Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Hillcrest Healthcare Center,	)	Date: March 19, 2007
	)	
Petitioner,	)	Docket Nos. C-01-754
	)	C-01-814
- v. -	)	Decision No. CR1579
	)	
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

Hillcrest Healthcare Center (Hillcrest) is an intermediate care facility located in Joliet, Illinois that is certified to participate in the Medicare and Medicaid programs as a provider of services. For reasons set forth below, I conclude that from May 14, 2001 through August 30, 2001, Hillcrest was out of substantial compliance with Medicare program participation requirements. I find reasonable and affirm the per instance civil monetary penalty (CMP) in the amount of $10,000, and the denial of payment of new admissions (DPNA) for residents admitted from May 14, 2001 through August 30, 2001. However, I do not find reasonable Centers for Medicare & Medicaid's (CMS) imposition of a $200 per day CMP from June 6, 2001 through August 30, 2001; rather, I find a $100 per day CMP for that time period to be reasonable.

I. Background

Hillcrest was surveyed for compliance with federal participation requirements by surveyors employed by the Illinois Department of Public Health (IDPH) on April 19, 2001 (April Survey); June 6, 2001 (June Survey); and August 30, 2001 (August Survey).

The April Survey resulted in deficiencies related to participation requirements under 42 C.F.R. §§ 483.25(h)(2) (Quality of Care) at level K; 483.15(a) (Quality of Life) at level B;[1] 483.20(k) (Resident Assessment) at level E; 483.45(a)(1) and (2) (Specialized Rehabilitative Services) at level E; and 483.75 (Administration) at level F. By notice letters dated May 8, 2001, June 21, 2001, and June 29, 2001, CMS informed Hillcrest that it would be imposing remedies which included a DPNA as of May 14, 2001, and, based on the immediate jeopardy finding related to the quality of care deficiency, a $10,000 per instance CMP.

The June Survey resulted in deficiencies related to participation requirements under 42 C.F.R. §§ 483.20(k) (Resident Assessment), a repeat deficiency at level D, and 483.25(h)(2) (Quality of Care), a repeat deficiency at level G. By notice letters dated June 29, 2001 and September 20, 2001, CMS advised Hillcrest that it would be imposing a $200 per day CMP for 91 days, from June 6, 2001 until September 4, 2001,[2] when Hillcrest was determined to have achieved substantial compliance with participation requirements. Additionally, because Hillcrest was subject to an extended or partial extended survey as the result of a substandard quality of care finding, CMS prohibited continued approval of any nurse aide training and competency evaluation program (NATCEP) for a two-year period beginning April 19, 2001.

Hillcrest requested a hearing by letter dated June 12, 2001, to challenge CMS's findings and remedies related to the April Survey. The request was docketed as C-01-754, and assigned to me for hearing and decision. On July 2, 2001, Hillcrest requested a hearing to challenge CMS's adverse actions related to the June Survey. The request was docketed as C-01-814, and assigned to me for hearing and decision. On September 10, 2001, I granted CMS's unopposed motion to consolidate the two cases, which were consolidated into the record of Docket No. C-01-754.

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[1] Because neither CMS nor Petitioner addressed the deficiency at 42 C.F.R. § 483.15(a), which was listed in the April Statement of Deficiencies (SOD), I do not include the deficiency in my discussion and analysis. CMS Ex. 1, at 1-2.

[2] As previously noted, Petitioner underwent an August Survey which resulted in a third SOD. A deficiency related to participation requirement 42 C.F.R. § 483.25 (Quality of Life) was found, and CMS continued the imposition of the $200 per day CMP from August 31, 2001 through September 4, 2001, when Hillcrest was found to have achieved substantial compliance. Hillcrest chose not to appeal the August Survey findings and remedy. Therefore, my review is limited to the findings and subsequent remedies relating to the April Survey and the June Survey only. I do not address the continuation of the $200 per day CMP through September 4, 2001.

The hearing was convened in Chicago, Illinois from January 12-16, 2004, and reconvened to continue with witness testimony from March 1-4, 2004. During the course of the hearing, the following exhibits were admitted: CMS exhibits (Exs.) 1-33,[3] 401-423, 600-622, Supplemental Ex. 1, Supplemental Ex. 2;[4] and Petitioner's exhibits (P. Exs.) 1-53, 55-58, 60-62.[5] Transcript (Tr.) at 21, 26.

During the course of the hearing, CMS proffered CMS Ex. 623 (Tr. at 1187), a three-page document obtained from the website www.behavenet.com and identified as *BehaveNet Clinical Capsule: DSM-4 and DSM-4TR: Intermittent Explosive Disorder (IED).* Hillcrest objected to the admission of the exhibit on the basis that there is considerable controversy within the field of psychology considering the legitimacy of the DSM-4 and DSM-4TR classifications. The parties were advised that I would rule on the admissibility of CMS Ex. 623 after I had an opportunity to review the complete record in this matter. Taking into consideration the parties' arguments, CMS Ex. 623 is admitted into evidence for the limited purpose of establishing that CMS Ex. 623 confirms the testimony on cross-examination of CMS's expert witness Dr. Suzanne Perraud, and not as a document which is conclusive as to the DSM-4 and DSM-4TR classifications as they relate to issues of violent behavior diagnosis or prediction.

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[3] During the course of the hearing, Hillcrest objected to the admission of CMS Ex. 5, to the extent that it reflects subsequent remedial measures. The objection was overruled and CMS Ex. 5 was admitted. I note that evidence of subsequent remedial measures is inadmissible to prove negligence or culpable conduct (Fed. R. Evid. 407), but is not necessarily inadmissible when offered for other purposes, as long as the evidence is relevant and its probative value outweighs any danger associated with its admission. *See Fairfax Nursing Home, Inc.*, DAB No. 1794, at 8-9 (2001); *Anderson v. Malloy*, 700 F.2d 1208 (8th Cir. March 9, 1983); Fed R. Evid. 402, 403.

[4] Pages 2-22 of CMS Ex. 422 were stricken from the record as they relate to a series of incident reports for residents whose care is not at issue in either the April Survey or June Survey findings (Tr. at 15, 19-20). Pages 1 and 2 were stricken from CMS Ex. 613 as they were attached in error. Additionally, CMS Exs. 800-816 were not admitted as they relate to the August Survey which, as previously noted, is not part of these proceedings and whose findings and remedies are not being contested by Petitioner. Tr. at 14, 15. At hearing, CMS did not proffer for admission into the record exhibits numbered 34-400 and 424-599.

[5] P. Ex. 54, an affidavit of a witness who was not available for cross-examination at the hearing, was withdrawn by Petitioner. Also, P. Ex. 59 was excluded based on my ruling of January 9, 2004. Tr. at 21, 25-26.

Five IDPH surveyors testified for CMS: Susan Pettenger; Daniel Pletcher; Elaine Moore; Steven Mott; and William Schubert. Also testifying for CMS was expert witness Suzanne Perraud, R.N., Ph.D.[6] Hillcrest presented the testimony of ten witnesses: Michael Mutterer, former Clinical Director; Jeff Kalkowski, former Administrator; Mary Locicero, registered nurse (R.N.); Llanie Jurilla, former R.N., Ellen Tierney, Director of Nursing (DON); Jeff Baker, Psychiatric Technician; Najat Williams, former Clinical Supervisor at time of the surveys and current Clinical Director; Brenna Costello, former Clinical Director; and expert witnesses Gershon H. Kaplan, M.D. and Maureen Lacy, PsyD.

The parties were provided with a copy of the certified transcript and no prejudicial errors were noted. CMS's post-hearing brief (CMS PHB) was received on July 20, 2004, and its reply brief was received on November 15, 2004. Petitioner's PHB (P. PHB) was received on October 12, 2004. Petitioner's motion requesting leave to file a sur-reply, dated January 7, 2005, was denied on January 14, 2005. *See* Summary of Telephone Conference: Ruling Denying Petitioner's Motion and Order Closing Record, issued January 21, 2005.

This decision is based on the complete record which includes the parties' arguments, submissions, all exhibits admitted into the record, and the witness testimony adduced during the hearing.[7]

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[6] During the course of the hearing, I qualified Dr. Perraud as an expert in nursing science based on information proffered that she holds a Ph.D. in nursing science and is a licensed R.N. Tr. at 1014, 1015, 1017, 1021, 1022, 1034. During the hearing, and again on April 20, 2004, Petitioner moved that I disqualify Dr. Perraud as a witness and strike her full or partial testimony from the hearing transcript. I denied Petitioner's motion to strike Dr. Perraud's testimony in full or in part. *See* Ruling on Motion to Strike Expert Testimony and Order for Post-Hearing Briefing Schedule, issued May 20, 2004.

[7] The transcript for the nine-day hearing totaled 2625 pages. CMS submitted its PHB totaling 208 pages and a reply brief of 118 pages. Petitioner's PHB was 94 pages with two appendixes totaling 18 pages. I note that it was the parties' responsibility in this proceeding to provide me with the support for the arguments that they want me to accept. Given this, it was my expectation that the parties would provide me with not just a detailed "road map" of their arguments, but a coherent explanation of why - including **accurate** citations to testimony, case law, relevant statutory and regulatory references, and any other references the parties were using to support their arguments. In the submissions of both parties, I found many instances of incorrect citations to exhibits and the transcript.

Preliminary Matters

Before reaching the merits of the dispute, I first address the notice and constitutional arguments which Hillcrest presented during these proceedings. Hillcrest argues that the appeal rights contained in the regulation at 42 C.F.R. § 498.3 exceed the scope of the statutory and regulatory authority of the Secretary of Health and Human Services (Secretary) and are an unconstitutional infringement on a facility's substantive and procedural due process rights. Additionally Hillcrest avers that CMS's interpretive guidelines, program letters, and survey and enforcement policies are invalid because they have not been promulgated pursuant to the Administrative Procedures Act (APA).

