Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Community Care of Rutherford County, Inc.,
(CCN: 44-5406),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-09-595

Decision No. CR2173

Date: July 06, 2010

DECISION AND ORDER OF REMAND

I find that Petitioner, Community Care of Rutherford County, Inc., failed to comply substantially with Medicare participation requirements. I also find that some of Petitioner's noncompliance was so egregious as to comprise immediate jeopardy for residents of Petitioner's facility and that this immediate jeopardy level noncompliance extended over a period of time that began on October 9, 2008 and ran through May 29, 2009. I also find that Petitioner manifested non-immediate jeopardy level noncompliance during a period that began on May 30, 2009 and ran through June 6, 2009. Consequently, I sustain the following remedies:

- Civil money penalties of $3,050 per day to remedy Petitioner's immediate jeopardy level noncompliance for a period running through May 29, 2009; and

- Civil money penalties of $150 per day to remedy Petitioner's non-immediate jeopardy level noncompliance for a period that began on May 30, 2009 and ran through June 6, 2009.

I do not establish a beginning date for the $3,050 civil money penalties. I do not do so, because Petitioner has alleged that a standard survey of Petitioner's facility was completed on February 26, 2009. As I find below, the Centers for Medicare and Medicaid Services (CMS) may not impose back-dated civil money penalties against a facility for dates prior to the date of the most recent standard survey of that facility. Consequently, if Petitioner's assertion of a February 26, 2009 standard survey is correct, the beginning date of immediate jeopardy level penalties would be February 27, 2009, notwithstanding that I find that Petitioner manifested immediate jeopardy level noncompliance beginning on October 9, 2008. However, Petitioner has not offered any evidence to support its assertion that a standard survey of its facility occurred on February 26, 2009, and CMS did not respond to Petitioner's argument. I remand in part this case to CMS to make a determination as to whether a standard survey of Petitioner's facility occurred at any time between October 9, 2008 and February 26, 2009.

I. Background

Petitioner is a skilled nursing facility in the State of Tennessee. It participates in the Medicare program. Its participation in Medicare is governed by sections 1819 and 1866 of the Social Security Act (Act) and by regulations at 42 C.F.R. Parts 483 and 488.

Petitioner was surveyed for Medicare compliance from April 27 to May 13, 2009 (May survey). Petitioner was found not to be complying substantially with several Medicare participation requirements. Three of the deficiencies were found to be so egregious as to comprise immediate jeopardy for Petitioner's residents. "Immediate jeopardy" is noncompliance that either causes, or is likely to cause, serious injury, harm, impairment, or death to a resident or residents of a facility. 42 C.F.R. § 488.301. CMS concurred with the survey findings and determined to impose remedies consisting of civil money penalties of: $3,050 per day for each day of a period that began on October 9, 2008 and ran through May 29, 2009; and $150 per day for each day of a period that began on May 30, 2009 and ran through June 6, 2009.

Petitioner requested a hearing, and the case was assigned to me for a hearing and decision. I ordered the parties to file pre-hearing exchanges consisting of briefs and proposed exhibits, including the written direct testimony of all proposed witnesses. The parties complied with my order, and CMS then moved for summary judgment. I denied the motion, because I found that disputed issues of material fact existed. The parties then agreed to waive an in-person hearing, and I received final briefs from them.

CMS submitted a total of 22 exhibits with its pre-hearing exchange, which it designated as CMS Ex. 1 – CMS Ex. 22. Petitioner submitted a total of 20 exhibits, which it designated as P. Ex. 1 – P. Ex. 20. I receive all of the parties' exhibits into evidence.

II. Issues, Findings of Fact, and Conclusions of Law

A. Issues

Petitioner did not address any of the non-immediate jeopardy level deficiencies that the May survey found in either its pre-hearing brief or in its final brief. I conclude that Petitioner has abandoned its challenge to these deficiencies, and CMS's determination of them has become administratively final.[1] Therefore, I sustain CMS's determination to impose civil money penalties of $150 per day for each day of the period that ran from May 30 through June 6, 2009.

Petitioner continues to challenge the immediate jeopardy level deficiencies that the May survey found and CMS's determination to impose remedies to address those deficiencies. The remaining issues in this case are whether:

1. Petitioner manifested immediate jeopardy level noncompliance with Medicare participation requirements;

2. CMS's determination of the duration of immediate jeopardy level noncompliance is correct; and

3. CMS's determination to impose civil money penalties of $3,050 per day to remedy immediate jeopardy level noncompliance is reasonable as a matter of law.

B. Findings of Fact and Conclusions of Law

The three immediate jeopardy level noncompliance findings that are at issue in this decision are Petitioner's alleged failures to comply with the requirements of 42 C.F.R. §§ 483.25(h), 483.75, and 483.75(o)(1). In this decision, I address only Petitioner's noncompliance with the requirements of 42 C.F.R. § 483.25(h), because Petitioner's immediate jeopardy level noncompliance with this regulation is all that is necessary to sustain CMS's determination of immediate jeopardy level noncompliance running from October 9, 2008 through May 29, 2009, and its determination to impose civil money penalties of $3,050 per day to remedy this noncompliance.

