long-term care facilities. The regulation provides that, in the case of a resident who is adjudged to be incompetent under State law, that resident's rights are to be exercised by the person who is appointed to exercise the resident's rights under State law. 42 C.F.R. § 483.10(a)(3). It provides further that, in the case of a resident who has not been adjudged to be incompetent under State law, that resident's rights may be exercised by any legal surrogate who has been designated according to State law. 42 C.F.R. § 483.10(a)(4). This subpart of the regulation is intended to apply to the exercise of rights for residents who are not competent to exercise their rights but who have not been adjudicated to be incompetent.

The surveyors concluded that Petitioner had not facilitated the exercise of rights for five residents who, based on their records, were not competent, but who had not been adjudicated to be incompetent. HCFA Ex. 17 at 2. The surveyors found that Petitioner had not implemented a system to prioritize and advocate for residents who needed to have individuals make decisions for them. Id. They found specifically that, in the cases that they cited as examples, Petitioner had not obtained documentation, required under State law to be from two physicians, certifying that the residents were not competent. Id.

Petitioner does not challenge the fact findings on which the surveyors based their conclusion of noncompliance by Petitioner. It does not deny that there were residents at Petitioner's facility who needed to have surrogate decision makers appointed for them. Nor does it deny that none had been appointed. Petitioner argues that the surveyors' allegations are based on their misconception of the requirements of Florida State law. Petitioner's posthearing brief at 31 - 32. It asserts that, under Florida law, there is no requirement that a facility obtain proxies or surrogates. Petitioner avers that Florida law merely sets forth a system to allow those persons to be designated. Id.

I find that Petitioner's arguments beg the question of its compliance with the requirement that the surveyors cited. Petitioner's argument that Florida law establishes an optional system for appointment of surrogates misses the point that there is a *federal* requirement implicitly stated in the regulations governing long-term care facilities that a long-term care facility obtain a surrogate decision maker for an incompetent resident. I find that 42 C.F.R. § 483.10(a)(3) and (4) implicitly require a facility to do what is necessary under State law to assure that a resident who needs a surrogate decision maker to be appointed has one appointed. Petitioner did not have an option with respect to the residents who were cited by the surveyors. These residents needed surrogates appointed to make decisions on their behalf. Petitioner failed to discharge its duties to comply with the federal requirement by not doing what it ought to have done pursuant to Florida State law.

b. Petitioner did not comply substantially with the participation requirement governing reporting of abuse, neglect, and mistreatment of residents.

The regulations which govern long-term care facilities require that a facility must report immediately to its administrator and to other officials in accordance with State law any episode of abuse, mistreatment, or neglect of a resident, including an episode involving an injury of an unknown source. 42 C.F.R. § 483.13(c). The surveyors found that Petitioner was not complying with this requirement as of the dates of the April 15 - 17, 1997 survey. They based their conclusion on two episodes: (1) an unexplained fracture of the tibia sustained by a resident who is identified as Resident 14 in the report of the April 15 - 17, 1997 survey, which was not reported until eight days after the occurrence of the incident; and (2) an injury to the leg of a resident who is identified as Resident 5 in the report of the April 15 - 17, 1997 survey, which was not investigated or reported. HCFA Ex. 17 at 6.

Petitioner does not deny that these residents sustained injuries. It asserts that there was no failure by it to report or investigate them. I find that Petitioner's explanations do not refute the surveyors' findings of noncompliance.

Petitioner does not deny the eight-day lapse in reporting the injury to Resident 14. It asserts with respect to Resident 14 that the incident was investigated by Petitioner's director of nursing, who concluded that there was no reason to suspect abuse of the resident. P. Ex. 4 at 18, 278; Tr. at 465. Petitioner's assertion may be true, but it does not answer the surveyors' finding that there was a failure to report immediately the injury to the resident.

According to Petitioner, the record clearly establishes that Resident 5 injured her leg during an attempt by the resident to transfer herself from a wheelchair. P. Ex. 4 at 18 - 23; Tr. at 465 - 466. Petitioner asserts that there was no reason to report or investigate this injury because there was no reason to suspect abuse or neglect of the resident. However, the evidence which relates to this incident suggests otherwise. The resident reported only the general circumstance under which she injured her leg. As Petitioner concedes, the resident did not know how she hurt her leg. The unexplained nature of the resident's injury was certainly sufficient to impose on Petitioner the duty to attempt to find out the cause of that injury.

c. Petitioner did not comply substantially with the requirement that it maintain a sanitary, orderly, and comfortable interior to its facility.

