Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Sandwich Rehabilitation & Health Care Center,
(CCN: 14-6133),

Petitioner,

v.

Centers for Medicare & Medicaid Services

Docket No. C-15-654

Decision No. CR4728

Date: November 7, 2016

DECISION

Petitioner, Sandwich Rehabilitation & Health Care Center, is a long-term care facility, located in Sandwich, Illinois, that participates in the Medicare program. After one of its residents fell and sustained what proved to be fatal injuries, the Illinois survey agency sent a team of surveyors to investigate. Based on the results of that investigation, the Centers for Medicare & Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare program requirements and that its deficiencies posed immediate jeopardy to resident health and safety. CMS imposed against the facility civil money penalties (CMPs) of $4,050 per day for 111 days of immediate jeopardy and $100 per day for 19 days of substantial noncompliance that was not immediate jeopardy. Petitioner appeals.

The parties have filed cross-motions for summary judgment (CMS) and partial summary judgment (Petitioner).

For the reasons set forth below, I grant CMS's motion and deny Petitioner's. The undisputed facts establish that: from March 8 through July 15, 2014, the facility was not

in substantial compliance with Medicare program requirements; and that, from March 8 through June 26, 2014, its deficiencies posed immediate jeopardy to resident health and safety. The penalties imposed are reasonable.

Background

The Social Security Act (Act) sets forth requirements for nursing facilities to participate in the Medicare program and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to survey skilled nursing facilities in order to determine whether they are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. Each facility must be surveyed annually, with no more than fifteen months elapsing between surveys, and must be surveyed more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308. The state agency must also investigate all complaints. Act § 1819(g)(4).

In this case, on July 9, 2014, surveyors from the Illinois Department of Public Health (state agency) completed a complaint investigation. Based on their findings, CMS determined that, beginning March 8, 2014, the facility did not comply substantially with the following program requirements and that its noncompliance posed immediate jeopardy to resident health and safety:

- 42 C.F.R. § 483.10(b)(11) (Tag F157 – resident rights: notification of changes) at scope and severity level J (isolated instance of noncompliance that poses immediate jeopardy to resident health and safety);

- 42 C.F.R. § 483.13(c) (Tag F224 – staff treatment of residents: prohibit neglect) at scope and severity level J; and

- 42 C.F.R. § 483.25 (Tag F309 – quality of care) at scope and severity level J.

CMS Exs. 1, 4. CMS also determined that the facility removed the immediate jeopardy on June 27, 2014, and returned to substantial compliance on July 16, 2014. CMS Ex. 1.

CMS has imposed against the facility penalties of $4,050 per day for 111 days of substantial noncompliance that posed immediate jeopardy to resident health and safety (March 8 – June 26, 2014) and $100 per day for 19 days of substantial noncompliance

that did not pose immediate jeopardy (June 27 – July 15, 2014), for penalties totaling $451,450. CMS Ex. 1 at 7.

CMS now moves for summary judgment. Petitioner moves for partial summary judgment, asking me to reject CMS's immediate jeopardy determination, the penalties imposed, and the duration of those penalties.

The parties filed initial briefs (CMS Br.; P. Br.) and proposed exhibits. CMS submitted 25 exhibits (CMS Exs. 1-25). Petitioner submitted 20 exhibits (P. Exs. 1-20). CMS has filed a motion for summary judgment (CMS MSJ), and Petitioner has filed a response (P. Response). Petitioner submitted a motion for partial summary judgment (P. MSJ), and CMS submitted a response to that motion (CMS Response).

Issues

As a threshold matter, I consider whether summary judgment is appropriate.

On the merits, the issues are:

1. From March 8 through July 15, 2014, was the facility in substantial compliance with the Medicare program requirements;

2. If, from March 8 through June 26, 2014, the facility was not in substantial compliance, did its deficiencies then pose immediate jeopardy to resident health and safety; and

3. If the facility was not in substantial compliance, are the penalties imposed ($4,050 per day for 111 days and $100 per day for 19 days) reasonable.

Discussion

Summary judgment. Summary judgment is appropriate if a case presents no genuine issue of material fact, and the moving party is entitled to judgment as a matter of law. *Bartley Healthcare Nursing & Rehab.*, DAB No. 2539 at 3 (2013), *citing Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986); *Ill. Knights Templar Home*, DAB No. 2274 at 3-4 (2009), and cases cited therein.

The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to [that party's] case, and on which [that party] will bear the burden of proof at trial." *Livingston Care Ctr. v. Dep't of Health & Human Servs.*, 388 F.3d 168, 173 (6th Cir. 2004), *quoting Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986). To

avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986); *see also Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing & Rehab. Ctr.*, DAB No. 1918 (2004). The non-moving party may not simply rely on denials, but must furnish admissible evidence of a dispute concerning a material fact. *Ill. Knights Templar*, DAB No. 2274 at 4; *Livingston Care Ctr*., DAB No. 1871 at 5 (2003).

In examining the evidence for purposes of determining the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *Brightview Care Ctr.*, DAB No. 2132 at 2, 9 (2007); *Livingston Care Ctr.*, 388 F.3d at 172; *Guardian Health Care Ctr.*, DAB No. 1943 at 8 (2004); *but see Brightview*, DAB No. 2132 at 10 (entry of summary judgment upheld where inferences and views of non-moving party are not reasonable). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cf. Guardian Health Care Ctr.*, DAB No. 1943 at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.").

1. ***CMS is entitled to summary judgment because the undisputed evidence establishes that, contrary to regulatory requirements and the facility's own policies, facility staff did not immediately consult a resident's physician following significant changes in a resident's condition and did not provide that resident the care and services he needed. The facility was therefore not in substantial compliance with 42 C.F.R. §§ 483.10(b)(11), 483.13(c), and 483.25.***[1]

Program requirements: 42 C.F.R. § 483.10(b)(11) (Tag F157). The facility must protect and promote the rights of each resident. In this regard, it must immediately consult with the resident's physician and notify the resident's legal representative or interested family member (if known) of: 1) an accident involving the resident that results in injury that may require physician intervention; 2) a significant change in the resident's physical, mental, or psychosocial status (i.e., deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); or 3) a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment). The Departmental Appeals Board has repeatedly explained that requiring staff to consult the physician "is

[1] My findings of fact and conclusions of law are set forth, in bold and italics, as captions in the discussion sections of this decision.

not a mere formality"; the requirement guarantees that the resident will timely receive his treating physician's input as to the care he requires under the circumstances. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 7 (2010), *quoting Britthaven of Goldsboro*, DAB No. 1960 at 11 (2005).

