Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Golden Living Center - Riverchase, (CCN: 01-5145),	)	Date: September 30, 2009
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-07-448
	)	Decision No. CR2012
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

Petitioner, Golden Living Center - Riverchase, was not in substantial compliance with program participation requirements from January 9, 2007 through April 19, 2007 due to violations of 42 C.F.R. §§ 483.20(d) and 483.20(k)(1); 483.20(k)(3)(ii); 483.20(d); 483.25(c); 483.25(h)(2); 483.25(k); 483.25(n); 483.60(a)-(b); 483.60(b),(d),(e); and 483.75(m)(2).[1] A civil money penalty (CMP) of $500 per day for the period from January 9, 2007 through April 19, 2007, a total CMP of $45,500, is reasonable.

I. Background

Petitioner, located in Birmingham, Alabama, is authorized to participate in Medicare as a skilled nursing facility (SNF) and in the Medicaid program as a nursing facility (NF). Petitioner was subject to a survey by the Alabama Department of Public Health (the state agency) completed on March 4, 2007. Joint Stipulations, dated August 27, 2007 (Jt. Stip.) at 1, ¶¶ 1-2.

[1] References are to the version of the Code of Federal Regulations (C.F.R.) in effect at the time of the survey, unless otherwise indicated.

The Centers for Medicare & Medicaid Services (CMS) notified Petitioner by letter dated April 11, 2007 that based on regulatory violations that posed more than minimal harm to its residents, i.e. deficiencies, found by the March 2007 survey, CMS was imposing a CMP of $3050 per day for the period January 7, 2007 through March 2, 2007, and $500 per day beginning March 3, 2007 and continuing until Petitioner returned to substantial compliance; a denial of payment for new admissions (DPNA) beginning on June 4, 2007 and continuing until Petitioner returned to substantial compliance; and termination of Petitioner's provider agreement on September 4, 2007, if Petitioner did not return to substantial compliance before that date. Jt. Stip. at 2, ¶ 7.

Petitioner was found to have returned to substantial compliance with program participation requirements by a revisit survey completed on April 20, 2007, and the DPNA and termination remedies were never effectuated. During pendency of this proceeding, CMS modified the CMP to $3050 per day for the period January 9, 2007 through March 2, 2007, and $500 per day for the period March 3, 2007 through April 19, 2007. Jt. Stip. at 2, ¶ 8.

Petitioner timely filed a request for hearing by letter dated May 10, 2007. The request for hearing was docketed and assigned to me on June 7, 2007 for hearing and decision. A Notice of Case Assignment and Prehearing Case Development Order (Prehearing Order) was issued at my direction on June 12, 2007. A hearing was held in Birmingham, Alabama on January 24 and 25, 2008. A 425-page transcript (Tr.) of the hearing was prepared. CMS offered, and I admitted, CMS exhibits (CMS Ex.) 1 through 51. Tr. 13-15. Petitioner offered, and I admitted, Petitioner exhibits (P. Ex.) 1 through 60. Tr. 22, 376. CMS called as witnesses: Toni Williams; Sherry Brock; Surveyor Elizabeth McGraw, R.N.; Surveyor Connie Pavelec, M.S.N.; and Surveyor Grace Lowe. Petitioner called as witnesses: Trevina Wilson, R.N.; Jane Hand, R.N.; Sara Barber, R.N.; and Nancy Stanford, the facility's Executive Director or Administrator. The parties submitted post-hearing briefs (CMS Brief and P. Brief) and post-hearing reply briefs (CMS Reply and P. Reply).

II. Discussion

A. Issues

The issues in this case are:

> Whether there is a basis for the imposition of an enforcement remedy; and
>
> Whether the remedy imposed is reasonable.

B. Applicable Law

The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 (SNF) and 1919 (NF) of the Social Security Act (Act) and at 42 C.F.R. Part 483. Section 1819(h)(2) of the Act vests the Secretary with authority to impose enforcement remedies against a SNF for failure to comply substantially with the federal participation requirements established by sections 1819(b), (c), and (d) of the Act.[2] Pursuant to 1819(h)(2)(C), the Secretary may continue Medicare payments to a SNF not longer than six months after the date the facility is first found not in compliance with participation requirements. Pursuant to 1819(h)(2)(D), if a SNF does not return to compliance with participation requirements within three months, the Secretary must deny payments for all individuals admitted to the facility after that date – commonly referred to as the mandatory or statutory DPNA. In addition to the authority to terminate a noncompliant SNF's participation in Medicare, the Act grants the Secretary authority to impose other enforcement remedies, including a discretionary DPNA, CMPs, appointment of temporary management, and other remedies such as a directed plan of correction. Act § 1819(h)(2)(B).

The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. "*Substantial compliance* means 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 (emphasis in original). A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act or the Secretary's regulations at 42 C.F.R. Part 483, subpart B. Facilities that participate in Medicare may be surveyed on behalf of CMS by state survey agencies in order to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-488.28, 488.300-488.335. The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406.

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMPs, $3050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents and, in some circumstances, for repeated

[2] Section 1919(h)(2) of the Act gives similar enforcement authority to the states to ensure that NFs comply with their participation requirements established by section 1919(b), (c), and (d) of the Act.

deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). Pursuant to 42 C.F.R. § 488.301, "*(i)mmediate jeopardy* means 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." (Emphasis in original.) The lower range of CMPs, $50 per day to $3000 per day, is reserved for deficiencies that do not constitute immediate jeopardy but either cause actual harm to residents, or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii).

The Act and regulations make a hearing before an administrative law judge (ALJ) available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act § 1128A(c)(2); 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et al*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Cal Turner Extended Care*, DAB No. 2030 (2006); *The Residence at Salem Woods*, DAB No. 2052 (2006). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e) and 498.3. However, the choice of remedies by CMS or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge would affect the range of the CMP that could be imposed by CMS or impact the facility's authority to conduct a nurse aide training and competency evaluation program. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i). The CMS determination as to the level of noncompliance "must be upheld unless it is clearly erroneous" (42 C.F.R. § 498.60(c)(2)), including the finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9, 38 (2000), *aff'd, Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g., Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Review of a CMP by an ALJ is subject to 42 C.F.R. § 488.438(e).

The standard of proof or quantum of evidence required is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a prima facie showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *See Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd, Hillman Rehabilitation Ctr. v. United States Dep't of Health and Human Services, Health Care Fin. Admin.*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999); *Cross Creek Health Care Center*,

DAB No. 1665 (1998); *Emerald Oaks*, DAB No. 1800; *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x 181 (6th Cir. 2005); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004).

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold followed by a statement of the pertinent facts and analysis.

Petitioner limited its request for hearing to the alleged deficiencies from the survey that ended on March 4, 2007, that allegedly posed immediate jeopardy or amounted to substandard quality of care. Petitioner challenges the alleged violations of: 42 C.F.R. § 483.13 (Tags F223, F225, and F226[3]), which were cited as a scope and severity (S/S)[4]

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[3] This is a "Tag" designation as used in CMS Publication 100-07, State Operations Manual (SOM), Appendix PP – Guidance to Surveyors for Long Term Care Facilities (http://www.cms.hhs.gov/Manuals/IOM/list.asp). The "Tag" refers to the specific regulatory provision allegedly violated and CMS's guidance to surveyors. Although the SOM does not have the force and effect of law, the provisions of the Act and regulations interpreted clearly do have such force and effect. *State of Indiana by the Indiana Department of Public Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991); *Northwest Tissue Center v. Shalala*, 1 F.3d 522 (7th Cir. 1993). Thus, while the Secretary may not seek to enforce the provisions of the SOM, the Secretary may seek to enforce the provisions of the Act or regulations as interpreted by the SOM.

[4] Scope and severity levels are used by CMS and a state when selecting remedies. The scope and severity level is designated by an alpha character, A through L, selected by CMS or the state agency from the scope and severity matrix published in the SOM, Chapter (Ch.) 7, § 7400E. A scope and severity level of A, B, or C indicates a deficiency that presents no actual harm but has the potential for minimal harm, which is an insufficient basis for imposing an enforcement remedy. Facilities with deficiencies of a level no greater than C remain in substantial compliance. 42 C.F.R. § 488.301. A scope and severity level of D, E, or F indicates a deficiency that presents no actual harm but has the potential for more than minimal harm that does not amount to immediate jeopardy. A scope and severity level of G, H, or I indicates a deficiency that involves actual harm that does not amount to immediate jeopardy. Scope and severity levels J, K, and L are deficiencies that constitute immediate jeopardy to resident health or safety. The matrix, which is based on 42 C.F.R. § 488.408, specifies which remedies are required and optional at each level based upon the frequency of the deficiency.

of I,[5] widespread actual harm that was not immediate jeopardy; and 483.25(h)(2) (Tag F324), which was cited at a scope and severity of J, an isolated instance of immediate jeopardy.[6] Request for Hearing at 2; Jt. Stip. at 2, ¶ 6. The uncontested deficiencies are violations of: 42 C.F.R. §§ 483.20(d) and 483.20(k)(1) (Tag F279, S/S D); 483.20(k)(3)(ii) (Tag F282, S/S D); 483.20(d) (Tag F286, S/S D); 483.25(c) (Tag F314, S/S G); 483.25(k) (Tag F328, S/S D); 483.25(n) (Tag F334, S/S D); 483.60(a)-(b) (Tag F425, S/S D; 483.60(b),(d),(e) (Tag F431, S/S D); and 483.75(m)(2) (Tag F518, S/S E).[7] Petitioner acknowledged at hearing and in its post-hearing brief that the unchallenged deficiencies provide a basis for the imposition of a CMP in the lower range of CMPs authorized by the regulations. Tr. 29, 416-17; P. Brief at 3. Petitioner urges me to find in its favor on the challenged deficiencies; to disapprove entirely the CMP based upon the violation alleged to have posed immediate jeopardy; and to reduce substantially the CMP related to the non-immediate jeopardy violations. Tr. 29.

CMS advised me at hearing that it would not proceed upon example 2 under Tag F225 related to Resident 19. Tr. 27; P. Ex. 1, at 12.

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[5] The parties stipulated that based upon informal dispute resolution (IDR), the state agency deleted the citation of Tag F223 and reduced the scope and severity of the citations of Tags F225 and F226 to E. However, CMS rejected the IDR result and the tags remain in issue as originally cited. Nevertheless, CMS admitted as evidence the SOD that was amended to reflect the IDR result. CMS Ex. 1. Therefore it is necessary to refer to the version of the SOD admitted in evidence as P. Ex. 1. Tr. 290.

[6] Petitioner asserts in its request for hearing that it elects the 35 percent regulatory reduction with respect to any CMP not related to the challenged deficiencies. Pursuant to 42 C.F.R. § 488.436, if a facility waives its right to hearing in writing, CMS or the state will reduce the CMP amount by 35 percent. Because Petitioner requested and has received a hearing, I would conclude that Petitioner has not satisfied the condition necessary to receive the 35 percent reduction under the regulation. However, I leave that issue to CMS for resolution, as application of that regulation to the CMP I approve is not an issue before me.