The surveyors found that Petitioner failed to comply substantially with the requirement that is stated at 42 C.F.R. § 483.15(h)(2) that it provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. HCFA Ex. 17 at 7. The surveyors cited ten examples of failures by Petitioner to perform needed maintenance, repairs, or housekeeping. Id. at 7 - 8.

Petitioner does not deny any of the facts cited by the surveyors. It dismisses the surveyors' findings by asserting that they address "what even on their face appear to be minor issues." Petitioner's posthearing brief at 33. Petitioner argues additionally that, after the February 10 - 13 survey of its facility, it had ordered new furniture and equipment for the facility. Id. Petitioner concedes that the new furniture and equipment had not arrived as of the April 15 - 17, 1997 survey, but argues that its proof that it had ordered the furniture and equipment should have been enough to satisfy the surveyors that it was complying with participation requirements. Id.

I am not persuaded that Petitioner's arguments overcome HCFA's prima facie evidence of noncompliance. It is true none of the examples cited by the surveyors represents a failure of maintenance by Petitioner that threatened the life or safety of residents. But, it is also true that when these examples are considered in the aggregate, they suggest that Petitioner maintained a facility that was not particularly attractive or pleasant. The

facility, after all, is the residents' place of abode. The purpose of the regulations is to assure that facilities are maintained in a way that makes them habitable. Petitioner's failure to maintain its facility plainly detracted from its residents' quality of life.

The fact that Petitioner had ordered furniture and equipment to replace that which was damaged or worn is not a basis for me to find that it was complying with the participation requirement. More than two months had elapsed from the February 10 - 13, 1997 survey and Petitioner still had not corrected deficiencies that were identified at that survey. I note that in its plan of correction for the February 10 - 13, 1997 survey, Petitioner averred that it would have new furniture and equipment by March 17, 1997. HCFA Ex. 11 at 27. Petitioner had not met its own timetable as of the April 15 - 17, 1997 survey.

d. Petitioner did not comply substantially with the requirement that it make complete and accurate assessments of the functional capacities of its residents.

The regulations which govern the participation of long-term care facilities require that a facility's professional staff conduct assessments of the functional capacities of each of the facility's residents. 42 C.F.R. § 483.20. The duty to assess includes a duty to assure that an assessment is accurate, which is done by requiring that each part of an assessment be signed and certified as to accuracy by each individual who has performed that part. 42 C.F.R. § 483.20(c)(2).

The surveyors who conducted the April 15 - 17, 1997 survey of Petitioner found that Petitioner was not making complete and accurate assessments of residents to document changes in the residents' conditions. HCFA Ex. 17 at 8 - 9. The surveyors cited six specific examples of failures to perform assessments. Id. at 9 - 11.

Petitioner did not provide any specific response to the surveyors' findings. See Petitioner's posthearing brief and reply brief. It is unclear to me whether Petitioner is conceding the accuracy of the surveyors' findings or whether Petitioner simply omitted to submit an argument as to the surveyors' findings. In any event, I find from the findings of the surveyors that there is prima facie evidence of Petitioner's noncompliance, which Petitioner did not rebut credibly.

e. Petitioner did not comply substantially with the requirement that it develop a care plan for each resident that includes measurable objectives and timetables to meet the resident's needs that are identified in the resident's comprehensive assessment.

Applicable participation requirements mandate that a long-term care facility develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 42 C.F.R. § 483.20(d)(1). The care plan must describe the services that are required to attain the resident's highest practicable physical, mental, and psychosocial well-being. 42 C.F.R. § 483.20(d)(1)(i). It must also describe other services that would otherwise be required but which the resident has refused. 42 C.F.R. § 483.20(d)(1)(ii).

The surveyors who conducted the April 15 - 17, 1997 survey of Petitioner found that it was not meeting these requirements in the cases of five residents. HCFA Ex. 17 at 11 - 13.