42 C.F.R. § 483.13(c) (Tag F224). "Neglect" means failure to provide a resident with the goods and services necessary to avoid his suffering physical harm, mental anguish, or mental illness. 42 C.F.R. § 488.301. Facilities must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. 42 C.F.R. § 483.13(c). A facility's failure to follow its anti-neglect policy can put it out of substantial compliance with section 483.13(c), as can its failure to follow its other policies and procedures where those policies define what the facility deems "the goods and services necessary to avoid physical harm." *Avalon Place Kirbyville*, DAB No. 2569 at 9 (2014).

42 C.F.R. § 483.25 (Tag 309). Under the statute and the "quality of care" regulation, each resident must receive, and the facility must provide, the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. *See* Act § 1819(b).

Facility policies: notification of change. The facility had in place a written policy requiring staff to notify the appropriate individuals of changes in a resident's "medical/mental condition and/or status." CMS Ex. 11. The policy directs facility staff to notify "promptly" the appropriate individuals (facility administrator, director of nursing (DON), physician, guardian or other representative) of changes in the resident's "condition" or "status." Under the policy, the nurse supervisor or charge nurse must notify the resident's attending physician or on-call physician of the following occurrences (among others):

- Any symptom, sign, or apparent discomfort that is 1) sudden in onset; 2) a marked change, i.e., more severe, than the resident's usual signs or symptoms; or 3) unrelieved by measures already prescribed;
- An accident or incident involving the resident;
- Discovery of injuries of unknown source;
- A significant change in the resident's physical/emotional/mental condition;
- A need to alter the resident's medical treatment significantly;
- A need to transfer the resident to a hospital/treatment center;
- Abnormal complaints of pain.

CMS Ex. 11 at 1.

The policy also directs the "nurse supervisor/charge nurse" to notify the DON, physician, and (unless instructed otherwise) the resident's next-of-kin or representative of the following:

- Any of the situations listed above;
- That the resident was involved in "any accident or incident that results in an injury, including injuries of an unknown source";
- A significant change in the resident's physical, mental, or psychosocial status;
- The need to transfer the resident to a hospital/treatment center.

CMS Ex. 11 at 1-2. The policy indicates that "except in medical emergencies," staff should notify the appropriate individuals within 24 hours of a change occurring in the resident's medical/mental condition or status.[2] The nurse supervisor/charge nurse must also record in the resident's medical record "information relative to changes in the resident's medical/mental condition or status." CMS Ex. 11 at 2.

Fall prevention policy. The facility had in place a fall prevention policy. During the morning quality assurance meetings, held Monday through Friday (but apparently not on weekends), staff are directed to report all falls. The policy provides that falls be discussed and comments written on a tracking form. New interventions are written in the resident's care plan, and the unit nurse documents new interventions on the nurse aide assignment worksheet. CMS Ex. 12 at 1.

Emergency care policy. The facility also had in place emergency care policies requiring the charge nurse or nurse aide to notify the physician that the resident needs emergency care and to describe the scope of the care provided. In "extreme emergencies," staff should "implement '911'" for immediate assistance. If the primary or on-call physician does not respond timely to the facility's call for assistance, staff must notify the DON and the facility's medical director. They must also document the situation in the nurse's notes. Documentation must include: the date and time of the situation; an assessment of the resident and the situation; the emergency care provided; the notification that took place; and any physician orders. CMS Ex. 13 at 1.

[2] Although CMS has not pressed the issue, this provision likely violates the regulation. "Immediately" does not mean 24 hours later. As the Board has explained, when first published, section 483.10(b)(11) gave facilities up to 24 hours to consult with the physician. After commenters objected that this was too much time, CMS changed the proposed regulation to require "immediate" consultation. *River City Care Ctr.*, DAB No. 2627 at 7 (2015), *quoting Magnolia Estates Skilled Care*, DAB No. 2228 at 8-9 (2009) and *The Laurels at Forest Glenn*, DAB No. 2182 at 13 (2008); *see also* 56 Fed. Reg. 48,867, 48,833 (Sept. 26, 1991) and discussion below.

Head trauma policies. The facility had in place two policies that addressed its staff's response to a resident's head trauma. The first, dated September 2009, provides: "It is the policy of [the facility] to evaluate head injuries for a minimum period of 72 hours, to determine any negative effects, and to allow for immediate treatment to minimize permanent damage." CMS Ex. 13 at 3. The policy lists specific assessment procedures that staff must follow, which include: assessing the resident (vital signs, consciousness, neurological status); assigning staff to remain with the resident; and notifying the physician "immediately." Staff must assess the resident (i.e., take vital signs and perform neuro checks) initially and every 15 minutes for the first hour; every 30 minutes for an hour; every hour for 4 hours; every 4 hours for 8 hours; and every shift for the remainder of the 72 hours. The assessments for the first 24 hours must be recorded on the neuro/head trauma assessment form, and additional documentation must be recorded in the clinical record. The policy directs staff to complete a "quality care tracking form" and to document all observations and occurrences. CMS Ex. 13 at 3; *see* CMS Ex. 13 at 5, 6.

The policy lists signs of increased cranial pressure that *must* be reported to the physician *immediately*:

- Diplopia (double vision)
- Dizziness
- Nausea and vomiting
- Lethargy
- Headache
- Depressed areas of the head
- Bleeding from the ear
- Drainage from the ear or nose
- Temperature elevation
- Bradycardia
- Widening of pulse pressure
- Elevation of systolic pressure
- Eye(s) crossing, pupils unequal or non-reactive to light
- Unable to move or change in strength of an extremity
- Irritability
- Belligerence
- Confusion
- Seizure
- Loss of consciousness
- Amnesia

CMS Ex. 13 at 4.

The facility updated its head trauma policy sometime before the time of R1's fall (March 2014). CMS Ex. 23 at 6. The amended policy requires staff to *send to the emergency department* any resident who falls and hits his head. According to the policy, if the resident is on Coumadin or other blood-thinning drug (including aspirin), staff must send him to the emergency department for evaluation, even if they don't know whether he hit his head. When the resident returns from the hospital, he must be put on a new neuro-check regimen, lasting one week. For three weeks thereafter, he must be watched and monitored for a change in condition. CMS Ex. 23 at 42.

At a deposition taken on April 16, 2015, the facility's DON, Jennifer Donahue, confirmed that, at the time of R1's injury, the facility's policy was to send to the emergency department for evaluation any resident who fell and hit his head. She characterized this as the standard of care and agreed that anyone on anticoagulation therapy, like Coumadin, should be sent to the emergency department after a fall, whether or not he has hit his head. CMS Ex. 23 at 6.

