

Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:)	
)	
Columbus Nursing & Rehabilitation)	
Center, (CCN: 52-5445))	Date: February 23, 2009
)	
Petitioner,)	
)	
- v. -)	Docket No. C-06-522
)	Decision No. CR1905
Centers for Medicare & Medicaid)	
Services.)	

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose a civil money penalty (CMP) against Petitioner, Columbus Nursing & Rehabilitation Center (Petitioner or facility), for failure to comply substantially with federal requirements governing participation of long-term care facilities in Medicare and State Medicaid programs. For the reasons that follow, I uphold the CMP of \$6200 per day from April 23, 2006 through April 26, 2006, based on a finding of immediate jeopardy.

I. Background

This case is before me pursuant to a request for hearing filed by Petitioner dated June 14, 2006. Petitioner is a long-term care provider located in Columbus, Wisconsin.

By letter dated May 31, 2006, CMS informed Petitioner that based on a survey completed by the Wisconsin Department of Health and Family Services (State Agency) on May 10, 2006, it was imposing selected remedies due to Petitioner's failure to be in substantial compliance with the applicable federal requirements for long-term care facilities. The most serious deficiency was deemed to be immediate jeopardy deficiencies under Tag F314 (Pressure Sores).

Prior to the in-person hearing that took place on March 19 and 20, 2008, the parties resolved most issues in the case. The parties agreed that the only remaining issue related to Tag F314 and residents who were identified as R2, R8, R9, R12, and R13. The parties agreed that the only portion of the CMP at issue was the portion of the CMP that was posed in the upper penalty range for 4 days, April 23-26, 2006.

CMS filed a motion for summary affirmance. Petitioner filed a brief in response to CMS's motion, and also a motion for partial summary disposition. On May 4, 2007, I issued an order denying CMS's motion for summary judgment and Petitioner's cross-motion for partial summary judgment.

CMS initially offered 63 exhibits identified as CMS Exhibits (CMS Exs.) 1-63. In an effort to confine the exhibits to those that relate to F314, certain exhibits were withdrawn. CMS offered 27 total exhibits at the in-person hearing. Petitioner objected to CMS Ex. 4 and CMS Ex. 6 and I granted Petitioner's objection to these exhibits. CMS withdrew CMS Ex. 48. I receive CMS Exs. 1, 2, 3, 5, 7, 8, 11, 12, 17, 22, 23, 26, 27, 44, 46, 47, 49, 50, 52, 55, 56, 59, 60, and 61 into evidence. Petitioner initially offered 50 exhibits, identified as Petitioner Exhibits (1-50). Petitioner's exhibits that relate to F314 are P. Exs. 1, 3, 6, 7, 9, 10, 22, 23, 29, 30, 31, 41, 42, 45, 46, 47, 48, 49 and 50. I admit these 19 exhibits into evidence without objection. In an April 8, 2008 letter issued at my direction, I instructed the parties to submit post-hearing briefs (CMS Br. and P. Br.) by May 22, 2008, and post-hearing reply briefs (CMS Reply and P. Reply) by June 11, 2008. The parties subsequently submitted their respective briefs as directed.

Based on the documentary evidence, the arguments of the parties, and the applicable law and regulations, I find that Petitioner was not in substantial compliance, at the immediate jeopardy level, on the dates determined by the State Agency and CMS. I further find that CMS was authorized to impose a CMP of \$6200 per day for noncompliance from April 23, 2006 through April 26, 2006.

II. Applicable Law and Regulations

Petitioner is considered a long-term care facility under the Social Security Act (Act) and regulations promulgated by the Secretary of Health and Human Services (Secretary). The statutory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Act, and at 42 C.F.R. Parts 483 and 488.

Sections 1819 and 1919 of the Act invest in the Secretary authority to impose CMPs against a long-term care facility for failure to comply substantially with participation requirements.

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; 42 C.F.R. §§ 488.300-488.335. Pursuant to 42 C.F.R. Part 488, CMS may impose either a per day CMP or a per instance CMP against a long-term care facility when a state survey agency concludes that the facility is not complying substantially with federal participation requirements. 42 C.F.R. §§ 488.406, 488.408, and 488.430. The penalty may start accruing as early as the date that the facility was first out of compliance until the date substantial compliance is achieved or the provider agreement is terminated. 42 C.F.R. § 488.440.

The regulations specify that a per day CMP that is imposed against a facility will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of 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), (d)(2). The lower range of CMPs, of 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).

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.

"Immediate jeopardy" is defined to mean:

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

42 C.F.R. § 488.301.

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 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.

The Act and regulations make a hearing before an administrative law judge (ALJ) available to a long-term care facility against whom CMS has determined to impose a CMP. But the scope of such hearings is limited to whether an *initial determination* made by CMS is correct. Act, section 1128A(c)(2); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). A facility may challenge the scope and severity level of noncompliance found by CMS only if a successful challenge would affect the range of CMP amounts that could be collected by CMS or impact upon 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 level 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).

In a CMP case, CMS must make a *prima facie* case that the facility has failed to comply substantially with participation requirements. To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd*, *Hillman Rehabilitation Center v. U.S. Dept. of Health and Human Services*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999).

III. Issues

- A. Whether the facility was complying substantially with federal participation requirements on the dates CMS determined to impose a CMP.
- B. Whether CMS's determination of immediate jeopardy was clearly erroneous.
- C. Whether the amount of the penalty imposed by CMS is reasonable, if noncompliance is established.

IV. Findings and Discussion

The findings of fact and conclusions of law noted below, in italics, are followed by a discussion of each finding.

A. Petitioner was not in substantial compliance with federal participation requirements from April 23, 2006 through April 26, 2006.

- 1. The facility failed to prevent R12 from developing avoidable pressure sores and failed to give R12 the necessary treatment and services to***

promote healing, prevent infection, and prevent new sores from developing (Tag F314).

R12 was an 83-year old woman who was admitted to the facility on February 15, 2006, without any pressure sores. P. Ex. 9, at 59; CMS Ex. 26, at 37. R12 had recently suffered a left hip fracture and was admitted to the facility following surgical correction. CMS Ex. 26, at 12, 60. She required a two-person assist for repositioning and was dependent for bed mobility as a result of her hip fracture. *Id.* at 38, 81-82. R12 had additional diagnoses of dementia and joint pain in her pelvis. *Id.* at 12.