While I have the authority to decide how the regulations apply to the facts, however, it is outside my jurisdiction to decide whether CMS or the Secretary failed to publish a rule in violation of the APA. In cases involving CMS, my authority is limited to that delegated to me by the Secretary and as described in 42 C.F.R. §§ 498.3 and 498.5. Although it is well-settled that I do not have the authority to address any arguments regarding the constitutionality of the law, Hillcrest's arguments have been properly preserved for the record. *See Mariner Health Home Care of South West*, DAB CR980 (2002), *citing Lauderhill Community Mental Health Center*, DAB CR652 (2000); *Heart Place Hospital, L.P.*, DAB CR1014 (2003); *Salvacion Lee, M.D.*, DAB CR920 (2002), *aff'd*, DAB No. 1850 (2002); and *Sentinel Medical Laboratories, Inc.*, DAB No. 1762, at 9 (2001).

Lastly, I address Hillcrest's assertion that certain of CMS's allegations are improper and should be barred from consideration since they were not specifically listed in the SODs and were raised by CMS for the first time at hearing and/or in its PHB. P. PHB at A-1 through A-14. Hillcrest pointed to no authority for its view that CMS is strictly constrained by the allegations in the SODs, and decisions from appellate panels of the Departmental Appeals Board (Board) have held to the contrary. In *Pacific Regency Arvin*, the Board found prejudicial error when an administrative law judge (ALJ) appeared to treat the SOD as rigidly framing the scope of admissible evidence concerning any allegation relating to a cited deficiency and required formal amendment of the SOD as a prerequisite to allowing any additional supporting evidence:

> The [SOD] is a notice document, and is not designed to lay out every single detail in support of a finding that a violation has been committed. If the opposite were the case, there would not be much of a need for an exchange of documents or, for that matter, a hearing. This approach is consistent with the intention of the regulations governing surveys as embodied in this exchange from the preamble to the regulations –

> Some commentators further suggested that the facility should be provided with full information that supports each citation and the survey agency's decisions including the underlying reason, basis or rationale for the findings of noncompliance with a regulatory requirement.
>
> Response: We are not accepting this suggestion because we believe that the Statement of Deficiencies and Plan of Correction (HCFA-2567) provides facilities with the specific information necessary to formulate an acceptable plan of correction. To include such detailed information regarding deficiencies in the notice of noncompliance would be duplicative and administratively burdensome. 59 Fed. Reg. 56,116, at 56, 155 [November 10, 2004].

Pacific Regency Arvin, DAB No. 1823, at 9-10 (2002).

In applying the Board's logic in *Pacific Regency Arvin*, I find that here, CMS has not added any new deficiency findings. Rather, CMS merely refers to further evidence which supports the conclusions in the SOD. *See also Northern Montana Care Center*, DAB No. 1930, at 26 (2004) ("The statement of deficiencies does not rigidly frame the scope of evidence to be admitted concerning any allegation relating to a cited deficiency, nor does it require formal amendment to allow additional supporting evidence.") I find that CMS's prehearing filings provided Hillcrest with ample notice of the issues and deficiencies in this case. Therefore, Hillcrest's assertion of inadequate notice fails.

II. Issues

The issues in this case are whether a sufficient basis existed for CMS to impose its remedies for the April Survey and June Survey and, if so, are they reasonable.

III. Applicable Law

Long-term care providers, such as Hillcrest, participate in the Medicare program by entering into provider agreements with the United States Department of Health and Human Services (HHS). Requirements of participation are imposed by statute and regulation. Social Security Act (Act), §§ 1819, 1919; 42 C.F.R. Parts 483, 488, and 489. In order to continue participation in the Medicare program, providers must remain in 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.

If a facility is not in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, which include imposing a CMP. Act § 1819(h). CMS may impose a CMP for the number of days that the facility is not in substantial compliance with one or more program requirements or for each instance that a facility is not in substantial compliance. 42 C.F.R. §§ 488.430(a), 488.440.

The regulations specify that a per day CMP imposed against a provider will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMPs, from $3,050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). The lower range of CMPs, from $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). There is only a single range of $1,000 to $10,000 for a per-instance CMP, which applies whether or not immediate jeopardy is present. *See* 42 C.F.R. § 488.438(a)(2). An ALJ may not reduce a penalty to zero if the ALJ finds a basis for imposing a CMP exists. 42 C.F.R. § 488.438(e).

IV. Burden of Proof

When a penalty is imposed and appealed, CMS must establish a prima facie case that the facility was not in substantial compliance with federal participation requirements. To prevail, the facility must overcome CMS's showing by a preponderance of the evidence.[8] *Emerald Oaks*, DAB No. 1800, at 4 (2001); *Cross Creek Health Care Center*, DAB No. 1665 (1998), applying *Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd, Hillman Rehabilitation Center v. HHS*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999). I adopt the burden as set forth in the Board's decision in the *Hillman* case, and as stated and discussed in detail in the *Batavia Nursing and Convalescent Center* and

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[8] By motion filed September 15, 2003, Hillcrest moved for an order stating that CMS had the burden of going forward and the burden of persuasion at the hearing for all issues except for affirmative defenses and mitigation circumstances asserted by Hillcrest. By an earlier order issued March 25, 2003, I had ruled that the burden of proof would be allocated pursuant to *Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd Hillman Rehabilitation Center v. HHS*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999). And, by order issued January 22, 2004, I directed Hillcrest to reassert its burden of proof argument in its PHB, which it did. P. PHB at 3-5. I have sufficiently addressed Hillcrest's argument in my ruling and orders of March 25, 2003 and January 22, 2004, and do not need to repeat my ruling here. However, I note that Hillcrest has properly preserved its argument for the record.

Batavia Nursing and Convalescent Inn cases. *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004); and *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004).

V. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision in this case. However, I do not make a Finding on every deficiency in controversy during these proceedings. Specifically, I discuss only those deficiency citations that have been assessed to support the noncompliance and the remedies imposed.[9]

The Board has previously approved an ALJ's discretion to exercise judicial economy and not discuss every alleged deficiency. *Beechwood Sanitarium*, DAB No. 1824 (2002), at 22; *Beechwood Sanitarium*, DAB No. 1906 (2004). Substantial noncompliance with only one participation requirement can support the imposition of a penalty. *Beechwood Sanitarium,* DAB No. 1824. My analysis and Findings are first presented for the April Survey followed by the Findings for the June Survey.

VI. April Survey

Incident Which Precipitated the April Survey

The April Survey was conducted after IDPH received two complaints relating to a homicide of a private citizen on March 22, 2001 by several residents of Hillcrest. CMS Ex. 1, at 1. A subsequent police investigation revealed that two residents of Hillcrest, R4 and R5, committed crimes of home invasion, robbery, and homicide at an apartment complex four miles from Hillcrest. CMS Ex. 414.[10]

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[9] I note that for deficiency tag F490, Administration, the April SOD alleges citations concerning Residents (R)39, R40, and R41. CMS Ex. 1, at 22, 24-25. However, CMS did not present evidence to support these allegations either at hearing or in its post-hearing submissions. Although I do not address these allegations in my discussion, the unsupported allegations relative to R39, R40, and R41 have been factored into my review, as appropriate, concerning the reasonableness of the penalties imposed by CMS.

[10] CMS Ex. 414 consists of the Joliet Illinois Police report dated March 23, 2001. The exhibit includes interviews with residents R3 and R6 on March 23, 2001; the Grand Jury Indictment; and the conviction document for R4.

A chronology of the events which occurred on March 22, 2001 reveals that R4, R5, and R6 signed out of Hillcrest at 9:10 a.m. CMS Exs. 402, at 69; 403, at 48; 404, at 57. Each resident indicated on his sign-out sheet that he was going to the store. *Id.* R4, R5, and R6 then proceeded to drive around in a car R3 kept at the facility. CMS Ex. 414, at 8, 12; P. PHB at A-1. That afternoon, R4, R5, and R6 returned to pick up R3, who had signed out of the facility at 1:30 p.m. indicating that she would be going to the store and mall. CMS Exs. 401, at 61; 414 at 8, 15. All four residents then proceeded to drink while driving throughout the Joliet, Illinois area. CMS Ex. 414, at 8-9, 12-13. According to the police report, R4 stated to the other residents in the car that he knew where a party was being held and the four residents then proceeded to drive to the crime scene apartment where R4 and R5 left R3 and R6 in the car. *Id.* R4 and R5 entered one of the units, robbed the tenant and then murdered him. *Id.* They returned to R3's car, carrying compact discs, placed the compact discs in the car trunk and returned to the apartment subsequently retrieving more compact discs and a toolbox. *Id.* Once in the vehicle, R4 and R5 informed R3 and R6 what had occurred inside the apartment. *Id.* at 9. All four residents then drove for a while, stopped at a forest reserve to drink beer and then returned to Hillcrest. *Id.* Upon their return, R4 attempted to sign all four residents back in, but Hillcrest staff went out to the parking lot to locate the other residents. CMS Ex. 410, at 6. According to the facility sign-in sheets, all four residents returned to Hillcrest sometime between 9:45-9:55 p.m. that evening. CMS Exs. 401, at 61; 402, at 69; 403, at 48; and 404, at 57.

Once at the facility, Hillcrest staff observed that R4 had "bloody knuckles, and his pants were covered in blood from approximately halfway down from his knees including bloody hand-prints." CMS Ex. 414, at 9. That evening, R4 subsequently became involved in a verbal altercation at Hillcrest with another resident. CMS Ex. 402, at 73. He was unresponsive to staff redirection and continued to verbalize threatening words to peers. *Id.* R5 was reported to have admitted to drinking and was noted to have a scratch on his forehead and a cut on his chest. CMS Ex. 414, at 13, 16. The former Administrator for Hillcrest, Jeff Kalkowski, testified that he was informed by staff that evening that the four residents "appeared to be drunk and out of their usual selves for the most part." Tr. at 1357.

R4 and R5 presented several different explanations to various staff at Hillcrest to justify their injuries. R4 first indicated that he had run into a brick wall, but then stated that he had been in a bar fight, only to report later that he had tripped and fallen on the ground. CMS Exs. 410, at 6; 408, at 7, 8; 411, at 5, 12. R5 claimed that his injuries were due to both he and R4 goofing around in a fighting manner. CMS 411, at 13.

On the evening of March 22, R4 left Hillcrest after he heard from staff that the police had been called. CMS Ex. 414, at 9-10. R4 and R5 were subsequently arrested, charged and indicted for the homicide and robbery. CMS Ex. 414, at 20-25. R4 pled guilty to first degree murder and was sentenced to 45 years in the Illinois Department of Corrections. *Id.* at 36-37. R5 later also pled guilty to the charges.[11] On March 23, 2001, both R3 and R6 were transferred to hospitals as a result of a "change in mood due to a traumatic event of the past 24 hours." CMS Exs. 401, at 65-66; 404, at 62-63.