Petitioner denies this conclusion. It asserts that it had planned adequately the care of its residents, including the five residents whose cases were cited as examples by the surveyors. I conclude that the evidence offered by Petitioner does not rebut fully the prima facie evidence of noncompliance that the surveyors cited in the cases of these residents. Consequently, Petitioner did not establish that it was in compliance with the care planning participation requirement.

Petitioner's failure to plan the care of its residents is made apparent in the following examples that were cited by the surveyors in their report of the April 15 - 17, 1997 survey:

• *Resident 4 as identified in the report of the April 15 - 17, 1997 survey.* The surveyors noted that on February 16, 1997, the resident had sustained an injury as a result of a fall. HCFA Ex. 17 at 12. They found that Petitioner did not complete a plan of care to deal with that fall until April 10, 1997. Petitioner asserts that, in fact, there was a care plan for the resident dated February 7, 1997, which dealt with the resident's propensity for sustaining falls. Petitioner's posthearing brief at 34; P. Ex. 4 at 33 - 34. I find that this assertion misses the point made by the surveyors. Obviously, the fall sustained by the resident on February 16, 1997, was evidence that whatever Petitioner had planned for the resident's care might not be working to prevent the resident from sustaining falls. Yet, Petitioner did not revisit that issue until April 10, 1997.

• *Resident 10 as identified in the report of the April 15 - 17, 1997 survey.* This resident had extremely impaired vision. The surveyors noted that the resident lacked a care plan to help the resident identify what foods were being served to her and where the foods were located on the resident's plate. HCFA Ex. 17 at 12 - 13. Petitioner's response to this conclusion is to aver that the resident had been thoroughly assessed for eating ability and was determined to be independent in eating. Petitioner's posthearing brief at 34; P. Ex. 4 at 38 - 51. While this may be true, it does not explain why Petitioner failed to include in the resident's care plans specific instructions designed to assure that the resident was aided in identifying the foods that were served to her. There plainly was a need for such assistance given the extent of the resident's vision impairment.

f. Petitioner did not comply substantially with the requirements that it assure that its residents did not develop pressure sores that are avoidable and that it give necessary treatments to those residents who suffered from pressure sores.

If there is a central finding that the surveyors made in their report of the April 15 - 17, 1997 survey of Petitioner it is that Petitioner failed to comply with the requirements of 42 C.F.R. § 483.25(c)(1) and (2). HCFA Ex. 17 at 22. The governing regulation establishes requirements for the prevention and treatment of pressure sores. A facility must assure that a resident: (1) who enters a facility does not develop pressure sores that are avoidable; and (2) having pressure sores be given necessary treatment to promote healing, prevent infection and prevent new sores from developing.

The surveyors concluded that Petitioner was not complying with the foregoing requirements. They found that Petitioner's noncompliance with these requirements was at a level of severity such as to constitute substandard care to Petitioner's residents. They found also that Petitioner's failure to comply with the requirements constituted continued failure by Petitioner to comply with the requirements as cited in the report of the February 10 - 13, 1997 survey of Petitioner. See HCFA Ex. 11 at 38 - 42. The surveyors cited their findings with respect to Petitioner's failure to prevent and to treat appropriately pressure sores as evidence to support other findings of deficiencies that they made in the report of the April 15 - 17, 1997 survey.

The surveyors concluded that Petitioner failed to comply in several respects with the requirements which governed prevention of and treatment of pressure sores. They based their findings on personal observations, interviews with Petitioner's staff, and their review of Petitioner's clinical records. Generally, they found that in ten of 13 cases that they reviewed, Petitioner did not provide aggressive treatment to prevent the development of pressure sores or to promote the healing of pressure sores. HCFA Ex. 17 at 22. More

specifically, the surveyors found that Petitioner: (1) provided poor preventive care to prevent pressure sores from developing; and (2) manifested a lack of prompt coordination among health care professionals which created a delay in interventions for wound healing. The surveyors cited specific examples of resident care by Petitioner to support their findings. Id. at 23 - 32.