I make the following findings of fact and conclusions of law (Findings):

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[1] The non-immediate jeopardy level deficiencies that Petitioner did not address, and which I conclude Petitioner no longer challenges, are Petitioner's failures to comply with the requirements of 42 C.F.R. §§ 483.13(c), 483.20(g)-(j), 483.20(d)(3), 483.10(k)(2), and 483.20(k)(3)(i).

1. Petitioner did not comply substantially with the requirements of 42 C.F.R. § 483.25(h).

The regulation at issue here has been the subject of much litigation. It requires a facility to ensure that its residents receive the supervision and assistance devices they need to prevent accidents. 42 C.F.R. § 483.25(h)(2). While the regulation does not make a facility strictly liable for accidents that its residents sustain, it does impose on the facility the duty to take all reasonable measures to protect those residents.

The gravamen of CMS's case against Petitioner is that Petitioner failed to take all reasonable measures to protect its residents against falling. CMS focuses on the care that Petitioner gave to several of its residents, most notably residents who it identifies as Residents #s 5, 15, 16, 18, 22, and 25. CMS argues that these residents were individuals who were extremely prone to falling and who were known to Petitioner's staff as falls prone individuals. However, according to CMS, Petitioner failed to implement all of the reasonable interventions that it could have implemented to protect these individuals, and, as a result, these individuals remained at great risk for sustaining serious and even life-threatening falls. CMS avers that one of the residents – Resident # 5 – sustained falls that injured him grievously and that he finally sustained a fall, which caused his death due to Petitioner's failure to protect him.

CMS makes a separate argument concerning Resident # 1. This resident, CMS alleges, was injured, because Petitioner's staff failed to follow an explicit written physician's order governing the manner in which the resident was supposed to be transferred from one location in Petitioner's facility to another. The case of Resident # 1, therefore, is not a case of Petitioner's failure to prevent the resident against sustaining a fall so much as it is a more generic failure to protect the resident against sustaining an accident.

The evidence amply supports CMS's assertions. The care that Petitioner gave to its residents evidences a pattern of deficient care. The evidence does not show that Petitioner ignored entirely these residents' needs. But, it establishes that Petitioner failed to implement aggressively the interventions – principally consisting of increased supervision and personal assistance – that might have better protected residents against falling. Several of Petitioner's residents were individuals who could not be trusted to ambulate unassisted or, in the cases of Residents #s 5 and 15, to be left alone. What these residents plainly needed was close supervision and even one-on-one assistance by Petitioner's staff. They did not receive this support and, as a consequence, were left unprotected against falling.

Moreover, the evidence establishes that Petitioner's staff failed to carry out Petitioner's own policy for falls prevention. CMS Ex. 7. Petitioner had a policy that mandated its staff to develop and implement new interventions for falls prone residents, as it became apparent that previously developed interventions were unsuccessful. The staff was

obligated to continue to develop, and to try, new interventions until falling ceased, or was at least reduced, or until continued falling was determined to be unavoidable. *Id.* at 2. The evidence that I discuss below shows that Petitioner failed repeatedly to comply with this policy.

As for Resident # 1, the evidence unequivocally supports a finding that Petitioner's staff failed to carry out an express physician's order governing the way in which the resident was to be transferred. As a consequence, the resident was seriously injured.

a. Resident # 5

This resident was a severely compromised individual. He became a resident at Petitioner's facility in 1996, and his medical conditions included Parkinson's Disease and osteoarthritis. CMS Ex. 1 at 14. His physical impairments included repetitive jerking motions. The resident had mental problems, which included short and long-term memory deficits, anxiety, periods of altered perception, and restlessness. *Id.* He was almost totally dependent on Petitioner's staff for support and assistance. He required extensive assistance with bed mobility, transfers, ambulation, and dressing. CMS Ex. 17 at 69, 72, 99.

Resident # 5 fell, and he fell often. Between March and July 2008, the resident fell at least 28 times, and on nine of these occasions the resident sustained injuries. CMS Ex. 1 at 17-23; CMS Ex. 17 at 9-11.

Petitioner's staff understood that the resident was at extreme risk for falling. The staff's falls risk assessment of the resident, which concluded that he was at high risk for sustaining falls, proves this. CMS Ex. 17 at 99-100. Obviously, the resident's extreme risk for sustaining falls should have been known to the staff simply as a result of the many falls the resident sustained.

Resident # 5's behavior exacerbated his risk of falling. The resident was, at times, restless, anxious, and confused. In his confused and restless state, Resident # 5 would engage in extremely risky and dangerous behavior, such as attempting to exit his wheelchair or a geri-chair unassisted. CMS Ex. 17 at 37, 41, 43, 129-30. On numerous occasions, the resident attempted to stand unaided, notwithstanding his extreme vulnerability to sustaining falls. CMS Ex. 1 at 16.