Neither party disputes the aforementioned events which are mentioned here in order to lay the foundation for the complaint that gave rise to the April Survey and subsequent findings.[12] However, where the parties do disagree is whether: (1) residents' care plans were individualized and behavior triggers were identified in their care plans; (2) residents' use of day passes were properly monitored; and (3) there were contra-indications exhibited by these four residents that should have prompted Hillcrest staff to revoke their daily passes prior to and on March 22, 2001.

A. Hillcrest was out of substantial compliance with the participation requirement at 42 C.F.R. § 483.20(k) - (tag F279, Resident Assessment).[13]

The regulation at section 483.20(k) requires a facility to develop comprehensive care plans including measurable objectives and timetables to meet medical, nursing, and mental and psycho-social needs as identified in the comprehensive assessment. The care plan must describe services furnished to residents in order to attain and maintain their highest practicable physical, mental, and psycho-social well-being. 42 C.F.R. § 483.20(k)(1)(i).

There is no dispute that Hillcrest created care plans for R4, R5, and R6 upon their admission. However, CMS challenges the adequacy of the care plans. CMS asserts that the care plans Hillcrest developed for R4, R5, and R6 were vague and were not individualized, and they did not detail the specific signs, symptoms, or triggers for certain

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[11] At the time of the hearing, R5 was awaiting trial on the charges.

[12] Hillcrest raised objections throughout the proceedings in this matter to any evidence of the homicide being admitted. However, Hillcrest's objections were overruled as I found that the probative value of the evidence outweighs any potential for prejudice to Hillcrest. *See* Summary of Prehearing Telephone Conferences; Rulings; and Order, issued January 22, 2004. I note that Hillcrest's argument has been properly preserved for the record.

[13] Tag F279 was cited as an E-level deficiency indicating there was a pattern that presented no actual harm but had the potential for more than minimal harm that did not amount to immediate jeopardy. *See* State Operations Manual § 7400E.

of the residents' behaviors. CMS PHB at 19-38. The April SOD recites eight pages of findings by IDPH surveyors alleging that the care plans did not meet R4, R5, and R6's individual needs as their care plans did not appropriately address their violent behaviors, depression, social and coping skills, and problems with medication compliance. CMS Ex. 1, at 2-10.

Hillcrest contends that R4's, R5's, and R6's care plans do address their individual needs and specifically warn against their criminal, self-injurious and substance abuse behaviors, and instruct staff on how to avoid and cope with these problems. P. PHB at 65. Hillcrest, however, asserts that a care plan cannot list every possible approach, sign, symptom, cause, or trigger for a resident's behavior; otherwise, the care plan would be too cumbersome. *Id.* at 66. In explaining Hillcrest's view of the development of resident care plans, former Clinical Director Brenna Costello testified that "[t]ypically the initial care plan is a more broad general care plan," and it is later "individualized based on the problem areas that we do know are currently at issue for that resident." Tr. at 2096, 2098. Hillcrest contends that because none of the three residents at issue were at Hillcrest for 90 days, "none of these residents' preliminary care plans received their first quarterly update at the time they were surveyed and therefore may have appeared as rather general and nonspecific." P. PHB at 15.

I find Hillcrest's position regarding its "preliminary" care plan development flawed. The regulatory language is clear when it states that the facility must develop a "comprehensive" care plan. A facility is required to develop the initial comprehensive care plan no later than seven days after it completes the resident's comprehensive assessment and not later than 14 calendar days after the resident has been admitted. 42 C.F.R. § 483.20(k)(2)(i). Additionally, the facility must review and revise the care plan after each further assessment of the resident at least every three months and no later than 14 days after any significant change in a resident's condition. 42 C.F.R. § 483.20(k)(2)(i) - (iii). Therefore, a care plan that is a "general guideline for treatment" and that "outlines general problem areas . . . and treatment approaches" does not meet the individual needs of a resident, nor does it comply with the requirements of the regulation that a care plan be developed for each resident which addresses **all** of that resident's needs. P. PHB at 14; Tr. at 2038, 2039.

Hillcrest argues that it is erroneous for CMS to use residents' pre-admission histories to question the facility's preliminary care planning.[14] According to Hillcrest, R4, R5, and

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[14] CMS provides a detailed discussion of the histories of R3, R4, R5, and R6 prior to their admission to Hillcrest. The information is referenced in this decision only to the extent that is necessary to discuss whether the behaviors at issue should have been identified and addressed in the residents' care plans or whether the care plans were sufficiently comprehensive. CMS

R6 did not re-manifest any of their previous extreme behaviors during their stay at Hillcrest, and, therefore, it was not necessary to have listed them in their preliminary care plans.[15] P. PHB at 14.

Hillcrest is mistaken in its view that it cannot consider pre-admission histories of residents in providing care for them. Also, its contention that the pre-admission behaviors were irrelevant and that there was no harm in excluding them from the care plans as its staff would be able to recognize the behaviors even if they were not care planned is flawed. P. PHB at 62, 65-66. I find that the pre-admission histories of R4, R5, and R6, particularly the history of aggressive and assaultive behaviors, are relevant in determining whether the facility has provided adequate supervision. *See Vandalia Park*, DAB No. 1940, at 17-19 (2004) (facility was cited under tag F324 for its failure to properly supervise residents with troubled backgrounds). With 163 residents placed at Hillcrest during the time period at issue, it is hard to imagine that Hillcrest could presuppose that all of its staff would be intimate with the records of each of the residents and their behaviors, medical conditions, and needs. The regulation at section 483.20 requires that resident assessments and care plans be written, comprehensive, accurate, standardized, and reproducible given that residents are transferred, there is staff turnover, and the memory of past services provided to individual residents can fade.

Additionally, Hillcrest is misguided when it attempts to defend its position that preliminary care plans are general by nature and that it must wait until residents "exhibit their individualized behavioral manifestations over the course of their first quarter at the facility" before it will reflect those behaviors in the care plan. P. PHB at 15, n.1. Hillcrest is required to address its residents' known problems in their initial care plans and not wait for the residents to exhibit the problems at the facility. The care plan serves as a road-map to staff in guiding them as to the needs of the residents they are responsible for and to assist them in implementing appropriate clinical and treatment methodologies to meet the residents' individual needs as identified in their assessments.

PHB at 8-16.

[15] R4 was admitted to Hillcrest on February 8, 2001; R5 on March 1, 2001; R6 on February 15, 2001; and all three residents were discharged on March 23, 2001. I note that none of these residents had received their first quarter update at the time Hillcrest was surveyed in April 2001.

Below, I outline my specific findings and conclusions related to R4's, R5's, and R6's care plans. However, as previously mentioned, it is not necessary that I address each of the survey findings listed by IDPH surveyors in the eight pages of the April SOD. Based upon the record in this case and the parties' arguments, I conclude that IDPH surveyors appropriately found that Hillcrest was out of substantial compliance with the participation requirement at 42 C.F.R. § 483.20(k) for the reasons addressed below.

1. R4's care plan

Hillcrest states that listing every sign, symptom and trigger of behavior in a care plan could cause staff to focus heavily on one specific problem at the expense of others. P. PHB at 16. Rather, according to the testimony of former Clinical Director Costello at hearing, specific signs, symptoms, and triggers are documented in social service and nursing notes, and that "[i]n the social service notes, the counseling sessions indicate what specific behaviors, interventions, treatment approaches were used with a specific resident." Tr. at 2040.

On the subject of the practical application of Hillcrest's position on generalized care plans and the expectation that staff rely on clinical notations in place of a comprehensive care plan, at hearing, former Clinical Director Costello was questioned regarding R4's noted difficulty in decision making, specifically the provision in R4's care plan under "Alteration of Thought Process" (CMS Ex. 402, at 56). Ms. Costello was asked what the provision was meant to address and what decisions R4 had difficulty making. She responded:

> A I would assume that based on the previous line that there's a problem with short-term memory and attention deficit, that he may have had some impulsivity and some difficulty in stressful situations.
>
> Q BY COUNSEL FOR CMS: But in particular what types of decisions do you think he would have difficulty making based on this provision?
>
> A Well, I can't suppose what kind of decision he would have had trouble making.
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> * * *

Q . . . You can't tell from that care plan provision whether he has difficulty deciding which socks to wear in the morning or whether he has difficulty deciding not to hit people, can you?

A No.

Tr. at 2114-15.

Additionally, the provision in R4's care plan relating to his difficulty in making decisions identifies as a goal that R4 "[w]ill have no decrease in level of consciousness or functional level," and instructs staff to "assess change in level of consciousness." CMS Ex. 402, at 56. However, the care plan does not identify for staff how the assessment of consciousness was to be done. At hearing, Ms. Ellen Tierney, DON at Hillcrest who supervised the preparation of care plans, acknowledged that she would have reviewed R4's record from the transferring hospital before his care plan was prepared. She testified that:

Q BY COUNSEL FOR CMS: So any problems that were noted in his records from the transferring hospital you would have known about?

A Yes.

Q And you would have made sure that they were specifically addressed in his care plan?

A And they were.

Tr. at 1735.

However, when asked to look at the entry on R4's care plan under the section of "Potential for criminal behavior" in order to describe what type of criminal behavior R4 was potentially capable of, DON Tierney testified:

A I would have to go back and look specifically at what - - I believe it was theft.

Q Is there something you could refer to that would refresh your memory on what sorts of criminal behavior he had potential for?

* * *

Q If you could look at page 17 [CMS Ex. 402] in the middle there under Legal. . . . Do you see what it says there?

A Incarceration for theft, assault with deadly weapon, battery charges.

Tr. at 1735-36.

Although, one cannot create an exhaustive list of every possible approach, sign, symptom, causes and triggers for each resident, however, one would expect that the most significant specific approaches, signs, symptoms, causes and triggers would be included by Hillcrest in a resident's care plan.

I find Hillcrest's rationale that its preliminary care plans start out as very general and identify broad areas of concern is applicable *only* if the resident is not known to the facility and there is little prior treatment history. However, that is not the case with the residents at issue here as Hillcrest was provided with documents regarding previous and recent treatment prior to admittance, and Hillcrest should have availed itself of these resources in developing the initial care plans for these residents. CMS Exs. 402, at 5-18; 403, at 5-33; 404, at 5-19.