Upon admission, R12 did not have any pressure sores; however she previously had been diagnosed with them. P. Ex. 9, at 26. A Braden Scale assessment performed on February 15, 2006, found R12 at high risk for pressure sores. CMS Ex. 26, at 36; P. Ex. 9, at 36. R12's initial care plan dated February 16, 2006, indicated under the heading "Skin Integrity" that staff monitor food and fluid intake, but did not include any goals for R12's skin integrity. CMS. Ex. 26, at 44. On February 19, 2006, facility staff noted that R12 had developed left leg edema. *Id.* at 61. R12's February 22, 2006 care plan indicated that she had several problems: a self-care deficit related to dementia and her left hip fracture, impaired thought processes, was at risk for falls and had a history of falls, was at nutritional risk, and at risk for alteration in comfort. *Id.* at 45-48. One of the goals according to R12's February 22, 2006 care plan was for her skin to remain intact. *Id.* at 46.¹ On February 25, 2006, Bruce Kraus, M.D., R12's treating physician, visited her for the first time. *Id.* at 63. The facility did not place R12 on a turning schedule upon admission. P. Ex. 48, at 29.

On February 26, 2006, the nurse's notes indicated that R12 had "firm, pitting, shining edema" on her left leg. CMS Ex. 26, at 64. On February 27, 2006, Dr. Kraus ordered bed rest, to continue administering Lovenox, and for a Doppler study to be performed on R12's left leg.² *Id.* at 14. On March 1, 2006, Dr. Kraus ordered facility staff to monitor R12's left leg for increased edema and to apply T.E.D. hose stockings³ in the morning and to take off the stockings in the evening. *Id.* at 14.

On March 3, 2006, the nurse's notes indicate that R12 had a 4 cm Stage IV pressure sore on her left heel. The pressure sore had a black center and red soft tissue surrounding it. CMS Ex. 26, at 66.

¹ This goal was crossed out on March 3, 2006.

² The Doppler study was ordered by Dr. Kraus to rule out deep vein thrombosis. CMS Ex. 26, at 14.

³ A T.E.D. anti-embolism stocking (T.E.D. hose) is a covering for the leg that is used to reduce swelling and the risk of blood clots. www.tedhose.com.

CMS contends that the facility failed to prevent R12 from developing pressure sores, and that these pressure sores were avoidable. CMS Br. 42-57. CMS has pointed to the timing of Dr. Kraus's first visit with R12 to show that a substantial amount of time passed between when R12 was first admitted, February 15, and Dr. Kraus's first visit to R12, February 25, 2006. Tr. at 206, 211, 227-28; CMS Br. at 44. Over the next couple of days after Dr. Kraus visited R12 he ordered bed rest and a Doppler study because of the edema on R12's left leg; then he discontinued bed rest and ordered T.E.D. hose stockings for R12 to wear daily. CMS Ex. 26, at 14, 64, 65-66. CMS argues that "the edema, the bed rest and the T.E.D. hose should have prompted proactive efforts to monitor R12's heel for breakdown and to attempt to devise methods to counter the ever-increasing risk" to R12's heel. CMS Br. at 45.

CMS asserts that despite the fact that R12 did not have pressure sores when admitted to the facility, R12 did have a history of pressure sores. P. Ex. 9, at 26. According to CMS, R12's history of pressure sores should have been one factor in facility staff closely monitoring for a reoccurrence of pressure sores. CMS points to R12's Braden Scale assessment, performed upon admission, that found R12 at high risk overall for pressure sores. CMS avers that particular attention should have been given to the high risk of R12 developing a left heel pressure sore due to her diabetes, hip fracture, and left leg pain. CMS Br. at 43.

CMS also finds fault with the facility concerning R12's initial care plan. CMS infers that the facility should have considered R12's history of pressure sores, the determination that she was at high risk for pressure sores, and her overall condition when developing goals and preventative interventions. In particular, CMS highlights that the facility did not identify any goals for skin integrity and included only to monitor R12's food and fluid intake as interventions in the area of skin integrity. CMS Ex. 26, at 44.

One of the skin integrity interventions preprinted on the facility's initial care plans is to turn the resident every two hours. CMS points out that the facility did not choose to reposition R12 on a regular schedule despite her high risk of pressure sores. CMS argues that a turn schedule should have been included in R12's initial care plan. CMS Br. at 43. CMS supports its contention by including testimony by Dr. Kraus, Barbara Schmidt, R.N. and Carol Wehland, R.N. that a turn schedule is a fundamental intervention for a resident who is at high risk of pressure sores and that R12 would have benefitted from a turning schedule upon admission. CMS Br. at 43; *see* Tr. at 37, 49, 234-35, 253, 347, 432.

CMS argues that the February 22, 2006 comprehensive care plan should have included more goals and interventions specifically related to preventing pressure sores for R12. According to CMS, the comprehensive care plan dated February 22, 2006, included many problems, but "did not identify R12's risk for skin breakdown as a separate problem." CMS Br. at 43. CMS acknowledges that the pressure sore interventions were listed under the self-care deficits problem, but argues that the risk for skin breakdown should have

been listed as a separate problem and that certain interventions should have been more specific. CMS Br. at 43-44.

CMS contends that facility staff should have kept R12's treating physician, Dr. Kraus, more informed. According to CMS, Dr. Kraus depended on facility staff to keep him informed, but through his reports on R12, CMS argues that it is evident that he was not getting an adequate amount of information from facility staff. CMS Br. at 44. CMS cites an example of the report completed by Dr. Kraus after his first visit where he did not mention R12's edema or improving pressure relief for R12's heel. CMS Br. at 44. CMS points out that the day after Dr. Kraus's visit, the nurse had to obtain orders from Dr. Kraus for bed rest, Lovenox, and a Doppler study of R12's leg due to the appearance of the edema of R12's leg. CMS Br. at 44.

CMS argues that R12's edema of her left leg, the bed rest order by Dr. Kraus, and Dr. Kraus's order for R12 to use the T.E.D. hose were "red flags that should have prompted proactive efforts to monitor R12's heel for breakdown and to attempt to devise methods to counter the ever-increasing risk to [R12's] heel." CMS Br. at 45. Instead, CMS contends, facility staff were focused almost exclusively on the edema in R12's left leg and not on the risk of a pressure sore. CMS reasons that facility staff's inattentiveness to the risk of skin breakdown contributed to R12's eventual pressure sore and defeats any assertion that R12's pressure sore was unavoidable. CMS Br. at 45. According to CMS, in order for a pressure sore to be deemed "unavoidable" routine preventative care must be provided. CMS Br. at 45. CMS contends that because the necessary preventative care was not provided, Petitioner failed to comply with 42 C.F.R. § 483.25(c)(1).