[7] Scope and severity ratings of D or E indicate a deficiency that does not cause actual harm but that has the potential for causing more than minimal harm, with D indicating an isolated instance while E indicates a pattern of incidents. A scope and severity of G indicates an isolated instance of actual harm that is not immediate jeopardy.

1. It is undisputed that Petitioner's request for hearing was timely and that I have jurisdiction to decide the issues.

2. Petitioner did not violate 42 C.F.R. § 483.13(b) (Tag F223).

The surveyors allege in the Statement of Deficiencies (SOD) for the survey that concluded on March 4, 2007, that Petitioner violated 42 C.F.R. § 483.13(b) because Petitioner failed to ensure that: (a) Resident 8 was free from verbal abuse by two certified nurse assistants (CNA); and (b) the CNAs continued to work at the facility after the allegation of abuse was made, contrary to facility policy.[8] P. Ex. 1, at 1.

a. Facts

Resident 8, a female, was 83 years and 11 months of age on February 26, 2007. She was admitted to Petitioner's facility on November 30, 2006. She was assessed as having, among other things, congestive heart failure with severe renal stenosis, neuropathy, atrial fibrillation, insulin-dependent diabetes mellitus, depression, and renal insufficiency. P. Ex. 1, at 1; CMS Ex. 8, at 20, 30-54. Resident 8's Minimum Data Set (MDS) with an assessment reference date of January 9, 2007, reflects that Resident 8 was cognitively intact and independent for daily decision-making. CMS Ex. 8, at 15. The MDS shows that Resident 8 required extensive assistance with all activities of daily living except eating, for which she required limited assistance. For transfers she required two or more persons to assist her, she required one person to assist with bed mobility, and she required one person to assist with locomotion in her wheelchair. CMS Ex. 8, at 18-19. Resident 8's December 2006 care plan was updated by a handwritten entry dated February 22, 2007 that required the use of a mechanical lift for transfers. The care plan does not specify the type of mechanical lift to be used. CMS Ex. 8, at 50. Resident 8's new care plan dated March 1, 2007, specified use of a mechanical lift and total assist of two persons for all transfers. CMS Ex. 8, at 30.

The surveyors allege in the SOD that Resident 8 reported to a surveyor and the Assistant Director of Nursing (ADON) at 2:45 p.m. on February 27, 2007, and in subsequent interviews on February 28 and March 1, 2007, that: (1) during the preceding morning of

[8] The requirement for a facility to prevent further potential abuse while its investigation is in process is found at 42 C.F.R. § 483.13(c)(3) (Tag F225) and not 42 C.F.R. § 483.13(b) (Tag F223). Therefore, the allegation that the CNAs were permitted to continue to work is addressed only under Tag F225.

February 26, 2007, between about 6:30 a.m. and 7 a.m.,[9] two CNAs attempted to transfer her without a lift; (2) she slid to the floor; (3) when she was placed in her wheelchair, the two CNAs would not position her legs up and out straight; (4) the CNAs hollered at her not to pull on their backs; (5) they fussed at her; and (6) they "blessed her out." P. Ex. 1, at 2. Resident 8 reported that the CNAs eventually retrieved a lift and put her in her wheelchair but left her sitting on the sling for the reminder of the day.

Nurse's notes dated February 26, 2007 at 4:21 p.m., do not mention a fall on that date or any injury. Nurse's notes from February 27, 2007 at 10:39 a.m., state that Resident 8 was receiving a return admission assessment; that she had aggressive diuresis during her past hospital stay (with no indication of when she was hospitalized); and that she had a blister on both her right and left thighs. There is no reference to a fall or abrasions to her buttocks. A note from February 27, 2007 at 12:43 p.m., reflects blisters to her right and left thighs. A note on February 28, 2007 at 3:57 p.m., indicates blisters were noted on Resident 8's bilateral lower limbs, hips, and buttock. On March 1, 2007, Resident 8 was sent to the hospital due to complaints of shortness of breath and chest tightness and her return is noted on March 5, 2007. A note dated March 9, 2007 at 10:50 a.m., noted blisters on her abdomen, torso, legs, hips, and buttocks, bruises were present on her left leg and abrasions were noted on her buttocks. P. Ex. 25; CMS Ex. 8, at 61-63. The nurse's notes do not refer to a fall on February 26, 2007 or any abrasions on Resident 8's buttocks prior to March 9, 2007. An IPN (interdisciplinary progress note) dated February 27, 2007 at 6:32 p.m., indicates that Resident 8 fell during an assisted transfer in her room at 6 a.m. on February 26, 2007, and she had abrasions on the left and right buttock that the resident said were due to the fall, and first aid was administered. CMS Ex. 8, at 10. A nurse's treatment note from February 27, 2007 at 9 a.m., indicates that Resident 8 had blisters filled with fluid on her upper legs and buttocks that were treated. There is a similar note dated February 28, 2007. CMS Ex. 8, at 58. No reference is made to any abrasions.

On February 27, 2007, Resident 8's granddaughter filed a grievance form that alleged, *inter alia*, that Resident 8 was lifted out of bed without a lift, that she slid to the floor, and that the CNAs "fused [sic]" at her. CMS Ex. 8, at 6; P. Ex. 28; Tr. 253-54. Several other complaints were also listed on the grievance form. The form indicated that the

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[9] A witness reported overhearing the incident and that it occurred about 6:30 a.m. P. Ex. 1, at 4. The two CNAs allegedly involved had worked the 11 p.m. to 7 a.m. shift. P. Ex. 1, at 3.

Administrator and Director of Nursing Services [10] were investigating. The report of the investigation dated February 27, 2007 at 10 p.m. indicates the incident was investigated as a fall based upon a report by the resident that the two CNAs attempted to move her without a lift and she fell to the ground. The report indicates that immediate resident protection was not required and that staff received in-service training for use of lifts and two-person assist for transfers. The report also indicates that Resident 8's care plan was revised.[11] CMS Ex. 8, at 7-8. A form titled "Change In Condition Report – Post Fall/Trauma" was also completed and dated February 27, 2007, that reflects the incident was treated as a fall and lists the same remedial action as the report of investigation. CMS Ex. 8, at 11-12.

CMS called Toni Williams to testify. Ms. Williams testified that her grandmother was a resident in a room that shared the bathroom with Resident 8; that she had spent the night in her grandmother's room; when she went into the bathroom in the morning she heard a commotion in Resident 8's room but the door to Resident 8's room was closed so she could not see who was present with Resident 8; she heard someone say "[i]t's your fault" but could not identify the speaker but assumed it was a CNA; she recognized the voice of one CNA; she thought that the people in Resident 8's room were upset; she did not hear Resident 8. Tr. 35-39. She testified that she left her grandmother's room and saw Resident 8 sitting on the floor in her room with a CNA standing over her. She passed another CNA in the hallway pushing a full body lift. Returning to her grandmother's room she looked in Resident 8's room again and saw her sitting in her wheelchair. She testified that she spoke with Resident 8 and she later asked Ms. Williams to elevate her legs but Ms. Williams went to get a nurse to assist Resident 8. Ms. Williams testified that Resident 8 was sitting on a lift pad. Tr. 39-45. Ms. Williams testified that she had problems with Petitioner's Administrator because she felt her grandmother was mistreated and her grievances were not handled correctly. She testified that the Administrator told her that she needed to stay in her grandmother's room and not interact with staff and other residents as family members had complained about her entering other residents' rooms. Tr. 47. On cross-examination Ms. Williams identified the handwriting on the Surveyor Notes Worksheet as her own and she testified that she wrote and signed the statement at the surveyor's request. Tr. 56, 63, 66-67. She testified on cross-

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[10] Petitioner uses the title Executive Director for a position that is commonly referred to in the industry as Administrator and Director of Nursing Services for a position referred to in the industry as Director of Nursing. Hereafter the positions are referred to as Administrator and DON, respectively.

[11] An entry dated February 27, 2007 regarding a fall does appear on Resident 8's care plan. CMS Ex. 8, at 50.

examination that she actually heard both CNAs speak during the incident on February 26, 2007, and one of the CNAs said "[i]t's your fault." Tr. 69. When she saw Resident 8 later, she was not complaining. Tr. 77. Ms. Williams testified in response to my questioning that she could not recall whether she actually heard two voices in Resident 8's room and that she could really only remember hearing one voice. Tr. 82-83. Referring to her written statement at CMS Ex. 16, at 13, she testified that by using the phrase "disrespectful and nasty" she meant that the CNAs were not being very nice to Resident 8. She testified that the voices she heard were not very loud, she did not hear any belittling words being used, she did not hear any curse words or profanity, she simply felt that Resident 8 was being blamed and she did not consider that nice, and she never heard the words fall or fell. Tr. 83-85. Ms. Williams agreed that she did not see or hear Resident 8 fall. Tr. 88. She testified that she recognized that the lift pad was under Resident 8 in the wheelchair due to the pad's unique color. Tr. 91-92. Ms. William's testimony is inconsistent with her written statement at CMS Ex. 16, at 13. In her statement Ms. Williams stated she heard two CNA's who she identified by name, she stated the CNA's were "fussing at [Resident 8] about falling." She indicated in her written statement that she saw the lift pad under Resident 8 the second time she passed and looked in the room and that is when Resident 8 asked that Ms. Williams elevate her legs rather than at some later time. In her statement she wrote that the tone of voice used by the two CNAs was "disrespectful and nasty" but at hearing she could not recall for sure that she heard two voices. CMS Ex. 16, at 13.

Petitioner called Sara Barber, R.N. to testify. R.N. Barber testified that during the survey she was Petitioner's interim DON. Tr. 347. She testified that she was given a grievance related to Resident 8 early in the survey that did not appear to be an abuse issue but rather an issue related to whether Resident 8 received a shower. Later the same day, it came to her attention that the resident complained to the ADON and the surveyor during an interview that she was dropped by the two CNAs and that they "talked ugly" but it was not clear whether the resident meant they spoke ugly to each other or to her. Tr. 348-49. She interviewed the CNAs separately and neither mentioned dropping Resident 8. Tr. 350. R.N. Barber testified that she found no evidence that Resident 8 had actually been dropped. She looked at the resident's body the day she received the grievance (which would have been February 27, 2007 according to other evidence) and found no redness, no bruising, and no abrasions. She was aware that blisters were found on the resident's buttocks but opined that the blisters were unlikely due to a fall to the floor. Tr. 352-53. She testified that at some point the allegation changed from the CNAs being ugly to being abusive. She testified that she spoke to the resident and the resident did not complain of anyone being abusive or dropping her. Tr. 354. R.N. Barber testified that Toni Williams moved in with her grandmother and occupied the empty bed in the room. Ms. Williams refused to shower and she was told she could not use the empty bed and needed to go home, though staff was aware she was homeless and really cared for her

grandmother, so they let her stay. R.N. Barber testified that she had to tell Ms. Williams several times that she could not go into other residents' rooms and ask about their medications and diagnoses, and Ms. Williams reacted very rudely. She was aware that Toni Williams despised both accused CNAs because she witnessed when they told Ms. Williams to clean-up after herself, and that they were not her maids. She knew that Ms. Williams continuously complained about how bad both CNAs were. She testified that Resident 8's granddaughter told her that Ms. Williams told her about the alleged incident on February 26. She testified that she interviewed other staff and found no evidence that either CNA used abusive language. She also testified that she never found evidence to substantiate that Resident 8 actually fell or was verbally abused on February 26, 2007. Tr. 354-58.