For example, upon R4's admission to Hillcrest on February 8, 2001, a community ability assessment dated October 4, 2000 was available to Hillcrest. CMS Ex. 402, at 7-8. The assessment describes R4 as having markedly abnormal moods, markedly impaired response to stress and anxiety, as being often abusive of drugs and/or alcohol, and frequently exhibiting episodes of extreme acting out. *Id.* On December 13, 2000, R4 had been admitted into the hospital due to suicidal ideation and self-inflected lacerations on his wrist. *Id.* at 30. His social history completed the day after his admission to Hillcrest, notes his tendency toward self-mutilation with depression; his use of heroin and alcohol;[16] his problems with short-term memory; and his attention deficit disorder. *Id.* at 40. He was noted to have problems with impulse control, that he "punch[es] things when frustrated or angry," that he has a history of suicidality, and that he had slit his wrist two or three times and slit his neck twice. *Id.* In addition, he had been convicted twice on gun charges and twice on theft charges. *Id.* at 41. Also noted in the social history was that R4 stated that his attitude toward placement at Hillcrest was that he was "[n]ot happy about it." *Id.* at 42.

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[16] R4's February 9, 2001 social history notes that he had a $70-100 per day heroin addiction and drank 40 ounces of beer nightly. At the time of admission to Hillcrest, R4 self-reported that he had been sober for two months and clean for five months. CMS Ex. 402, at 41.

Additionally, in reviewing the provision of R4's care plan which deals with his "Potential for criminal behavior," I find that it states only that it is related to his current probation status.[17] CMS Ex. 402, at 56. Staff are instructed to "monitor for signs and symptoms of criminal behavior or potential for criminal behavior due to agitation or anxiety." *Id.* However, the "signs and symptoms" are not identified, and as noted at hearing by Hillcrest's DON, Ms. Tierney, it would be difficult for staff to ascertain specifically what type of criminal behavior to look for. Tr. at 1735-36. I find Hillcrest had sufficient information from R4's pre-admission documents to provide a more comprehensive and individualized initial care plan.

2. R5's care plan

R5 was admitted to Hillcrest on March 1, 2001 from an inpatient hospital. His clinical record reveals that he was a 28-year-old male with diagnoses of bipolar affective disorder; manic, severe depression; and attention deficit disorder. CMS Ex. 403, at 1, 22-24, 26, 28. A Notice of Determination, dated February 26, 2001, reveals that the death of R5's mother "set off a cycle of non-compliance with medication and substance abuse." *Id.* at 19. Also noted is that R5 "is not able to deal with stress and reverts to depression and substance abuse." *Id.* at 20. R5's social history, dated March 2, 2001, notes a history of cocaine, LSD, marijuana, PCP, and alcohol abuse, and that R5 had been sober for one week prior to admission to Hillcrest, and clean from drug use for two months prior to admission. *Id.* at 27. R5 had been admitted to the transferring inpatient hospital on February 21, 2001 for acute suicidality due to severe depression and noncompliance with his medication. *Id.* at 5, 8. The hospital admitting report, dated February 21, 2001, and recorded seven days before his admission to Hillcrest, further reveals that R5 had "stopped taking his medications and began decompensating rapidly . . . and that "[h]e began feeling severely depressed, sad, suicidal." *Id.* at 8. R5 had previously been reported as overdosing on pills several times and had cut the veins in his elbows in August 2000. *Id.* at 26.

The provision in R5's March 23, 2001 care plan addressing his "Potential for Ineffective Individual Coping" states that this problem is manifested when he cannot meet his own needs. CMS Ex. 403, at 59. Staff instructions include: reduce stimulation, encourage support system use and record episodes of depression, involve resident in planning, encourage self care, praise accomplishment, uninterrupted 1:1 visits when depressed, encourage R5 to attend Coping Session 2-3 times weekly, allow him to ventilate, teach relaxation techniques, and involve his family. *Id.*

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[17] An August 12, 2000 Psychosocial/Environmental Assessment from the transferring inpatient hospital states that R4 was incarcerated from July 1, 2000 through August 3, 2000, due to a probation violation, and that he was on probation until 2002. CMS Ex. 402, at 6.

At hearing, Surveyor Susan Pettenger testified that staff were instructed to refer R5 to social services as needed when he exhibited certain signs, however, she stated specifically that "you're not going to refer him if you don't know what the signs are." Tr. at 122. Ms. Pettenger further stated that the care plan does not describe R5's support system and therefore questioned the staff's ability to know what supports R5 should be encouraged to use. *Id.* In reviewing R5's care plan, I find that the instruction to staff which states "encourage support system use" does not provide sufficient information for staff to know what his support systems were. CMS Ex. 403, at 59.

The provision addressing R5's "Poor Affect Management" states that his poor affect management problem is related to his bi-polar disorder and is manifested by severe mood swings, impulsive behavior, attention-seeking behavior, self-injurious behavior, and threats of violence. CMS Ex. 403, at 60. Staff were instructed to: encourage compliance with medications, monitor for signs and symptoms of increased anger, anxiety, depression, and decreased impulse control; allow R5 to vent and process stressful situations; teach alternative ways to express feelings; encourage attendance in therapeutic group activities; teach relaxation and anger management techniques; increase 1:1 contact during periods of stress; and encourage R5 to seek nursing intervention for evaluation of the need for PRN (as needed) medications as ordered by his medical doctor. CMS Ex. 403, at 60.

During the hearing, DON Tierney was asked to look at R5's plan of care, specifically the provision addressing R5's "Poor Affect Management. " When asked whether people repeat the same type of self-injurious behavior, she responded that it was "sometimes true." Tr. at 1779. Upon further inquiry, DON Tierney stated:

> Q BY COUNSEL FOR CMS: So then for nurses watching for self-injurious behavior, wouldn't it be at least somewhat helpful to know what the prior self-injurious behavior was?
>
> A And they can see that by the record.
>
> Q But not the care plan?
>
> A But not the care plan.

Q Threats of violence in this care plan – what was threats of violence meant to address with respect to R5?

A I'm not sure.

Tr. at 1779.

* * *

When DON Tierney was asked to answer how staff looking at the care plan would know what sorts of "threats of violence" R5 was predisposed to, DON Tierney stated:

A I'm truly not sure why that's in there, because I don't see where there have been threats of violence.

Q BY COUNSEL FOR CMS: Okay. So then that provision of this care plan – you don't understand why that was put in here?

A At this point, no.

Q And there's no helpful information just from this care plan about why it was included, is there?

A No.

Tr. at 1781.

The provision in R5's care plan addressing his "Potential for criminal behavior," states that the problem is related to his current probation status for criminal trespass. CMS Ex. 403, at 59. Staff were instructed to: watch for signs of increased anxiety, and watch for signs of increased agitation which may indicate potential for criminal behavior. *Id.* Hillcrest was found to have not been in substantial compliance with the resident assessment requirement because R5's care plan does not identify individualized signs and symptoms which lead to increased anxiety, agitation, and potential criminal behavior. CMS Ex. 1, at 7-8. Upon cross-examination, DON Tierney stated that R5 received the same general entry relating to "potential for criminal behavior" in his care plan as did the other residents merely due to his general probationary status without specific consideration of his criminal history.[18] Tr. at 1738. And, when asked about R5's signs of

[18] R5, on probation since July 1999, was convicted of burglary in January 2001, and was still on probation at the time of his admission to Hillcrest. CMS Ex. 403, at 5, 27.

agitation or anxiety, DON Tierney responded that "[R5] had had none while in the facility, so it would not be identified." Tr. at 1739. Again, Hillcrest's practice was to address in its care plans only specific issues or behaviors that residents manifested while at Hillcrest, and not rely on any specific issues or behaviors which may have been identified and documented in the pre-admission records.

R5's inpatient hospitalization for an acute suicidal episode occurred on February 21, 2001, which was only seven days before his admission to Hillcrest on March 1, 2001. In reviewing R5's care plan at hearing, DON Tierney testified:

> Q BY COUNSEL FOR CMS: What were R5's signs of increasing anxiety? It refers here to, watch for signs of increasing anxiety. . . .
>
> A I don't know that any had been identified.
>
> Q None were identified while he was at Hillcrest?
>
> A Right.
>
> Q Did you review R5's complete record from the transferring hospital before he was admitted to Hillcrest?
>
> A I read it.
>
> Q Did that include any signs of increasing anxiety?
>
> A Specifically, I'm not sure. I'd have to re-read the whole thing.
>
> Q But if it did, they would be included in the care plan. Right?
>
> A They may be. They may not be.
>
> Q Why wouldn't they be?
>
> A Because he did not exhibit any of the signs and symptoms here in the facility.

Tr. at 1744-45.

R5's care plan was also found deficient because it did not identify any signs of increased anger, anxiety, depression, or decreased impulse control for R5. Additionally, it did not address R5's suicidal tendencies and did not address R5's grieving over the death of his mother. CMS Ex. 1, at 7. In response to a question as to how a nurse looking at R5's care plan would know specifically how R5's mood swings manifested themselves, DON Tierney testified:

> A From knowing the history, they would know. From looking at the care plan, they may not.
>
> * * *
>
> Q BY COUNSEL FOR CMS: Isn't it true that the plan of care is meant for all facility staff?
>
> A Yes.
>
> Q So do all facility staff have access to and regularly review these records . . . .
>
> A All facility staff have hands-on, direct care.
>
> Q So . . . they'd have no idea of how frequently R5 cycles between moods, would they?
>
> A No.

Tr. at 1768-69.

The crux of Hillcrest's defense is that the level of specificity for each resident that CMS alleges was missing from the preliminary care plans was in each of the resident's nursing and social services notes. P. PHB at 61. However, Hillcrest is misguided as care plans are intended to summarize all major needs and approaches for a resident. *Beverly Health & Rehabilitation-Springhill*, DAB CR553 (1998), *aff'd*, DAB No. 1696 (1999). A care plan identifies a resident's needs and must provide staff with sufficient information and guidance so that they can meet those needs, and also monitor the resident's progress. The care plan is the central document in a resident's record. *Haverhill Care Center*, DAB CR522 (1998). Although nurse and social service notes chronicle the daily behaviors of residents, they are not a substitute for a comprehensive, detailed care plan.

