Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of: Mercy Bellbrook, CCN: 23-5470 Petitioner, - v. - Centers for Medicare & Medicaid Services.	Date: July 7, 2008 Docket No. C-07-437 Decision No. CR1812

DECISION

In this appeal, Petitioner Mercy Bellbrook contests a determination by the Centers for Medicare & Medicaid Services (CMS) that it was not in substantial compliance with a requirement for participation in the Medicare and Medicaid programs between February 20, 2007 and March 14, 2007, and challenges the remedy imposed on it by CMS as a result. For the reasons set out below, I sustain CMS's determination and affirm the remedy.

I. Procedural Background

Petitioner is a long-term care facility located in Rochester Heights, Michigan. It participates in the Medicare and Medicaid programs. The Michigan Department of Community Health (MDCH) conducted a complaint investigation survey of Petitioner's facility on February 27, 2007. The survey finding was based on an incident at Petitioner's facility on February 20, 2007. That survey found Petitioner not to be in substantial compliance with one of the requirements for participation in those programs, specifically, the requirement set out at 42 C.F.R. § 483.25(h)(2) that obliges such facilities to ensure that each facility resident receives adequate supervision and assistance devices to prevent accidents.

On March 14, 2007, CMS notified Petitioner that it would impose a Civil Monetary Penalty (CMP) of $4500 per day beginning February 20, 2007 and continuing through February 25, 2007 based on a period of substantial noncompliance creating a condition of immediate jeopardy at a scope and severity level of "J" and a CMP of $150 per-day beginning on February 26, 2007 at a scope and severity level of "G" until the facility had substantially corrected the deficiency. CMS proposed additional sanctions, but they did not take effect and are thus not before me.

MDCH conducted a revisit survey on March 30, 2007 and found that Petitioner had returned to substantial compliance with the requirement effective March 15, 2007. On April 3, 2007, CMS notified Petitioner that it would impose the $150 per-day CMP for the 17 days from February 26, 2007 through March 14, 2007, for a total CMP of $29,550.

Petitioner perfected its appeal of CMS's action in its May 11, 2007 Request for Hearing. By Order of September 7, 2007, I permitted the parties to submit this case for decision on a written record consisting of exhibits and briefs. The briefing cycle has closed. CMS had proffered CMS Exhibits 1-52 (CMS Exs. 1-52); all are admitted in the absence of objection. Petitioner has proffered Petitioner's Exhibits 1-40 (P. Ex. 1-40); in the absence of objection, all are admitted.

II. Issues

The issues before me in this appeal are:

> 1. Whether Petitioner was in substantial compliance with requirements for participation in the Medicare and Medicaid programs, in this case, the specific requirements set out at 42 C.F.R. § 483.25(h)(2); and, if so,
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> 2. Whether the CMP imposed on Petitioner by CMS as a result of its alleged substantial noncompliance is reasonable.

III. Controlling Statutes and Regulations

Petitioner is a long-term care facility. Its participation in Medicare and Medicaid is governed by sections 1819 and 1919 of the Social Security Act (Act), 42 U.S.C. § 301 *et seq*., and the regulations at 42 C.F.R. Part 483. Sections 1819 and 1919 of the Act invest the Secretary with authority to impose remedies, including CMPs, against long-term care facilities for failure to comply substantially with participation requirements.

The regulations define the term "substantial compliance" to mean:

> [A] level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to

> resident health or safety than the potential for causing minimal harm.

42 C.F.R. § 488.301.

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

The regulations specify that if a CMP is imposed against a facility on a per-day basis, it must fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, from $3050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). The lower range of CMP, from $50 per day to $3000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii).

"Immediate jeopardy" is defined as:

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

42 C.F.R. § 488.301.

The requirement of participation directly at issue in this litigation is set out at 42 C.F.R. § 483.25(h)(2), and is part of a broad regulatory scheme intended to assure that facilities provide, and that their residents receive, the care and services necessary to attain and maintain each resident's highest practical level of physical, mental, and psychological

well-being. The terms of that regulation require that the facility must ensure that:

> Each resident receives adequate supervision and assistance devices to prevent accidents.