Petitioner contends that the left heel pressure sore was unavoidable. According to Petitioner, "while facilities are expected to do what is necessary to prevent pressure sores, strict liability is not placed on nursing homes for the development of pressure sores," and thus, the appearance of a pressure sore after admission is only a deficiency if unavoidable. P. Br. at 38. Petitioner suggests that R12's pressure sore developed as a side effect of complying with R12's treating physician's orders. Petitioner asserts that there had been no indication of a pressure sore on R12's heel until the application of the T.E.D. hose and that the blister on her heel appeared two days after the T.E.D. hose was applied. P. Br. at 40. The T.E.D. hose applies pressure to the extremity with edema to reduce swelling, and Petitioner argues that the pressure applied to the skin on R12's heel caused the pressure sore to develop. P. Br. at 40. Petitioner argues that for CMS to suggest that the facility should have used another type of T.E.D. hose on R12 because of the eventual development of the pressure sore is "20/20 hindsight." P. Reply at 25.

In countering CMS's contentions that an insufficient number of goals and interventions were listed in R12's care plan, Petitioner argues that improving the goals and interventions of a care plan does not render pressure sores as unavoidable. According to Petitioner, CMS does not show how "perceived deficits" in the care plan would have

prevented the pressure sore on R12's heel. P. Br. at 41-42. Also, Petitioner contends that a facility can temporarily make alterations in a resident's treatment without changing the resident's permanent care plan. P. Br. at 42. Petitioner avers that the care provided to R12 up until her pressure sore developed was consistent with the care plan that was developed for R12 and that her care plan was updated when necessary.

Petitioner finds issue with CMS's connotation that the length of time between R12's admission and Dr. Kraus's first visit factored into R12 developing a pressure sore. Petitioner argues that this is not a deficient practice and is not abnormal. According to Petitioner, Dr. Kraus reviewed R12's records prior to her entering the facility and communicated with staff by telephone after R12 was admitted. P. Reply at 24. Petitioner also asserts that when Dr. Kraus did visit R12 he paid more than adequate attention to R12.

Once the nurse discovered the Stage IV pressure sore on R12's heel, CMS contends that facility staff did not provide the correct treatment for the pressure sore. CMS asserts that it was on March 3, 2006, when the facility amended the comprehensive care plan to identify the pressure sore as a separate problem. CMS Br. at 46. CMS argues that there were conflicts between R12's comprehensive care plan and the Nursing Aide Care Plans when the interventions were determined for R12's pressure sore. According to CMS, the comprehensive care plan called for an air mattress, which is different from a "special mattress" that the Nursing Aide Care Plan specified. CMS Br. at 47.

Another intervention that was used but not listed in either of R12's care plans was a heel protector or soft boot. The concern of the surveyors, according to CMS, was that the nurses intermittently documented the use of a heel protector or soft boot in their notes. According to CMS, in order for consistent use to be ensured, they should be listed in a resident's care plan and if not in a resident's care plan, they should be listed as a temporary intervention somewhere in the resident's record. CMS Br. at 47-48. CMS argues that these unapproved devices increased pressure on the wound in comparison to the treatment that was actually ordered. CMS Br. at 48.

CMS contends that R12's pressure sore went through a series of changes without proper notification to R12's treating physician. CMS Br. at 48. As an example of not providing proper notification, CMS points to a March 7, 2006 incident where R12's blister broke up and bled on her sheet and Dr. Kraus was not notified. CMS also avers that on March 8, 2006, the nursing staff discontinued placing a dressing over the wound and left it open to air. CMS Ex. 26, at 68-69. R12's records show that her wound transformed from a closed blister, to an open wound, to a dry black area, and according to CMS, Dr. Kraus should have been consulted about the changes in order to identify the best treatment. CMS. Br. at 48.

CMS also argues that because R12 had a Stage IV pressure sore, it should have been covered and protected. CMS Br. at 49. According to CMS, when facility staff left R12's wound open to air, they deviated from facility policy and CMS's pressure sore guidance. CMS Br. at 49; *see* SOM, App. PP, Data Tag F-314 and CMS Ex. 44, at 27. CMS contends that facility staff did not consult with Dr. Kraus or document their rationale for leaving R12's wound uncovered. CMS Br. at 50.

CMS asserts that facility staff discontinued elevating R12's heel off the bed despite Dr. Kraus's express orders and this specific intervention listed in her care plan. CMS Br. at 50. CMS argues that this action done per nursing order on March 10, 2006, should not have superseded a treating physician's orders without contacting the treating physician. CMS Br. at 50. According to CMS, instead of elevating R12's heel, the facility started using an air mattress. CMS asserts that there was no physician's order for R12 to use an air mattress. CMS Br. at 51. CMS contends that instead of an air mattress, facility staff should have continued to elevate R12's heel per her physician's order.

On April 9, 2006, Dr. Kraus prescribed Santyl and ordered it to be applied to R12's heel for debridement twice per day. On April 26, 2006, Surveyor Ann Angell observed a facility nurse change the Santyl dressing on R12's heel. According to CMS, the dressing was not being changed twice per day according to Dr. Kraus's order, the nurse did not follow appropriate wound care technique, and R12's foot was not properly assessed. CMS Br. at 52. After interviewing Karen Hanamann, L.P.N. and Judy Miller, L.P.N. it was discovered that the Santyl dressing had not been changed in the evening three nights in a row. CMS Ex. 59, at 13; P. Ex. 9, at 101-02. CMS also avers that during the April 26, 2006 Santyl dressing change, Nurse Hanamann did not change her gloves or wash her hands after she removed the old dressing and she did not clean the wound properly. Tr. at 48.

According to Petitioner, once the pressure sore appeared, Dr. Kraus was immediately notified and the care plan was immediately modified to address the new problem. The changes that developed with the sore, Petitioner contends, were handled by standard nursing protocol and did not require physician notification. Petitioner argues that the facility leaving R12's wound "open to air" was an acceptable method of treatment if there is not an open draining wound and that Dr. Kraus did not have a problem with this method of treatment and did not order any new treatment after he visited R12. P. Br. at 44.

Petitioner contends that the manufacturer's recommendation was for Santyl to be applied only once per day, and the fact that facility staff did not apply it and change the dressing in the evening over a three-day period did not create a potential for more than minimal harm. Petitioner suggests that R12's pressure sore was not a true Stage IV pressure sore, but an unstageable pressure ulcer and that one reason this deficiency did not create a

potential for more than minimal harm was because it was not a more serious Stage IV pressure sore. P. Br. at 45-46.

Petitioner also argues that the use of the air mattress instead of elevating R12's heels was appropriate. Petitioner relies on the testimony of Dr. Kraus to contend that even though he did not specifically order that R12 use an air mattress, he would have approved its use and did not expect to be consulted if the facility decided to use this intervention as part of its treatment for R12. Petitioner contends that the use of the air mattress was a better fit for R12, especially because elevating R12's heel may have produced a pressure sore on R12's left calf.