Hillcrest had 163 residents admitted during the time period at issue here and to expect staff to familiarize themselves with the clinical records of each of these residents for pertinent behavioral clues would be unreasonable. A facility cannot satisfy its care planning requirement by cross-referencing other notes in a resident's record.

3. R6's care plan

Upon his admission on February 15, 2001, R6 was a 33-year-old male with diagnoses of polysubstance abuse including marijuana and alcohol, heroin abuse, heavy drinking, and antisocial personality. In addition, the record notes that R6 suffered from depression, schizo-affective disorder, antisocial personality disorder, migraine headaches, a brain (pineal gland) tumor, and tobacco abuse. CMS Ex. 404, at 6, 9, 11, 26, 29. A social history recorded on February 16, 2001, reports R6 as being sober for three weeks and clean for three weeks prior to his admission to Hillcrest. *Id.* at 25.

On February 6, 2001, eight days before his admission to Hillcrest, R6 was admitted to an inpatient hospital for treatment of his bipolar disorder. Based on R6's medical reports from the inpatient hospital, R6 reported feelings of being overwhelmed, had difficulty sleeping, and experienced anxiety, racing thoughts, and difficulty concentrating. CMS Ex. 404, at 5, 7. R6 reported that he "can't function out of prison," and was feeling "overwhelmed and had violent thoughts."[19] *Id.* at 7. As self-reported in his past medical history, R6 complained of having "spells" where he loses time and "wakes up somewhere else." *Id.* at 8. The psychiatric evaluation from the inpatient hospital states that R6 had been talking about "violent thoughts, rape, and some other thoughts of losing control." *Id.* He stated that he felt he needed to get into a long-term treatment program and that he "didn't feel comfortable being unsupervised." *Id.* The evaluation also notes that "[t]here is significant substance use and this further adds to his difficulties." *Id.*

I find that similar to the deficiencies found in R4's and R5's care plans, R6's care plan fail to identify specific approaches, signs, symptoms, causes and triggers relating to R6's poor anger and stress management, poor coping skills, poor impulse control, his suicidal tendencies, and his potential for relapse into drug and alcohol abuse. Specifically, the provision of R6's care plan addressing his "[p]oor anger/stress management coping skills and poor impulse control" states that they are manifested by verbal outbursts, agitated interactions with staff and peers and related to his schizo-affective bipolar disorder, depression and antisocial personality. CMS Ex. 404, at 38. Staff instructions included monitoring R6 for signs and symptoms of increased stress, anxiety, agitation; make

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[19] R6 had a prior criminal history. From 1992 to 1999, he was imprisoned due to a home invasion and armed robbery after breaking into an ex-girlfriend's home with a gun. CMS Ex. 404, at 8, 24, 25. He was on parole at the time of the March 22 homicide. *Id.* at 1.

referrals to social service for 1:1 intervention during periods of stress or behavior problems; and assess need for PRN medication and administer the medication per doctors' order; and to encourage relaxation during periods of stress, to de-escalate and remove R6 from anxiety or stress-producing situations; and allow him to vent and problem solve. *Id.* However, the care plan fails to identify the triggers for increased stress, anxiety and agitation for R6, which are significant issues in the treatment of R6's mental and psycho-social needs.

Additionally, the care plan failed to address R6's suicidal tendencies. R6 was suicidal just one month prior to being admitted to Hillcrest; however, the care plan failed to address R6's suicidal tendencies. CMS Ex. 404, at 38. At the hearing, former Clinical Director Brenna Costello stated that it would not be important to note suicide in R6's care plan:

> We don't care plan for suicidality; that's a manifestation of depression, so we would continue to monitor for suicidality, that's part of something that the staff are trained on and you probably saw in the social service notes that they continually assess for that and documented that, but we wouldn't care plan for that because that is a specific manifestation. There may be 50 manifestations that that resident would display for depression, so what we would care plan is the depression itself.

Tr. at 2100. When asked if all patients who have depression are suicidal, former Clinical Director Costello testified:

> A No.
>
> Q BY COUNSEL FOR CMS: So then how do you know if the care plan just says depression which ones are suicidal and which ones aren't?
>
> A Well, you don't, you know that for the individual assessment you do in the individual and group sessions.
>
> Q Okay, so you can't tell from the care plan but if you go back and look dig [sic] the records you can find it.
>
> A You can't tell from the care plan whether they're suicidal?

Q Right.

A Correct.

Tr. at 2100.

The section of the care plan addressing R6's potential for relapse (related to a history and diagnoses of alcohol drug abuse dependence) lacked preceding factors that would lead to R6 having a relapse. CMS Ex. 404, at 9-10. DON Tierney, on redirect, testified in relation to the potential for R6's relapse that "[i]f there was one certain thing that would trigger a relapse, that may have been included [in R6's care plan]. But at this point, none were known." Tr. at 1700. However, the February 15, 2001 Minimum Data Set (MDS)[20] reveals under Mood and Behavior Patterns that R6 made negative statements, persistent anger with self and others was noted, and R6 was repetitively anxious. CMS Ex. 404, at 31.

In the care plans at issue for R4, R5, and R6, I did not find specific, concrete interventions for maintaining each of the resident's optimal cognitive functioning, nor were there clear, measurable plans or interventions. Rather, Hillcrest provided a broad, general list of interventions in the residents' care plans rather than interventions tailored to that resident's individual needs. Information must be in the resident's care plan so that facility staff will know how to care for the resident. This becomes especially important given the nature of residential management, especially given that there are times when there are either new staff or staff working with a resident for the first time.

Hillcrest takes the position that it would be at the first quarterly review that R4's, R5's, and R6's preliminary care plans would have been updated. P. PHB at 60-61. Hillcrest states that "[h]ad they remained at Hillcrest long enough to receive the required 90-day review, then additional observations would have been incorporated into R4's, R5's, and R6's care plans based on their manifestations while at Hillcrest over the past quarter." *Id.* at 61. Hillcrest states further that none of the residents at issue had a change in their behavior that warranted an update to their care plan during their short stays at Hillcrest. *Id.* Hillcrest contends that the cited behaviors of the three residents which CMS addresses "all occurred long before these residents came to Hillcrest." *Id.* at 62. Hillcrest asserts that its highly trained staff are able to notice extreme behaviors such as theft, assault, battery, self-mutilation, drug overdose, or alcohol abuse, and these do not have to be

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[20] The MDS is a component of a resident assessment instrument which contains information about a resident's functional capacity.

specifically care planned. *Id.* at 62. I do not find Hillcrest's argument persuasive. Although these three residents had not undergone their first quarterly review, Hillcrest was responsible for providing each resident with interim care while the assessment and care planning processes were on-going. The purpose of a care plan is not to merely recognize a resident's behaviors, but also to prescribe a plan of care and develop strategies for addressing and treating those particular behaviors. Hillcrest's rationale regarding care plans is not consistent with the intent and mandate of the relevant regulations. The care plan should address the problems identified in the assessment by including specific, concrete, and measurable interventions. This then allows for the objective evaluation as to whether the resident's needs are being met as anticipated and whether there is a need for further adjustments in intervention methods.

Although there is no issue with Hillcrest using its computer program as a template for the resident care plans, the evidence established that the care plans of R4, R5, and R6 were found to be identical, even down to the same spelling mistakes.[21] Additionally, the care plans at issue were overly general and vague, and lacked individualization.
Clearly, the record before me supports the deficiency cited by the IDPH surveyors. Accordingly, based on the foregoing, I conclude that Petitioner was not in substantial compliance with the participation requirement at 42 C.F.R. § 483.20(k) of the regulations.

B. Hillcrest was out of substantial compliance with the participation requirement at 42 C.F.R. § 483.25(h)(2) - (tag F324, Quality of Care).

The regulation at 42 C.F.R. § 483.25(h)(2) requires that each resident be provided with adequate supervision and assistance devices in order to prevent accidents. In interpreting and applying section 483.25, the Board has been consistent in the opinion that providers are not strictly liable as insurers or unconditional guarantors of good outcomes in the delivery of services to facility residents. Rather, the quality of care provisions of section 483.25 impose an affirmative duty upon providers to deliver services designed to achieve the best possible outcomes to the highest practicable degree. *Woodstock Care Center*, DAB No. 1726, at 25 (2000), *aff'd*, *Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). This interpretation is based upon the legislative history of the Act and regulations which reflect that Congress and the Secretary chose to focus upon the desired

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[21] Hillcrest stipulated that for R4's, R5's, and R6's care plans, under the provisions relating to "potential for relapse" and "risk," both the problem identified and staff approach were identical for all three residents. CMS Exs. 402 at 56; 403 at 59; 404 at 38; Tr. at 2101. Also, Hillcrest stipulated that the entries providing staff with direction on how to intervene with each resident were identical in each of the three care plans (R4, R5, and R6). CMS Exs. 402, at 57; 403, at 59; 404, at 39.

ends or results of care, thus allowing facilities to meet the requirements for individual care in a variety of ways. *See* Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203 (Dec. 22, 1987); 54 Fed. Reg. 5316 (Feb. 2, 1989).

The specific manner by which facilities are to deliver care and services is not prescribed by 42 C.F.R. § 483.25(h)(2). A facility is permitted to determine the means to achieve the regulatory end which is the prevention of accidental injury of facility residents. Therefore, in order to evaluate Hillcrest's compliance with section 483.25(h)(2), it is necessary to examine whether the facility provided adequate supervision designed to meet the residents' assessed needs and to mitigate foreseeable risks of harm to them. *Northeastern Ohio Alzheimer's Research Center*, DAB No. 1935 (2004); *Tri-County Extended Care Center*, DAB No. 1936 (2004).

The level and kind of supervision provided to the residents is reviewed in order to determine whether it was sufficient to prevent any untoward events. The regulation at 42 C.F.R. § 483.25(h)(2) requires that a facility provide *both* "assistance devices" *and* "adequate supervision" to prevent accidents. Whether the supervision or assistance devices are adequate depends on what kind of measures would be determined to prevent potential accidents from occurring given the known or reasonably foreseeable risks. For instance, in *Woodstock*, the Board considered whether the facility had notice of, or should reasonably have anticipated, the risk of the types of events that occurred and whether any reasonable means were available to prevent them without violating the residents' rights. *Woodstock*, DAB No. 1726, at 26-27. In the case before me, the question has to be answered as to whether the facility did "everything in its power to prevent accidents." *Odd Fellow and Rebekah Health Care Facility*, DAB No. 1839, at 6-7 (2002), quoting *Asbury Center at Johnson City*, DAB No. 1815, at 12 (2002) and *Koester Pavilion*, DAB No. 1750, at 25-26 (2000).