Petitioner does not exactly deny that this policy was in place at the time of R1's accident but criticizes CMS for providing a copy of the in-service training on the policy rather than the policy itself and for relying on sworn testimony from "two former employees." P. Response at 12; *but see* P. MSJ at 3. This does not establish a material fact in dispute. CMS has come forward with compelling evidence that the policy was in place – including a written statement of the policy, signed by employees who were trained to follow it (CMS Ex. 23 at 42) and the sworn testimony of the facility's DON at the time of the accident. For its part, Petitioner has not come forward with any evidence establishing a dispute over whether the facility adopted such a policy.[3] Indeed, Petitioner's witnesses are silent on the issue, except for Corporate Nurse Elizabeth Gilbert, R.N., who testified that, in June 2014, she trained the facility's DON "with respect to . . . [e]mergency care – head trauma with specific emphasis on residents prescribed anticoagulants *being sent to the emergency room* for evaluation." P. Ex. 14 at 2 (Gilbert Decl. ¶ 6) (emphasis added). The DON then trained licensed staff. P. Ex. 14 at 2 (Gilbert Decl. ¶ 7). Neither Corporate Nurse Gilbert nor anyone else claims that this was not the facility's existing policy for treating head trauma.

Because Petitioner has not come forward with any evidence, admissible or otherwise, to establish a dispute over whether this policy was in place, it cannot avoid summary judgment based on this issue. *Ill. Knights Templar*, DAB No. 2274 at 4. The undisputed

[3] It would be very strange (and violate any number of regulations) for a facility to train its staff to follow policies and procedures that the facility had not adopted.

evidence establishes that the facility's head trauma policies directed staff to send to the emergency department any resident on anti-coagulants who suffered a head injury.[4]

Charting policy. Finally, a separate policy sets forth the facility's charting guidelines. For falls with "non-apparent injuries," staff should nevertheless record: 1) complete vital signs; 2) pain (type and location) and range of motion; 3) edema/deformity; 4) weight bearing and activity level; 5) skin status; 6) level of consciousness/dizziness; 7) movement/strength of extremities; 8) orientation to time, place, person; 9) pupillary responses (using the head injury assessment tool); 10) headaches/nausea or vomiting; 11) paresthesia or paralysis; 12) speech patterns and alterations; 13) all **physician**, family, other party notifications; 14) any treatment or medical/nursing measures taken; and 15) other. CMS Ex. 15 at 1 (emphasis in original).

For "neurological" issues, staff should record: 1) complete vital signs; 2) pain; 3) level of consciousness; 4) dizziness; 5) memory; 6) seizures; 7) movement and strength of extremities; 8) orientation to time, place, and person; 9) pupillary responses; 10) sleep patterns; 11) headaches/nausea or vomiting; 12) paresthesia or paralysis; 13) speech patterns; 14) all **physician**, family, other party notifications; 15) any treatment or medical/nursing measures that are taken; and 16) other. CMS Ex. 15 at 1 (emphasis in original). The policy mandates that every shift document, "for a minimum of 24 hours or until symptoms have resolved," any time a physician is called. Staff must also document episodes of vomiting and other conditions. The policy reminds staff "always" to be prepared to report vital signs when calling a physician. CMS Ex. 15 at 4.

With respect to special observations and monitoring, staff must record: 1) the date and time the observation is made; 2) any expected side effects; 3) the effects of new medications or treatments; 4) all observations ordered, including their length of time; 5) all pertinent observations; and 6) the date, time, signature, and title of person recording the data. CMS Ex. 15 at 7.

Finally, the policy includes requirements for documenting vital signs: 1) date and time the vital signs are taken; 2) any deviations from the resident's normal pattern; 3) date and time the physician is notified, as well as the physician's response, if applicable; 4) all pertinent observations; and 5) date, time, signature, and title of person recording the data. CMS Ex. 15 at 9.

[4] Even if Petitioner had established that this fact was in dispute (which it did not), the undisputed evidence establishes that facility staff disregarded other policies that were in place to protect residents. That disregard, by itself, puts the facility out of substantial compliance. Thus, while staff's disregard of the amended head trauma policy certainly strengthens CMS's case, the question of whether the policy was in place at the relevant time may not even be material.

Resident 1 (R1). R1 was a 75-year-old man suffering from a multitude of disorders, including: coronary artery disease; type 2 diabetes with complications; history of gangrenous toes, which were amputated; peripheral vascular disease; and chronic atrial fibrillation. CMS Ex. 9 at 63. Among numerous other prescription medications, he took aspirin as well as the blood thinner Warfarin (Coumadin). CMS Ex. 9 at 13, 45. At the same time, his mental faculties were intact, and he was progressing well with his occupational therapy. CMS Ex. 9 at 35-36; *see* CMS Ex. 9 at 64 (describing R1 as "alert and appropriate"); CMS Ex. 9 at 68 (indicating that R1 is "oriented at all times").

R1's fall, injuries, and the facility's responses. The undisputed evidence establishes the following sequence of events:

- March 8, 2014 at 12:20 a.m.: Assisted by a nurse aide, R1 was attempting to use a urinal. While trying to pull his pants down, he fell off the edge of his bed and hit the top of his head on his night stand. Staff lifted him off the floor and returned him to bed. A small bump formed on his head, but Registered Nurse (RN) Kelsey Shelton noted no bruising. She took his vital signs and reported that, as of 12:40 a.m., he was not complaining of pain, dizziness, nausea, or blurred vision. CMS Ex. 9 at 337; CMS Ex. 14 at 3; CMS Ex. 19 at 55-56.

- March 8, 2014 at 12:30 to 12:40 a.m.: RN Shelton notified DON Donahue and R1's attending physician, Erik Englehart, of R1's fall. According to her nurse's note, Dr. Englehart told her to continue monitoring the resident but not to send him to the hospital. CMS Ex. 9 at 337; CMS Ex. 19 at 55-56. She did not remind Dr. Englehart that R1 was on Coumadin or suggest that his blood levels be taken. CMS Ex. 8 at 7; CMS Ex. 21 at 2 (Anderson Decl. ¶ 11). She did not mention that the facility's policy directed her to send the resident to the emergency room. CMS Ex. 9 at 337; P. Ex. 11 at 3-4.

  In a form titled "Newly Acquired Skin Conditions," dated March 8, RN Shelton writes that the resident suffered a fall and "bump on top of head." The note confirms that the physician was notified at 12:40 a.m. and indicates that the DON was notified at 12:30 a.m. CMS Ex. 19 at 55.

  In his own note, Dr. Englehart confirms that he told RN Shelton to "monitor closely" and, given the resident's "complicated history," to call back or send the resident to the emergency department for evaluation if there were any change in his condition. P. Ex. 11 at 6; *see* P. Ex. 11 at 4.

- March 8, 2014 at 11:30 a.m.: about 11 hours after the accident, staff noted that R1 had a purple bruise on his hip, which they associated with his recent fall. The resident complained that he felt sore, especially in his lower back, and the nurse

gave him pain medications. Staff took his vital signs, but no one called his doctor. CMS Ex. 9 at 337.