Surveyor Connie Pavelec testified that she was responsible for conducting the survey related to Resident 8 and for citing Tags F223, F225, and F226. Tr. 203. She testified that she went to Resident 8's room during her initial tour on February 27, 2007, and when she asked Resident 8 how her stay was, Resident 8 complained about two nurses trying to get her up without a lift, she slid to the floor, she was left on a pad all day, and staff would not elevate her legs. Tr. 203-04. She testified that she did two subsequent interviews and each time Resident 8 provided more detail. She testified that Resident 8 told her the nurses hollered at her, that she should not pull on their backs because she was going to hurt their backs; Resident 8 said she landed on the floor softly but the nurses were very upset or mad at her; and that Resident 8 was upset or angry and flushed while relating her story. Tr. 204-05. Resident 8 told her that she was left sitting on the lift pad all day and that a hard metal object the size of a quarter or 50-cent piece hurt her bottom. Surveyor Pavelec did not observe Resident 8's bottom but she was aware of a history of pressure sores and later some nurses told her Resident 8's bottom was bleeding. She admitted she was not familiar with lift pads or slings and she did not see the sling or pad in question but she asked to see a similar sling and did not see anything on the sling that would have caused Resident 8 any kind of blisters, but she agreed with CMS counsel that one of the grommets used to attached the sling could have slid under Resident 8. Her perception was that Resident 8 was cognitively intact. Tr. 205-07. Surveyor Pavelec interviewed Toni Williams. Tr. 210. She also interviewed LPN Hubert Daniels who verified Ms. Williams' statement that she got him to elevate Resident 8's legs. Tr. 211; CMS Ex. 20, at 14. Surveyor Pavelec also interviewed CNA Katrina Holiday who told her that when she was putting Resident 8 to bed the resident complained that her bottom was bleeding and she observed that Resident 8's bottom was bruised, reddish, and bleeding and later Resident 8 seemed depressed. Tr. 214-16. Surveyor Pavelec testified that CNA Holiday told her that Ms. Williams said she was going to report the incident with Resident 8 as an incident of "verbal harassment, a verbal altercation, ..." Tr. 216-18. Surveyor Pavelec interviewed both CNAs allegedly involved and they did not admit any facts related to a fall, verbal abuse, or other inappropriate conduct. Surveyor

Pavelec's testimony suggested that she did not believe the CNAs. Tr. 231. Surveyor Pavelec testified that Petitioner made no report of alleged abuse to the state agency within 24 hours of the incident and that the report was not made until March 5, 2007. She concluded that Petitioner's investigation was incomplete because Petitioner did not interview staff, they did not interview Toni Williams, and they did not interview Resident 8. Petitioner violated its own policy because it did not suspend the two CNAs allegedly involved during the investigation until after the issue was raised by the surveyors. Tr. 232-34. Surveyor Pavelec testified that the IDR panel deleted the alleged violation of Tag F223 because she had done an incomplete interview of the two CNAs because she did not ask them about verbal abuse. She subsequently conducted telephone interviews with both CNAs on July 10 and 11, 2007, which are memorialized in CMS Exs. 41 and 42. Tr. 240. Surveyor Pavelec testified that her interview with Toni Williams convinced her that abuse was an issue due to the "tones with which the CNAs spoke to the resident." Tr. 241. She testified that the survey team felt at the end of the survey that there was sufficient evidence to substantiate an allegation of abuse by the CNAs based on "the way the resident was feeling, the way that she was made to feel through the whole event, was evidence that there had been an interchange of words that were conducive to verbal abuse." Tr. 241-42. She conceded however, that at the end of both statements recorded on CMS Exs. 41 and 42, she noted that she was unable to substantiate verbal abuse and she testified that she felt that was necessary due to the results of the IDR. Tr. 242. On cross-examination, Surveyor Pavelec conceded that the grievance form filed by Resident 8's granddaughter on February 27, 2007 said nothing about the CNAs hollering at or blaming Resident 8 for the alleged fall. Tr. 254-55; CMS Ex. 8, at 6; P. Ex. 28. Surveyor Pavelec conceded on cross-examination that she did not investigate Resident 8's complaint that she was made to sit on the lift sling all day and that was uncomfortable. Tr. 257-62. She agreed that sling seats are made to be sat upon. She testified that she observed a sling that she was told was similar to the one used with Resident 8 and she observed no metal parts other than the grommets on either end of the sling used to attach the sling to the lift. Tr. 262-63. Surveyor Pavelec agreed that she found no nursing notes from February 26, 2007 that showed that Resident 8 complained of pain or discomfort associated with a fall on the morning of February 26. The only record she found was the IPN dated February 27, 2007 at 6:32 p.m., that indicates that Resident 8 fell during an assisted transfer in her room at 6 a.m. on February 26, 2007, and she had abrasions on the left and right buttocks that the resident said were due to the fall. Tr. 273-76; P. Ex. 25; CMS Ex. 8, at 10, 61-63. She testified that at the time of the alleged fall, Resident 8's roommate was in the hospital. Tr. 277-78.

Petitioner's Administrator Nancy Stanford testified that during the morning of February 27, 2007, she received a telephone call from Resident 8's granddaughter, the substance of which she recorded on the grievance form (CMS Ex. 8, at 6; P. Ex. 28). She testified that she was familiar with Resident 8's granddaughter and she did not perceive that she was

upset but she said she wanted Ms. Stanford to check on some patient care issues. Ms. Stanford testified that the granddaughter did not allege that Resident 8 had been dropped or abused, only that she had slid to the floor and the CNAs were talking ugly. She gave R.N. Barber the task of investigating the grievance because she was busy with the survey. Tr. 383-85, 408. She testified that during the evening on February 27, 2007, the CNA asked her to look at Resident 8. When the CNA removed Resident 8's diaper Administrator Stanford observed bright red blood which she thought to be rectal or hemorrhoid bleeding. However, a nurse came to the room and dressed both buttocks. Tr. 385-87. Administrator Stanford testified that Resident 8 did not complain about being mistreated, upset, or dropped when she observed her buttocks on February 27. Tr. 390-91. Resident 8's granddaughter did call the state hotline and made a complaint. Tr. 388-90; P. Ex. 48. She participated in the investigation when it became an allegation of verbal abuse on March 1 or 2, 2007. She interviewed the two CNAs. She concluded that no abuse occurred, but that Resident 8's story kept growing. Tr. 392-99.

A Beverly Healthcare and Rehabilitation, Inc. Statement Form dated March 7, 2007, purports to record the interview of Resident 8 regarding the alleged verbal abuse of her. The form indicates that Resident 8 said that two of "them," which I construe refers to two CNAs, let her fall to the floor approximately two weeks before the statement; the two CNAs came to place her in her wheelchair and they tried to do so without a lift; when they picked her off the bed they had to put her on the floor; they started abusing her, "not hitting [her] or anything, just what they were saying to [her], that kind of abusing," the CNAs were saying "that it was [her] fault, that it would not have happened [if she] had done what they said, that kind of stuff." P. Ex. 33 at 2-3. Resident 8 further indicated that the CNAs got the lift and put her in her chair, they were mad at her, and they refused to put her legs up. P. Ex. 33, at 3.

The two CNAs involved deny that they attempted to transfer Resident 8 without a lift, that Resident 8 had to be lowered to the floor, or that they verbally abused Resident 8. P. Ex. 29, at 5-7; P. Ex. 33, at 5-9.

The state investigation of the two CNAs allegedly involved could not substantiate abuse. P. Ex. 36.

b. Analysis

A resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion as provided by 42 C.F.R. § 483.13(b). "Abuse" is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. 42 C.F.R. § 488.301. According to the SOM, Guidance to Surveyors, Tag F223, verbal

abuse is "the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of there age, ability to comprehend, or disability." The Board has held that "[p]rotecting and promoting a resident's right to be free from abuse necessarily obligates the facility to take reasonable steps to prevent abusive acts, regardless of their source." *Western Care Management Corp.*, DAB No. 1921, at 12 (2004); *Pinehurst Healthcare & Rehabilitation Center*, DAB No. 2246, at 6 (2009). The Board's prior holdings reflect the conclusion that 42 C.F.R. § 483.13(b) does not make a facility strictly liable for all incidents of abuse that may occur.

CMS argues that the facts show that Petitioner was not in substantial compliance with Tag F223 because it failed to ensure that Resident 8 was free from verbal abuse by two CNAs during an improper transfer on February 26, 2007. CMS Brief at 15-16; CMS Reply at 2-4. However, I conclude that the evidence does not show that any abuse occurred. The only direct evidence of the incident comes from Resident 8 and Ms. Williams.

Resident 8's statement dated March 7, 2007, was that two CNAs came to place her in her wheelchair and they tried to do so without a lift; when they picked her off the bed they had to put her on the floor; they started abusing her, "not hitting [her] or anything, just what they were saying to [her], that kind of abusing," the CNAs were saying "that it was [her] fault, that it would not have happened [if she] had done what they said, that kind of stuff." P. Ex. 33 at 2-3. Ms. Williams' sworn testimony at hearing was internally inconsistent and also inconsistent in respects with the prior written statement she gave the surveyors. In her written statement, she characterized the CNAs as fussing at Resident 8, and she characterized their "tone" as disrespectful and nasty. "They did not use profanity, but were very nasty with their words. They faulted [Resident 8] for falling. They accepted no part in the incident." CMS Ex. 16, at 13. She testified at hearing that she could not recall whether she actually heard two voices in Resident 8's room and she could only remember hearing one voice. Tr. 82-83. Ms. Williams testified that she meant by the phrase "disrespectful and nasty" that the CNAs were not being very nice to Resident 8. She testified that the voice or voices she heard were not very loud, she did not hear belittling words, curse words, or profanity. She testified that she felt it was not nice for the CNAs to blame Resident 8. Tr. 83-85. I find that the statement of Resident 8 and the statement and testimony of Ms. Williams do not show that Resident 8 was verbally abused by the two CNAs. The evidence does not show any willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. 42 C.F.R. § 488.301.