The surveyors found also that Petitioner had failed to implement an element of its plan of correction for the deficiencies that were identified at the February 10 - 13, 1997 survey. Petitioner had promised to deal with pressure sores partly by having its Nutrition Risk Committee review on a weekly basis those residents who were at risk for suffering from skin problems. See HCFA Ex. 11 at 40. Yet, according to the surveyors, the residents whose cases they reviewed at the April 15 - 17, 1997 survey were not being reviewed by the committee. HCFA Ex. 17 at 23.

Petitioner vigorously contests the surveyors' findings. It asserts that, as of April 15 - 17, 1997, it was complying fully with the pressure sore requirements. It contends that it implemented numerous corrective actions after the conclusion of the February 10 - 13, 1997 survey and that these corrective actions were effectively preventing the development of avoidable pressure sores and assuring prompt and aggressive treatment of pressure sores as of April 15 - 17, 1997. Petitioner's posthearing brief at 19 - 20. It disputes each of the specific examples that the surveyors cited in their report of the April 15 - 17, 1997 survey as evidence of Petitioner's noncompliance.

The evidence presented by HCFA concerning the surveyors' findings about Petitioner's efforts to prevent and to treat pressure sores comprises a prima facie case of noncompliance by Petitioner with the requirements which govern pressure sore prevention and treatment. Petitioner's evidence and arguments fail to overcome this prima facie case. That is not to say that I accept as true every detail of HCFA's assertions. But, I am satisfied from my review of the record as a whole that, on balance, HCFA's allegations about the way in which Petitioner dealt with pressure sores are sustained.

i. The standard of care which governs the prevention of and treatment of pressure sores

A pressure sore is a loss of skin caused by prolonged pressure on a patient's body. Tr. at 713. Most commonly, a pressure sore develops on skin that is over a bony prominence such as a patient's coccyx or heels. Tr. at 105, 713. Medical professionals use the terminology "Stage I - IV" to describe the severity of a pressure sore. Tr. at 104 - 105, 713 - 714. A Stage I pressure sore is a reddened area that doesn't blanch. Id. at 104. A Stage II pressure sore involves a loss of dermis or epidermis. Id. at 105. A Stage II

pressure sore might appear to be a blister or an abrasion. Id.; See Id. at 713 - 714. A Stage III pressure sore involves exposure of underlying tissues. Id. at 105. A Stage IV pressure sore exposes muscle and/or bone. Id.

Contributing factors in the development of pressure sores may include poor nutrition, poor hydration, and poor treatment of incontinence. Tr. at 105 - 106. Generally, sick and debilitated individuals, including many residents of long-term care facilities, comprise the population which is at greatest risk for developing pressure sores. Tr. at 713 - 717. A pressure sore can develop very rapidly in a patient who is at risk for developing pressure sores. Id.

The standard of care which governs the prevention and treatment of pressure sores requires a long-term care facility to be aggressive in identifying residents who are at risk, applying preventive measures to those residents, and treating pressure sores. HCFA Ex. 26 at 8 - 10; See Tr. at 107, 717 - 718. Prevention and treatment of pressure sores necessarily involves coordination of care among health care professionals. Tr. at 107 - 108. For example, it is frequently necessary to consult a dietician in developing a plan of care for a resident who is at risk for developing a pressure sore or who has developed one, because poor nutrition is one of the risk factors which causes or exacerbates the development of pressure sores. Id.

ii. Petitioner's failure to comply with the standard of care governing prevention and treatment of pressure sores

The evidence gathered by the surveyors and adduced by HCFA, which Petitioner did not fully rebut, establishes Petitioner's failure to comply with the standard of care governing prevention and treatment of pressure sores and with the overall requirements of 42 C.F.R. § 483.25(c)(1) and (2). I draw my overall conclusion that Petitioner was deficient from examples which include the following.

• *Petitioner's failure to assure that its Nutrition Risk Committee reviewed the status of residents who were at risk for developing pressure sores.* One of the specific promises that Petitioner made in its plan of correction from the February 10 - 13, 1997 survey was that each of its at-risk residents would have his or her case reviewed weekly by Petitioner's Nutrition Risk Committee. P. Ex. 11 at 40. This mandatory weekly review was Petitioner's way of assuring that the nutritional needs of residents who were susceptible to developing pressure sores would not be ignored.