42 C.F.R. § 483.25(h)(2).

A facility may challenge the scope and severity of noncompliance cited by CMS only if a successful challenge would affect the range of CMP amounts imposed by CMS or would affect the facility's nurse aide training program. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i). CMS's determination as to the scope and severity of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9 (2000), *aff'd, Woodstock Care Center v. U.S. Dept. of Health and Human Services*, 363 F.3d 583 (6th Cir. 2003). Since the scope and severity of Petitioner's alleged noncompliance between February 20, 2007 and February 25, 2007 is cited and sanctioned at a level of immediate jeopardy, the scope and severity of that alleged noncompliance is properly before me.

The Departmental Appeals Board (Board) has long held that the net effect of these regulations is that a provider has no right to challenge the scope and severity assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g.*, *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Thus, the scope and severity of Petitioner's noncompliance between February 26, 2007 and March 14, 2007, cited at a level below that of immediate jeopardy, is not properly before me in this appeal.

IV. Findings and Conclusions

I find and conclude as follows:

1. Because it failed to ensure that R-500 received adequate supervision and assistance devices to prevent accidents, Petitioner was not in substantial compliance with 42 C.F.R. § 482.25(h)(2) on February 20, 2007.

2. Petitioner remained substantially non-compliant with 42 C.F.R. § 482.25(h)(2) until March 14, 2007.

3. CMS's assessment of the scope and severity of Petitioner's substantial noncompliance between February 20, 2007 and February 25, 2007 at an immediate jeopardy "J" level is not clearly erroneous.

4. CMS's assessment of the scope and severity of Petitioner's substantial noncompliance between February 26, 2007 and March 14, 2007 at "G" level is not properly before me in this appeal.

5. The CMP assessed by CMS for the period of Petitioner's substantial noncompliance between February 20, 2007 and February 25, 2007 at $4500 per day is not unreasonable.

6. The CMP assessed by CMS for the period of Petitioner's substantial noncompliance between February 26, 2007 and March 14, 2007 at $150 per day is not unreasonable.

7. The total CMP assessed by CMS against Petitioner in this case, $29,550, is not unreasonable.

V. Discussion

A. *The facility did not provide an adequate level of supervision or assistance devices to prevent accidents as required by 42 C.F.R. § 483.25(h)(2).*

The material contours of this litigation are neither obscure nor complex. In February, 2007, an 86-year-old woman who will be called R-500 in this discussion was a resident in Petitioner's facility. She had been a resident there for almost five years and was well-known to the staff.

By early 2007, R-500's facility records reflected diagnoses of arthritis, spinal stenosis, severe kyphosis, osteoporosis, chronic obstructive pulmonary disease, degenerative joint disease, depression, and dementia. Facility staff had noted tremor in R-500's arms and decreased control over the position of her head, as well as muscular wasting and atrophy. Within the month immediately prior to the incident from which this litigation arises, R-500 had been observed by facility staff to require assistance with eating as the result of her poor sitting posture, her poor head and trunk control, her physical inability to push her wheelchair and reach for food items on tables before her, her moderately-impaired cognitive and memory functions, and her poor decision-making skills. CMS Ex. 13, at 3; CMS Ex. 14, at 1, 3, 10; CMS Ex. 20, at 5-6; CMS Ex. 40, at 4; P. Ex. 7, at 3, 11, 13; P. Ex. 9, at 3, 6.

Not more than five weeks before the incident at issue, R-500 had been reassigned from the facility's general dining room to a special location, the Robin's Nest, intended for residents who required substantial help and supervision with their meals. CMS Ex. 28, at 1; CMS Ex. 40, at 2, 3; P. Ex. 16, at 2. Less than four weeks before the incident, the facility recorded its observation that R-500 tended to spill her food as she reached from the table to her mouth, the result of decreased strength and range of motion in her right arm. CMS Ex. 20, at 8; P. Ex. 9, at 8. Her doctor had ordered "shallow bowls for soup"

because of R-500's limitations. CMS Ex. 19, at 1-2. One of the facility's staff recalled that R-500 always asked for an extra "cloth protector" to be placed in her lap at meals, because she didn't like her clothes soiled with spilled food. The facility knew of R-500's desire to be independent and "eat by herself," and it knew that she believed herself capable of doing so.