- March 9, 2014 at 4:30 p.m.: the next afternoon, RN Michael Frolik faxed to Dr. Englehart's office the following message: "Since [R1] fell on 3/8/14, he has had pain in his right hip and a bruise on his right hip as well. Can we get an x-ray of his right hip?" Dr. Englehart did not respond. CMS Ex. 9 at 37; P. Ex. 16 at 2 (Frolik Decl. ¶ 7); *see* CMS Ex. 4 at 18. This is understandable inasmuch as March 9 was a Sunday, and Dr. Englehart's office was closed. No one was there to receive the fax. CMS Ex. 25 at 4-5, 21.

- March 9, 2014 at 10:10 p.m.:[5] late that night, licensed practical nurse (LPN) Dani Hickey noted that R1 had "emesis [vomiting] of green bile." His pupils were "reactive, but sluggish." He was pale and did not respond to questioning. Neither LPN Hickey nor anyone else contacted R1's physician or called emergency medical services. CMS Ex. 9 at 338; P. Ex. 16 at 2-3 (Frolik Decl. ¶ 8).

- March 9, 2014 at 10:45 p.m.: R1 had a second bout of vomiting green bile and was speaking "more incoherently," not responding appropriately to the nurse's questions. CMS Ex. 9 at 338.

- March 9, 2014 at 10:50 p.m.: 40 minutes after R1 vomited for the first time, LPN Hickey called 911. CMS Ex. 9 at 338.

- March 9, 2014 at 11:05 p.m.: an ambulance arrived and took R1 to Valley West Hospital. CMS Ex. 9 at 338.

- March 9, 2014 at 11:15 p.m.: LPN Hickey notified R1's family, the DON, and R1's physician of the night's events. CMS Ex. 9 at 338.

- March 9, 2014 at 11:24 p.m.: R1 arrived at the emergency department of Valley West Hospital. CMS Ex. 9 at 6-8. He was "unable to follow verbal questions and [was] incoherent in speech." CMS Ex. 9 at 22, 23; *see* CMS Ex. 9 at 7. A CT scan showed that he had suffered a cerebral hemorrhage. Valley West transferred him to Central DuPage Hospital so that he could receive a higher level of care. CMS Ex. 9 at 5-9, 25.

- March 18, 2014: R1 died, having suffered a hemorrhagic stroke. CMS Ex. 9 at 81; *see also* CMS Ex. 9 at 80, 82-85.

[5] In error, the nurse dated her entry March 10. The parties agree that March 9 is the correct date, and, in context, March 9 is the only date that makes sense. CMS Ex. 9 at 338.

These undisputed facts put the facility out of substantial compliance with 42 C.F.R. §§ 483.10(b)(11), 483.13(c), and 483.25.

a. The facility was not in substantial compliance with 42 C.F.R. § 483.10(b)(11) because, between 12:20 a.m. on March 8 and 10:50 p.m. on March 9, its staff repeatedly failed to consult R1's physician as required.

On at least four occasions following R1's accident, facility staff failed to consult, immediately and adequately, R1's physician about significant changes in the resident's condition. Specifically: 1) although she contacted Dr. Englehart shortly after the accident, RN Shelton did not tell the doctor that R1 took Coumadin nor that Dr. Englehart's instructions violated the facility's policy, which dictated that the resident be sent to the hospital;[6] 2) although staff detected a purple bruise on R1's hip at 11:30 a.m. on March 8, no one consulted Dr. Englehart; 3) at 4:30 p.m. on March 9, when staff belatedly decided to inform Dr. Englehart about R1's hip pain and bruising, they sent a fax containing the information to the physician's closed office. Receiving no reply, they took no further action; and 4) at 10:10 p.m. on March 9, R1 began to vomit, could not respond to questions, and his pupils were "sluggish." Yet, staff did not immediately contact his physician. Instead, they waited 40 minutes and called emergency services only after R1 went through a second bout of vomiting and exhibited ongoing incoherence.

1) With respect to the information RN Shelton conveyed – or failed to convey – when she called Dr. Englehart at 12:40 a.m. on March 8, Petitioner concedes that the nurse did not tell the doctor that the facility's policy required her to send to the emergency department any resident suffering a head injury. Petitioner also concedes that RN Shelton did not tell Dr. Englehart that R1 was on Coumadin. According to Petitioner, RN Shelton was not required to do so because the physician already knew it. After all, Dr. Englehart himself prescribed the drug, and the evidence shows that Dr. Englehart had examined and treated R1 shortly before the time of the accident. P. Response at 2; CMS Ex. 9 at 60, 61-62, 63-64; CMS Ex. 19 at 60, 68; P. Ex. 11 at 3.

For its part, CMS points out that Dr. Englehart was the primary care physician for residents in seven or eight other nursing homes and was serving as the medical director for three of those facilities, suggesting that he was simply too busy to remember an

[6] CMS maintains that RN Shelton did not tell Dr. Englehart that R1 had a bump on his head, and, in fact, the nursing note does not explicitly indicate that she mentioned the bump. CMS Ex. 9 at 337. Petitioner disputes this assertion and points out that RN Shelton's entry on the "Newly Acquired Skin Conditions" form mentions the bump. CMS Ex. 19 at 55; P. Response at 6. For purposes of summary judgment, I resolve this factual dispute in Petitioner's favor. However, the fact is not material.

individual patient's medications. CMS Ex. 25 at 3; *see* P. Ex. 12 at 4 (noting that physicians who work in nursing homes have a large case load so "it would be incumbent on the person making the phone call" to emphasize "just how significant of an issue is going on."). In deposition testimony given nine months after R1's accident, Dr. Englehart could not say whether he knew that R1 was on Coumadin, but added: "I don't remember everybody's medication list at midnight. I know that for sure." He pointed out that R1 was a new patient at the time and maintained that a facility is responsible for notifying the physician that a resident is on Coumadin. P. Ex. 11 at 2, 3. He claimed that his "custom and practice" in such situations would have been to send the patient to the emergency room. P. Ex. 11 at 3.

For purposes of summary judgment, I accept that Dr. Englehart knew or should have asked about R1's medications. But I do not find that fact material. Physician error does not absolve the facility of its responsibility to keep the resident safe. In this case, keeping the resident safe meant making sure that his physician understood and considered all relevant factors before deciding on a course of action (or inaction).

> The [Departmental Appeals] Board has repeatedly explained that to "consult" properly with the resident's physician, the facility must provide "all the information" the physician needs to assess properly the resident's condition and necessary treatment. "Failure to provide even one aspect of the change in a resident's condition can significantly impact whether the physician has been properly consulted."