Surveyor Pavelec's testimony (Tr. 216-18) and her notes reflecting her interview with CNA Holiday (CMS Ex. 16, at 17) in which CNA Holiday told Surveyor Pavelec that Resident 8 complained to her the evening of February 26, 2007, that she had been talked to like she was not a human being and that Resident 8 seemed depressed to CNA Holiday, is simply too unreliable to be treated as weighty evidence. We have no clear idea about what Resident 8 meant by saying that she had been spoken to like she was not a human being. Surveyor Pavelec's notes also indicate that Resident 8 never told CNA Holiday who she was referring to. I have no evidence that CNA Holiday was qualified to determine whether Resident 8 was manifesting depression or whether Resident 8 was simply angry. I further note that Resident 8 had a history of depression prior to the alleged incident.

Accordingly, I conclude that Petitioner did not violate 42 C.F.R. § 483.13(b) (Tag F223).

3. Petitioner did not violate 42 C.F.R. § 483.13(c) (Tag F225 or F226).

The surveyors allege in the SOD under Tag F225 that Petitioner violated 42 C.F.R. § 483.13(c) and all its subsections because: (1) the allegation of verbal abuse of Resident 8 by two CNAs was not immediately reported to Petitioner's Executive Director/Administrator and to the state agency within 24 hours; (2) Petitioner did not thoroughly investigate the allegation of verbal abuse of Resident 8;[12] and (3) Petitioner did not report to the Board of Nursing that a licensed nurse on staff was found guilty of misappropriation of Resident 2's pain medication. P. Ex. 1, at 8.

The surveyors allege in the SOD under Tag F226 that Petitioner violated 42 C.F.R. § 483.13(c) because Petitioner failed to follow its own policy and procedure for "Reporting Alleged Violations" because: (1) staff did not immediately report the alleged verbal abuse of Resident 8 to the Executive Director/Administrator; (2) the allegation was not fully investigated because Petitioner failed to interview Resident 8, visitors and staff members who had knowledge; and (3) the two CNAs alleged to have committed the abuse continued to work during the investigation. P. Ex. 1, at 15.

> a. Petitioner had the policy required by 42 C.F.R. § 483.13(c) and did not violate that policy by the reporting and investigation of the incident involving Resident 8 during the morning of February 26, 2007.

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[12] CMS determined at hearing not to pursue the example related to Resident 19. Tr. at 27.

(i) Facts

The facts related to the alleged verbal abuse of Resident 8 have been set forth in detail under the discussion of Tag 223.

(ii) Analysis

The surveyors allege at Tag F225, related to the incident involving Resident 8, that Petitioner failed to ensure that an allegation of verbal abuse was immediately reported to the facility's Executive Director/Administrator and to the state agency within 24 hours of the alleged verbal abuse; and Petitioner failed to thoroughly investigate the allegations of verbal abuse. P. Ex. 1, at 8. Under Tag F226, the surveyors allege that Petitioner failed to implement or violated its policy because staff did not immediately report the alleged abuse to the Administrator; Petitioner did not conduct a thorough investigation; and Petitioner did not protect Resident 8 from further abuse by ensuring that the two CNAs allegedly involved, did not work with her during the investigation. The two alleged deficiencies are discussed together for convenience as they are based upon the same regulatory provision and turn upon the same facts.

The regulation requires:

> (c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
>
> * * * *
>
> (2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).
>
> (3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

* * * *

> (4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

42 C.F.R. § 483.13(c).

There is no dispute that Petitioner had the policy required by 42 C.F.R. § 483.13(c), and it is quoted at length in the SOD. P. Ex. 1, at 15-16. Petitioner also placed a copy of its policy in evidence as P. Ex. 41. The provisions of Petitioner's policy included in the SOD impose upon all employees the responsibility to immediately report any alleged abuse to the Administrator and the Administrator notifies the appropriate state agency in accordance with state law. The policy provides that the Administrator will place any employee accused of abuse on suspension while the investigation is completed. The policy further provides that the investigation will include interviews of employees, visitors, or residents who might have knowledge of the alleged incident. P. Ex. 1, at 15-16.

The fact that I have found the evidence does not show that Resident 8 was verbally abused by the two CNAs during the early morning of February 26, 2007, does not exonerate Petitioner of the charges under Tags F225 and F226. Petitioner is obligated to investigate and report allegations of abuse pursuant to the policy it adopts to comply with 42 C.F.R. § 483.13(c), whether or not the allegations prove founded. Petitioner argues that as soon as it was determined that Resident 8 was actually complaining of abuse, there was a prompt and thorough investigation. P. Brief at 16.

The alleged fall and verbal abuse of Resident 8 occurred between 6:30 a.m. and 7 a.m. on Monday, February 26, 2007. P. Ex. 1, at 2. There is no evidence that, on February 26, 2007, Resident 8 or Toni Williams, the only two witnesses to the incident other than the alleged perpetrators, reported that Resident 8 was verbally abused. According to the notes of Surveyor Pavelec who interviewed CNA Holiday on March 2, 2007,[13] Resident 8 complained to CNA Holiday during the evening of February 26 that she had been on the floor in the morning of February 26, and that she was still bleeding. CNA Holiday told Surveyor Pavelec that she looked at Resident 8's buttocks and it appeared bruised

[13] This was four days after the alleged incident.

and reddened like from a fall, and there was bleeding. CNA Holiday told Surveyor Pavelec that she had not seen redness on Resident 8's bottom on the previous Friday when she worked with her. CNA Holiday then called for the Administrator, Nancy Stanford. According to CNA Holiday, the Administrator interviewed Resident 8 and the Administrator later told CNA Holiday that Resident 8 did not say she fell. CNA Holiday told Surveyor Pavelec that she later checked on Resident 8 who seemed to be depressed and complained that she had been talked to like she was not a human being, without stating who spoke to her like that. CNA Holiday also told Surveyor Pavelec that Resident 8 was confused at times. CNA Holiday told Surveyor Pavelec that she only worked Monday, Wednesday and Friday. CMS Ex. 16, at 17. Surveyor Pavelec's notes do not indicate that CNA Holiday understood Resident 8 to have complained that she was verbally abused.

Administrator Stanford testified that CNA Holiday called for her during the evening on February 27, 2006 rather than February 26, 2007. Administrator Stanford testified that CNA Holiday had the diaper off Resident 8, that there was bright red blood on the diaper, and she went to get a nurse who came and applied a dressing on each buttock. Tr. 385-86. I conclude that Administrator Stanford's memory was faulty regarding the date on which she was called by CNA Holiday. There are no nurse's notes that reflect that dressings were applied to Resident 8's buttocks on either Monday, February 26, 2007 or Tuesday, February 27, 2007. P. Ex. 25. However, I am confident that CNA Holiday remembered her work schedule for the week preceding her discussion with Surveyor Pavelec and she correctly remembered that she worked Monday, February 26, 2007 and not Tuesday, February 27, 2007. Therefore, I conclude that Administrator Stanford was actually called to Resident 8's room by CNA Holiday on February 26, 2007. Administrator Stanford testified that when she saw Resident 8, the resident did not complain about being upset or mistreated or that she had been dropped. Tr. 390-91.

On February 27, 2007, Resident 8's granddaughter filed a grievance that was heard and recorded by Administrator Stanford on a grievance form. The grievance as recorded by Administrator Stanford was:

> States [Resident 8] has had one [deletion] shower this week, was lifted out of bed [without] lift [and] slid to floor [and] CNAs were fusing [at] her; states one week ago did not get treatment, [blood glucose] checks are given at night [and] insulin at night. States she is waiting for 1-2 hours with call-light.

CMS Ex. 8, at 6; P. Ex. 8; Tr. 253-54. The form indicated that the Administrator and the DON were investigating. Administrator Stanford testified that she received the grievance by telephone. Resident 8's granddaughter said she had some issues for Administrator Stanford to check. Administrator Stanford testified that she was familiar with the granddaughter's demeanor having dealt with her before and the granddaughter did not seem upset. Administrator Stanford did not construe the complaint of the granddaughter to be that Resident 8 was abused, though she did testify that the granddaughter may have said that the CNAs were "talking ugly." She testified that with approximately 20 years experience as an administrator she could distinguish between a patient care complaint and an abuse allegation. She testified she told the granddaughter that she would investigate and get back to her. Because the surveyors arrived the same day, she gave the investigation to R.N. Barber. Tr. 382-85.

R.N. Barber testified that during the survey she was Petitioner's interim DON. Tr. 347. She testified that she was given a grievance related to Resident 8 early in the survey that did not appear to be an abuse issue but rather an issue related to whether Resident 8 received a shower. Later the same day, it came to her attention that the resident complained to the ADON and surveyor during an interview that she was dropped by the two CNAs and that they "talked ugly" but it was not clear whether the resident meant they spoke ugly to each other or to her. Tr. 348-49. She testified that she spoke to the resident and the resident did not complain of anyone being abusive or dropping her. Tr. 354. She testified that she interviewed other staff and found no evidence that either CNA used abusive language. She also testified that she never found evidence to substantiate that Resident 8 actually fell or was verbally abused on February 26, 2007. Tr. 354-58; P. Ex. 30, 31.

The report of the investigation dated February 27, 2007 at 10 p.m., indicates the incident was investigated as a fall based upon a report by the resident that the two CNAs attempted to move her without a lift and she fell to the ground. The report indicates that immediate resident protection was not required and that staff received in-service training for use of lifts and two-person assist for transfers. The report also indicates that Resident 8's care plan was revised (CMS Ex. 8, at 7-8) and a revision is reflected on the care plan (CMS Ex. 8, at 50). An IPN dated February 27, 2007 at 6:32 p.m., indicates that Resident 8 fell during an assisted transfer in her room at 6 a.m. on February 26, 2007, and she had abrasions on the left and right buttock that the resident said were due to the fall, and first aid was administered. CMS Ex. 8, at 10. A form titled "Change In Condition Report – Post Fall/Trauma" was also completed and dated February 27, 2007, that reflects the incident was treated as a fall and lists the same remedial action as the report of investigation. CMS Ex. 8, at 11-12.

The evidence shows that Administrator Stanford was first called into the situation with Resident 8 on February 26, 2007, and she was then involved the next morning with receiving the grievance from Resident 8's granddaughter. Accordingly, it cannot be concluded that the Administrator was not on notice of the incident involving Resident 8. However, it is also clear that the Administrator and her staff did not recognize that there was a complaint of abuse related to Resident 8. Rather, the Administrator treated the situation as one requiring a fall investigation which was completed about 10 p.m. on February 27, 2007. I conclude that the Administrator was not unreasonable in not recognizing or treating the complaint as an abuse complaint on February 26 or 27, 2007. The definition of verbal abuse in Petitioner's policy (P. Ex. 41, at 5) is virtually identical to that in the SOM, Guidance to Surveyors, Tag F223, and the evidence does not show that there were any specific allegations that the CNAs used language that was "disparaging and derogatory" or included threats of harm, words intended to frighten Resident 8, or similar language. Because this situation did not initially involve an allegation of verbal abuse, Petitioner's policy was not triggered and the fact that the two CNAs were not suspended was not a violation of Petitioner's policy.