In preparation for the noon meal on Tuesday, February 20, 2007, R-500 was moved in her wheelchair to the Robin's Nest and seated at a table by herself. Nothing was on the table except a glass of ice-water. Hot soup in covered individual bowls was brought to a counter just inside the Robin's Nest by tray from the main dining room. R-500 and the two other residents dining in the Robin's Nest were then left alone for not more than 10 minutes.

There were six Certified Nurse Assistants (CNAs) on duty in the facility at the time, and at least two Food Service Aides (FSAs), five Registered Nurses (RNs), one Speech Language Pathologist (SLP), one Registered Dietician (RD), the Assistant Food Service Director (AFSD), and the Directors of Food Services (FSD) and of Nurses (DON). Nevertheless, the three residents in the Robin's Nest were left unattended, unobserved, and unsupervised while they waited to be served their hot soup.

It is not clear how, or from where or from whom, or in what sort of vessel R-500 got the hot soup with which she burned herself: R-500 was unobserved, unsupervised, and unattended when the incident occurred. But get the soup she certainly did. And burn herself with it by spilling it into her lap she most certainly did: R-500 suffered a second-degree burn on her left thigh six to eight inches long, and varying from two inches wide at its narrowest to approximately twice that width at its broadest point which was still visible five week later. CMS Ex. 11, at 4; CMS Ex. 16, at 1; CMS Ex. 20, at 15; CMS Ex. 21, at 1; CMS Ex. 40, at 3; P. Ex. 11, at 1. When a staff-member returned to the Robin's Nest, R-500 was found to be visibly distressed, her fingers in the ice-water still on the table before her, her lap, wheelchair and the floor around her wet with spilled hot soup. R-500 said nothing at the time about how the spill occurred, but three days later R-500 stated that she believed that the "tea was on the stove, she took it off stove, didn't know it was so hot. She spilled some and burned her leg . . . ." CMS Ex. 28, at 1; CMS Ex. 40, at 3. R-500 also insisted again that she remained capable of eating independently, and needed no help in doing so.

CMS argues that these facts demonstrate that Petitioner's facility then and there failed to comply with 42 C.F.R. § 483.25(h)(2), by failing to ensure that R-500 received adequate supervision and assistance devices to prevent accidents.[1] CMS determined that the

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[1] This alleged deficiency was cited as F-324. In August, 2007, the requirements established by 42 C.F.R. §§ 483.25(h)(1) and 483.25(h)(2) were combined into a single F-Tag, F-323. This Decision will cite F-324, the F-Tag employed at the time of the

immediate jeopardy was abated on February 27, 2007, during the survey. The facility was found to be back in substantial compliance, effective March 15, 2007, based on a revisit survey that was conducted on March 30, 2007.

Petitioner generally admits the facts but rejects the conclusion: it reminds CMS and me that 42 C.F.R. § 483.25(h)(2) does not impose on skilled nursing facilities a standard of strict liability for accidents, and asserts that "[i]n this case the Facility did everything in its power to assess R-500 and anticipate any possible injuries that could occur as a result of her mental and physical capacity." P. Br. at 16. This argument seems to suggest that because nobody knows how, where, from whom, or in what vessel R-500 got her hot soup, Petitioner cannot now be expected to have anticipated the precise manner in which the accident ultimately occurred and to have mitigated the risk. While a facility's duty of care owed to its residents is not one of strict liability, the facility must provide *adequate* supervision and assistance devices to prevent accidents. *Crestview Manor*, DAB CR1350 (2005); *Windsor Health Care Center*, DAB No. 1902, at 5 (2003). It is evident here that the facility failed to provide adequate supervision, in fact it provided no supervision at all. For this reason, I find that the facility did not provide an adequate level of supervision to prevent accidents, as required by 42 C.F.R. § 483.25(h)(2) (Tag F-324).

The well-understood law of this forum declares that a facility may not dismiss an accident as beyond its obligation to guard against simply because that accident has not occurred before to the same resident in precisely the same manner, or because its potential has not become obvious by having already happened. *Josephine Nursing Home*, DAB No. 1908 (2004). Put another way, while the facility might not have been expected to foresee all of the details of the hot-soup incident, it could reasonably be expected to foresee that R-500 was at risk of burns from hot soup or any other hot liquid if not adequately supervised when hot soup or any hot liquid was present. *Batavia Nursing and Convalescent Center*, DAB No. 1905, at 45 (2004).