River City Care Ctr., DAB No. 2627 at 8 (2015), *quoting Magnolia Estates Skilled Care*, DAB No. 2228 at 8-9 (2009). The hope is that, so long as he is provided all relevant information, the physician will make the right decisions. If his judgment runs contrary to facility policy in a way that could jeopardize resident safety, staff should involve the facility's medical director.

I therefore agree that the facility did not adequately consult R1's physician immediately following the resident's March 8 accident.

2) Even if I found that the 12:40 a.m. call to Dr. Englehart satisfied the requirement to "consult," I would nevertheless find that staff violated section 483.10(b)(11) later that morning, when they did not call Dr. Englehart immediately after they discovered R1's bruised hip.

Petitioner maintains that staff were not required to consult the physician because the appearance of the bruise was not a significant change.

To be "significant," a change need not be life-threatening. As the Board has observed, changes involving "non-emergency clinical complications" are also significant and mandate physician consultation. *Stone Cnty. Nursing & Rehab. Ctr.*, DAB No. 2276 at 6 (2009).

In any event, for an individual on Coumadin, the appearance of a bruise is no small matter and could indeed signify a life-threatening condition. Individuals on blood-thinners face an increased risk of hemorrhage or excessive bleeding if they suffer a fall or other trauma. CMS Ex. 25 at 7. For this reason, in *Western Care Management Corp.*, the Board concluded that the appearance of a bruise following a resident's fall constituted a significant change for which facility staff should have consulted the attending physician. The bruise suggested the possibility of a hip fracture and, because the resident was taking Coumadin, potentially serious bleeding and tissue damage. DAB No. 1921 at 18 (2004).

I also reject Petitioner's argument that R1's bruised hip did not represent a change in condition because a hip bruise is "an expected outcome of a fall." P. Response at 7. In assessing the significance of a fall, the physician must have complete and accurate information as to any resulting injuries. *See, e.g.*, P. Ex. 12 at 4 (emphasizing that a physician's assessment of the situation, and therefore his response, depends on what information is conveyed and how it is conveyed). Immediately after R1's accident, RN Shelton affirmatively reported that the resident suffered no bruising and had no pain, which suggests that the fall was not very serious. *See* P. Ex. 19 at 1-2 (Fielitz Decl. ¶¶ 6, 7) (declaring that, immediately after the accident, R1 "was laughing and stated that he was not hurt"). But the complaints of pain and the discovery of a bruise changed that, suggesting the possibility of bleeding or tissue damage, or, as staff ultimately recognized, the possibility of a hip fracture. CMS Ex. 9 at 37.

I note also that a physician's purported awareness of a significant change does not discharge the facility's express obligation to consult with the physician. *Stone Cnty.*, DAB No. 2276 at 10.

For these reasons, I conclude that the facility violated section 483.10(b)(11) when its staff did not immediately consult with Dr. Englehart about R1's bruise and complaints of pain.

3) Facility staff eventually attempted to notify Dr. Englehart of R1's bruise and hip pain, but their efforts – sending a fax to his closed office – did not satisfy the consultation requirements of section 483.10(b)(11).

Petitioner does not dispute that March 9 was a Sunday and has not come forward with any evidence to suggest a dispute over whether Dr. Englehart's office was closed on that particular day. Nevertheless, without directly addressing those undisputed facts, Petitioner presents evidence that staff regularly faxed information to Dr. Englehart's

office and that this was the physician's preferred method of notification. P. Ex. 15 at 2 (Engel Decl. ¶ 6); P. Ex. 16 at 2 (Frolik Decl. ¶ 7). Petitioner points to specific dates on which staff faxed requests to Dr. Englehart, to which he timely responded: March 3, 2014 (Monday), and March 6, 2014 (Thursday). CMS Ex. 9 at 75; CMS Ex. 19 at 60; *see* P. Ex. 15 at 2 (Engel Decl. ¶ 8).

For purposes of summary judgment, I accept that staff regularly faxed information to Dr. Englehart's office and that this was his preferred method of communication, but I find those facts not material.

Even if Dr. Englehart had received the fax – which he did not – sending a fax hours after the change is noted is not sufficient to satisfy the requirement for "immediate" consultation. As the Board has repeatedly explained, "immediate consultation" means just that: "as soon as the change . . . is detected, without any intervening interval of time." *River City Care Ctr.*, DAB No. 2627 at 7 (2015), *quoting Magnolia Estates Skilled Care*, DAB No. 2228 at 8-9 (2009) and *The Laurels at Forest Glen*, DAB No. 2182 at 13 (2008).

The Board also long ago resolved any debate about what it means to "consult" the resident's physician. It does not mean "notifying" or "informing" the physician. Leaving a message does not satisfy the regulatory requirement. To consult "requires a dialogue with and a responsive directive . . . ." *River City Care Ctr.*, DAB No. 2627 at 8, *quoting Magnolia Estates*, DAB No. 2228 at 8-9. Thus, sending a fax, without any follow-up, does not satisfy the requirements of section 483.10(b)(11).

4) Finally, at 10:10 p.m., when R1 began to vomit and could not respond to questions, staff immediately should have consulted his physician and contacted the emergency medical department. They did neither, but instead waited until after a second bout of vomiting, some 40 minutes later.

Petitioner argues that nausea and vomiting were not changes for R1. In support, Petitioner relies on the opinion of its consulting physician, Michael Ahearn, M.D. Dr. Ahearn did not know or treat R1 but bases his opinion on a March 3 medication order for a drug prescribed to reduce nausea and vomiting. P. Ex. 20 at 1, 4 (Ahearn Decl. ¶¶ 2, 5(i)). R1's medication records include a March 3 telephone order for Zofran, which is used to treat nausea and vomiting. CMS Ex. 9 at 13.

Dr. Ahearn concedes that "vomiting may be a sign of increased intracranial pressure or intracranial bleeding" but argues that, because of R1's purported "history of nausea and vomiting," it "was not possible" to conclude whether this symptom was related to his head injury. P. Ex. 20 at 4 (Ahearn Decl. ¶ 5(i)). I find three major problems with his position.

First, nothing in the regulations, the facility's policies, or any standard of care justifies waiting to report symptoms of a serious head injury until nursing staff have eliminated other possible causes for those symptoms.

Second, the record does not support Dr. Ahearn's inference that, for R1, nausea and vomiting were ordinary occurrences, for which no interventions were required. R1's medication administration record indicates that the drug was administered only twice – on March 3 and March 5 – and each time staff considered those symptoms significant changes. CMS Ex. 9 at 38. Nursing notes record an episode of stomach upset and vomiting on March 3; staff called R1's physician, who prescribed Zofran. CMS Ex. 9 at 334. On March 5, R1 complained of nausea and vomiting, for which staff gave him Zofran. Staff called his physician, who referred R1 to a gastroenterologist. CMS Ex. 9 at 335. Thus, R1 had vomited only twice prior to March 9 and, treating the symptom as a significant change, staff called Dr. Englehart both times. He responded by altering the resident's treatment and ordering a consult.