Several residents who were identified by the surveyors did not have their cases reviewed by Petitioner's Nutrition Risk Committee, notwithstanding Petitioner's plan of correction. HCFA Ex. 17 at 30 - 32. Petitioner responds to these facts with two arguments. First,

Petitioner argues that none of the residents whose cases were cited by the surveyors needed to have their cases reviewed by the Nutrition Risk Committee. Second, it argues that no resident suffered harm by virtue of not having his or her case reviewed by the Nutrition Risk Committee. See Petitioner's posthearing brief at 27 - 29.

Petitioner did not substantiate its first argument at least with respect to some of the residents whose cases were cited by the surveyors. For example, Resident 3, as identified in the report of the April 15 - 17, 1997 survey, was not reviewed by the Nutrition Risk Committee after March 28, 1997, despite Petitioner's assertion that residents' cases would be reviewed weekly. Yet, as of March 28, 1997, the resident's case had been reviewed due to the resident's loss of weight. HCFA Ex. 17 at 32. Petitioner has not offered an explanation for its Nutrition Risk Committee's failure to review the case of Resident 3 after March 28, 1997.

As another example, Resident 16 developed a pressure sore on one arm. HCFA Ex. 17 at 32. The resident was assessed one week after developing the sore by Petitioner's dietician but the resident's case was not reviewed by Petitioner's Nutrition Risk Committee. Id. Petitioner characterizes the pressure sore as a "small blister." Petitioner's posthearing brief at 29. Petitioner observes that the sore healed within two weeks. From this, Petitioner argues that there was no need to have had the resident's case reviewed by its Nutrition Risk Committee. But, the fact that the resident's sore may have healed without intervention by the Nutrition Risk Committee is hardly an explanation for the committee's failure to review the resident's case. The failure by Petitioner to have this resident's case reviewed is a failure to aggressively pursue the resident's nutrition needs, in violation of the applicable standard of care.

Petitioner's second argument is irrelevant. The purpose in establishing a Nutrition Risk Committee was to assure that all residents who were *potentially* at risk have their cases reviewed regularly. Such reviews would presumably avert the possibility that residents' nutrition needs would be ignored or overlooked. There was a potential for harm in not having cases reviewed even if no actual harm occurred. And, the fact that residents were not harmed by Petitioner's failure to have their cases reviewed does not mean that they would not have benefitted from a review.

• *Petitioner's failure to provide care which complied with the applicable standard of care in the case of Resident 10 as identified in the report of the April 15 - 17, 1997 survey.* The surveyors concluded that Resident 10 had developed avoidable pressure sores as a consequence of a failure of care by Petitioner. The surveyors concluded that this resident suffered actual harm as a consequence of the derelictions of care by Petitioner.

The resident had been identified as having one Stage II pressure sore as of January 29, 1997. HCFA Ex. 17 at 23. By April, 1997, the resident manifested a total of three pressure sores. Id. at 23 - 24. One of these was identified as being in the resident's sacral area. The other two were on the resident's left gluteal area. I take notice of the fact that all three of the pressure sores were on the resident's posterior.

Petitioner planned to care for these ongoing pressure sores by keeping the resident's skin clean and by applying medication and a dressing to be changed at three-day intervals. HCFA Ex. 17 at 24. On April 16, 1997, the surveyors observed the resident lying in bed flat on her back. Id. The padding beneath the resident was wet. Id. The dressing was soaked and crumpled and barely sticking to the resident's wounds. Id. During the three days of the survey, the resident was observed to be on her back without evidence that the resident was turned or positioned. Id. As part of the resident's treatment plan, the resident was supposed to be up in a chair for no more than one hour per day. However, on April 16, 1997, the resident was observed to be in a chair for at least two continuous hours. Id.

Petitioner's first response to these findings is to assert that the resident probably did not develop pressure sores but, rather, showed damage to her skin as a consequence of scratching a rash. Petitioner's posthearing brief at 22. This assertion is premised on the testimony of Ms. Vogelpohl. Tr. at 729 - 30. The testimony cited by Petitioner does not refute the surveyors' findings – which were in part based on their observations of the resident – that the resident had developed pressure sores. In her testimony, Ms. Vogelpohl speculates that the cause of the resident's skin condition may have been something other than pressure sores. But, she offered no dispositive finding that the resident had not developed pressure sores. Indeed, Ms. Vogelpohl did not observe the resident first hand.