In *Briarwood Nursing Center*, DAB No. 2115 (2007) and *Century Care of Crystal Coast*, DAB No. 2076 (2007), the Board recently distilled the requirements of 42 C.F.R. § 483.25(h)(2) into this cogent language, explaining that the regulatory requirement —

> obligates the facility to provide supervision and assistance devices designed to meet the resident's assessed needs and to mitigate foreseeable risks of harm from accidents. In addition, the Board has indicated that a facility must provide supervision and assistance devices that reduce known or foreseeable accident risks to the highest practicable degree, consistent with accepted standards of nursing practice.

See also Golden Age Skilled Nursing & Rehabilitation Center, DAB No. 2026 (2006).

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incident.

Illuminating as that language is, it leaves one important question unresolved: how to determine when an "accident risk" was — or became — "foreseeable?" The quantum of care demanded of a facility in terms of supervision and assistance devices is "the highest practical degree" consistent with accepted nursing standards when "foreseeable accident risks" or "foreseeable risks of harm" are present. Marshaling a facility's resources to provide the highest practical degree of supervision and assistance may in many situations be the easier part of the job: the harder part may be knowing when to do so.

Now, there may be no more-debated concept in this country's jurisprudence than the concept of foreseeability. Ambiguous, attenuated webs of causation and intervening events have defied any simple definition of the concept since well before Mrs. Palsgraf bought her ticket to Rockaway Beach. But when the Board decided *Briarwood*, it was not addressing an ambiguous web of attenuated facts. It was examining a facility's specific response to its resident's known vulnerabilities and proclivities in a concrete context of event-potential and risk of harm. Its definition of "foreseeable" is realistic and practical, and it is the definition I shall apply in assessing the facts before me:

> The Board has held that assessing foreseeability, simply requires looking at the "circumstances that were apparent or should have been apparent to the facility and then evaluat[ing] whether those circumstances – which can often be unique — were such that the facility could reasonably have anticipated the possibility of harm to the resident." Lutheran Home at Trinity Oaks, DAB No. 2111, at 17 (2007).

Briarwood, DAB No. 2115, at 13, n.9.

Applying that definition, I have no difficulty in finding that R-500's accident was foreseeable. Her physical impairments made her inordinately susceptible to spilling hot soup on herself if she attempted to feed herself without help, and the facility knew it. The facility knew that she might attempt such an undertaking. Her cognitive impairments made it quite unlikely that she would perceive the whole range of dangers inherent in attempting to feed herself hot soup without help, and the facility knew that, too. The facility knew that hot soup could be spilled and if spilled could do harm, as is shown by the fact that the bowls of hot soup were covered when they were left unwatched in the Robin's Nest. There was, in short, nothing unforeseeable about the accident.

Nor have I any difficulty in concluding that the facility fell short in its duty to provide the highest practicable degree of supervision and assistance devices, consistent with accepted standards of nursing practice, in the face of that foreseeable accident. The facility was not in substantial compliance with 42 C.F.R. § 483.25(h)(2) on February 20, 2007 because it left R-500 unsupervised, unobserved, and unattended in the Robin's Nest after the hot soup had been delivered and left there unwatched.

CMS was not clearly erroneous in its assessment of the scope, severity, and duration of the facility's noncompliance. The injury R-500 sustained was serious, and could have been far more serious still; in any case, the criteria for a determination of immediate jeopardy set out in 42 C.F.R. § 488.301 are more than satisfied by a second-degree burn covering approximately 20 square inches of an 86-year-old woman's leg. CMS was not unreasonable in its assessment of the total amount of the CMP, nor was it unreasonable in assessing any of the component elements of that total, that is, the period of Petitioner's noncompliance, and the assignment of daily CMP amounts during the period.

The foregoing discussion sets out the broad character of my view of the evidence in this record, and the principles I have applied to that evidence in reaching my findings and conclusions. What follows below will supply the details and explain the connections among that evidence, those principles, and my ultimate decision in this case.