Petitioner's staff implemented a number of interventions in response to Resident # 5's pattern of falls. These interventions included: providing the resident with a low bed with mats beside it; providing him with a body alarm; adjusting his medication to decrease his agitation; installing a lap buddy in his wheelchair to prevent him from exiting the chair; providing him with therapy to assist his sitting in a wheelchair; putting the resident in a geri-chair when necessary; walking him with the assistance of a therapist; placing the

resident near Petitioner's nurse's station and in the proximity of the nurses who worked there; providing the resident with a Broda chair when needed; toileting the resident at regular intervals; and psychiatric consultations. P. Ex. 9.[2]

None of these interventions were successful. That was made evident by the fact that the resident continued to fall, frequently, even after the interventions were in place. The use of a lap buddy was conspicuously ineffective, because the resident continued to fall even after the lap buddy was installed. Between March and July 2008, the resident fell, on average, several times per week. These falls often left the resident injured. On March 22, 2008, Resident # 5 fell from his bed, injuring his head. CMS Ex. 17 at 4, 9, 174. On April 29, 2008, the resident fell, sustaining a skin tear to his left elbow. He fell again and was again injured on May 1, 2008. CMS Ex. 1 at 18. On May 23, 2008, he fell again, and, on this occasion, he injured his head. CMS Ex. 17 at 23. On July 5, 2008, the resident was seated in a geri-chair by Petitioner's nurse's station, and he fell again, injuring his head. CMS Ex. 1 at 22; CMS Ex. 11. The head trauma that he sustained from this fall caused his death. CMS Ex. 1 at 22; CMS Ex. 17 at 5.

It is obvious – and I infer that Petitioner's staff knew – that the interventions that Petitioner had put in place to protect Resident # 5 were ineffective. None of these interventions prevented the resident from falling, and, indeed, his risk for falling increased while these interventions were in place. The question, then, is what more within reason could Petitioner have done to protect Resident # 5? There certainly was more that Petitioner could have done and that it did not do. Its staff could have put the resident under close and even continuous observation at least during that part of the day when the resident was not in bed.

It is apparent that leaving the resident unwatched, even for a short period of time, was an invitation for the resident to fall. According to one member of Petitioner's staff, it only took seconds for the resident to rise out of his chair and fall. CMS Ex. 17 at 7. But, Petitioner never implemented continuous supervision of the resident despite the obvious failure of all other interventions. Petitioner's director of nursing admitted that continuous supervision was never attempted. *Id.* The resident was kept in the line of sight of Petitioner's staff meaning that the staff could see the resident. *Id.* However, at no time were staff members instructed to watch the resident continuously and to remain in close enough proximity to the resident so that they could stabilize him if he attempted to stand unassisted. *Id.* Thus, the resident was not being observed when he fell, fatally, on July 5, 2008.

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[2] I take notice that a "geri-chair" and a "Broda chair" are chairs designed to provide a seated individual with greater support and security than an ordinary wheelchair. These devices, however, are not foolproof protection against falling, because an individual who is seated in them can fall while attempting to rise out of them or after exiting them.

Continuous supervision was plainly called for in the case of Resident # 5, given his history of almost daily falls and the several serious injuries he sustained from falls. Petitioner has given me no explanation for its failure even to consider implementing this intervention. Petitioner has not provided any evidence or argument to show that continuous supervision was beyond its capability to provide nor has it shown that such an intervention would have been unreasonable. And, if Petitioner had, in fact, been unable to provide such supervision, it should have documented why it was unable to do so. It did not.

Petitioner argues that the only untried intervention that it might have implemented for Resident # 5 was to restrain him with a device that tied him to his wheelchair, such as a Posey vest. I find that argument to be unpersuasive. I make no finding that restraining the resident would have benefited him. But, Petitioner did not have to restrain Resident # 5 to protect him.

Petitioner also argues at great length that Resident # 5 and other falls prone residents were, in fact, the beneficiaries of Petitioner's philosophy of care, which Petitioner calls the "Eden Alternative." This philosophy, according to Petitioner, gave residents, such as Resident # 5 and the other residents whose care that CMS cited, maximum freedom to enjoy their lives in an environment that promotes their dignity:

> Eden promotes allowing residents mobility and the ability to express preferences, recognizing that there will be ensuing risks. Eden promotes allowing residents to take reasonable risks and enjoy the last years of their lives.

Petitioner's Final Brief at 3. Petitioner asserts that the Tennessee Legislature mandates that facilities such as Petitioner employ the Eden Alternative program in providing care to residents. *Id.* at 4. Petitioner argues that CMS's allegations of noncompliance butt heads with the Eden Alternative to the extent that CMS would have Petitioner implement interventions that the Eden Alternative does not permit.