Administrator Stanford testified and the evidence shows that when it became clear that there was an allegation of verbal abuse against the two CNA's, the incident was reported to the state agency (CMS Ex. 20), the two CNAs were suspended (P. Ex. 33) and an investigation focusing upon the alleged abuse was conducted. P. Exs. 30-34; CMS Ex. 34, at 4-5. The surveyors do not allege that the second or supplemental investigation was inadequate or that Petitioner failed to follow its policy after it became clear that the allegation was that verbal abuse had occurred. P. Ex. 1, at 8-17. The state agency ultimately determined that the evidence was insufficient to show that any abuse occurred. P. Ex. 36.

I conclude that Petitioner had the policy required by 42 C.F.R. § 483.13(c) and that Petitioner fully implemented and followed its policy in reporting and investigating the alleged verbal abuse of Resident 8, when the complaint of verbal abuse was made and reasonably recognized as such.

> b. Petitioner's failure to report the misappropriation of resident property to the Alabama Board of Nursing was not a violation of 42 C.F.R. § 483.13(c).
>
> (i) Facts

The surveyors' third example of a violation of 42 C.F.R. § 483.13(c) relates to the misappropriation of one resident's Duragesic Patch. P. Ex. 1, at 14. The facts are not in dispute. On January 2, 2007, Petitioner began to investigate the missing Duragesic Patch

of Resident 2. The investigation revealed that on December 22, 2006, LPN Shannon Burgess and LPN Belinda Jackson reported to DON Renee Sumlin that during a narcotics count they determined that one Duragesic Patch for Resident 7 was missing. The fact that a Duragesic Patch was missing was documented in writing on December 22, 2006. CMS Ex. 48, at 1, 3, 4; P. Ex. 59, at 1; Tr. 377-78. On January 4, 2007, DON Sumlin was interviewed as part of the investigation. The DON admitted that she had completed a medication disposition record that falsely indicated that a Duragesic Patch for Resident 2 had been opened by mistake and that it was destroyed by flushing it. She signed the false medication disposition and directed LPN Burgess to also sign. She knew that the documentation was false because she had directed that the Duragesic Patch for Resident 2 be applied to Resident 7 on December 25, 2006. She knew that Resident 7 was missing one Duragesic Patch because that had been reported to her by LPN Burgess and LPN Jackson on December 22, 2006. CMS Ex. 48, at 5, P. Ex. 59, at 39. DON Sumlin was terminated on January 4, 2007 for falsification of documentation. LPN Burgess was disciplined and received training. CMS Ex. 48, at 5, 14-15; P. Ex. 59, at 35-36; Tr. 378.

Petitioner's report of investigation reflects that the state agency was notified by Administrator Stanford of the misappropriation on January 3, 2007. CMS Ex. 48, at 2; P. Ex. 56; P. Ex. 59, at 2. Administrator Stanford testified that she reported to both the state agency and the police and, in her opinion, that was all that was required under Alabama law. She was contacted by the state board of nursing in January 2007, which requested copies of the results of drug screening and she understood the request to be a follow-up to the missing medication reported to the state agency. Tr. 379-80, 401-05, 409-14. CMS questions the credibility of Administrator Stanford but offers no evidence to either rebut or impeach her testimony that she reported to the state agency and the local police. CMS Brief at 19-21. If find credible Administrator Stanford's testimony that she reported to the state agency and to the local police, but that she failed to report to the state board of nursing.

(ii) Analysis

The surveyors allege that Petitioner violated 42 C.F.R. § 483.13(c) because the Administrator failed to report to the Alabama Board of Nursing that a licensed nursing staff was "found guilty of misappropriation of [resident] pain medication." P. Ex. 1, at 8. Surveyor Grace Lowe testified that she cited the example because she understood that Tag F225 requires that a facility report to the licensing agency any substantiated allegation[14] of misappropriation of narcotic medication. Tr. 296-97.

[14] I have no evidence that the nurses involved were prosecuted or convicted of any crime related to the incident and it is not clear what Surveyor Lowe intended by the

(continued...)

CMS cites 42 C.F.R. § 483.13(c)(2) and (4) as the federal requirement violated by Petitioner in this example. P. Brief at 18. The regulation provides:

> (c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
>
> * * * *
>
> (2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).
>
> * * * *
>
> (4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

The regulation clearly requires that allegations of misappropriation of resident property and the results of investigation of such allegations be reported to state officials in accordance with state law. CMS cites the Alabama Administrative Code as the source for the state requirement that Petitioner should have reported to the Alabama Nursing Board, specifically Ala. Admin. Code r. 420-5-10-.07(1)(d) (1996); 610-X-6-.02 (2001); 610-X-8-.03(6)(g) and .03(6)(v) (2001). CMS's reliance upon these state regulatory provisions is misplaced. Section 610-X-6-.02 of the Alabama code is limited by its terms to imposing requirements upon registered nurses and licensed practical nurses. The section imposes no reporting obligation upon long-term care facilities. Sections 610-X-8-

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[14] (...continued)
quoted language above. However, my resolution does not require consideration of whether staff was found guilty or not.

.01-.11 of the Alabama code provide for disciplinary actions and impose no reporting requirement upon a long-term care facility. Section 420-5-10.07 of the Alabama code is essentially the state version of 42 C.F.R. § 483.13 that is applicable to state regulated NFs rather than federal SNFs. The regulation does not specifically require that a long-term care facility report anything to the Alabama Board of Nursing. After reviewing the Alabama administrative code, I conclude that there is no state regulatory requirement that a long-term care facility make any report to the Alabama Board of Nursing. CMS has cited no state statute that imposes such a requirement. The evidence shows that Petitioner did report to the police and the state agency, and I conclude that is all that was required by 42 C.F.R. § 483.13(c)(2) and (4). Accordingly, this example does not establish a violation of 42 C.F.R. § 483.13(c) (Tag F225).

4. Petitioner violated 42 C.F.R. § 483.25(h)(2) (Tag 324).

The surveyors allege five examples of violations of this regulation: (1) Petitioner failed to ensure that Resident 4 did not leave the facility without staff knowledge; (2) Petitioner failed to consistently monitor the function of WatchMate® transmitters; (3) Petitioner failed to ensure staff did not prop open exit doors; (4) Petitioner failed to ensure that Resident 9 did not sustain a fracture at her wrist during a transfer with a lift; and (5) Petitioner failed to ensure that a mechanical lift was used to transfer Resident 8 from bed to chair on February 26, 2007.

The regulation requires that a facility must ensure that "[e]ach resident receives adequate supervision and assistance devices to prevent accidents." 42 C.F.R. § 483.25(h)(2). The Board has explained the requirements of 42 C.F.R. § 483.25(h)(2) in numerous decisions. *See, e.g., Eastwood Convalescent Center,* DAB No. 2088 (2007); *Liberty Commons Nursing and Rehab - Alamance,* DAB No. 2070 (2007); *Golden Age Skilled Nursing & Rehabilitation Center*, DAB No. 2026 (2006); *Estes Nursing Facility Civic Center*, DAB No. 2000 (2005); *Northeastern Ohio Alzheimer's Research Center*, DAB No. 1935 (2004); *Woodstock Care Center*, DAB No. 1726, at 28 (2000), *aff'd*, *Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). Section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, but it does require that a facility take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents. *Woodstock Care Center v. Thompson*, 363 F.3d at 589 (a SNF must take "all reasonable precautions against residents' accidents"). A facility is permitted the flexibility to choose the methods of supervision it uses to prevent accidents, but the chosen methods must be adequate under the circumstances. *Id.* Whether supervision is "adequate" depends in part upon the resident's ability to protect himself or herself from harm. *Id.* Based on the regulation and the cases in this area, CMS meets its burden to show a *prima facie* case if the evidence demonstrates that the facility failed to provide adequate supervision and

assistance devices to prevent accidents, given what was reasonably foreseeable. *Alden Town Manor Rehabilitation & HCC*, DAB No. 2054, at 5-6, 7-12 (2006). An "accident" is "an unexpected, unintended event that can cause a resident bodily injury," excluding "adverse outcomes associated as a direct consequence of treatment or care (*e.g.*, drug side effects or reactions)." SOM, App. PP, Tag F324; *Woodstock Care Center*, DAB No. 1726, at 4.

My findings of fact and my analysis based upon the foregoing statement of the law and its interpretation are set forth for each example cited by the surveyors.

a. Resident 4 received reasonable supervision and assistance devices.

(i) Facts

The surveyors allege, based upon a review of Petitioner's clinical records, that on January 9, 2007, Resident 4 left the facility through the back door causing the door alarm to sound. P. Ex. 1, at 32. There is no dispute that Resident 4 did exit through the back door triggering the alarm. At the time of the incident, Resident 4, a female, was nearly 81 years old. She was admitted to Petitioner's facility on January 5, 2007, and her diagnoses included diabetes, advanced dementia with psychosis, osteoporosis, and emphysema. She was assessed as having an unsteady gait, she ambulated with a walker, she was assessed as requiring the extensive assistance of one person for ambulation on or off her unit, but she was assessed as being independent for walking in her room or corridor with only setup assistance, and she wandered. CMS Ex. 7, at 36-52; P. Exs. 4, 5, 11. On January 7, 2007, Resident 4 was assessed as "at risk for elopement" due to her expressed desire to leave the facility and her history of leaving, or attempting to leave, the previous facility. CMS Ex. 7, at 10, 12, 27, 28; P. Ex. 9; P. Ex. 10, at 1-2; P. Ex. 12, at 1. In order to monitor Resident 4's whereabouts, a WanderMate® (also referred to in the record as a WanderGuard®) monitoring device was applied to the resident. CMS Ex. 7, at 12, 18.

On January 9, 2007, Resident 4 left the facility through a back door, setting off the door alarm. CMS Ex. 7, at 5, 18, 66, 68; P. Ex. 18; P. Ex. 20, at 1-2, 4, P. Exs. 21, 22. Resident 4 was found in the facility parking lot and returned to the facility unharmed by facility staff. P. Ex. 1, at 20, 21, 22. A written statement dated January 9, 2007, signed by Jane Hand, R.N. and Unit Manager, states that she heard the alarm and then she and a dietary employee went to the door to investigate. She saw Resident 4 with her walker and Resident 4 said she wanted to go home. R.N. Hand's statement indicates that she escorted Resident 4 into the facility and back to her room. P. Ex. 20, at 1. A hand-written record of a telephone interview of Debra Smith, Dietary Associate, dated January 9, 2007, states that she was coming from lunch and heard the alarm at the back door. She

went to the back door and a visitor told her that a lady with a walker just went out the door. The Unit Manager came to the door and went and brought the resident back inside. P. Ex. 20, at 2.