R-500 was originally admitted to the facility on May 2, 2002, and readmitted on March 30, 2005 after a hospitalization. CMS Ex. 12. Five years after her initial admission, on February 20, 2007, R-500 received a second degree burn when she spilled soup on herself. It is evident that she had been in the facility long enough to be well known to the staff.

Her diagnoses are undisputed and are supported by the evidence. R-500 had arthritis, spinal stenosis, severe kyphosis, osteoporosis, chronic obstructive pulmonary disease, degenerative joint disease, depression, and dementia. *Id.;* CMS Ex. 11, at 3; CMS Ex. 20, at 5; CMS Ex. 40, at 4; P. Ex. 9, at 3. R-50 also had upper extremity tremors. CMS Ex. 11, at 4; CMS Ex. 20, at 11-12; CMS Ex. 28, at 10; P. Ex. 9, at 11-12.

In January, 2007, staff noted that R-500 required assistance with eating (CMS Ex. 15, at 1-2; P. Ex. 8, at 6-7); required staff to set up meal trays (CMS Ex. 15, at 4; P. Ex. 8, at 3); was receiving occupational therapy for poor sitting posture and decreased head control; was in a deconditioned state and displayed severe kyphotic posture (CMS Ex. 20, at 3; CMS Ex. 40, at 4; P. Ex. 9, at 4); was dependent upon staff for *all* activities of daily living, including eating; had poor sitting balance and severely impaired limb movements (CMS Ex. 14, at 1, 3; P. Ex. 7, at 11); had moderate cognitive impairment and memory loss, made poor decisions, and required cues and supervision (CMS Ex. 13, at 3; CMS Ex. 14, at 10; CMS Ex. 23, at 1; CMS Ex. 40, at 4; P. Ex. 7, at 3, 13); had a tendency to spill food reaching from table to mouth (*Id.*). Shallow soup bowls were recommended for R-500's use (CMS Ex. 20, at 10; P. Ex. 9, at 10). Her head was noted to be in her lap as a result of her poor posture (CMS Ex. 20, at 8; P. Ex. 9, at 8); and a physician's order dated January 26, 2007, ordered the use of shallow bowls for soup. CMS Ex. 19, at 1-2.

R-500's plan of care dated January 13, 2007, recorded that R-500 required "assistance with eating as needed." CMS Ex. 15, at 1; P. Ex. 8, at 6. In fact, Petitioner admits that R-500 required "assistance with eating due to her mental and physical limitations (P. Br. at 6) and that her care plan "specifically states that the resident is to receive supervision with hot liquids." P. Br. at 5-6.

In February, 2007, prior to the burn incident, it was noted that R-500 required maximum assistance with eating because she was spilling foods (CMS Ex. 19, at 1-2; CMS Ex. 20, at 12; P. Ex. 9, at 12; P. Ex. 10); that there was a marked increase in her right upper extremity tremors and that she was spilling food (*Id.);* that her hand tremor was markedly increased (CMS Ex. 28, at 10-11; CMS Ex. 1, at 2; CMS Ex. 40, at 3); and that she was in a deconditioned state (CMS Ex. 20, at 14; P. Ex. 9, at 14).

All of these observations, diagnoses, and cautionary notations were of record at the facility prior to the incident on February 20, 2007, when, at 11:50 a.m., R-500 spilled hot soup on her left thigh while she was in the Robin's Nest dining room. This event resulted in a complaint survey of the facility on February 27, 2007.

The Robin's Nest dining room is one of three dining rooms at the facility. Residents who eat in the Robin's Nest dining room are those who need assistance and supervision with meals. CMS Ex. 28, at 1; CMS Ex. 40, at 2; P. Ex. 16, at 2. Petitioner admits that the Robin's Nest dining room was designed for those residents that required assistance and supervision with meals. P. Br. at 4. Mr. Dan Novak, the Food Service Director and Ms. Susan Spurrier, the Director of Nurses, stated that R-500 was moved from another dining room to the Robin's Nest dining room because she was having difficulty with her posture and getting food to her mouth. CMS Ex. 28, at 3-5. Mr. Novak and Ms. Spurrier informed the surveyor that even though all soup was supposed to be served to residents in "narrow necked bowls," they did not know how it happened that R-500's soup was served in a mug on the day of the incident. CMS Ex. 28, at 3; CMS Ex. 40, at 4. They also stated that there was "[n]o staff in the room when [the] soup spilled," and that they "don't know who gave the soup to [R-500]." CMS Ex. 28, at 4; CMS Ex. 1, at 4.