I find this argument to be without merit. First, although Petitioner devotes much energy to extolling the virtues of the Eden Alternative, it never describes the specific elements of the program. For example, Petitioner introduced the testimony of George Smith, M.D., Petitioner's medical director, who describes himself as a proponent of the Eden Alternative. P. Ex. 9 at 1. In his testimony, he avers that the Eden Alternative is:

> dedicated to eliminating loneliness, helplessness, and boredom and to transforming institutional approaches to care into the creation of a community where life is worth living. Our building [Petitioner's facility]

> embraces the philosophy of a resident-centered environment. We promote residents making their preferences known. Even if these preferences are considered by some to be poor, we recognize that permitting freedom and quality of life includes risks.

Id. at 1.

These objectives certainly sound laudable but, in fact, neither Dr. Smith's testimony nor any of the other evidence that Petitioner introduced offer me a clue as to what the Eden Alternative actually mandates a facility to do. The record is devoid of specifics as to what the Eden Alternative actually is. Petitioner has not provided me with anything to prove that enhanced supervision of Resident # 5 or of other falls prone residents would contravene the Eden Alternative. Moreover, Petitioner's participation in Medicare is governed by the Act and implementing regulations and not by Tennessee law or the Eden Alternative. To the extent that conflicts exist between the Eden Alternative and the requirements of the Act and regulations (and, I stress, Petitioner has not established any conflicts), the Act and the regulations control. Finally, Petitioner had a falls policy, which it plainly did not comply with. Petitioner has not argued that the Eden Alternative superseded or conflicted with this policy.

Petitioner also seeks to describe its situation as one in which it was offered the choice of either: (1) following the Eden Alternative and being found noncompliant with Medicare participation requirements; or (2) restraining its residents to comply with the State survey agency's and CMS's demands. This is a false choice. As I discuss at length in this decision, there was an option – enhanced supervision of falls prone residents – that Petitioner neither considered nor implemented. Petitioner never was forced to choose restraints as the only remaining intervention for falls prone residents.

Petitioner argues also that its staffing to resident ratio exceeded that which is required under Tennessee law. Petitioner's Final Brief at 4. However, CMS has not alleged that Petitioner is inadequately staffed. In the case of Resident # 5, the issue certainly is not whether Petitioner was adequately staffed. It is, rather, whether Petitioner adequately utilized the staff resources that it had to protect the resident. I find that it did not for the reasons that I have explained.

b. Resident # 15

Petitioner's failure to do all that was reasonably required to protect its residents against falls is illustrated also by the care that Petitioner gave to other residents besides Resident # 5. In the case of Resident # 15, Petitioner failed to take reasonable alternative measures to protect the resident, when it became apparent that Resident # 15 knew how to remove or disable the chair alarm that the staff had installed to alert them to the resident's efforts to rise from his wheelchair unaided.

Resident # 15, like Resident # 5, is at great risk for falling. His diagnoses include Parkinson's disease, dementia, delusions, and muscle atrophy. CMS Ex. 1 at 31. He has impaired decision-making skills and is easily distracted. *Id.* He is assessed as acting impulsively, which he manifested by attempting to engage in unsafe activities. *Id.* at 32. Petitioner's staff assessed Resident # 15 as being at high risk for sustaining falls in part due to his intermittent confusion. *Id.*

The resident has fallen often. Between July 1, 2008 and April 30, 2009, the resident fell at least 41 times. CMS Ex. 1 at 32. Petitioner's staff recommended a bed alarm for the resident, but the alarm was not installed. The resident was also issued a chair alarm. However, the resident frequently disabled or removed the alarm. *Id.* at 33. In fact, the alarm had been disabled or removed at the time of approximately 20 of the documented falls that Resident # 15 sustained. *Id.*

Petitioner's staff thus knew that Resident # 15 was at high risk for falls, and they knew also that the resident often disabled his chair alarm, a principal intervention that was designed to warn the staff that the resident was leaving his wheelchair. Yet, and despite this knowledge, the staff neither planned nor implemented additional interventions that were designed to substitute for the obviously ineffective alarm. CMS Ex. 1 at 34.

I find the failure to consider and to implement alternatives to a chair alarm to be a clear violation of Petitioner's duty to protect Resident # 15 from accident hazards. A chair alarm is, at best, a device that enhances a facility staff's ability to supervise a falls prone resident. It serves as a warning device that sounds a need for staff immediately to come to the aid of a resident who is doing something inappropriate, such as attempting to rise out of a wheelchair unaided. Obviously, Petitioner's staff depended on a chair alarm to warn them about Resident # 15. That protection was stripped away by the resident's proclivity for disabling the alarm. Staff knew about that but did not develop or implement alternative interventions.

What could the staff have done? As was the case with Resident # 5, the obvious solution in the case of Resident # 15 would have been to implement increased, and, if necessary, continuous supervision of that resident during waking hours. If the staff could not rely on an alarm to tell them to come to the resident's aid, then the staff needed to watch the resident to assure that he did not engage in dangerous activity, such as attempting to rise from his wheelchair unaided.