Based on the regulation and the cases addressing this provision, CMS will meet its burden in establishing a prima facie case if it: (1) presents evidence that an accident occurred (with or without harm to a resident); or (2) shows that Hillcrest failed to do what it could to supervise residents or provide assistance devices to minimize risks that could lead to accidents. If CMS makes a prima facie case, the burden shifts to Hillcrest and the record will then be considered in terms of where the preponderance of the evidence lay.

CMS contends that Hillcrest was found not to be in substantial compliance with section 483.25(h)(2) because it allegedly failed to provide adequate supervision of R3, R4, R5, and R6 who had known behaviors which included suicidal thoughts, depression, anger, poor impulse control, potential for criminal behavior, refusal to follow treatment regime, potential for relapse of drug and alcohol abuse, ineffective coping, and history of abusive

relationships. CMS Ex. 1, at 10. CMS further contends that Hillcrest's failure to supervise these four residents placed them and other residents in the facility at risk for harm.[22] Specifically, Hillcrest is alleged to have been deficient because of its failure to:

> 1. properly monitor the use of day passes by R3, R4, R5, and R6;
>
> 2. ensure that the four residents attended their group counseling sessions or received appropriate individual counseling; and
>
> 3. respond properly when these same four residents returned to Hillcrest intoxicated and, with respect to R4 and R5, bloody and bruised after they had committed a homicide.

During the April Survey, the IDPH surveyor findings in relation to section 483.25(h)(2) were determined to be so egregious as to place residents of Hillcrest in a state of immediate jeopardy. Below, I address each of CMS's allegations separately.

1. Hillcrest failed to properly monitor the use of day passes by R3, R4, R5, and R6.

CMS states that R3, R4, R5, and R6 had been referred for placement at Hillcrest specifically because they were found to need the "support and structure" of an intermediate care facility and 24-hour nursing level care. CMS Exs. 401, at 22, 26; 402, at 23, 24; 403, at 5, 8, 18; 404, at 16. Specifically, R3, R4, and R5 had histories of suicidality. CMS Exs. 401, at 8, 31; 402, at 30; 403, at 5, 8. R4, R5, and R6 had histories of substance abuse. CMS Exs. 402, at 7-8; 403, at 18, 20, 27, 29; 404, at 9, 38. R4, R5, and R6 had criminal records, of which R4 and R6's included violent crimes. CMS Exs. 402, at 17; 404, at 8, 17. CMS states that despite the known pre-admission histories of each of these residents, Hillcrest routinely allowed R3, R4, R5, and R6 to leave the facility on passes without supervision, often for several days at a time.

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[22] The April SOD lists 21 pages of examples under tag F324. Although I consider each and every example identified by the IDPH surveyors in reaching my conclusions, due to judicial economy I do not discuss in this decision each example listed. CMS Ex. 1, at 10-31.

Hillcrest's house rules, which each resident must sign and agree to upon admission, required that all residents "must sign in and out when leaving and returning" and "[r]esidents must be inside the building by 10:30 p.m. each evening." CMS Ex. 419, at 1, 2; CMS Ex. 419, at 10 ("When signing out, residents indicate the time they are leaving and the purpose for which they are leaving the facility.")

The day pass history for R3, R4, R5, and R6 during their stay at Hillcrest is addressed separately below:

R3

R3 was a 19-year old female at the time of her admission to Hillcrest on March 6, 2001. CMS Ex. 401, at 28. She was transferred from an inpatient hospital with diagnoses of major depression, borderline personality disorder, bipolar disorder, asthma, and hypothyroid-type tension. *Id.* at 17, 28, 29, 31. Her pre-admission records note that R3 had been admitted to an inpatient hospital on February 20, 2001, "feeling very depressed and felt hopeless and helpless," and "having suicidal thoughts and suicidal plans." *Id.* at 8. A hospital note, dated March 2, 2001, describes R3 as being "massively" depressed "with poor defenses against suicidal impulses," and that she "remains a suicide risk even with support." CMS Ex. 401, at 15, 16. In reference to prior abusive relationships, the hospital note describes R3 as having "no relationship skills" and that "relationship-wise she is like a moth drawn to a flame." *Id.* at 16.

CMS contends that Hillcrest saw very little of R3 after her first ten days at the facility. CMS PHB at 74. Hillcrest states that allowing R3 to go out on pass was consistent with her care plan goal which was for her to be in the "least restrictive level of care" within three months. CMS Ex. 401, at 51. Hillcrest further states that R3 had a doctor's order permitting her to leave on pass. *See* P. Ex. 4. Hillcrest contends that before the day of the homicide (March 22), there were no unusual circumstances justifying revoking R3's pass privileges.

R3's pass usage during her stay at Hillcrest is reflected below:

Sign-out For R3

DATE	RESPONSIBLE PARTY	TIME OUT	TIME IN	WHERE TO
3/10	[R3]	7:15	9:55	STORE
3/16	[R3]	8:22		HOME
3/20	[R3]		10:00	
3/21	[R3]	2:15	6:00	MALL
3/22	[R3]	1:30	0	STORE/MALL
3/22	[R3]		9:55	

CMS Ex. 401, at 61.

R3 was admitted to Hillcrest on March 6, 2001, and in the total of 16 days which she resided at Hillcrest, she was listed as being out on pass on March 10, 2001, for over 2.5 hours, just four days after her admission to Hillcrest; then from March 16, 2001 through March 20, 2001, which included overnight stays to "home;" then for most of the afternoon on March 21, 2001; and then again for most of the day on March 22, the day of the homicide. CMS Ex. 401, at 61. R3's first pass outing was only four days after her March 6 admission date. When signing out, R3 recorded her absences as "store," "home," "mall," or "store/mall." The sign-out sheet does not require residents to estimate their time of return; rather, once back at the facility, they must document their time of arrival. Also noted is that residents were not required to indicate "a.m." or "p.m." *Id.* Additionally, a review of the Hillcrest floor sheet shows that R3's absences were not noted on that sheet, and therefore, staff may not have been aware that R3 was out of the facility. CMS Ex. 416, at 20.

Hillcrest has admitted that staff were not aware until after the incident that R3 had access to a car at Hillcrest. P. PHB at A-1. Former Administrator Kalkowski testified that Hillcrest did have a vehicle policy in effect as of March 22, 2001, which precluded residents from having a vehicle at the facility. Tr. at 1432-33. As is evident from the record, not only did R3 have a vehicle at the facility for her use, other residents such as R4, R5, and R6 were able to borrow the vehicle from her as was evident on March 22, 2001.

Hillcrest argues that R3's screening counselor wrote that she did "not need specialized services (in-patient hospitalization)" and that her "[c]urrent condition is stable." CMS Ex. 401, at 25. I note that R3's Notice of Determination, dated March 6, 2001, states that her current condition is stable, but also goes on to reveal that R3 "has extremely poor coping skills and little support;" is "not able to manage her mental illness" and "needs the support and structure of an [intermediate care facility]." *Id.* at 25, 26. Additionally, R3's hospital transfer record states that she "needs to be involved in as many groups as possible." *Id.* at 18. R3's social history from Hillcrest notes her difficulties with concentration; her tendency to internalize and become depressed, angry and frustrated, and her history of suicide attempts (for instance, overdosing, and an attempt to stab herself with a butcher knife in February 2001, one month prior to her admission to Hillcrest). *Id.* at 31.

R3's care plan listed among her problems a potential for ineffective individual coping; a potential for trauma/falls related to borderline personality depression; and poor affect management manifested by severe mood swings, impulsive behavior, attention-seeking behavior, self-injurious behavior, and threats of violence. CMS Ex. 401, at 50, 53, 55.

R3's first unsupervised pass outing was only four days after her March 6 admission. Also, from March 16 through March 20, a five-day period, R3 is noted as being at "home," although there is no specific location identified. However, according to R3's Notice of Determination, she was noted as being "homeless" when she was admitted to Hillcrest. CMS Ex. 401, at 25. As is evident from R3's sign-out sheet, in the 16 days R3 was a resident at Hillcrest, she spent a good portion of that time away from the facility.

R4

R4 was admitted to Hillcrest on February 8, 2001. CMS Ex. 402, at 7. A community ability assessment, dated October 4, 2000, describes R4 as having markedly abnormal moods, markedly impaired response to stress and anxiety, as being often abusive of drugs and/or alcohol, and frequently exhibiting episodes of extreme acting out. *Id.* at 7-8. Also noted is that on December 13, 2000, R4 had been admitted into the hospital due to suicidal ideation and self-inflected lacerations on his wrist. *Id.* at 30. R4's care plan established a three-month goal for treating each of his identified problems, and instructed staff to monitor R4 for increased agitation and anxiety or for signs of use of alcohol or drugs or of potential criminal behavior and to observe, record and report all unsafe conditions. CMS Ex. 403, at 56-57. However, Hillcrest staff saw very little of R4 after his first two weeks at the facility.

The facility sign-out sheet for R4 during his stay at Hillcrest is reflected below:

Sign-out For R4

DATE	RESPONSIBLE PARTY	TIME OUT	TIME IN	WHERE TO
2/18	[R4]	5:50	6:10	STORE
2/18	[R4]	6:30	8:45	TO EAT
2/20	[R4]	12:45	6:15	MALL
2/23	[ST][23]	11:00	2/25 7:25	HOME
3/2	[ST]	1:40	3/6 12:10	HOME
3/6	[R4]	6:55	7:19	STORE
3/7	[R4]	4:10	4:40	STORE
3/9	[ST]	2:56	1:30	HOME
3/19	[R4]	12:40	9:55	SISTERS
3/20	[R4]	10:35	7:45	SISTERS
3/22	[R4]	9:10	9:45[24]	STORE

CMS Ex. 402, at 69.