Speech therapist Kris Umphrey wheeled R-500 into the Robin's Nest dining room for the noon meal on February 20, 2007, and sat her at a table with only ice water on the table. Then Ms. Umphrey left to get other residents into the dining room. After Ms. Umphrey returned to the dining room, about 5-10 minutes later, R-500 called out to Ms. Umphrey saying that she needed assistance because she had spilled her soup. Ms. Umphrey observed that R-500 had already spilled her soup at that time. CMS Ex. 28, at 12, 18; CMS Ex. 1, at 3; CMS Ex. 40, at 3; P. Ex. 34.

Although the staff concluded that R-500 would have been unable to get the soup on her own, no one at the facility knew then or knows now how R-500 got her soup on February 20, 2007. CMS Ex. 1, at 4-5; P. Ex. 13, at 3.

Petitioner's normal procedure was that the dietary staff was to transport the soup to the Robin's nest dining room and nursing staff was to serve the soup. P. Br. at 10-11. The normal procedure was that soup was first served to residents in another dining room. Staff members would fill soup bowls from a steam table in the other dining room and a food service aide would transport the soup on a tray to the Robin's Nest dining room and place the tray of food on a cabinet just inside the door of the Robin's Nest. CMS Ex. 1, at 3. Thereafter, CNAs would serve the soup to the residents in the Robin's Nest dining room. CMS Ex. 28, at 4, 18; CMS Ex. 1, at 2-3; CMS Ex. 26, at 6-11. Carrie Sutton, the food service aide who delivered the soup on February 20, 2007, asserts that she placed the servings of soup on the cabinet inside the doorway of the Robin's Nest dining room and confirmed that the soup was served in narrow neck bowls with lids that were to be served by the nursing staff. CMS Ex. 28, at 6, 18; CMS Ex. 29, at 6, 18; P. Br. at 7. It is possible that Ms. Sutton's statement was self-serving. At any rate, the facility claims and the Facility Incident Report (P. Ex. 1) states that R-500 spilled a mug, not a bowl, of hot soup on February 20, 2007, which resulted in a burn of her thigh.

All six CNAs on staff during the noon meal when the hot soup incident occurred denied giving R-500 her soup, denied knowing how R-500 got her soup, and denied being present in the Robin's Nest dining room when the incident occurred. CMS Ex. 1, at 4-5; CMS Ex. 28, at 8-9; CMS Ex. 11, at 4; P. Ex. 17; P. Ex. 23, P. Ex. 24. The exact same denials were expressed by all five of the registered nurses on duty on February 20, 2007. P. Exs. 18-22. DON Spurrier also expressed the same denials. P. Ex. 17, at 1. The dietary staff and the other facility staff expressed the same denials, as well. P. Exs. 25-40. Even the Administrator of the facility, Administrator Wideman, who was not working on February 20, 2007, stated that she did not know how R-500 obtained the soup. P. Ex. 16, at 1.

R-500, when interviewed by the surveyor, stated that she spilled the "tea" on her leg after she "took it off the stove." CMS Ex. 40, at 3. Surveyor Kaelin concluded that R-500 could not remember the details of the spilled soup incident given R-500's incoherent response. *Id.* Surveyor Kaelin examined the wound and saw a second degree burn on R-500's left thigh which measured six by eight inches long, three to four inches wide in two areas, and two inches wide in the remaining area. *Id.* Surveyor Kaelin also observed R-500 spill a lot of food on her lap while eating, which at the time of the survey was protected by a cloth protector.