Petitioner argues that it undertook numerous interventions to protect Resident # 15. These included: providing the resident with a new wheelchair; equipping the chair with a lap buddy; rearranging the resident's room to prevent falls; providing the resident with shoulder and side positioners; placing a warning sign in the resident's room; providing

the resident with a remote control for operation of his CD player; providing the resident with activities; and installing a chair alarm in the resident's wheelchair. Petitioner's Final Brief at 16-17.

But, it is obvious that none of these interventions worked. Resident # 15 continued to fall despite these interventions. Petitioner's staff knew that they were not working. Nor did these interventions substitute for what might have worked, increased supervision of the resident. No evidence exists that the staff even considered taking this measure.[3]

c. Resident # 16

Resident # 16 is another resident with medical problems that make him prone to falling. His problems include partial paralysis, short and long-term memory problems, and moderately impaired decision-making skills. CMS Ex. 1 at 34. Petitioner's staff assessed the resident as needing extensive assistance with bed mobility and transfers. He has a history of falling. *Id.* He sustained falls in January and February 2009. *Id.* at 34-35.

The evidence concerning the care that Petitioner gave to Resident # 16 proves that Petitioner was remiss in providing him with that which its staff had recommended as interventions to protect the resident against falling. In short, Petitioner failed to provide the resident with the reasonable assistance that its own staff had determined to be necessary.

A body alarm was recommended for this resident. However, none was ever installed. CMS Ex.1 at 35. The resident was also supposed to be provided with a non-slide pad for his wheelchair to stabilize him while he was in the chair. However, the pad was not in place on February 21, 2009 when the resident sustained a fall. *Id.* at 35-36.

Petitioner argues that the allegations concerning Resident # 16 are a "singular falsity that appropriate interventions to reduce falls were not thoughtfully considered, balanced against competing interests, and implemented when warranted." Petitioner's Final brief at 18. Petitioner lists a series of interventions that it contends it provided to the resident. Petitioner's arguments and contentions notwithstanding, it has offered no evidence to prove that it in fact provided Resident # 16 with the assistance that its staff determined to be necessary. Petitioner does not deny that it failed to provide Resident # 16 with a body

[3] After the completion of the May survey, Petitioner restrained Resident # 15 with a Posey belt. Petitioner asserts that, as a consequence of this restraint, the resident now tips over his wheelchair. Petitioner's Final Brief at 17-18. I make no finding that a Posey belt or other type of restraint was necessary or that it has been effective in protecting Resident # 15. Evidently, Petitioner has still not attempted to keep the resident under increased observation without restraining him.

alarm. Instead, it asserts that "[o]n admission, per facility protocol, an order was given for a body alarm for seven days." Petitioner's Final Brief at 18. Giving an order for a body alarm is not the same thing as supplying a body alarm. And, even if the alarm was supplied to the resident for seven days, the resident had been in the facility for several months (since May 2008), when he sustained falls in January and February 2009. At the time of these falls, he was not equipped with a body alarm and did not receive one subsequently. CMS Ex. 1 at 35.

As for the failure to provide the resident with a non-slide pad, Petitioner contends only that this failure was a "one-time mistake that was promptly corrected." Petitioner's Final Brief at 18. In other words, Petitioner concedes the failure to provide the resident with that which he needed.

d. Resident # 18

Resident # 18 is another resident at Petitioner's facility who sustained many falls. Between June 13, 2008 and April 5, 2009, this resident fell at least 66 times. CMS Ex. 1 at 37. The resident sustained minor injuries from some of these falls. She was assessed as having an unsteady and unsafe gait. *Id.* at 36. She had periods of restlessness and wandering. She required extensive assistance with transfers and limited assistance with mobility. Despite these obvious problems, the resident persisted in attempting to ambulate unassisted or with the use of a walker. Petitioner's staff assessed the resident as being oblivious to her own personal safety. *Id.* at 37.

The resident's pattern of falls should have made it evident that whatever interventions were being provided to her were of little benefit. An obvious need existed to assess the resident and to plan additional interventions, including, perhaps, much closer supervision than had been provided, to protect her against falling. However, Petitioner's physical therapy staff did not conduct a falls assessment of Resident # 18 between March 25, 2008 and the May survey, a period of about 13 months. CMS Ex. 1 at 39. Petitioner's staff had recommended providing the resident with a wheelchair for use at all times and providing assistance with ambulation. *Id.* But, these recommendations had not been implemented as of the May survey. The failure of Petitioner's staff to intervene aggressively to protect Resident # 18 was a failure to take all reasonable measures to protect her.

Petitioner argues that it implemented multiple interventions to protect Resident # 18. According to Petitioner, these interventions included: numerous interventions that were attempted prior to December 2007; physical therapy; prescribing medication to treat dizziness; involving the resident in activities; and discussing issues of personal safety with the resident. Petitioner's Final Brief at 22-24.