CMS called Sherry Brock to testify. Ms. Brock was visiting her mother on January 9, 2007, and she had gone into the hall to see if there was another room available for her mother away from the alarm that went off all the time. She saw a woman with her walker go down the hall and out the door, causing the alarm to sound. She testified that she saw a woman, a food service person, open the door, turn off the alarm, and then close the door. She testified that she told the woman she needed to check because she saw a resident go out the door. She was not certain whether the food service person actually looked out the door or not. She testified that at the time R.N. Hand was down the hall so she went to her and told her someone had gone out the door and R.N. Hand quickly went outside. She testified that another staff member went outside with R.N. Hand but she could not recall who. Ms. Brock identified a statement she signed dated March 4, 2007 at CMS Ex. 34, at 44. She testified that she agreed with the statement that she signed that staff did not "stall" in responding to the alarm. But she opined that the food service worker did not respond properly because she did not go outside. Tr. 100-10.

CMS also elicited testimony from Surveyor Elizabeth McGraw, who was responsible for the citation related to Resident 4 under Tag F324. She testified that she had the maintenance man measure the distance from the door to where Resident 4 was found and it was determined to be 46 feet. Tr. 143. She opined that the care planned intervention to monitor the resident's location every two hours was inadequate. However, when I inquired, she agreed that more facts were needed to determine whether two hour monitoring was adequate or not. Tr. 149-51. On cross-examination, Surveyor McGraw indicated that this example was cited as a basis for a deficiency because the dietary service worker did not look for Resident 4 outside, and because she speculated that R.N. Hand may not have searched outside if the visitor had not told her she saw a resident go out the door. Tr. 174-77.

R.N. Hand testified for Petitioner. R.N. Hand testified that she was doing rounds with Dr. McInnis when she heard the alarm sound at the back exit door. As she went to the door another resident's sponsor said she saw someone with a walker outside. When she got to the door another employee was also there. She testified that she went outside and did not immediately see the resident but as she walked further she saw the resident in the employee parking lot with her walker and coat on. She spoke with Resident 4 who was returned to the facility without incident. Dr. McInnis examined Resident 4 and her sponsors were called. She estimated that it took her less than a minute to get to the back door after she heard the alarm. Tr. 331-34.

(ii) Analysis

The gist of the allegation from the SOD is that staff did not respond properly to Resident 4 triggering the alarm when she went out the back door of the facility. P. Ex. 1, at 36-39. Surveyor McGraw was particularly concerned that the dietary aide shut off the alarm and did not go outside to search for someone, and that a sponsor of a resident had to tell R.N. Hand that a resident had left the facility. Tr. 174-77. Although the timing and specific actions of the dietary staff member and R.N. Hand are subject to different characterizations by counsel, the key facts are not really in dispute. Resident 4 was admitted to Petitioner's facility on January 5, 2007. She was assessed as at risk to elope, and Petitioner had a plan of care in place to address the risk that included the use of a personal alarm, in this case a WatchMate®. Petitioner also had other types of alarms on its doors to alert staff of a possible unsupervised departure by any resident. The back door through which Resident 4 departed had an alarm that sounded when she opened the back door. A dietary staff member who was in the area responded to the door when the alarm sounded. R.N. Hand also responded to the door. Ms. Brock testified that in her opinion neither staff member "stalled" in responding to the door. R.N. Hand exited the facility through the back door and found Resident 4 within 46 feet of that door on, as characterized by Ms. Brock, a flat surface. Tr. 127-28. No reliable estimate of the total elapsed time was made regarding the time from when the resident triggered the alarm to the time she was safely under the supervision of R.N. Hand again. Testimony regarding what the dietary aide was thinking by closing the door and silencing the alarm; whether she saw R.N. Hand, the Unit Manager, approaching and understood she was taking charge; or even whether she might have been observing Resident 4 through the small window while waiting for qualified assistance to go get her is nothing but speculation. Further, the only credible testimony of R.N. Hand's intent and knowledge of the situation is her own testimony. Testimony of Ms. Brock is speculative as are the suppositions of the surveyor. R.N. Hand's testimony is consistent with her hearing the alarm, recognizing the risk, going promptly to and out the door, and establishing supervision of Resident 4 no more than 46 feet from the door. R.N. Hand's reaction to the alarm was clearly reasonable and appropriate. The fact that the dietary aide silenced the alarm was also reasonable to minimize the disruption to the residents of the facility, e.g., Ms. Brock was already searching for a room for her mother away from the alarm that was going off. It was also not unreasonable for the dietary aide to close the door and to wait for more qualified staff to assist or accomplish the recovery of Resident 4. Whether Ms. Brock's meddling in the situation served any purpose is speculative in light of the testimony of R.N. Hand and the fact that there is no dispute that neither she nor the aide delayed responding to the door alarm, and that supervision of the resident was gained within 46 feet of the back door.

CMS argues in its post-hearing brief that the evidence does not show how frequently Petitioner monitored Resident 4's whereabouts. CMS Brief at 7. However, the allegations of the SOD did not include an allegation that Petitioner failed to adopt an intervention to monitor the resident or failed to implement such an intervention. Further, there is no allegation that the interventions actually adopted by the care planning team (CMS Ex. 7, at 18) were inadequate as implemented. Accordingly, the CMS argument is not on point. Contrary to the assertion of CMS, the evidence does not show a need for "frequent monitoring" of Resident 4 prior to her elopement, at least to the extent that by "frequent monitoring" CMS means visual checks more frequently than every two yours or one-on-one supervision. CMS Brief at 7.

I conclude that the incident does not amount to a violation of the requirement of 42 C.F.R. § 483.25(h)(2) to provide Resident 4 the supervision necessary to minimize the risk for accidents. Petitioner is not subject to strict liability for compliance with the regulation. Rather, Petitioner is responsible to take all reasonable steps necessary to eliminate or reduce the foreseeable risk for harm. In this instance, the resident was accurately assessed, reasonable interventions were in place, and the nonspecific intervention of the alarm on the back door functioned properly and alerted staff to retrieve Resident 4 before she encountered any foreseeable accident hazard reflected in the evidence.[15]

b. The evidence does not show that Petitioner failed to regularly test WatchMate® transmitters as recommended by the manufacturer.

The surveyors allege that Petitioner violated 42 C.F.R. § 483.25(h)(2) because it failed to "[c]onsistently monitor WatchMate® transmitters to aid in monitoring indentified wandering residents. . . ." The surveyors list resident identifiers for nine residents but Resident 4 is not listed. P. Ex. 1, at 33. The surveyors state in the SOD that they reviewed the manufacturer's information that stated that WatchMate® transmitters should be tested regularly. P. Ex. 1, at 39. According to the surveyors they interviewed a unit manager who said the WatchMate® transmitter did not require testing, just checking to ensure it is in place. However, the surveyors state that the ADON used a transmitter tester and found all transmitters present at the facility at the time were working. The

[15] After this incident it was foreseeable that Resident 4 moved too fast for staff to successfully prevent her from exiting the backdoor before staff could arrive when alerted by the alarm and prevent her exit. Therefore, Petitioner was obliged to implement other interventions to ensure Petitioner did not exit and thereby the reduce the risk for harm from accidental injury. The SOD does not allege any violation by Petitioner in this regard.

surveyors found that five residents did not have an order to test the transmitter and three had orders to check the function of the transmitters each day. However, the surveyors found no documentation on the three residents' Medication Administration Records (MAR) for the month of February showing that the function of the transmitters had been checked. P. Ex. 1, at 39-40.

Surveyor McGraw testified at hearing that Resident 4 was no longer at the facility and, therefore, her WatchMate® and the history of the alarm were not checked. She testified that nine residents had orders for a WatchMate®; three residents had orders to check placement and functioning of the device; however, Petitioner's practice was to document checks on a resident's MAR and there were no entries for checks on the three residents' MARs for the month of February; and the other residents had no order or documentation that functioning of the device was being checked. Surveyor McGraw testified that two of Petitioner's staff, a R.N. and a LPN, were interviewed and they were not aware of any testing procedure but that she failed to ask about any requirement for documentation. Tr. 148-49, 180. On cross-examination she conceded that the ADON was familiar with the tester and how to test. She also testified that the failure to check the WatchMate® devices did not pose immediate jeopardy in the absence of an elopement where the device failed to work. She agreed with counsel for Petitioner that the WatchMate® was not a factor in Resident 4's elopement. Tr. 181.

CMS argues that there was "no evidence to show whether Wanderguard devices were being monitored for proper functioning." CMS Brief at 7. However, that argument is in error as the surveyors found that the ADON knew how to test the devices and the surveyors only allege that documentation of testing was missing for one month.

Petitioner does not address the allegation but rather simply asserts that the surveyor agreed that the allegation did not support the finding of immediate jeopardy. P. Brief at 7, n.4. Petitioner does not deny the surveyors finding in the SOD that the manufacturer recommended regular testing. Petitioner also does not dispute that documentation was not produced showing testing for three residents in February or for the other five residents who did not have an order to check the functioning of the WatchMate® devices.

I do not find the absence of an order for testing to be determinative. CMS cites no authority for the proposition that an order to test a personal alarm needs to be in a resident's clinical record and I am aware of no such requirement. CMS also points to no regulation that specifies the frequency of testing for personal alarms or that such testing

be recorded in a clinical record or elsewhere, and I am aware of no such requirements.[16] Rather, the manufacturer's instruction to test regularly is the basis for concluding that Petitioner is required to test the functioning of the devices regularly, i.e., the manufacturer's instruction establishes the standard of care to regularly test to ensure that the WatchMate® devices operate properly and are effective to accomplish their intended purpose as an intervention. The manufacturer's instructions did not recommend "consistent" testing and, therefore, the surveyors conclusion that Petitioner violated the regulation by not "consistently" testing the devices is in error. P. Ex. 1, at 33. I note that Surveyor McGraw, who drafted the deficiency, offered no opinion that there was a standard of care other than that specified by the manufacturer. However, the evidence does not indicate how frequently the devices are to be tested to satisfy the manufacturer's recommendation that the devices be tested regularly. Although the evidence shows that Petitioner did not document testing on the MARs of three residents during February 2007, and that some staff did not know about testing, the evidence does not show that the devices were not regularly tested. Further, there is no evidence that any WatchMate® device was not an effective intervention for monitoring residents as all functioned when tested in the presence of the surveyor and there is no evidence of a malfunction of a device at Petitioner's facility. Accordingly, I conclude that this example does not amount to a violation of 42 C.F.R. § 483.25(h)(2).

c. Petitioner failed to ensure staff did not prop open exit doors but this does not amount to a violation of the regulation.