Petitioner protests that it does not know how R-500 obtained the soup and asserts that the soup was in a mug when R-500 was left at her table for up to 10 minutes with only a glass of water in front of her. Petitioner completely denies the possibility that one of its own staff served R-500 the soup, and it opines that possibly a visitor, volunteer, student, or family member may have served R-500 the soup. P. Br. at 12. Such a suggestion might benefit from even a scrap of evidence that a visitor, volunteer, student, or family member had been observed in or near the Robin's Nest; in the absence of any such evidence, the suggestion seems embarrassingly unlikely. The much more likely possibility is that one of the 15 or more hands-on care-givers in the immediate area at the time did so. Even though all of the staff denied serving soup to R-500, it is obvious that such denials are at least in part subject to examination through the prism of the staff's own self interest. Ms. Sutton, the food service aide, claimed that the soup was in narrow-necked bowls but the evidence established that R-500 spilled a mug of soup. Therefore, to accept Petitioner's speculative theory that a visitor, volunteer, student, or family member served R-500 the soup would require me to imagine that such an unknown and unobserved visitor, volunteer, student, or family member happened along in those few minutes that R-500 was unattended and happened to have a mug available, took off the lid from the narrow necked bowl containing the soup, transferred the soup from the narrow necked bowl into a mug, and served R-500 the soup. My imagination cannot stretch so far.

The very fact that no one knows how R-500 obtained the soup and no one admits to being there to supervise or assist her when hot soup was present in the dining room clearly demonstrates a failure of supervision and a failure of the facility and its staff to provide R-500 with the necessary assistance to eat hot soup safely. Petitioner's argument that this incident was not foreseeable because no resident should have been able to obtain hot liquids without nursing staff present and that the nursing staff should have been free to continue to transport residents to the Robin's Nest dining room without concern fails. Under these circumstances, as soon as any resident was brought to the Robin's Nest dining room, at least one staff member should have remained to supervise the resident or hot liquids should not have been brought into the dining room until supervision could be provided. The possibility of a burning accident is entirely foreseeable when R-500, a resident with significant physical limitations and dementia, was left unsupervised, unattended, and unobserved in the presence of hot soup.

B. CMS's determination that the deficiency cited against Petitioner was at an immediate jeopardy level is clearly not erroneous.

I next consider whether CMS's immediate jeopardy finding was "clearly erroneous." CMS's determination as to the level of a facility's noncompliance, including a finding of immediate jeopardy, must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed that the "clearly erroneous" standard imposes a "heavy burden" on facilities to show that no immediate jeopardy exists, and has

sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1962, at 11 (2005) (citing *Florence Park Care Center*, DAB No. 1931, at 27-28 (2004) (citing *Koester Pavilion*, DAB No. 1750 (2000)); *see also* 42 C.F.R. § 498.3(d)(10).

CMS argues that R-500 may have been burned because she was given hot soup to eat without assistance and spilled it or she could have been burned because she sat with spilled soup on her leg for as much as 10 minutes, when Ms. Umphrey noticed the spilled soup after an absence from the Robin's Nest dining room. Either hypothetical case clearly shows inadequate supervision by the facility, and neither hypothetical case affords Petitioner a defense. R-500's burn was classified as a second degree burn that covered a large surface area on her thigh that was still evident one month after her injury, definitely a serious injury. CMS Ex. 21, at 1; CMS Ex. 36, at 1, 2, 3; CMS Ex. 50, at 1, 5; P. Ex. 11, at 1, 3-5. The lack of supervision that resulted in the burn that R-500 received amounts to an immediate jeopardy situation. R-500 was one of three residents present in the Robin's Nest dining room at the time of the incident. Since not even one — I emphasize, not even a single — staff member acknowledges having been present in the Robin's Nest dining room at the time of the spilled soup incident, that absence of staff left R-500 and any other resident present in the dining room without any supervision whatsoever. That was, then, by the evidence of the facility's own staff, a manifestly perilous situation in the only dining room that served all the residents in the facility who require assistance and supervision with eating. CMS's determination is certainly not clearly erroneous.

I reject Petitioner's argument that R-500's burn did not amount to an immediate jeopardy situation because R-500's burn was a minor burn on her thigh and the burn did not cover 15% or more of R-500's body surface area. Petitioner misunderstands the definition of immediate jeopardy.

Immediate jeopardy is defined as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is *likely to cause*, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301 (emphasis added). Leaving an elderly demented resident, with significant physical limitations and who has been assessed as requiring supervision with eating, completely alone and unsupervised in the presence of hot liquids is likely to cause serious injury. In addition, any similarly-situated resident was also in immediate jeopardy.