Third, R1's treatment records consistently describe a coherent and rational person. CMS Ex. 9 at 63-64, 68, 279-281, 326, 327, 328, 331, 334-335. Never before had R1's stomach upset been accompanied by incoherence or other neurological changes. The sluggish pupils and incoherence, combined with nausea and vomiting, should have set off alarm bells. All are signs of increased cranial pressure, which, according to the facility's policies, must be reported to the physician immediately (i.e., without any intervening interval of time). CMS Ex. 13 at 4; *River City Care Ctr.*, DAB No. 2627 at 8.

Ultimately, even Dr. Ahearn concedes that at 10:10 p.m. on March 9, R1 exhibited signs and symptoms of a change in condition. P. Ex. 20 at 4 (Ahearn Decl. ¶ 5(j)). RN Frolik characterizes R1's first bout of vomiting and neurological changes as "a significant change in condition." P. Ex. 16 at 2 (Frolik Decl. ¶ 8). He is correct.

Thus, because staff did not immediately consult R1's physician when the resident experienced a significant change in status, the facility was not in substantial compliance with section 483.10(b)(11). In reaching this conclusion, I have considered Dr. Ahearn's opinion that the 40-minute delay caused R1 no harm because the treatment protocol remained the same. I find this not material. Regardless of its ultimate effect on the outcome, the resident has a right to have his physician directly involved in his care. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 12 (2010).[7]

[7] Although, for purposes of summary judgment, the question is not material to the outcome of this matter, I view Dr. Ahearn's opinion with skepticism. It does not follow that R1 suffered no harm simply because the treatment protocol would have been the same if staff had acted more quickly. The question is not whether the treatment would have been the same but whether the *outcome* would have been the same. Dr. Ahearn does not expressly claim that it would have. Indeed, because prolonged bleeding

b. The facility was not in substantial compliance with 42 C.F.R. § 483.13(c) because its staff did not follow the policies the facility had in place for providing the services necessary to avoid harm to facility residents.

The facility was not in substantial compliance with section 483.13(c), because its staff did not follow the policies and procedures it had in place to provide residents with the goods and services they needed to avoid physical harm.

As a threshold matter, I find that R1 was neglected because the facility did not provide him the services he needed to avoid physical harm. *See* 42 C.F.R. § 488.301. But my analysis does not stop there. Section 483.13(c) "addresses a deficiency related to lack of an effective policy as opposed to one directed at the occurrence of neglect itself." *Emerald Oaks*, DAB No. 1800 at 12 (2001).[8]

The parties agree that the facility had written policies and procedures in place but, in CMS's view, the facility's repeated failures to follow them demonstrate "systemic problems in implementing" policies and procedures, putting the facility out of substantial compliance with section 483.13(c). CMS MSJ at 8, *citing Oceanside Nursing & Rehab. Ctr.*, DAB No. 2382 at 11 (2011). Petitioner responds that there could not have been a "systemic" failure because the deficiency refers to just one resident. P. Response at 11-12.

The Board has repeatedly emphasized that, in considering a facility's compliance with section 483.13(c), the focus "is not simply on the number or nature of the instances of neglect (i.e., failure to provide necessary care or services) but on whether the facts . . . surrounding such instance(s) demonstrate an *underlying breakdown in the facility's implementation of the provisions of an anti-neglect policy*." *Oceanside*, DAB No. 2382 at 11 (emphasis added); *see Columbus Nursing & Rehab. Ctr.*, DAB No. 2247 at 27 (2009) (holding that CMS need not show multiple incidents of abuse in order to cite noncompliance under section 483.13; instead, the question is "whether the circumstances presented, viewed as a whole, demonstrate a systemic problem in implementing policies and procedures").

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increases the pressure on the brain, it seems that the earlier the intervention – to stop the bleeding and relieve the pressure – the better the chances of a favorable outcome.

[8] This does not mean that the regulation countenances neglect. Its drafters characterized as "inherent in [section] 483.13(c)" the requirement that "each resident should be free from neglect as well as other forms of mistreatment." 59 Fed. Reg. 56,130 (November 10, 1994).

A facility violates section 483.13(c) if it fails to follow its own policies defining the goods and services needed to prevent physical harm to its residents. *Avalon Place Kirbyville*, DAB No. 2569 at 9 (2014). As set forth above, the facility had in place policies and procedures defining the goods and services needed to protect residents from physical harm. The undisputed evidence establishes that multiple staff members at all levels disregarded those policies and procedures. Specifically:

- Both RN Shelton and DON Donahue, to whom RN Shelton reported R1's fall, disregarded the policy that directed staff to send to the emergency room a resident who, while taking Coumadin, fell and suffered a head injury. CMS Ex. 23 at 6, 42.

- R1 subsequently displayed bruising and complained of pain – significant changes in his condition. Yet, over nearly two days, multiple staff members disregarded the facility's "notification of change" policy, which directed them to notify promptly the appropriate individuals, including the facility administrator, DON, *resident's physician*, guardian or other representative, of changes in the resident's condition. CMS Ex. 11 at 1.

- Nursing staff disregarded the facility's head trauma policy, which specifically listed nausea, vomiting, and confusion as signs of increased cranial pressure that *must immediately* be reported to the resident's physician. CMS Ex. 13 at 4.

The facility was thus not in substantial compliance with 42 C.F.R. § 483.13(c).

c. The facility was not in substantial compliance with 42 C.F.R. § 483.25 because it did not provide R1 with the care and services he needed to attain or maintain his highest practicable physical, mental, and psychosocial well-being.

Because he was on blood-thinning medication, R1 was at risk for excessive bleeding, particularly if he injured himself. His care plan identified that risk as a significant problem and required staff to monitor him for "increased bleeding tendencies." The plan specifically lists bruising as one of the symptoms staff should watch for, and it directs them to refer the resident to his physician "as soon as able" after the symptoms are detected. CMS Ex. 9 at 262, 263. That staff failed to do so put the facility out of substantial compliance with 42 C.F.R. § 483.25. Further, the facility's policies recognized how vulnerable someone like R1 would be if he suffered a head injury and, for that reason, required staff to send to the emergency department any resident on blood-thinning medications who fell, as well as any resident who suffers a head injury. CMS Ex. 23 at 42.