Petitioner avers that the nurse who performed the dressing change for R12, Nurse Hanamann, cleansed the wound with saline. P. Br. at 48; *see* Tr. at 313-314. Petitioner also asserts that Surveyor Angell did not indicate to Nurse Hanamann that she had done anything wrong when caring for R12's wound. Thus, Petitioner contends, the facility was in substantial compliance with respect to the dressing change. P. Br. at 48-49.

I find that the facility failed to prevent R12 from developing avoidable pressure sores and failed to give R12 the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. Pursuant to 42 C.F.R. § 483.25(c)(1), a resident's clinical condition must demonstrate that a pressure sore was unavoidable if a resident enters a facility without pressure sores and then develops pressure sores while in the facility. The regulations require a facility to assume that no pressure sore is unavoidable. Although R12 had a history of pressure sores, she entered the facility without a pressure sore. P. Ex. 9, at 26. Petitioner has demonstrated that it implemented relatively basic steps to prevent R12 from developing pressure sores while in its facility. However, Petitioner has not shown that it took the necessary steps to prevent R12 from developing pressure sores and Petitioner has not established that because of R12's clinical condition the pressure sores were unavoidable.

The fact that R12 was at high risk for pressure sores is not in dispute. P. Ex. 9, at 36; CMS Ex. 26, at 36; Tr. at 444. R12's history of pressure sores and the determination that she was at high risk should have prompted Petitioner to implement a plan of care and treatment that took these factors into account from the moment the facility admitted her. Special attention should have been given to R12 due to her diabetes and the treatment given for her left leg pain as a result of the surgery for her hip fracture. It does not appear that Petitioner put very much effort into developing R12's initial care plan. Goals for skin integrity should have been identified for a resident that had a history of pressure sores. And once it was determined that R12 was at high risk for pressure sores, the facility should have put substantial effort into identifying goals and implementing interventions to prevent her from developing new pressure sores. The option to reposition R12 on a regular schedule was preprinted on the initial care plan. Yet, facility staff chose not to check that option and implement that method of intervention. CMS Ex. 26, at 44.

Petitioner argues that R12 was not put on a turning schedule because it was anticipated that she would not spend very much time in bed. P. Br. at 35. Facility staff must not have considered that at night a resident would potentially spend 6-10 hours in bed. Petitioner's argument is even more unconvincing when those who put forth the reasoning that R12 did not need to be on a turning schedule were either not a part of the decision-making process on admission or had no recollection of care planning when R12 was admitted. *See* Tr. 364-66 and Tr. at 444. Petitioner's witnesses' testimony that the facility anticipated that R12 would not spend very much time in bed is an argument in the aftermath. I cannot find analysis in the care plan to support why R12 would be out of bed. Also, the affidavits of Nurse Schmidt and Nurse Wehland are strikingly similar and I deem the testimony given in their declarations as not credible. *See* P. Ex. 48, at 29; P. Ex. 49, at 30.

When R12's situation was taken into account, the facility did not provide any individualized interventions to prevent her from developing pressure sores. R12 had fractured her hip and had corrective surgery, she had edema and pain in her left leg and had diabetes. The facility filled out a generic initial care plan, but did not fill in any specific interventions under skin integrity in the space provided. CMS, Ex. 26, at 44. When R12's comprehensive care plan was completed on February 22, 2006, it did not sufficiently identify R12's risk for pressure sores or skin breakdown. CMS Ex. 26, at 45-49. Petitioner argues that:

Columbus chose several interventions to accomplish [skin remaining intact], which included assessing skin daily, reporting any red/open areas to [a licensed nurse] and updating the doctor, repositioning routinely and PRN, assisting [R12] to the toilet every 2 hours and PRN, and using a side rail to enable the resident to assist with repositioning. *See*, CMS Ex. 26 at 45-46.

P. Br. at 35.

However, at the very least Petitioner should have included a provision for elevating R12's left heel or giving her left heel extra protection due to the pain in her leg. In R12's comprehensive care plan, as in R12's initial care plan, it appears that Petitioner only addressed skin integrity as an afterthought. Yet, much more is required of a facility when the issue is pressure sore prevention. The Departmental Appeals Board (Board) has determined that a facility has a duty to "go beyond merely what seems reasonable to, instead, always furnish what is necessary to prevent new sores unless clinically unavoidable, and to treat existing ones as needed." *Koester Pavilion v. HCFA*, DAB No. 1750, at 32 (2000). If there was a goal to keep skin intact, there seemed to be no achievable method to reach that goal. With no realistic plan to achieve the goal of keeping a resident's skin intact, Petitioner has trouble proving and establishing that the pressure sore was unavoidable.

CMS has made a convincing argument that facility staff should have kept Dr. Kraus, R12's treating physician, more informed about R12's condition, treatment, and measures to prevent pressure sores. When determining whether R12's clinical condition made the pressure sores that developed after she was admitted into Petitioner's facility, I must consider every reasonable factor that could have made R12's pressure sores avoidable. According to the testimony, Dr. Kraus relied heavily on facility staff to keep him informed. Tr. at 206-08, 229-30, 277. It is apparent when reviewing the record that Dr. Kraus was not aware of R12's contemporaneous condition or the interventions that facility staff had implemented with respect to R12. As of February 25, 2006, Dr. Kraus did not mention R12's edema in his visit notes. He also indicated that the nursing staff had not reported any significant changes, that R12 did not have any deformities on her extremities, and that R12's "gait is normal," despite the fact that R12 was recovering from a fractured hip. P. Ex. 9, at 26. As a result of the edema, which Dr. Kraus failed to note, on February 26, 2006, a nurse called Dr. Kraus to obtain orders for bed rest, Lovenox and a Doppler study. The Doppler study came back negative for Deep Vein Thrombosis, and on March 1, Dr. Kraus discontinued bed rest and ordered that R12 wear a T.E.D. hose on her left leg. Dr. Kraus failed to remind staff to continue monitoring R12's heel for skin integrity and the nursing staff failed to keep Dr. Kraus adequately informed as to the treatment and interventions they were using. Perhaps as a result of the edema, the T.E.D. hose and the amount of time R12 spent in her bed – despite Dr. Kraus discontinuing his order of bed rest – R12 developed a pressure sore. The nursing staff did not alert Dr. Kraus that even though he discontinued R12's bed rest, R12 was still at high risk of developing a pressure sore due to the T.E.D. hose on her leg, the pressure it exerted on her heel and, while in bed, the pressure of her heel against the bed.