Petitioner's second argument is that the resident had numerous medical conditions which made the resident prone to developing pressure sores. Petitioner's posthearing brief. I take Petitioner to be asserting that the sores that the resident developed were an unavoidable consequence of the resident's underlying medical conditions. I am not persuaded by this argument. A person may be highly susceptible to developing pressure sores yet still develop an avoidable sore. An unavoidable pressure sore is one which develops *despite* the use of aggressive preventive and treatment measures mandated under the applicable standard of care. Petitioner has not made any showing that Resident 10 developed pressure sores despite its implementation of aggressive measures.

Petitioner's response to the surveyors' direct observations of the care that the resident received is to argue that the care was good care. In effect, Petitioner is saying that it could not prevent the resident from lying on her back and could not prevent the resident

from lying on a soaked mattress with a wet and crumpled dressing. I find this argument to be unpersuasive. It is an excuse for not providing the kind of aggressive care to the resident that the standard of care and the regulations required.

• *Petitioner's failure to provide care which complied with the applicable standard of care in the case of Resident 3, as identified in the report of the April 15 - 17, 1997 survey.* The surveyors found that this resident developed a Stage II pressure sore on her buttocks. HCFA Ex. 17 at 28. The surveyors concluded that Resident 3 suffered actual harm from Petitioner's failure to provide aggressive care to the resident.

The surveyors ascertained from interviews with Petitioner's staff that the reason that the sore developed was that the resident enjoyed sitting in a wheelchair for lengthy periods. The resident contracted the sore from prolonged contact with the hard cushion of the chair. The seat cushion of the wheelchair was changed after the resident developed the pressure sore. The surveyors found also that an instruction for administering care to the resident to treat the pressure sore was not carried out timely. HCFA Ex. 17 at 28. The surveyors concluded that the pressure sore that Resident 3 developed was avoidable. Id.

Petitioner makes several responses to the surveyors' findings. First, Petitioner concedes that the resident developed a pressure sore, but asserts that it had healed by April 26, 1997, nine days after completion of the April 15 - 17, 1997 survey of Petitioner. According to Petitioner, the rapid healing of the resident's sore demonstrates that the resident received good nutrition and nursing care. Petitioner's posthearing brief at 25 - 26. I find this argument not to be relevant to the surveyors' conclusions. Petitioner may have treated Resident 3's pressure sore aggressively after April 17, 1997. But, the question here is why the sore developed at all. Good treatment given after the fact of development of a pressure sore does not excuse poor preventive care.

Second, Petitioner asserts that the surveyors concluded erroneously that the resident was given a hard wheelchair seat cushion prior to her developing a pressure sore. In fact, according to Petitioner, the seat was a special, gel-filled cushion with a soft center. P. Ex. 4 at 145. Although this assertion may be true, it begs the question of whether Petitioner was remiss in allowing Resident 3 to develop a pressure sore. Petitioner's staff attributed the development of the sore to the resident's protracted sitting in a wheelchair. In this case, the length of time that the resident was permitted to sit may have been more of a contributing factor to the development of a pressure sore than the type of cushion that the resident sat on. But, the point is, that Petitioner failed to intervene to assure that the resident did not sit for too long a period of time, irrespective of the type of cushion that the resident sat on.

Petitioner did not address the surveyors' findings that treatment of the resident's pressure sore was delayed. I infer that Petitioner did not do so because the facts support the surveyors' findings.

g. Petitioner did not comply substantially with other participation requirements.