But, Petitioner does not deny that it failed to implement any new interventions after September 1, 2008 with the exception of adjusting her medication for dizziness. CMS Ex. 1 at 39; Petitioner's Final Brief at 22-24. Nor does it deny that it failed to implement the staff's recommendation that the resident be given increased assistance with ambulation. Indeed, it is clear that the one thing that Petitioner never seems to have considered in providing care to Resident # 18 is that, as was the case with other residents, this resident needed close personal supervision and companionship to assure that she did not fall.

Petitioner argues that this is a case of a mentally-competent resident asserting her desire to remain independent. As Petitioner frames it, the resident had a right to assume certain risks, even if her refusal to accept assistance from Petitioner's staff was inadvisable. I do not find this to be a persuasive statement of the issue. It may be that Resident # 18 was within her rights to refuse certain forms of treatment or protection. But, Petitioner has offered no evidence to show that its staff offered Resident # 18 increased personal assistance and supervision and that she refused this offer.[4]

e. Resident # 19

Resident # 19 is an individual who sustained at least 10 falls while residing at Petitioner's facility. These falls included falls that the resident sustained on April 6 and 17, 2009. CMS Ex. 1 at 39-40. On both of these occasions, the resident fell after leaving her bed unobserved. Petitioner's staff had placed a pressure alarm in the resident's bed to sound a warning when the resident attempted to leave the bed unassisted. However, the alarm failed to function when the April 6 and 17 falls occurred. *Id.*

Petitioner acknowledges that the pressure alarm did not work at the time of the April 6 and 17 falls. Petitioner asserts that this failure does not support a finding of noncompliance. According to Petitioner, its staff checked the resident's alarm regularly to assure that it functioned properly. The problem, according to Petitioner, was that Resident # 19:

[4] Petitioner avers that, since the May survey, Resident # 18 has been restrained in a wheelchair with a Posey belt and that the resident has deteriorated physically and mentally as a consequence. Petitioner's Final Brief at 24. Its unstated assertion is that the Tennessee State survey agency, or CMS, forced Petitioner to implement this intervention. However, neither of these two agencies forced this choice on Petitioner. As I discuss above, the failure of Petitioner in the case of Resident # 18 was not that it failed to restrain the resident but that it failed to offer the resident increased assistance and supervision as a falls protection measure.

> had learned to unhook alarms. . . She previously had worn a pull alarm, but she had figured out how to unhook it. She would hide the alarm under her pillow, take the batteries out of the alarm and put the back of the alarm on again, and pull the alarm cord out of the end and break it so it would not sound. It is not surprising that she broke the end of her cord off since she had [done] that before . . . After . . . [Resident # 19] was switched to the pressure alarm, these behaviors improved somewhat. However she still tries to find ways to avoid the alarm going off . . . These alarms are very fragile and even without tampering, need to be replaced regularly. In both the April 6 and the April 17 instances, the alarm had been checked within the prior week and was working the morning after the incident.

Petitioner's Final Brief at 25-26 (citations omitted).

These contentions do not support Petitioner. Rather, they show how Petitioner was deficient in providing care to Resident # 19. Relying on an alarm to alert the staff about potentially hazardous behavior (in this instance, leaving bed unattended) makes no sense if it is known that the resident has a propensity and ability for disabling the alarm. The alarm was inherently unreliable in that event. Yet, Petitioner's staff continued to rely on it without considering whether other interventions, such as closer supervision of the resident or more frequent bed checks, might be needed. That is a failure to provide all reasonable measures to protect the resident.

f. Resident # 22

Resident # 22, like the other residents whose care I address in this decision, is prone to falling. Petitioner's staff equipped the resident with both a bed and a body alarm. On April 7, 2009, the resident was found lying on the floor of his room. He had attempted to leave his bed unassisted. The bed alarm did not sound, because it was not equipped with a battery. The body alarm did not sound, because the resident had removed his gown with the alarm attached to it. CMS Ex. 1 at 42.

Petitioner's staff knew that the resident's bed alarm was ineffective. The resident is a large individual and, apparently, would trigger the bed alarm even in situations when he was not attempting to leave his bed unaided. Petitioner's Brief at 26-27. The staff's purpose in supplying the resident with a body alarm was to provide him with an alarm in lieu of, and not as a supplement to, his bed alarm.