Petitioner contends that the T.E.D. hose rendered R12's pressure sore unavoidable. Petitioner cites *Heritage Manor of Columbia v. CMS*, DAB CR995 (2003) to argue that if reasonable measures are implemented and a pressure sore develops, that the pressure sore is unavoidable. Petitioner also asserts the Board has indicated that pressure sores that develop resulting from ordered treatments are unavoidable. However, as CMS points out in its reply brief, "heightened risk alone is not equivalent to unavoidability - even if a treatment creates the heightened risk. Staff must still take appropriate steps to help prevent pressure sores and mitigate any added risk caused by the treatment." CMS Reply at 29; see *Beverly Healthcare-Ingram v. CMS*, CR1597, at 4-6 (2007). An appropriate step would have been for Petitioner to consider using a type of T.E.D. hose that would be less likely to cause pressure sores. According to testimony provided by Surveyor Angell, some types of T.E.D. hose relieve the pressure on an individual's heel by placing a hole where the heel would be. Tr. at 95. This type of T.E.D. hose would have the added benefit of allowing caregivers to visually monitor a part of the body that is very vulnerable to pressure sores. Other appropriate steps to relieve the pressure that a T.E.D. hose would have on a resident's heel would be to strictly comply with a physician's orders as to how often the T.E.D. hose must be worn and to float or raise a resident's heel when the resident was in bed.

Once the pressure sore was discovered on R12, Petitioner failed to give her the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. One problem with how Petitioner dealt with R12's pressure sore was that it had conflicting plans for the treatment of R12's pressure sore. CMS contends that the comprehensive care plan called for an air mattress while the nurse aide care plan called for a "special mattress." CMS Ex. 26, at 58; CMS Ex. 59, at 7-8. Once treatment is ordered it should be consistent. If some of Petitioner's nurses rely on the nurse aide care plan, and it calls for different treatment and interventions than R12's comprehensive care plan, proper healing could be prevented. Petitioner does not directly address the discrepancy between the comprehensive care plan and the nurse aide care plan. I find that the difference between the care plans had the potential to hinder healing of R12's pressure sore.

In addition to the discrepancy between R12's comprehensive care plan and the nurse aide plan, Petitioner provided some forms of intervention that were not in either of the plans. One such intervention was a heel protector or soft boot that was administered to R12 and that she occasionally wore. CMS Ex. 26, at 67, 68, 70; P. Ex. 9, at 146. There are a couple of problems with using interventions such as a heel protector or soft boot, as they relate to R12, that are not in the care plan. The first problem is that consistent use of such a treatment must be ensured. In the case of R12, Petitioner did not use these interventions on a consistent basis even though they documented their use occasionally. CMS Ex. 26, at 67, 68, 70; P. Ex. 9, at 146. If these devices were not in the care plan they should have been listed as a temporary intervention in R12's record so they could have been used consistently, if only on a temporary basis. The second problem is they were not specifically approved by R12's treating physician. That Dr. Kraus would have approved these interventions had he known about them does not excuse Petitioner from using these unapproved devices. And if Dr. Kraus had approved these devices, one would hope that their use would be documented in R12's comprehensive care plan and used on a consistent basis.

On March 8, 2006, the nursing staff discontinued covering R12's pressure sore and left it "open to air." CMS Ex. 26, at 68-69; CMS Ex. 44, at 1, 7, 8, 13. As previously mentioned, R12 had a Stage IV pressure sore. Facility policy and CMS guidance indicate that Stage IV ulcers should be covered. SOM, App. PP; CMS Ex. 44, at 27. Without consulting Dr. Kraus, Petitioner deviated from facility policy and did not cover R12's pressure sore as ordered. Dr. Kraus admitted in testimony that if a nurse exercises her professional judgement in regard to wound care protocols, she should consult the treating physician and document the decision in the resident's records based upon an assessment of the resident's needs. Tr. at 239-40. Petitioner argues that Dr. Kraus found no fault in the facility's decision to leave the pressure sore "open to air" as a method of treatment. Once again, this does not excuse Petitioner from consulting Dr. Kraus and providing sound rationale about the change in treatment for R12.

On March 3, 2006, Dr. Kraus gave an order by telephone to “elevate both heels off bed.” CMS Ex. 26, at 14. On March 3, 2006, R12’s care plan was amended to include “heels off of bed, prop up with pillow.” *Id.* at 53. By a nursing order dated March 10, 2006, the nursing staff discontinued elevating R12’s heels off her bed. P. Ex. 9, at 87. This change was made without consulting R12’s treating physician. Dr. Kraus testified that if he had ordered elevating the heels, he would expect his order to be carried out and if a nurse wanted to discontinue this intervention, he would expect the nurse to call him to discuss deviating from his orders before doing so and to document that discussion. Tr. at 242-43. Instead of continuing to elevate R12’s heels, the facility started using an air mattress for R12, despite not obtaining authorization from the physician for an air mattress. Petitioner argues that the facility was not required to get an order to elevate the heels and that Dr. Kraus would have approved the use of an air mattress instead of elevating R12’s heels if initially asked to do so. P. Br. at 46. Dr. Kraus testified that he would not have expected to be consulted about the change from elevating the heels to using an air mattress. Tr. at 253. This too is an after the fact argument by Petitioner. Dr. Kraus gave express orders to elevate R12’s heels. These orders were documented in the care plan. Then, the nursing staff unilaterally discontinued the physician’s orders without providing rationale for their decision. I find that the decision by the nursing staff to discontinue elevating R12’s heels and to instead use an air mattress does not meet the standard of promoting healing and does not take the necessary steps to prevent new sores from developing. I agree with CMS that by choosing the less effective option of using an air mattress, the nursing staff increased the potential for further skin breakdown and delayed healing. P. Br. at 51.

As for the failure of the nursing staff to change the dressing twice per day instead of once per day from April 24-26, Petitioner concedes that this care was not consistent with accepted nursing practices. P. Br. at 45. Though, Petitioner suggests that this oversight was caused by a manufacturer’s recommendation that differed from the physician’s orders and Petitioner also contends that changing the dressing once instead of twice per day did not create a potential for more than minimal harm. I am not persuaded by the evidence offered by Petitioner that not following the physician’s recommendation to change the dressing twice daily did not create a potential for more than minimal harm. A resident such as R12, who was 83-years old, at high risk for pressure sores, and who had this particular pressure sore for almost two months needed appropriate wound care to prevent infection and to ensure that her pressure sore would heal properly. It was the duty of the nursing staff to take every reasonable precaution and to follow every order by R12’s physician and their failure to do so put R12 at an increased likelihood of serious injury, harm, or death.

2. The facility failed to prevent R2 from developing avoidable pressure sores and failed to give R2 the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing (Tag F314).