The surveyors allege that Petitioner violated the regulation by failing to ensure that staff did not prop open exit doors in the facility. P. Ex. 1, at 33. The surveyors allege, and it is undisputed, that when R.N. Hand took Surveyor McGraw outside the facility to show where she found Resident 4, R.N. Hand stuck a rock in the door to prevent it from closing. P. Ex. 1, at 40; Tr. 145, 197, 336. The surveyors alleged in the SOD that a family member and staff stated that at times a rock was used to prop an exit door open. P. Ex. 1, at 40. The family member referred to was Toni Williams who testified at the hearing. Tr. 146. Ms. Williams testified that on one occasion, she could not recall the date, she saw the back door propped open and she reported that to the Administrator. She testified that it was between 10 and 11 p.m. and she saw no staff standing by the door, in the hall, or at the nurse's station. Tr. 48-49. On cross-examination and redirect Ms.

[16] The inability of a facility to produce evidence in the form of documentation often prevents the facility from rebutting a CMS *prima facie* showing. However, the regulations defining the conditions for participation at 42 C.F.R. Part 483, generally do not specify the form of documentation or what must be documented, with some exceptions.

Williams elaborated that she could also see through a window that there was no one outside the door. Tr. 59, 96-97. There is no dispute that the door in question was the door through which Resident 4 departed the facility, triggering the alarm. The door is also the door used for pick-up and delivery of residents by families or ambulance. Tr. 59-60, 336-37.

The regulation does not make a facility strictly liable for accidents that occur, but it does require that a facility take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents. *Woodstock Care Center v. Thompson*, 363 F.3d at 589. The regulations do not specify the means by which a facility is to satisfy the regulation. Certainly, the regulation does not require the use of door alarms or even that doors be closed or supervised. Rather, the regulation speaks in terms of ensuring that a resident receives necessary supervision. Thus, while an open exit door that is unsupervised may be some evidence that a facility failed to provide reasonable supervision for the resident who elopes through that door, an unsupervised open door is not, standing alone, evidence that Petitioner failed to provide adequate supervision to a resident. There is nothing inherently wrong with Petitioner's staff silencing an alarm on a door and opening the door to permit access to the facility without disturbing the residents. So long as the residents have other reasonable supervision to prevent them from eloping, the open door does not necessarily increase the risk for accidental harm to those residents. Thus, even if I find credible[17] Ms. Williams' testimony that she saw no one guarding an open door on one occasion between 10 and 11 p.m., that testimony does not establish that any resident did not receive the supervision required by the regulation. The evidence does not show that Petitioner relied only upon the door alarm as supervision for its residents or that residents were not otherwise adequately and reasonably supervised when the door alarm was off and the door was open. Furthermore, when Resident 4 exited the back door, the door was closed as the alarm sounded. Thus, Resident 4's elopement is not evidence of a lack of supervision because an exit door was open and unsupervised. Accordingly, I conclude that this example does not amount to a violation of 42 C.F.R. § 483.25(h)(2).

d. Resident 9's fall did not result from a failure to provide adequate and reasonable supervision or assistance devices.

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[17] In fact, Ms. Williams' testimony that she observed no staff monitoring the door was not credible. The evidence shows that Ms. Williams had motive to provide testimony contrary to Petitioner's interests. Her demeanor at trial and her elaboration upon her observations related to that open back door both indicate that she was expanding upon her testimony to the perceived detriment of Petitioner.

(i) Facts

The surveyors allege in example 4 that Petitioner violated the regulation because Petitioner failed to ensure Resident 9 did not suffer a fracture to her wrist during a transfer with a lift. P. Ex. 1, at 33, 43. There is no dispute that Resident 9 broke her wrist on February 17, 2009, as alleged. P. Ex. 1, at 33, 43; P. Exs. 37, 38, 39; CMS Ex. 9, at 5-10. Resident 9 was an 85-year-old female diagnosed with dementia, congestive heart failure, a history of cerebrovascular accident or stroke, and osteoporosis. Resident 9 suffered cognitive loss including long and short-term memory loss and moderately impaired decision-making due to progressing dementia. CMS Ex. 9, at 22. She suffered deficits in her mobility due to limitation in movement in her feet and legs, and range of motion in her right hip. She was assessed as requiring extensive assistance for bed mobility, transfers, dressing, toileting, and personal hygiene. CMS Ex. 9, at 23-29. Her care plan dated January 20, 2007, required that she receive extensive assistance of one person for bed mobility, transfers, dressing, toileting, and personal hygiene. CMS Ex. 9, at 34.

On February 17, 2007, a CNA was transferring Resident 9 from her wheelchair to her bed using a stand-up lift. According to the CNA, Resident 9 wiggled so that she slid out of the wheelchair and to the floor. CMS Ex. 9, at 7. Although Petitioner's documentation related to the fall and admitted as evidence is cursory, it indicates that the resident's right arm had to be dislodged from the wheelchair (CMS Ex. 9, at 5); that an x-ray was performed and it was determined that Resident 9 had a fracture (CMS Ex. 9, at 6); and that Resident 9 also had a skin tear on her right thigh, which was cleaned and bandaged (CMS Ex. 9, at 6). Petitioner noted in its documentation that the resident suffered impaired safety awareness and judgment and she tended to fidget while being given care. CMS Ex. 9, at 8-9. Petitioner's documentation indicates that the resident fell from her wheelchair and not the lift. A progress note dated February 18, 2007 at 4:32 a.m., indicates that the Charge Nurse was called to Resident 9's room by the nurse from the previous shift. Resident 9 was sitting on the floor but partially on the footrest to her wheelchair with her right arm caught in the right arm of the wheelchair. After several attempts, the resident's right arm was dislodged, she was moved to bed, assessed, and her doctor and family were notified. The CNA reported to the nurse that the resident slid to the floor during the transfer due to fidgeting. CMS Ex. 9, at 18. A final x-ray report done on February 18, 2007, indicated a mildly displaced fracture of the ulnar styloid of the right wrist. CMS Ex. 9, at 20.

(ii) Analysis

It is not clear from the allegations of the SOD what Petitioner did or failed to do to ensure that Resident 9 had adequate and reasonable supervision or assistance devices. P. Ex. 1,

at 33, 43-44. Surveyor McGraw testified that Resident 9 was not assessed for the use of a mechanical lift. Tr. 152-53. She testified that the unit manager, who indicated she did not see the accident, speculated that the lift was used incorrectly with the resident holding the wheelchair rather than the lift which caused Petitioner to in-service staff on correct use of the lift. Tr. 157, 162-68. Surveyor McGraw's testimony indicates that she concluded that the CNA used the lift incorrectly and Resident 9 suffered an injury. Tr. 159, 161. Surveyor McGraw had difficulty describing the lift or its operation. She did testify that use of the lift requires strapping the resident to the lift and having the resident hold a grab bar while the resident is raised to a standing position. Tr. 154-55, 192-97. She admitted on redirect that she did not know based on the documents and her interviews whether or not Resident 9 was strapped to a lift when she fell or at what point during the transfer she fell. Tr. 192, 195.

Trevina Wilson, R.N., the Unit Manager interviewed by Surveyor McGraw, testified for Petitioner. She testified that she concluded that the CNA was attempting to transfer Resident 9 with the stand-up lift, when the resident became nervous she let go of the lift and reached for the chair, her right arm went though the gap under the right arm rest of the wheelchair and between the spokes of the right wheel. She opined that the CNA was not using the lift incorrectly. Tr. 314-16. In response to my questioning, R.N. Wilson indicated that she assumed that when the resident began to fidget, the CNA must have lowered the resident back to the wheelchair. Tr. 316-19. R.N. Wilson admitted on cross-examination that she was not the first person on the scene, she did not interview the CNA, she participated in the investigation but she did not do the investigation. Tr. 320-21, 326. She testified that after the incident the CNA was able to demonstrate the proper procedure for using the stand-up lift. Tr. 323. She testified that this was the first incident of Resident 9 falling from her wheelchair. Tr. 327.

I find based on the evidence that on February 17, 2007, while she was being prepared for transfer from her wheelchair, Resident 9 slipped down the front of her wheelchair. Resident 9 landed with her bottom resting partially on the floor and partially on the foot-pedals of the wheelchair and with her right arm extended through the opening below the right arm of the wheelchair, either into the spokes of the right wheel or in the space between the wheel and the wheelchair body. Resident 9 suffered a fracture of her right wrist as a result. It is not credible that Resident 9 fell from the lift or that she was attached to the lift at the time of her fall. Both Surveyor McGraw and R.N. Wilson were consistent in their testimony that if the stand-up lift was in use at the time, a strap would have been behind the resident's back and attached to the lift in front of the resident as depicted at P. Ex. 50, at 1. The evidence does not show that the strap on the lift was broken, that the strap was observed attached to the resident by any staff, that the strap was observed behind the resident when she was observed by nursing staff, or that the CNA removed the strap prior to summoning assistance of a nurse.

R.N. Wilson's conclusion that the lift was in use and that the CNA lowered the resident back to the wheelchair and her arm became entrapped, is not consistent with the evidence. R.N. Wilson also eventually admitted that she did not conduct the investigation and did not interview the CNA except to have the CNA successful demonstrate the correct use of the stand-up lift. The only credible evidence is the contemporaneous records of Petitioner that indicate the resident fidgeted and fell from her wheelchair. Therefore, I conclude that the surveyors' factual basis for citing this as an example of a violation of 42 C.F.R. § 483.25(h)(2) was erroneous. I nevertheless consider whether my findings of fact reflect a violation and conclude they do not. The evidence does not show that Resident 9 was incorrectly assessed. The evidence does not show that the standard of care requires that a resident be assessed as specifically requiring a lift or a particular type of lift. The evidence does not show that Resident 9's fracture was due to a failure by Petitioner to ensure that adequate assistance devices or supervision were provided for Resident 9.

d. Resident 8's fall resulted from a failure to use the care planned assistance device.

(i) Facts

The facts related to Resident 8 are set forth in detail under Tag 223. For the alleged violation of 42 C.F.R. § 483.25(h)(2), it is important to note that Resident 8 was assessed as requiring extensive assistance with all activities except eating and for transfers she required two or more persons to assist her. CMS Exs. 8, 18-19. Her care plan included a handwritten entry dated February 22, 2007, that required the use of a mechanical lift for transfers. CMS Ex. 8, at 50. Petitioner's investigation concluded that on February 26, 2007, Resident 8 was being moved from her bed by two CNA's without a lift and Resident 8 fell to the ground, resulting in abrasions to the resident's buttocks. CMS Ex. 8, at 7-12; P. Exs. 26, 27, 29. Other evidence consistent with Resident 8 either falling or being lowered to the floor on February 26, 2007, is the testimony of Toni Williams (Tr. 39-40), and Resident 8's statements to Surveyor Pavelec. Tr. 203-04. I have considered the testimony of R.N. Barber (Tr. 347-58) but do not find her conclusions based upon her investigation including the denials of the CNAs more persuasive than Petitioner's own investigative reports supported by the statements of the resident and the testimony of Toni Williams. Thus, I find that Resident 8 was dropped or lowered to the floor on February 26, 2007, when two CNAs attempted to transfer her without using a lift.