Given that, it was absolutely necessary that the resident's body alarm function flawlessly. The staff was, after all, using it as a substitute for keeping the resident under observation or, at least, from checking on the resident more frequently. The fact that the staff knew that the resident could disable his body alarm put them on notice that this device was not an effective substitute for the bed alarm. Failure to address that problem was a failure by

Petitioner's staff to take all reasonable measures to protect Resident # 22. And, as was the case with other residents, Petitioner's staff never considered closer observation of Resident # 22 as an intervention.

g. Resident # 25

Resident # 25 is an individual who is prone to falling. In February 2009, Petitioner's staff assessed this resident as being at high risk for sustaining falls. CMS Ex. 1 at 43. In fact, the resident sustained several falls while at Petitioner's facility. The resident fell on: November 16 or 17, 2008; January 17, 2009; March 25, 2009; and April 10, 23, and 28, 2009. After the resident sustained a fall in November 2008, a nurse recommended that the resident be given a safety device (presumably an alarm). However, the recommendation was never implemented, notwithstanding the several falls that the resident experienced subsequently. *Id.* at 44.

Failure to equip this resident with an alarm – or to develop alternative interventions that effectively protected the resident against falling – was an obvious failure by Petitioner to comply with regulatory requirements. A member of Petitioner's staff had assessed the resident as needing an alarm. That, obviously, was intended to compensate for the staff's not keeping the resident under closer observation. In effect, it was determined that either the resident needed to be observed more closely or that the resident needed to wear an alarm so that staff could be summoned on very short notice if the resident attempted to do something that was unsafe. Failing to equip the resident with the alarm and not compensating for that failure with increased observation meant that the staff was leaving the resident unprotected.

Petitioner argues that its management had determined at various times that a body alarm would be counterproductive for this resident. Petitioner's Final Brief at 28-29. But, if that was so, that was not a license for Petitioner to leave the resident unprotected. If Petitioner decided – for whatever reason – not to equip the resident with an alarm, it then had to confront the reality that the resident was continuing to fall while unobserved by Petitioner's staff and deal with that reality. The obvious substitute for the alarm was heightened observation and supervision of the resident, an intervention that Petitioner neither considered nor implemented.

h. Resident # 1

The facts pertaining to Resident # 1 differ somewhat from the pattern of facts pertaining to other residents whose care I have discussed. This is not a case of a failure by Petitioner's staff to develop effective interventions to protect a resident against falling. Rather, it is a failure by Petitioner's staff to implement an intervention.

Resident # 1 is an individual who was assessed by Petitioner's staff as being totally dependent on the staff for mobility, transfer, and for all activities of daily living. CMS Ex. 1 at 26; CMS Ex. 16 at 40. A physician's order had been issued directing that a mechanical lift be used for all transfers of Resident # 1. CMS Ex. 16 at 101. In fact, Petitioner's staff seldom used the lift to transfer the resident. CMS Ex. 1 at 29-30; CMS Ex. 16 at 4. On October 9, 2008, the resident sustained a fractured left femur, when two of Petitioner's staff transferred the resident without using the mechanical lift. CMS Ex. 1 at 30-31; CMS Ex. 16 at 5-18.

The failure to follow a physician's order and to employ a mechanical lift to transfer Resident # 1 was a patent violation of the facility's duty to implement reasonable measures to protect Resident # 1. The staff had no discretion here, it was obligated to carry out the resident's physician's order. Their failure to do so caused the resident to sustain a serious injury.

Petitioner does not deny the facts that CMS contends. It argues, however, that it undertook immediate corrective action following the incident on October 9, 2008 and that it completed its corrections by October 23, 2008. Therefore, according to Petitioner, it self-corrected the deficiency after only two weeks.

I discuss the duration of Petitioner's noncompliance at Finding # 3 of this decision. It is sufficient for me to say here that the facts that Petitioner alleged – even if they may show correction of deficient care after the fact – are no defense to CMS's allegations of noncompliance. What is unchallenged is that Petitioner's staff failed to carry out a physician's explicit order and, so, caused Resident # 1 to sustain a serious injury.

2. CMS's determination of immediate jeopardy level noncompliance is not clearly erroneous.

The evidence in this case strongly supports a finding of immediate jeopardy level noncompliance by Petitioner with the requirements of 42 C.F.R. § 483.25(h). There was a very high likelihood of harm to Petitioner's residents that Petitioner's failure to provide them with all reasonable support and assistance to prevent accidents caused.

Petitioner's noncompliance actually caused residents to sustain serious injuries. Resident # 1, for example, sustained a broken femur as a consequence of Petitioner's staff's failure to follow an explicit physician's order governing transfer of the resident. Furthermore, the likelihood of serious injury to falls and other accident prone residents was quite high. A pattern exists in this case of failure by Petitioner and its staff to seek out and implement all reasonable measures designed to protect residents. That left the residents vulnerable to injuries or worse.

3. The evidence supports a finding of immediate jeopardy level noncompliance from at least October 9, 2008 through May 29, 2009.