R2 was an 85-year old resident who suffered from dementia and end-stage Alzheimer's Disease. P. Ex. 3, at 66; CMS Ex. 17, at 16-17. R2 needed assistance repositioning and generally he required total care. CMS Ex. 17, at 17; Tr. at 474. R2 was admitted to the facility without any pressure sores, but he was assessed to be at high risk for pressure sores. P. Ex. 3, at 56, 66. Because of a history of a pressure sore on R2's right heel and other factors related to R2's health, a physician's order sheet dated February 2006 for R2 indicated that both his heels should be elevated off his bed and that his right heel should be monitored daily for signs of skin breakdown. P. Ex. 3, at 7. On April 11, 2006, the wound tracking form dated April 11, 2006, noted a Stage II sore on R2's gluteus. P. Ex. 3, at 72.

During three separate times on April 24 and 25, 2006, Surveyor Ramer observed that R2's heels were not suspended as ordered by R2's physician. CMS Ex. 17, at 4-5; CMS Ex. 61, at 3. Petitioner has presented no reasonable explanation for why R2's heels were not elevated, instead focusing on the brief amount of time that Surveyor Ramer observed R2 and the contention that this does not rise to the level of the potential for more than minimal harm. While no pressure sore was found on R2's heel during the time in question, Petitioner's inability to follow the orders of residents' physicians as far as the prevention and treatment of pressure sores is concerned, seems to be a disturbing pattern at this facility. As previously mentioned with respect to R12, and later in my decision regarding other residents, the facility has disregarded the express orders of residents' physicians for inexplicable reasons.

3. The facility failed to give R8 the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing (Tag F314).

R8 was a paraplegic female who suffered from congestive heart failure, hypertension, and diabetes mellitus. CMS Ex. 61, at 6; Tr. at 194. Upon admission on February 14, 2005, R8 had no indication of pressure sores. P. Ex. 6, at 68. R8's February 1, 2006 MDS assessment indicated that she had a Stage I pressure sore. CMS Ex. 22, at 55, 61. The wound tracking log for the week of March 12, 2006, indicated that R8 had four Stage IV pressure sores. CMS Ex. 44, at 3. On April 26, Surveyor Angell inquired as to the whereabouts of R8's wound tracking logs subsequent to April 5, 2006. According to notes from an interview of Jenny Lloyd, the interim DON, there were no tracking logs for R8 after April 5 because the facility fired the wound nurse. The nurse notes indicate that R8's wounds were not documented and tracked for two weeks. P. Ex. 6, at 32, 36. Proper documentation of a resident's wounds is one of the necessary components of treatment

and services to promote healing and prevent new sores from developing. Petitioner has presented no evidence that R8's wounds were documented during mid-April 2006, nor provided cogent reason why the wounds could not be documented by facility staff.

CMS also alleges that State Agency surveyors observed improper treatment of R8's pressure sores. CMS indicates that Surveyor Ramer personally observed a nurse caring for R8 failing to wash her hands, failing to cleanse the wounds and applying excessive pressure to the wounds while treating them. CMS Br. at 28. According to Surveyor Ramer, Nurse Hanamann did not wash her hands after removing an old dressing, she did not clean the wound, and she used a gloved finger to spread the ointment on a tissue instead of using an applicator. CMS Ex. 61, at 7. Nurse Hanamann admitted using a gloved finger to spread the ointment during an interview with Surveyor Ramer, but said she was in a hurry to complete the procedure. *Id.* at 7; Tr. at 293. There were other instances of Nurse Hanamann using improper treatment while caring for R8's other wounds, including using undue force while applying treatment with her gloved finger. *See* CMS Ex. 61, at 7, 8, 9; Tr. at 154-155. Petitioner avers that Nurse Hanamann used her finger instead of Q-tips because the wounds were large, and that using her finger would give her more control in spreading the Santyl ointment. Petitioner contends that Nurse Hanamann tried to provide the care quickly, and use methods to quicken the process, because R8 was uncooperative. P. Br. at 19-20. These arguments by Petitioner are not convincing. Nurse Hanamann also failed to cleanse R12's wound properly and R12 did not have problems with being resistant to care. Tr. at 48. Nurse Hanamann testified that hand washing was required and she did not indicate that she skipped washing her hands because of the behavior R8. Tr. at 307-08. The facts clearly indicate that Nurse Hanamann was taking short cuts and not compliant with acceptable nursing standards when treating R8's wounds.

4. The facility failed to give R9 the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing (Tag F314).

R9 was a 90 year old female who had a history of circulatory disorders, anemia, edema, diabetes mellitus and cerebrovascular accident. CMS Ex. 23, at 1; CMS Ex. 61, at 9. R9 was rated on the Braden Scale as being at mild or less risk for pressure sores. She suffered from urinary incontinence and had an indwelling catheter while wearing a leg bag. According to R9's care plan for alteration in skin integrity dated December 28, 2005, she developed a left heel blister from wearing an improper fitting shoe. CMS Ex. 23, at 48.

CMS asserts that on December 28, 2005, R9's care plan called for facility staff to elevate her heels off the mattress with a foam cushion, and on January 10, 2006, R9's physician ordered a "foam heel" to keep R9's heel off the mattress. CMS Br. at 68; *see* P. Ex. 7, at 2, 7, 13; CMS Ex. 23, at 48. According to CMS, the blister on R9 was a Stage IV

pressure sore and during the April 2006 survey of the facility, R9's heel still had the pressure sore. CMS Br. at 31, 68; CMS Ex. at 23. CMS avers that there were eight separate instances when R9 was in bed and her heels were not elevated per her physician's order and her care plan. CMS Ex. 61, at 11-13. There were other problems with R9's care that CMS cited. R9 was under her physician's orders to have a dressing on her wound, but according to CMS, she had no dressing when observed by Surveyor Ramer on April 24, 2006. *Id.* at 12; Tr. at 158. R9 was observed wearing non-pressure relieving slippers. *Id.* at 11-13. CMS argues that the nurse who applied medication to R9's wound used improper infection control practices by using her gloved finger to spread the ointment. This method of distributing the medication on R9's wound can apply undue force which can delay healing. CMS Br. at 72; *see* CMS Ex. 23, at 54; Tr. at 159. CMS also asserts, that a new Stage II pressure sore was discovered on R9's outer right malleolus, but it was not reported to R9's physician until two days after it was discovered. CMS Ex. 23, at 6, 12, 13; Tr. at 312, 343. CMS argues that the nursing staff failed to report R9's Stage II pressure sore to her physician in a timely manner. CMS Br. at 73.

Petitioner counters CMS's assertions by arguing that most of surveyor Ramer's observations included visual evidence that R9 had transferred herself and that facility staff was unaware of this. P. Br. at 30. Petitioner also contends that interventions related to R9's pressure sores, including elevating her heels, only applied if R9 was to be in bed a significant amount of time, and according to Petitioner, R9 was not in bed enough to warrant staff always elevating R9's heels. Petitioner argues that R9's heel dressing had been taken off and reapplied on April 24, 2006, and that CMS has presented no evidence to show that the dressing was not applied as ordered. P. Br. at 32.