As noted above, from February 23, 2001 through March 19, 2001, a period of 23 days, R4 was out on pass for most of or all of 17 days. Twice, R4 was out on pass for several days at a time, on February 23-25, and again on March 2-6. However, because the sign-out sheet does not have "a.m." or "p.m." designations for times on the sheet, there is no way of determining by reviewing the sheet whether, for instance, R4 returned on March 20 at 7:45 a.m. or 7:45 p.m. It would also be difficult for anyone reviewing at the sign-out sheet to ascertain whether R4 was complying with the 10:45 p.m. curfew, or identify patterns to determine whether R4 was absent for minutes or twelve hours. For instance, in reviewing the entry for March 9, it appears that R4 signed out at 2:56 and returned at 1:30 - however, it is unclear as to which day he returned. While testifying, Mr. Mutterer, the former Clinical Director, agreed that the entry for March 9 was "confusing." Tr. at 1555. In reviewing a facility floor sheet which shows the status of each resident on each floor, I

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[23] To ensure privacy, "ST" is being used as an abbreviation in this decision and designates the name of a family member of R4. Tr. at 1554.

[24] It is difficult to ascertain from the sign-out sheet whether R4 returned to the facility on March 22 at 9:43, 9:45 or 9:49, as the last number on the sign-out sheet is scribbled. However, both parties agree that R3, R4, R5, and R6 returned to Hillcrest between 9:45 and 9:55 p.m. CMS PHB at 131; P. PHB at 58.

find that R4 is noted as being "OOP [out on pass]" from March 9-17. CMS Ex. 416, at 18. There is no entry on the sign-out sheet for March 17 showing R4's return. CMS Ex. 402, at 69.

Former Administrator Kalkowski testified that it was Hillcrest's policy that "a resident may not be out on pass longer than seven consecutive days . . . or ten days in a month," and if a resident failed to comply, then Hillcrest could discharge that individual. Tr. at 1393-94. However, based on R4's sign-out sheet, he was out of the facility on March 2-6, 9-17, 19, 20, and 22, for a total of 18 days in March, including nine consecutive days from March 9 through March 17. CMS Ex. 402, at 69.

During his pass usage from March 9-17, R4 called into the facility to request a one-day extension to his pass. CMS 402, at 73. Clinical notes for that period indicate that R4 claimed to have sufficient medications to cover his extended absence. *Id.* However, on March 19, upon his return to Hillcrest, R4 admitted that he had run out of medication while on pass. *Id.* In addition to R4's running out of medication during the extended stay, a March 19 social service note reveals that R4 reported to his counselor that he: (1) had initiated a confrontation with his wife's boyfriend out of anger; (2) had used alcohol; and (3) had resumed a sexual relationship with his estranged wife.[25] CMS Ex. 402, at 73. The notation then states that staff will "[m]onitor as needed." *Id.* In addressing the March 19 social service note, former Clinical Director Mutterer testified:

> Q BY COUNSEL FOR PETITIONER: After this note on March 19, 2001, in your experience in evaluating people that are dangerous to themselves or others, what was your conclusion whether or not this resident was a danger to himself or others after that therapeutic session?
>
> A He was presenting in a manner that was danger[ous] to himself or others.

Tr. at 1274-75.

Although the March 19 social service note indicates that staff are to monitor R4 as needed, there is no notation to describe R4's visit with his sister on March 20. It is surprising that Hillcrest staff did not monitor R4 after he disclosed to his counselor on March 19 the

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[25] When R4 first met with a Hillcrest social service staff person, he claimed that his pass had gone well and that he had not had any conflicts. CMS Ex. 402, at 73. It wasn't until the following day when he met with another social service staff person that he admitted to the difficulties. However, R4 had a history of inconsistent self-reporting. Tr. at 2293-95.

events that occurred during his prior pass outing. At hearing, former Clinical Director Costello testified:

Q BY COUNSEL FOR CMS: Now, after all of this was reported here, you specifically indicated that you would continue to monitor the resident as needed. Isn't that right?

A Yes.

Q . . . and what time was this note written?

A 11:15:51

Q On 3/19?

A Yes.

Q Then if you turn back to his pass sheet, he signed out of the facility just an hour and a half later for nine hours. Right?

A Correct. He went to his sister's home.

Q He signed out to go to his sister's but you don't know for sure that he went to his sister's. Right?

A True, because we can't follow a resident once they leave the facility.

Q And you can't call him at his sister's to see if he's there?

A It's not our policy; we have lots of residents that go out on pass on a daily basis; we couldn't call every one of them.

* * *

Q BY COUNSEL FOR CMS: How was he being monitored when he signed out just an hour and a half later for nine hours to his sister's?

A As I said, when residents come back from pass they're met with and assessed upon their return.

Q Okay. Where in the record is that assessment documented when he returned from his sister's that night?

A He doesn't look like he had a followup session after that pass or the one the following day.

Q So does that mean he wasn't – there's no assessment that's recorded. Right?

* * *

A Correct, there's nothing documented.

Tr. at 2143-45.

Given R4's relapse into alcohol abuse and his resort to violence, Hillcrest should have reviewed R4's care plan to determine whether any adjustments to his pass privileges and his treatment plan were needed. However, on March 22, R4 signed out on pass. A March 23, 2001 social service note describes R4 when he returned to the facility after the home invasion and homicide incident on March 22:

> Res returned to the facility with intoxication, agitation, and anger. . . . Res got into a verbal alteraction [sic] which almost lead to a fight. Counselor had to separate the res from one another. As counselor attempted to redirect res res [sic] continued to verbalize threatening words to peer. Res left the facility in rage. Counselor seeked [sic] res and res could not be found. Police department to follow up facility on res's location.

CMS Ex. 402, at 73.

CMS's expert witness, Dr. Perraud, testified that Hillcrest violated standards of nursing practice when they allowed R4 to go out on pass so frequently because "[h]e was inaccessible for assessment and treatment, so it's impossible to follow through with your plan of care if he's not there." Tr. at 1089. Hillcrest maintains that R4 had no history of violent crimes, just theft and firearm charges. Hillcrest asserts that in R4's plan of care, it specifically contemplated that R4 would go out on pass to transition to independent living. The plan for R4 was to have successful "pass returns home" and demonstrate "potential to live independently." P. PHB at 35.

I find that Hillcrest's assertion that allowing R4 to go out on pass was consistent with his care plan is unpersuasive. As previously noted, in late March 2001, R4 exhibited escalating behaviors that warranted close supervision. While out on his week-long pass, R4 admitted to running out of medications, using alcohol, and to initiating an altercation. Additionally, although the counselor that screened R4 for transfer to Hillcrest noted that he was stable, it is also noted that R4 was "unable to care for himself in the community," and needed psycho-social rehabilitation services and medication monitoring. CMS Ex. 402, at 24. R4's care plan identified his potential for relapse into alcohol and drug abuse as well as his potential for criminal behavior and trauma/falls. *Id.* at 56-58. His care plan further directs staff to monitor, record and report R4's increased agitation and anxiety, signs of use of alcohol or drugs, or potential for criminal behavior. *Id.* Following his return from his extended pass (March 9 through 17), R4 specifically informed his counselor that he had been drinking with "peers" while out on extended pass. *Id.* at 73.

R4 signed a drug and alcohol contract and policy while at Hillcrest which required that he: (1) adhere to treatment recommendations or be subject to discharge; (2) attend a relapse prevention group; (3) submit to random drug/alcohol screens; and (4) follow any and all treatment recommendations of the medical doctor and psychiatrist (i.e. take prescribed anti-abuse medications, etc.) related to drug/alcohol use. CMS Ex. 402, at 44. However, Hillcrest failed to take any of the actions as outlined in the contract and policy when R4 admitted to use of alcohol while on pass from March 9 through 17, despite the fact that R4's behavior had violated the terms of the drug and alcohol contract.

CMS alleges that Hillcrest did not follow either R4's care plan pr the drug and alcohol contract and policy when it failed to perform a drug screen and notify R4's doctor of his alcohol use while on pass. CMS PHB at 78. CMS also argues that Hillcrest failed to document anywhere in R4's record the reasons why the terms of R4's contract and policy were not followed. *Id.* at 79. R4's care plan required staff to educate R4 about the medical impact of substance and alcohol use, to obtain drug/alcohol screens as needed, to contact the doctor, and to inform the charge nurse if use was suspected. CMS Ex. 402, at 56. Hillcrest's expert witness, Gershon H. Kaplan, M.D., testified that under circumstances similar to those presented by R4, he would have wanted to be contacted:

> Q BY COUNSEL FOR CMS: Okay. So if you were a psychiatrist treating this patient [R4], and you knew he was taking these meds, you knew he had this diagnosis, you knew he had this past history of serious psychiatric problems and you heard that he went drinking, wouldn't you want to be notified?

A Yes, I think that that's something I'd like to know about, sure.

Tr. at 2310-11.

However, there is no record that R4's interdisciplinary team, his doctor, or his psychiatrist were advised of his relapse into alcohol abuse and other pass problems so that they could have made a decision regarding R4's continued treatment and pass usage. This is of particular concern given R4's clinical diagnosis and past history of substance abuse.

R5

The facility sign-out sheet for R5 during his stay at Hillcrest is reflected below:

Sign-out For R5

DATE	RESPONSIBLE PARTY	TIME OUT	TIME IN	WHERE TO
3/10	[R5]	7:25 pm	9:55 pm	Store
3/13	[R5]	1:20	1:45	Store
3/15	[R5]	3:50	4:45	Store
3/16	[R5]	6:50	8:00	Joggin
3/19	[R5]	5:00	6:45	Downtown
3/20	[R5]	11:05 am	11:45 am	Flower store
3/20	[R5]	7:30	7:45	Store
3/21	[R5]	5:40	5:53	Joggin
3/21	[R5]	2:00 pm	6:00 pm	Mall
3/22	[R5]	6:25 am	7:00	Walking
3/22	[R5]	9:10 am	9:45	Store

CMS Ex. 403, at 48.

R5 was admitted to Hillcrest on March 1, 2001. From March 19 through March 22, 2001, R5 signed out eight times with destinations noted as "downtown," "store," "mall," or "walking." Also noted is that each of these absences was not recorded in the Hillcrest floor sheet which shows the status of each resident on each floor. The floor sheet documentation would have enabled all staff to know that R5 was out on pass. CMS Ex. 416, at 20.