I do not have to accept Petitioner's highly speculative and conclusory assertion that transferring R1 to the emergency room would have been "more dangerous" than leaving

him at the facility and "monitoring" his symptoms. P. Ex. 20 at 3 (Ahearn Decl. ¶¶ 5(c) and 5(e)). Nothing in R1's clinical record – including his multiple examinations and tests – suggests that an emergency department evaluation would have jeopardized his health and safety. He suffered from chronic and troubling conditions but, on March 8, he was perfectly cogent and capable of understanding the reason for the transfer and evaluation. Moreover, if I accepted Dr. Ahearn's opinion, I would have to conclude that the facility's written policies – which direct staff to send its residents to the emergency room – were inconsistent with acceptable medical practices. Another of Petitioner's witnesses, Corporate Nurse Gilbert, implicitly defends the practice of sending such residents to the emergency room by pointing out that the in-service training she provided in June 2014 emphasized sending to the emergency room for evaluation individuals on prescribed anticoagulants who suffer head trauma. P. Ex. 14 at 2 (Gilbert Decl. ¶¶ 6, 7).

Because the facility did not provide R1 with the goods and services he needed to attain or maintain his highest physical well-being, it was not in substantial compliance with 42 C.F.R. § 483.25.

2. CMS's determination that, from March 8 through June 26, 2014, the facility's substantial noncompliance posed immediate jeopardy to resident health and safety is not clearly erroneous.

Immediate jeopardy. Immediate jeopardy exists if a facility's noncompliance has caused or is likely to cause "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1962 at 11 (2005), *citing Florence Park Care Ctr.*, DAB No. 1931 at 27-28 (2004)); *Daughters of Miriam Ctr.*, DAB No. 2067 at 7, 9 (2007).

Here, a vulnerable resident suffered a head injury and, over the next two days, experienced symptoms of potentially serious consequences. Yet the facility did not immediately consult his physician or provide him with the services the facility had determined someone in his position would need to avoid harm. The facility's deficiencies likely caused him serious harm and may even have led to his death. I need not make that finding, however. By any standard the facility's response, or lack of

response, to R1's accident and deteriorating condition was likely to cause serious harm. CMS's immediate jeopardy determination is therefore not erroneous.[9]

3. The penalties imposed are reasonable.

To determine whether a civil money penalty is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): (1) the facility's history of noncompliance; (2) the facility's financial condition; (3) factors specified in 42 C.F.R. § 488.404; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating factor. The factors in 42 C.F.R. § 488.404 include: (1) the scope and severity of the deficiency; (2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and (3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the section 488.438(f) factors. I am neither bound to defer to CMS's factual assertions nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848 at 21 (2002); *Cmty. Nursing Home*, DAB No. 1807 at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800 at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638 at 8 (1999).

Here, CMS imposes penalties of $4,050 per day for each day of immediate jeopardy, which is in the lower range for a per-day CMP ($3,050 to $10,000). 42 C.F.R. §§ 488.408(e)(1)(iii); 488.438(a)(1)(i). For the period of substantial noncompliance that was not immediate jeopardy, CMS imposes a penalty of $100 per day, which is at the very low end of the applicable penalty range ($50 to $3,000). 42 C.F.R. § 488.408(d)(1)(iii); 488.438(a)(1)(ii). Considering the relevant factors, these penalties are reasonable.

The facility has a dismal compliance history. For the decade preceding this complaint investigation, the facility was not in substantial compliance for every annual survey and several complaint investigation surveys. Many of its deficiencies were repeated. In fact, the deficiencies that are the subject of this case – 42 C.F.R. §§ 483.10(b)(11); 483.13(c); and 483.25 – have all been cited before at various levels of scope and severity, including immediate jeopardy.

- The facility was not in substantial compliance at the time of its recertification surveys – health and life safety code (LSC) – completed **February 2014**. At that

[9] I explain below why CMS's determination as to the duration of the immediate jeopardy is fully supported.

time its health deficiencies, 42 C.F.R. § 483.10(f)(1) (Tag F166 – resident rights: right to voice grievances); and 42 C.F.R. § 483.35(d)(1)-(2) (Tag F364 – dietary services: food), were at scope and severity level E (pattern of substantial noncompliance that causes no actual harm with the potential for more than minimal harm). Its three LSC deficiencies were at scope and severity level F (widespread substantial noncompliance that causes no actual harm with the potential for more than minimal harm).

- Just a few months before the February 2014 recertification survey, in **November 2013**, a complaint investigation revealed that the facility was not in substantial compliance with two of the deficiencies that underlie this case: ***42 C.F.R. § 483.10(b)(11)*** (Tag F157 – resident rights: notification of changes) and ***42 C.F.R. § 483.25*** (Tag F309 – quality of care), at scope and severity level D (isolated instance of substantial noncompliance that causes no actual harm with the potential for more than minimal harm).

- The facility's **January 2013** health and LSC surveys also found the facility out of substantial compliance, with a LSC deficiency cited at scope and severity level F and a health deficiency – 42 C.F.R. § 483.65 (Tag F441 – infection control) – cited at scope and severity level E.

- A complaint investigation, completed in **December 2012,** found the facility out of substantial compliance with 42 C.F.R. § 483.25(h) (Tag F323 – quality of care: accident prevention) at scope and severity level D.

- Surveys completed in **December 2011** showed an especially seriously deficient facility. Not only did it have two LSC deficiencies cited at scope and severity level F, it had multiple health deficiencies. Notably, the facility was not in substantial compliance with ***42 C.F.R. § 483.13(c) (Tag F224))*** – the same deficiency cited in this case. As here, the deficiency was cited at *scope and severity level J*.

  The facility's other immediate jeopardy level deficiencies were cited under 42 C.F.R. § 483.25(h) (Tag F323) and 42 C.F.R. § 483.75(d)(1) and (2) (Tag F493 – administration: governing body). Four additional health deficiencies were cited at scope and severity level F: 42 C.F.R. § 483.35 (Tag F360 – dietary services); 42 C.F.R. § 483.35(d)(1)-(2) (Tag F364 – dietary services: food); 42 C.F.R. § 483.35(f) (Tag F368 – dietary services: frequency of meals); and 42 C.F.R. § 483.65 (Tag F441 – infection control).

- The facility's health and LSC surveys, completed in **February 2011**, found substantial noncompliance, including four LSC deficiencies, cited at scope and severity level E, and one G-level health deficiency – ***42 C.F.R. § 483.13(c)(Tag***

F224) – again, the same deficiency cited in this case, cited at a scope and severity level that indicates actual harm to a resident.

- For the health and LSC surveys completed in **December 2009**, the facility was not in substantial compliance with a LSC requirement at scope and severity level F and with three health requirements, also cited at scope and severity level F: 42 C.F.R. § 483.10(c)(7) (Tag F161 – resident rights: assurance of financial security); 42 C.F.R. § 483.10(f)(1) (Tag F166 – resident rights: right to voice grievances); and 42 C.F.R. § 483.35(f) (Tag F368 – dietary services: frequency of meals).