C. A $4500 per-day CMP, effective from February 20, 2007 through February 25, 2007, and a $150 per-day CMP, effective from February 26, 2007 through March 14, 2007 is reasonable.

CMS determined to impose a $4500 per-day CMP for six days of immediate jeopardy, effective from February 20, 2007 through February 25, 2007, and a $150 per-day CMP for 17 days, effective from February 26, 2007 through March 14, 2007, until the facility came back into substantial compliance. The total amount of the CMP imposed against Petitioner amounts to $29,550. The regulations authorize the imposition of a CMP, of from $3050 per day to $10,000 per day, for deficiencies that constitute immediate jeopardy to a facility's residents. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). The lower range of CMP, from $50 per day to $3000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). I must assess *de novo* the reasonableness of the CMP proposed by CMS based on the factors set forth at 42 C.F.R. § 488.438(f). In determining the amount of the CMP, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of non-compliance, 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.

CMS provided evidence concerning Petitioner's history of noncompliance. Petitioner was out of compliance with three deficiencies during a survey that was conducted in May 2004, with two deficiencies during a survey that was conducted in April 2005, with one deficiency during a survey that was conducted in May 2006, and with four deficiencies during a survey that was conducted in April 2007. CMS Ex. 52, at 1. Petitioner's financial assets establish that Petitioner has the assets to pay the CMP. CMS Ex. 51, at 1, 5. The seriousness of R-500's injury, as I have already discussed, was substantial. Finally, Petitioner's culpability was also substantial in that it completely failed to provide any supervision whatsoever for R-500 during her meal on February 20, 2007. This shows a disregard for R-500 and for other residents who may have been present in the Robin's Nest dining room. In light of the relevant factors, a $4500 per-day CMP is not only reasonable in the case before me but it is also on the lower end of the range of possible immediate jeopardy CMPs.

Petitioner argues that the period of immediate jeopardy did not last six days. Instead, it argues that it implemented an action plan which was shared with the surveyor on February 23, 2007. P. Reply Br. at 12; P. Ex. 4. Petitioner continued to send additional information to MDCH and emailed the plan of correction on February 25, 2007. P. Reply Br. at 12. Also statistical data on the number of residents assessed and the number of staff "in-serviced" (*ad-hoc* training conducted by the facility itself) was faxed on February 26, 2007. Petitioner argues that no substantive changes to the plan were made since it was presented to the surveyor on February 23, 2007.

Immediate jeopardy was determined by CMS to last through February 25, 2007. The accepted case law is that it is Petitioner's burden to show an earlier abatement date for immediate jeopardy and that CMS's determination of the duration of immediate jeopardy must be clearly erroneous. *Barn Hill Care Center,* DAB No. 1848 (2004), *Spring Meadows Health Care Center*, DAB No. 1966 (2005); *Parkway Manor Health Center*, DAB CR1146 (2004). CMS is not clearly erroneous in determining that the immediate jeopardy lasted for two additional days past February 23, 2007. The plan of correction established that a number of Petitioner's staff had not yet been "in-serviced" prior to February 23, 2007. Several staff members, approximately 16, were "in-serviced" on February 24, 2007 and several more, approximately 12, were "in-serviced" on February 25, 2007. CMS Ex. 31, at 2, 13-15. CMS determined that a substantial number of Petitioner's staff were "in-serviced" on the responsibilities of monitoring the dining process and elder safety with hot liquids by February 25, 2007 and that the immediate jeopardy period terminated on that date. CMS's determination was not clearly erroneous.

Even after Petitioner had abated the immediate jeopardy, Petitioner continued to be out of substantial compliance for 17 additional days because the entire staff had not been oriented to the new policies and procedures and compliance with the new policies and procedures had not yet been verified by the state agency. CMS Ex. 1, at 7. A $150 per-day CMP is almost the minimum CMP available for non-immediate jeopardy deficiencies and is also reasonable.

VI. CONCLUSION

For the foregoing reasons, I conclude that Petitioner failed to comply substantially with federal participation requirements and that the CMPs imposed against it are reasonable.

/s/
Richard J. Smith
Administrative Law Judge