According to Petitioner, the wound that Surveyor Ramer classified as a Stage II pressure ulcer on R9's outer right malleolus was not a Stage II pressure sore. P. Br. at 32. Petitioner asserts that testimony by the nursing staff contradicts CMS's assertion that the reddened area was an open wound and that Surveyor Ramer's contemporaneous notes do not indicate that the wound in question was a Stage II pressure sore. P. Br. at 32; *see* Tr. at 297, 359; *see also* P. Ex. 48, at 19-20; P. Ex. 49 at 19-20. Petitioner also argues that a two-day delay in reporting a Stage II pressure sore and a nurse using her gloved finger to spread the ointment on R9's wound had no potential for more than minimal harm. P. Br. at 33.

I find that Petitioner failed to give R9 the necessary treatment to promote healing, prevent infection and prevent new pressure sores. Testimony provided by Surveyor Ramer indicated that she never saw any evidence that Petitioner was following R9's physician's orders to elevate her heels using a foam wedge. Tr. at 156-158. Petitioner contends that one reason why R9's foam wedge was not in place was because R9 would self-transfer fairly frequently. However, even if R9 self-transferred, the foam wedge should have been somewhere on or near R9's bed as evidence that it was being used at some point in time.

Petitioner has also failed to give a plausible reason for not following R9's physician's orders to elevate her heels in general. Petitioner claims that heel elevators to elevate R9's heels were not required. The record counters Petitioner's assertion and includes the treating physician's order for heel elevators to keep R9's heels off the mattress. P. Ex. 7, at 2, 7, 13. Petitioner seems to give a variety of excuses for not elevating R9's heels per her physician's orders, but none convincingly explain why Surveyor Ramer observed eight separate times that R9's heels were not elevated as ordered. Petitioner has not presented credible evidence or testimony to explain why the nursing staff was not providing proper treatment for R9's pressure sore. The evidence suggests that the nursing staff totally disregarded some aspects of treating R9's Stage II pressure sore. CMS has presented a prima facie case that Petitioner did not substantially comply with promoting healing, preventing infection, and preventing new pressure sores from developing.

5. The facility failed to give R13 the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing (Tag F314).

On March 16, 2006, R13 was admitted to the facility without any pressure sores. CMS Ex. 27, at 39; P. Ex. 10, at 3, 64, 74, 94. R13 was diabetic, but her Braden Scale assessment found that she was not even at mild risk for pressure sores. CMS Ex. 27, at 9, 12, 49; P. Ex. 10, at 100. On April 9, 2006, a wound nurse assessed a 0.3 cm x 0.2 cm pressure sore on R13's right buttock. This pressure sore was about 3 inches away from the crease of R13's buttock and 2 inches below the belt. Tr. at 326, 332. The following notation was in R13's medical record as a nurse's note on April 9, 2006: "Allevyn⁴ dressing, Q 3 day/PRN for Stage II." CMS Ex. 27, at 62.

CMS avers that the pressure sore was in a location on R13 that created a risk of fecal contamination. CMS Br. at 35; see Tr. at 115, 122. CMS also asserts that the sore was in a location that could be irritated because there would be a good amount of pressure on that area when R13 was in a sitting position. CMS Br. at 35. According to CMS, facility staff were to cover R13's pressure sore with the Allevyn dressing and change the dressing every three days and as needed. CMS Br. at 35-38. This dressing, asserts CMS, protects the wound and helps prevent microorganisms from contaminating the wound. CMS Br. at 36. According to CMS, on April 10, 2006, a nurse wrote a telephone order as "Allevyn dressing to Stage II Decubi 0.3 x 0.2 cm to [right] buttock [change] Q3day/PRN till healed." CMS Ex. 27, at 18. CMS asserts that the Petitioner's nursing staff did not follow the physician's treatment order and decided that the wound would be left "open to air," and the dressing would be applied as needed, instead of every three days. This change, according to CMS, was implemented without the physician's approval. CMS Br.

⁴ Allevyn is an absorbent foam dressing with a protective backing that is intended to absorb excess fluid, while maintaining a moist environment to assist in healing the wound. CMS Ex. 60, at 3; Tr. at 32; Tr. at 108.

at 37. CMS avers that it was not until April 27, 2006, that the nursing staff started to follow the order of R13's treating physician, Sam Poser, M.D. During the time between when the treatment was discontinued and started again, CMS argues, R13's pressure sore worsened. CMS Br. at 37. According to CMS, once the dressing was applied on April 27, 2006, the pressure sore started to heal, and within a month it had healed completely. P. Ex. 10, at 97.

Petitioner has questioned whether the open area was even a pressure sore. P. Reply 33. According to Petitioner, the Licensed Practical Nurse who wrote the order probably never saw the wound, and she would not know whether it was a pressure sore. Petitioner also asserts that two nurses who regularly communicated with R13's treating physician were familiar with how he gave his orders and that they interpreted his order to mean "as needed" and that the dressing was not required to be changed every three days. P. Br. at 52-55. Petitioner further argues that the facility had the discretion to leave the wound "open to air." P. Br. at 52-53.

I find that Petitioner failed to give R13 the necessary treatment to promote healing and prevent infection. I find Petitioner's suggestion that the wound on R13's right buttocks was not a pressure sore unpersuasive. It is highly unlikely that the wound on R13 was not a pressure sore. Petitioner has presented no evidence to counter that it was a pressure sore. The facility's own wound nurse determined it was indeed a Stage II pressure sore and labeled it as such on the facility's wound tracking log. CMS Ex. 44, at 17; CMS Ex. 27, at 62.

Petitioner's argument that the true interpretation of the April 10 notation of the physician's order was that the dressing was only to be applied as needed, is equally unpersuasive. The physician's order does not seem that difficult to translate, and it appears that Petitioner is trying to obscure a notation that seems fairly clear and self explanatory. If the nursing staff had a question about this order they should have contacted R13's physician. Petitioner has presented no evidence that they tried to do this to avoid mistakes in R13's treatment. Also, Petitioner chose not to present R13's physician, Dr. Poser, at the hearing so he could offer what he meant in his own words. I infer that facility staff unilaterally changed an express order from a resident's physician, and in order to justify the change, they rely on an undocumented rationale.

It is clear that because of the location of the wound, there was moderate risk of fecal contamination to the wound. In order to minimize the risk, covering the wound would have been appropriate. Therefore, it is unclear to me how leaving such a wound as "open to air" would have been better than covering the wound. Also, Petitioner did not provide any convincing reason and could not show the nurse's rationale for deciding to leave the wound "open to air."