CMS Ex. 3.

This history, by itself, justifies increasing the CMP well above the minimum.

With respect to financial condition, Petitioner complains that the amount of the CMP constitutes a financial hardship. P. Response at 21. The facility has the burden of proving, by a preponderance of the evidence, that paying the CMP would render it insolvent or would compromise the health and safety of its residents. *Van Duyn Home & Hosp.*, DAB No. 2368 (2011); *Gilman Care Ctr.*, DAB No. 2362 (2010). To meet the standard for lowering a CMP based on financial condition, claims must be supported by compelling financial documentation. In *Guardian Care Nursing & Rehabilitation Center*, DAB No. 2260 (2009), for example, the facility could not even afford to represent itself on appeal. Its Medicaid census was 90%; its annual shortfall was $250,000; and it relied on charitable contributions for its continuing viability. The Board nevertheless criticized the absence of financial documentation and concluded that the facility had not established that additional resources would not be available. *But see Columbus Nursing & Rehab. Ctr.*, DAB No. 2505 (2013) (finding that the absence of documentation regarding the facility's financial condition did not preclude ALJ from concluding, based on witness testimony, that financial condition justified reducing the CMP).

Petitioner proffers no financial documentation or testimony to establish its inability to pay. It has not shown, nor even alleged, that paying the penalty would cause it to go out of business. The evidence therefore does not justify lowering the CMP based on its financial condition.

Applying the remaining factors, multiple staff members at all levels either did not know or chose to disregard the facility's policies for protecting its resident who, while taking blood-thinning medications, suffered a head injury. The facility is culpable for these failings.

For these reasons, I find that the CMPs are reasonable.

4. CMS's determinations as to the duration of the facility's substantial noncompliance and immediate jeopardy are consistent with statutory and regulatory requirements.

CMS determined that the facility's immediate-jeopardy-level noncompliance began on March 8, 2014, the day of R1's accident. On that day, staff did not provide R1's physician with all necessary information and, later in the day, did not consult him about R1's bruise and complaints of pain. These facts more than justify CMS's setting March 8 as the onset date of the facility's noncompliance at the immediate jeopardy level of scope and severity.

With respect to the date that the facility's deficiencies no longer posed immediate jeopardy to resident health and safety (June 27) and the date it returned to substantial compliance (July 16), the facility has not met its burden of establishing that it alleviated the immediate jeopardy nor that it returned to substantial compliance any earlier.

Substantial compliance means not only that the facility corrected the specific cited instances of substantial noncompliance, but also that it implemented a plan of correction *designed to assure that no future incidents would occur*. A facility remains out of substantial compliance until it affirmatively demonstrates that it has achieved substantial compliance once again. *Life Care Ctr. of Elizabethton*, DAB No. 2367 at 16-17 (2011); *Premier Living & Rehab Ctr.*, DAB No. 2146 at 23 (2008); *Lake City Extended Care Ctr.*,, DAB No. 1658 at 12-15 (1998). The burden is on the facility to prove that it has resumed complying with program requirements, not on CMS to prove that deficiencies continued to exist after they were discovered. *Asbury Ctr. at Johnson City*, DAB No. 1815 at 19-20 (2002). A facility's return to substantial compliance usually must be established through a resurvey. 42 C.F.R. § 488.454(a). To be found in substantial compliance earlier than the date of the resurvey, the facility must supply documentation "acceptable to CMS" showing that it "was in substantial compliance and *was capable of remaining in substantial compliance*" on an earlier date. 42 C.F.R. § 488.456(e) (emphasis added); *Hermina Traeye Mem'l Nursing Home*, DAB No. 1810 at 12, *citing* 42 C.F.R. § 488.456(a) and (e); *Cross Creek Care Ctr.*, DAB No. 1665 (1998).

Similarly, CMS's determination that a facility's ongoing noncompliance remains at the level of immediate jeopardy during a given period "is subject to the clearly erroneous standard of review under [42 C.F.R. §] 498.60(c)(2)." *Life Care Ctr. of Elizabethton*, DAB No. 2367 at 16, *quoting Brian Ctr.*, DAB No. 2336 at 7-8 (2010). Further, if CMS accepts a deficient facility's plan of correction, the facility must then timely implement all of the steps that it identified in the plan as necessary to correct the cited problems. *Cal Turner Extended Care Pavilion*, DAB No. 2030 at 19 (2006); *see also Meridian Nursing Ctr.*, DAB No. 2265 (2009); *Lake Mary Health Care*, DAB No. 2081 at 29 (2007).

Here, the facility responded to the immediate jeopardy determination in a statement dated June 27, 2014. The statement listed one in-service training session, held March 10, addressing "Incident Protocol with emphasis on Residents on anticoagulants who fall and hit their heads be sent to the ED for evaluation." CMS Ex. 17 at 1. In addition, the statement listed training, conducted June 27, and promised to provide more training. CMS Ex. 17 at 1-2.

On July 22, 2014, the facility submitted its plan of correction. In that plan were sign-in sheets for training sessions conducted on June 27 and July 10, copies of the policies the facility promised to implement, and written tools that staff would use to ensure that the policies were followed. P. Ex. 6. The facility promised to complete corrections on *July 16, 2014*. P. Ex. 6 at 5.

Petitioner argues that the immediate jeopardy abated on March 10, when it provided to some staff the first of its in-service training sessions. But in-service training and promises of change, by themselves, are not sufficient to ensure that the cited deficiencies will not recur, particularly for a facility with Petitioner's history. As I noted in *Premier Living & Rehab Center*, the facility must follow up with staff to verify that they understand the training, have implemented the necessary changes, and that the changes, in fact, corrected the problem. DAB CR1602 (2007), *aff'd*, DAB No. 2146 (2008). This cannot be accomplished in one training session, as the facility implicitly acknowledged when, in its plan of correction, it set the completion date. Remarkably, CMS accepted the facility's representations and did not require a follow-up survey. Petitioner can hardly complain that CMS accepted the date that the facility itself set for implementing the corrections necessary.

Conclusion

The uncontroverted evidence establishes that, from March 8 through July 15, 2014, the facility was not in substantial compliance with Medicare participation requirements, and, from March 8 through June 26, 2014, those deficiencies posed immediate jeopardy to resident health and safety. The penalties imposed – $4,050 per day for the period of immediate jeopardy and $100 per day for the period of substantial noncompliance that was not immediate jeopardy – are reasonable.

I therefore grant CMS's motion for summary judgment and deny Petitioner's motion.

/s/
Carolyn Cozad Hughes
Administrative Law Judge