(ii) Analysis

Based on my findings of fact, I conclude that Petitioner violated 42 C.F.R. § 483.25(h)(2). Petitioner assessed Resident 8 as requiring an assistance device for transfers, specifically a lift – an intervention added to her care plan on February 22, 2007. On February 26, 2007, two CNAs attempted to transfer Resident 8 without a lift and she fell or was lowered to the floor and suffered abrasions to her buttocks. Therefore, Petitioner failed to ensure that an assistance device was used that Resident 8's care planning team had determined was necessary. Petitioner has not presented sufficient credible evidence to rebut the charge that Resident 8 was dropped or lowered to the floor when two CNAs tried to transfer her without a lift on February 26, 2007. Resident 8 suffered actual harm as a result of her fall or being lowered to the floor. Tr. 385-87 (Administrator Stanford observed blood and a nurse dressed both buttocks).

Accordingly, I conclude that Petitioner violated 42 C.F.R. § 483.25(h)(2).

5. The state agency and CMS determinations that the alleged violation of 42 C.F.R. § 483.25(h)(2) (Tag F324) posed immediate jeopardy to Petitioner's residents is clearly erroneous.

Regulations define "immediate jeopardy" as follows:

> [a] situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

42 C.F.R. § 488.301. The surveyors alleged in the SOD that the alleged violation of 42 C.F.R. § 483.25(h)(2) posed immediate jeopardy to Petitioner's residents. As already discussed, the surveyors cited five examples in support of the alleged violation. The surveyors alleged more specifically that the alleged deficiency related to Resident 4 "placed [her] in jeopardy for potential harm." P. Ex. 1, at 33. The surveyors did not make a similar allegation for any of the four remaining examples. P. Ex. 1, at 32-48. The surveyors stated:

> The facility presented a credible allegation of compliance to address the jeopardy situation on 03/03/07. [Resident 4] was transferred to another facility on 01/26/07. According to the credible allegation the following measures were implemented, inservicing was started on 03/03/07 and all staff will be inserviced on elopement policy and procedure before being

> allowed to work. Nursing staff will be inserviced on the lift policy and procedure prior to working. Elopement drills will be conducted daily by the facility.
>
> The jeopardy was abated on 03/03/07 and the scope and severity level was lowered to a G, due to the harm sustained by [Resident 8] and [Resident 9], to allow the facility time to implement all corrective actions and to monitor to ensure the problems do not recur.

P. Ex. 1, at 33-34. The foregoing language from the SOD establishes that the surveyors' finding of immediate jeopardy was based upon the alleged elopement of Resident 4 rather than the other four examples cited under Tag F324. The testimony of Surveyor McGraw supports my conclusion. Tr. 174-77, 181. The foregoing quotation from the SOD also indicates that the surveyors considered that the alleged deficiencies related to Residents 8 and 9 were isolated incidents of actual harm that was not immediate jeopardy. I have found no deficiency related to the elopement of Resident 4 and, therefore, I must conclude the finding of immediate jeopardy was clearly erroneous.

> **6. Petitioner does not dispute that it was in violation of 42 C.F.R. §§ 483.20(d) and 483.20(k)(1) (Tag F279, S/S D); 483.20(k)(3)(ii) (Tag F282, S/S D); 483.20(d) (Tag F286, S/S D); 483.25(c) (Tag F314, S/S G); 483.25(k) (Tag F328, S/S D); 483.25(n) (Tag F334, S/S D); 483.60(a)-(b) (Tag F425, S/S D); 483.60(b),(d),(e) (Tag F431, S/S D); and 483.75(m)(2) (Tag F518, S/S E) during the period January 9, 2007 through April 19, 2007, or that these regulatory violations are a basis for the imposition of a CMP. Tr. 29; P. Brief at 3.**
>
> **7. A CMP of $3050 per day for the period January 9 through March 2, 2007, and $500 per day for the period March 3, 2007 through April 19, 2007 is not reasonable.**
>
> **8. A CMP of $500 per day for the period from January 9, 2007 through April 19, 2007, a total CMP of $45,500 (91 days at $500 per day), is reasonable.**

Petitioner was not in substantial compliance with program participation requirements from January 9, 2007 through April 19, 2007 due to violations of 42 C.F.R. §§ 483.20(d) and 483.20(k)(1) (Tag F279, S/S D); 483.20(k)(3)(ii) (Tag F282, S/S D); 483.20(d) (Tag F286, S/S D); 483.25(c) (Tag F314, S/S G); 483.25(h)(2) (Tag 324, S/S G); 483.25(k)

(Tag F328, S/S D); 483.25(n) (Tag F334, S/S D); 483.60(a)-(b) (Tag F425, S/S D); 483.60(b),(d),(e) (Tag F431, S/S D); and 483.75(m)(2) (Tag F518, S/S E).

CMS seeks approval of a CMP of $3050 per day for the period January 9, 2007 through March 2, 2007, and $500 per day for the period March 3, 2007 through April 19, 2007. Jt. Stip. at 2. For the reasons discussed below, I find that a CMP of $3050 per day for the relevant period is not reasonable. However, a CMP in the amount of $500 per day for the period from January 9, 2007 through April 19, 2007 is reasonable.

Petitioner conceded at hearing and in its post-hearing brief that, based upon the uncontested deficiencies, some level of CMP could be imposed. Tr. 29; P. Brief at 3. Petitioner requests that I disapprove, entirely, the CMP based upon the alleged violation at the level of immediate jeopardy and to reduce substantially the CMP related to the non-immediate jeopardy violations. Tr. 29. The uncontested deficiencies are: 483.20(d) and 483.20(k)(1) (Tag F279) (S/S) D;, 483.20(k)(3)(ii) (Tag F282) (S/S D); 483.20(d) (Tag F286) (S/S D); 483.25(c) (Tag F314) (S/S G); 483.25(k) (Tag F328) (S/S D); 483.25(n) (Tag F334) (S/S D); 483.60(a)-(b) (Tag F425) (S/S D); 483.60(b),(d),(e) (Tag F431) (S/S D); and 483.75(m)(2) (Tag F518) (S/S E). Additionally, I have concluded that Petitioner violated 42 C.F.R. § 483.25(h)(2), but that the finding of immediate jeopardy based upon that violation was clearly erroneous.

The upper range of CMPs, of from $3050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). The lower range of CMPs, from $50 per day to $3000 per day, is reserved for deficiencies that do not constitute immediate jeopardy but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). A CMP of $3050 per day may only be sustained based upon finding a deficiency that posed immediate jeopardy to Petitioner's residents. Absent immediate jeopardy, a CMP that may be imposed is limited to $50 to $3000 per day. Because I concluded that there was no immediate jeopardy, a $3050 per day CMP is not authorized by the regulations and is unreasonable.

Petitioner's violations 42 C.F.R. § 483.25(c) and (h)(2) resulted in actual harm to residents. The other deficiencies are all cited as posing more than minimal harm without actual harm. Accordingly, there is a basis for the imposition of an enforcement remedy, in this case a CMP in the lower range of $50 to $3000 per day.

Pursuant to 42 C.F.R. § 488.438(e) and (f), my authority on review of the reasonableness of the CMP is limited: (1) I may not set the penalty at or reduce it to zero; (2) I may not review the CMS or state decision to use a CMP as an enforcement remedy; and (3) I may

only consider the factors specified at 42 C.F.R. § 488.438(f). In determining whether the amount of the CMP is reasonable, the following factors specified at 42 C.F.R. § 488.438(f) must be considered:

> (1) the facility's history of noncompliance, including repeated deficiencies;
> (2) the facility's financial condition;
> (3) the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404; and
> (4) the facility's degree of culpability.

Neither CMS nor Petitioner has presented any evidence to demonstrate a history of Petitioner's noncompliance.

As to the second factor – Petitioner's financial condition – Petitioner has not brought forth any evidence or testimony that it is unable to pay the CMP as originally proposed by CMS. Therefore, I conclude that the amount of the reduced CMP would not cause a substantial financial burden to Petitioner. *Crestview Parke Care Center v. Thompson*, 373 F.3d 743,756 (6th Cir. 2004).

As to the remaining factors, I note that the uncontested deficiencies cited were not inconsequential but, rather, were serious. Seven of the nine uncontested deficiencies cited in the March 2007 SOD were at a "D" scope and severity level (isolated instances of no actual harm, but potential for more than minimal harm that is not immediate jeopardy); one deficiency was "E" level (a pattern of no actual harm with more than minimal harm that is not immediate jeopardy); and one "G" level deficiency (isolated instance of actual harm that is not immediate jeopardy). Petitioner's violation of 42 C.F.R. § 483.25(h)(2), which involved staff failure to comply with Resident 8's plan of care resulting in actual harm to Resident 8, was also serious. Culpability is defined by the regulation to include "but is not limited to, neglect, indifference or disregard for resident care, comfort or safety." 42 C.F.R. § 483.438(f)(4). The regulation also provides that the absence of culpability is not a mitigating factor for reducing the amount of a penalty. I conclude that Petitioner was culpable.

9. The burden of persuasion does not affect the outcome of this case.

10. Review of the reasonableness of the proposed enforcement remedy was de novo and review of how CMS considered the regulatory factors when proposing an enforcement remedy is not relevant to my review.

Petitioner attempts to preserve two additional issues for appeal. Petitioner argues that the allocation of the burden of persuasion in this case according to the rationale of the Board in the prior decisions cited above violates the Administrative Procedures Act, 5 U.S.C. § 551 *et. seq.*, specifically 5 U.S.C. § 556(d). Request for Hearing at 7; P. Prehearing Brief at 23. Because the evidence is not in equipoise, the burden of persuasion did not affect my decision, and Petitioner suffered no prejudice.

Petitioner also argues that the Medicare Act is violated and Petitioner is deprived of due process if CMS is not required to submit evidence to prove it considered the regulatory criteria established by 42 C.F.R. §§ 488.404 and 488.438(f). Request for Hearing at 7-8; P. Prehearing Brief at 23-24. I reviewed the evidence related to the regulatory factors de novo and perceive no prejudice to Petitioner because I did not require CMS to submit evidence related to its consideration of the regulatory factors.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner was not in substantial compliance with program participation requirement and that a CMP of $500 per day for the period from January 9, 2007 through April 19, 2007, is reasonable.

/s/ Keith W. Sickendick
Administrative Law Judge