As Petitioner acknowledges, several additional conclusions of noncompliance made by the surveyors at the April 15 - 17, 1997 survey rest at least in part on the surveyors' findings that Petitioner did not aggressively seek to prevent or to treat pressure sores. These findings of noncompliance include findings that Petitioner failed to comply with the requirements stated in: 42 C.F.R. § 483.20(d)(3)(ii) (HCFA Ex. 17 at 13 - 16); 42 C.F.R. § 483.25 (HCFA Ex. 17 at 17 - 22); 42 C.F.R. § 483.30(a)(1) and (2) (HCFA Ex. 17 at 33 - 36); 42 C.F.R. § 483.75 (HCFA Ex. 17 at 36 - 38); 42 C.F.R. § 483.75(d)(1) and (2) (HCFA Ex. 17 at 38 - 39); 42 C.F.R. § 483.75(i) (HCFA Ex. 17 at 39 - 40); 42 C.F.R. § 483.75(l)(1) (HCFA Ex. 17 at 40 - 43). These conclusions are supported by the evidence which relates to Petitioner's failure aggressively to prevent or to treat pressure sores. I sustain these conclusions with the exception – which I explain below – that I do not sustain the surveyors' conclusion that Petitioner did not comply substantially with the requirements of 42 C.F.R. § 483.30(a)(1) and (2).

It is not necessary for me to discuss in detail my analysis of the evidence which results in my sustaining these conclusions. Finding the presence of deficiencies in addition to the ones that I have discussed in detail does not make any difference to my overall conclusion that Petitioner was not complying with participation requirements as of April 15 - 17, 1997. Nor would it result in my sustaining greater civil money penalties than those which I have sustained for the period that begins with April 16, 1997.

I do not sustain the surveyors' conclusion that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.30(a)(1) and (2). The requirement that is stated under this regulation is that a long-term care facility must have sufficient numbers of nursing staff to provide requisite care. I conclude that HCFA did not make out a prima facie case that Petitioner had an inadequate number of nursing staff. As I discuss in my recent decision in Life Care Center at Hendersonville, DAB CR542 (1998), a finding that a facility maintains inadequate numbers of staff may not be based solely on evidence that shows that the facility provided a quality of care or life that is poor. That is because there may be many reasons to explain poor care besides inadequate staffing. Here, the surveyors based their conclusions essentially on the quality of care that they found that Petitioner provided. They made no measurements of the numbers of staff on hand or on the ratio of staff to patients.

11. HCFA established a basis to impose a civil money penalty against Petitioner in the range of civil money penalties that is imposed to remedy noncompliance at a level of less than immediate jeopardy for each day of the period beginning on April 17, 1997, and running through May 21, 1997.

The prerequisite elements exist to establish a basis to impose a civil money penalty against Petitioner in the lower range of civil money penalties for each day of the period which begins on April 17, 1997, and which runs through May 21, 1997. HCFA determined that Petitioner did not attain substantial compliance with participation requirements until May 22, 1997. Petitioner did not rebut this determination. Petitioner argued that it was complying fully with all participation requirements as of April 17, 1997. But, as I have found above at Finding 10, that is not the case.

12. A civil money penalty of $1,500 per day for each day of the period which begins on April 17, 1997, and which runs through May 21, 1997, is reasonable.

I sustain a civil money penalty of $1,500 per day against Petitioner for each day of the period which begins on April 17, 1997, and which runs through May 21, 1997. The amount of the penalty falls in the middle of the range of penalties (of from $50 - $3,000 per day) which is permitted for deficiencies that are not at the level of immediate jeopardy.

I base my conclusion to sustain a $1,500 per day civil money penalty for the period on the following factors. First, the deficiencies that were identified at the April 15 - 17, 1997 survey of Petitioner were serious deficiencies. 42 C.F.R. § 488.404(b). I have found that, in some respects, Petitioner was causing actual harm to its residents.

Second, the relationship of deficiencies to each other establishes a generalized indifference by Petitioner to the welfare and safety of its residents. 42 C.F.R. § 488.404(c)(1). That is made evident by Petitioner's failures to: protect the rights of its residents; report and investigate unexplained injuries; maintain its facility; assess residents' conditions; and aggressively take preventive measures to assure that avoidable pressure sores did not occur.

Third, Petitioner manifested a history of noncompliance with participation requirements. 42 C.F.R. § 488.438(f)(1). By the dates of the April 15 - 17, 1997 survey, Petitioner had been out of compliance with participation requirements for nearly three months. And, several of the deficiencies that were identified at the April 15 - 17, 1997 survey were deficiencies that had been identified previously but which remained uncorrected. The

deficiencies that were identified in April, in some respects, reflect promises that Petitioner made after the February 10 - 13, 1997 survey to rectify deficiencies that Petitioner did not keep.

/s/

Steven T. Kessel
Administrative Law Judge