B. CMS's finding of immediate jeopardy was not clearly erroneous.

Immediate jeopardy exists where a “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. For a finding of immediate jeopardy, it is not necessary to show that the noncompliance caused serious injury, harm, impairment, or death. It is sufficient to show that the noncompliance was likely to cause serious injury, harm, impairment, or death. *Fairfax Nursing Home, Inc.*, DAB No. 1794, at 14 (2001).

It is Petitioner’s burden to prove clearly erroneous a finding by CMS that a deficiency puts residents at immediate jeopardy. 42 C.F.R. § 498.60(c)(2). Here, CMS established strong prima facie evidence of immediate jeopardy level deficiencies under Tag F314. Petitioner contends in its brief that there were no immediate jeopardy level deficiencies with respect to R2, R8, R9, R12 and R13. Petitioner argues that CMS has failed to prove that there was a likelihood of serious injury or harm to these residents. Specifically, Petitioner argues that CMS failed to show a potential for more than minimal harm with respect to whether R2’s heels should have been elevated. Petitioner also argues that the failure to change R12’s dressing did not create the potential for more than minimal harm. Petitioner argues that the failure to use proper wound cleaning techniques with R8 did not create the potential for more than minimal harm. Using the testimony of Nurse Wehland, Nurse Schmidt, and Dr. Krause, Petitioner contends that none of the allegations of the surveyors with respect to the care and services provided to R12 after the pressure sore appeared would have created a potential for more than minimal harm. Dr. Krause also opined that even if all the allegations relating to R8 in the Statement of Deficiencies (SOD) were true, in his professional opinion they were not likely to cause serious injury, harm, impairment or death. P. Br. at 59.

Again, I am not persuaded by Petitioner’s arguments or Petitioner’s witnesses’ testimony. Petitioner offered no persuasive evidence to show that CMS’s determination of immediate jeopardy was clearly erroneous. Pressure sores on elderly residents can be very difficult to treat, especially if a resident is immobile or cognitively impaired. In the examples of R9 and R12, the pressure sores that developed on these residents lasted for months. Pressure sores can cause life threatening infections, especially for elderly residents who have weakened immune systems. R12 was 83 years old and had recently undergone surgery on her hip and had edema in her left leg. R9 was 90 years old and had a history of circulatory disorders, anemia, edema, and cerebrovascular accident. R13 was diabetic as were three of the other residents used as examples in the SOD. Much of the focus has been on heel wounds, and such a wound in a diabetic patient could develop to gangrene and eventual amputation. Tr. at 148. The overwhelming evidence is that Petitioner’s staff was inattentive to the needs of R2, R8, R9, R12 and R13. Petitioner failed in providing these residents with a level of care that is mandated by the regulations. Petitioner knew or should have known that its inattentiveness was likely to cause serious

injury, harm, impairment, or death to these residents. Moreover, Petitioner's systemic flaw equally exposed other residents similarly situated to the likelihood of suffering serious injury, harm, impairment, or death. The pattern related to improper treatment and care of pressure sores at Petitioner's facility is sobering. Petitioner has not proved that CMS's determination of immediate jeopardy was clearly erroneous.

C. The amount of the CMP is reasonable.

CMS imposed a \$6200 CMP for each day of noncompliance at the immediate jeopardy level from April 23 through April 26, 2006. When an ALJ finds that the basis for imposing a CMP exists, the ALJ may not: (1) set a penalty of zero or reduce the penalty to zero; (2) review the exercise of discretion by CMS to impose a CMP; and (3) consider any factors in reviewing the amount of the penalty other than those specified by regulation. 42 C.F.R. § 488.438(e). I have found that a basis exists for CMS to impose a CMP because I have found that Petitioner was not in compliance with 42 C.F.R.

§ 483.25(c). I must, therefore, review de novo whether the amount of the CMP is reasonable by considering four factors specified in 42 C.F.R. § 488.438(f). These four factors are: (1) the facility's history of noncompliance, including repeated deficiencies; (2) the facility's financial condition; (3) the scope and severity of the deficiencies, the relationship of one deficiency to other deficiencies, a facility's prior history of noncompliance with reference to the deficiency at issue (factors specified in 42 C.F.R. § 488.404); and (4) the facility's degree of culpability.

Petitioner has not questioned the duration of the deficiencies, but has argued that the deficiencies cited as immediate jeopardy do not rise to a level of immediate jeopardy. Petitioner contends that the immediate jeopardy citation in this case is inappropriate because CMS has failed to prove that there was a likelihood of serious injury or harm as a result of the cited deficiencies. P. Br. at 57-59. I have already amply discussed the basis for a finding of noncompliance at the immediate jeopardy level.

CMS has provided evidence of an extensive history of noncompliance. CMS cited Petitioner with noncompliance in June, July and August of 2004 and in June 2005. CMS Ex. 3, at 2-3. Also, Petitioner was cited for noncompliance due to pressure sores in August 2002, July 2003, and as recently as August 2004. *Id.*

CMS has also provided evidence that Petitioner can handle a \$24,800 total CMP. Petitioner had a net profit of \$385,748 in 2004 and a net income of \$397,712 reported on April 26, 2006. CMS Ex. 3, at 6-10. Petitioner has provided no evidence that the CMP assessed by CMS for this case would put it out of business. *See Kelsey Memorial Hospital*, DAB CR583 (1999); *Capitol Hill Community Rehab and Specialty Care Center*, DAB CR469 (1997), *aff'd* DAB No. 1629 (1997).

The regulations define culpability as neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. § 488.438(f)(4). Petitioner had a high occurrence of pressure sores and a slow rate of healing for pressure sores. The incidence of pressure sores appeared to be widespread at the facility. Four of the residents entered the facility with no pressure sores and the facility failed to pay special attention to those residents, such as R12, who was at high risk for pressure sores. Based on the indifference of the facility to proper nursing standards and the disregard that Petitioner had for resident care, especially concerning physician's orders, Petitioner was extremely culpable as to the noncompliance with 42 C.F.R. § 483.25(c). Specific examples of Petitioner's nursing staff ignoring express orders from patients' physicians have been cited. CMS has imposed a per day CMP at about the mid-point of the upper range for the immediate jeopardy deficiency. In view of the foregoing, I find that the amount of the CMP is reasonable.

V. Conclusion

Based on the documentary evidence, the arguments of the parties, and the applicable law and regulations, I find that Petitioner was not in substantial compliance at the immediate jeopardy level from April 23, 2006 through April 26, 2006, and that the imposition of a CMP of \$6200 per day during that period is reasonable.

/s/

José A. Anglada
Administrative Law Judge