The evidence in this case unequivocally proves that Petitioner manifested immediate jeopardy level noncompliance with the requirements of 42 C.F.R. § 483.25(h), beginning well before October 9, 2008 and continuing through May 29, 2009. CMS found that immediate jeopardy level noncompliance commenced on October 9, 2008, the date when Resident # 1 sustained a fractured femur as a consequence of her being transferred by Petitioner's staff in violation of a physician's order that she be transferred only with the assistance of a mechanical lift. In fact, immediate jeopardy began months before that, with the failure of Petitioner's staff to address the falls risk of Resident # 5. A persistent pattern of immediate jeopardy level noncompliance existed thereafter, as is evidenced by the care that Petitioner gave to Residents #s 15, 16, 18, 19, 22, and 25.

Furthermore, Petitioner has not shown that it corrected its immediate jeopardy level noncompliance prior to May 29, 2009. It asserts that it self-corrected the noncompliance as respects Resident # 1 within two weeks of the resident's October 9, 2008 fall. But, those corrective measures – which focused on assuring that staff carried out physicians' orders for resident transfers – did not address the broader problem of Petitioner's failure to develop and implement reasonable measures for protecting residents against accidents and falls in particular.

Petitioner argues strenuously that immediate jeopardy level noncompliance may not be found for the entire October 9, 2008 – May 29, 2009 period, because the Tennessee State survey agency allegedly did not follow proper protocol and survey procedures in investigating allegations of noncompliance, particularly as respects the care that Petitioner gave to Residents #s 1 and 5. Petitioner argues also that inconsistencies existed in the surveyors' findings and that the individuals who were involved in surveying Petitioner's facility had an inadequate understanding of how Petitioner operated. Petitioner's Final Brief at 34-36. However and Petitioner's arguments notwithstanding, this case is not in any sense a review of the propriety of a State survey agency's actions. It is a de novo hearing in which I decide based solely on the evidence relevant to Petitioner's compliance whether Petitioner complied with participation requirements. The objective evidence in this case overwhelmingly supports my findings of noncompliance, scope and severity, and duration.

4. Civil money penalties of $3,050 and $150 per day are reasonable.

CMS determined to impose civil money penalties of $3,050 per day for each day of Petitioner's immediate jeopardy level noncompliance. That is the *minimum* immediate jeopardy penalty amount that the regulations allow. 42 C.F.R. § 488.438(a)(1)(i). I do not have the authority to impose a penalty of less than $3,050 per day to remedy

immediate jeopardy level noncompliance. CMS's determination is therefore reasonable as a matter of law.[5]

Petitioner argues that the penalty amount is unreasonable, citing a variety of reasons. However, and as I have stated, I have no discretion to go below $3,050 per day.

Penalties of $3,050 per day may be imposed against Petitioner for each day of its immediate jeopardy level noncompliance through May 29, 2009. However, although I have found that Petitioner's immediate jeopardy level noncompliance began on October 9, 2008 (and, in fact, at least several months prior to that date), I do not establish a beginning date for the imposition of the $3,050 per day penalties.

42 C.F.R. § 488.430(b) governs the beginning point for imposition of civil money penalties in any case:

> CMS or the State may impose a civil money penalty for the number of days of past noncompliance since the last standard survey, including the number of days of immediate jeopardy.

This regulation plainly says that penalties may be imposed for past noncompliance only as far back as the date of the last standard survey of a facility. That is true even if the actual noncompliance – including immediate jeopardy level noncompliance – originated on a date that is earlier than the date of the last standard survey. The last standard survey date is thus a cut off of the dates when civil money penalties for past noncompliance may be imposed. *North Ridge Care Ctr.*, DAB No. 1857 (2002).

Petitioner argues that the standard survey that was made of its facility prior to the May survey took place on February 26, 2009. If Petitioner is correct, then, arguably, no civil money penalties for past noncompliance may be imposed for days prior to February 27, 2009, even though immediate jeopardy level noncompliance persisted at Petitioner's facility beginning on at least October 9, 2008. CMS filed no arguments or evidence challenging Petitioner's assertion.

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[5] This is also why I do not address the other two immediate jeopardy level noncompliance findings that CMS made. CMS has not asked for penalties of more than the minimum immediate jeopardy level amount. Finding additional instances of immediate jeopardy level noncompliance are simply unnecessary as support for the minimum penalty. Also, the possible absence of additional noncompliance at the immediate jeopardy level would under no circumstance support a penalty amount of less than $3,050 per day.

I am not in a position as of this time to decide what would be the cut off date for imposition of past penalties. I am, accordingly, remanding the case to CMS so that it may make a determination as to when the last standard survey was completed of Petitioner's facility. If that date is February 26, 2009, then immediate jeopardy level penalties would begin to run on February 27, 2009. If, however, the date is earlier than February 26, then that date would control except that in no event will penalties be imposed for dates beginning earlier than October 9, 2008.

As I note in the Background to this decision, Petitioner offered no evidence or argument concerning the non-immediate jeopardy level deficiencies that were found at the May survey. Therefore, penalties of $150 per day for each day of the period running from May 30 through June 6, 2009 are reasonable as a matter of law.

/s/
Steven T. Kessel
Administrative Law Judge