Hillcrest states that R5's care plan identified a need for therapeutic recreation and that R5 was "interested in working around facility cleaning up outside until he gets employment." P. PHB at 43. Hillcrest states further that the care plan goal for R5 was to obtain gainful employment and ultimately be discharged from Hillcrest, and that the doctor's order to allow him to go out on pass was consistent with R5's care plan. *Id.* Hillcrest argues that R5 was 28 years old, and, according to R5, he had overcome his problem of striking out violently seven years earlier. Hillcrest contends that R5's screening counselor wrote that "[h]e has good work skills and insight into himself and his situation," that he does "not need specialized services (in-patient hospitalization)," and that his "current condition is stable." CMS Ex. 403, at 19. However, Hillcrest's contentions do not persuasively explain how in late March 2001, R5 exhibited behaviors that warranted close supervision. On March 19, 2001, R5 sought help for nightmares that disturbed him through the day, yet he went out on pass repeatedly on the subsequent days, and on March 22, he was away from the facility from 6:25 a.m. through 9:45 p.m., except for a brief period of time when he returned to the facility that day, 7:00 a.m. to 9:10 a.m. Because of R5's frequent absences from the facility, it is difficult to understand how Hillcrest was able to continuously assess him and provide him with the services his care plan called for.

R6

CMS contends that Hillcrest violated section 483.25(h)(2) by failing to monitor R6's use of passes. CMS PHB at 75. Hillcrest asserts that most of R6's absences were to the store and many were for less than one hour. Hillcrest maintains that these were consistent with independent living, and thus, staff had no basis to revoke R6's pass privileges the morning of March 22. However, a psychiatric evaluation dated February 10, 2001, five days prior to R6's admission to Hillcrest, notes that R6 stated to his hospital psychiatrist that he was preoccupied with "violent thoughts, rape, and some other thoughts about losing control," on which he was afraid he might act, and also stated, "I don't feel comfortable being unsupervised." CMS Ex. 404, at 8. In R6's Notice of Determination, dated February 12, 2001, the counselor that screened R6 for placement into Hillcrest noted that R6 "has gotten to the point where he is unable to maintain himself into the community and manage his mental illness." *Id.* at 18.

Additionally, R6's care plan identified his potential for relapse into alcohol and drug abuse; his potential for criminal behavior; his potential for trauma/falls; and his poor anger and stress management, coping skills and impulse control, as manifested by severe mood swings, impulsive behavior, attention-seeking behavior, self-injurious behavior, and threats of violence. CMS Ex. 404, at 38-40. The care plan directed staff to monitor R6 for increased stress, agitation or anxiety, signs of use of alcohol or drugs, or of potential criminal behavior, and to observe, record and report all unsafe conditions. *Id.* On

February 21, R6 told a counselor that he was "depressed and often agitated," and on February 26, he described himself as "unhealthy." *Id.* at 60.

The facility sign-out sheet for R6 during his stay at Hillcrest is reflected below:

Sign-out For R6

DATE	RESPONSIBLE PARTY	TIME OUT	TIME IN	WHERE TO
2/18	[R6]	5:45 pm	6:00 pm	Store
2/19	[R6]	10:25 am	11:45 am	Lunch
2/20	[R6]	12:45 pm	6:15 pm	Mall
2/20	[R6]	6:55 pm	7:15 pm	Store
2/21	[R6]	9:45 am	2:00 pm	Store
2/22	[R6]	2:45 pm	3:35 pm	Store
2/23	[R6]	12:45 pm	1:55 pm	Thrift store
2/24	[R6]	3:25 pm	3:45 pm	Store
2/26	[R6]	3:40 pm	6:00 pm	Store
3/1	[R6]	2:30 pm	2:50 pm	Store
3/5	[R6]	6:35 pm	7:00 pm	Store
3/6	[R6]	6:55 pm	7:10 pm	Store
3/7	[R6]	2:40 pm	3:30 pm	Chicago
3/7	[R6]	4:10	4:40 pm	Store
3/8	[R6]	1:15 pm	1:35 pm	Store
3/10	[R6]	7:15 pm	9:55 pm	Store
3/11	[R6]	6:45 pm	7:09 pm	Store
3/12	[R6]	10:35	6:45	Chicago
3/15	[R6]	1:35 p	4:35 p	Lewis University
3/15	[R6]	7:10 p	7:25 p	Store
3/22	[R6]	9:10	9:50	Store

CMS Ex. 404, at 57.

R6 was admitted to Hillcrest on February 15, 2001. From February 18 through March 22, 2001, R6 signed out 23 times to destinations such as "store," "mall," or "Chicago." CMS Ex. 404, at 56-57. R6 left Hillcrest at least five times within a week after his admission. A review of the Hillcrest floor sheet shows that R6's absences were not noted on that sheet, and therefore, staff may not have been aware that R6 was out of the facility. CMS Ex. 416, at 19. On March 22, 2001, R6 was absent for over 12 consecutive hours, from 9:10 a.m. to 9:50 p.m. CMS Ex. 404, at 56-57.

Given R6's history, diagnoses, pre-admission screening results, the problems identified in his care plan, and his report to the counselor at the inpatient hospital on February 21 as to his feelings of depression and agitation, I find that Hillcrest should have monitored R6 more carefully during his stay at Hillcrest, and should have provided him with closer supervision.

Typically, facility residents receive an increasing degree of pass freedom based on their ability to tolerate the freedom. Reciprocally the pass freedom is decreased or revoked if they demonstrate inappropriate behavior or fail to return in a timely manner. Newly admitted residents at Hillcrest were afforded liberal unsupervised pass outings which raises questions as to why residents were not required to document their estimated time of return when they signed out for pass periods. It is not clear who was assessing location appropriateness for the residents at Hillcrest when they would go out on pass outings. Without this information, it would be difficult for staff to properly plan for medication administration and to ensure that residents with psychiatric diagnoses had enough medications to last for the length of their passes. By reviewing the sign-out sheets and the resident records submitted as evidence, I find that it is not possible to know whether the residents had sufficient medications for their pass outings.

At hearing, Llanie Jurilla, former R.N. at Hillcrest, testified that staff do record in the nursing notes that medication has been sent with a resident. Tr. at 1671. She further testified that the amount of medication she would send home with a resident on an extended pass was recorded in the record and she would be able to ascertain from the record whether a resident who was out on pass for four days and who called in to extend his pass an additional two days, had sufficient medications for the extended two days. Tr. at 1671. Additionally, former Administrator Kalkowski, testified that it would be important to know whether residents had received sufficient medications to last through their pass absence, and if a resident were given extra medications to take while on pass, "[t]he nurses would chart - - or they would put it in the MAR [Medication Administration Record]." Tr. at 1387.

However, a review of R4's March 2001 MAR, from March 1 through March 22, 2001, revealed: (1) staff did not record R4as having received Remeron medication on 15 of the 22 days (P. Ex. 49; Tr. at 1659-62); (2) there was no record of R4 receiving his 9:00 a.m. Depakote medication on 12 of the 22 days; and (3) for at least 10 of the 22 days, R4 was listed out on pass (OOP) for his 9:00 p.m. Depakote medication administration. P. Ex. 49, at 3.

Monitoring compliance with medications is essential to treatment. Hillcrest staff would need to know whether residents were taking their medications, especially as some of the residents' care plans identified their challenges in following a medication regime. Maureen Lacy, PsyD, an expert witness for Hillcrest, testified that "[w]e'd want to know patients are taking their medications. You'd want to document that in some way." Tr. at 2517.

Based on the lack of documentation in the nursing notes and MARs in evidence, Hillcrest failed: (1) to monitor medication compliance while residents were out on pass; (2) to document how long the residents intended to be out on pass; and (3) to document whether the residents were given medications; and, if so, to document how much medication was provided.

Hillcrest is alleged to have failed to properly monitor residents' pass usage and to require compliance with its sign-out sheets. Hillcrest contends that its pre-March 22 sign-out sheet required residents to record the date and time of their departure and return, whether they were leaving alone or with a "responsible party," and their destination. P. PHB at 30. However, I find it problematic that residents were apparently required to complete the date and time of return information after they returned from a pass, and not when they left. Hillcrest has not been able to persuasively establish how staff could know the length of time a resident expected to be gone from the facility. Additionally, the sign-out sheets did not include an area for information whether the resident was leaving alone. Rather, it merely included a space for a responsible party to sign a resident out.

Hillcrest asserts that all four residents' (R3, R4, R5, and R6) pass usage was consistent with their care plans as the goal ultimately was for them to be stabilized so they could live independently once again. Thus, Hillcrest contends there was no reason to attempt to revoke their pass privileges on March 22. Hillcrest states that it is an intermediate care facility that specializes in working with the mentally ill and is less restrictive than an in-patient hospital unit; for instance, it does not maintain lock-down units and is a hands-off facility (staff cannot lay hands on residents except to protect themselves or another resident). Therefore, if a resident is determined to leave the facility, staff cannot stop them. Additionally, Hillcrest states that the incident on March 22 involved an unforeseeable violent crime by two residents away from the facility and that Hillcrest was under no obligation, legal or otherwise, to accompany the residents to supervise their behavior toward non-residents while they were out on pass. Hillcrest avers that 42 C.F.R. § 483.25(h)(2) does not impose surveillance or law-enforcement obligations when residents are outside of the facility on pass pursuant to a doctor's order. Throughout these proceedings, Hillcrest has argued that the March 22 home invasion and homicide occurred outside of the facility's property, and that therefore, section 483.25(h)(2) is not applicable. Although I address Hillcrest's argument regarding the applicability of section 483.25(h)(2)

to the March 22 events later in this section, I note here that Hillcrest is mistaken in that the question is not whether the incident occurred inside or outside of the facility, but whether the supervision provided by Hillcrest to these residents was adequate. Given the record before me, I find that it was not. Here, R3, R4, R5, and R6 had histories of impulse control and substance abuse problems as well as tendencies toward engaging in destructive and self-destructive behaviors. Clearly, Hillcrest failed to develop criteria to determine which residents should be allowed to leave on passes and how frequently and how long they should be allowed to leave. Rather, Hillcrest looked at the pass usage policy to determine whether a resident needed to be transferred to a psychiatric hospital, or could leave on pass as frequently and for as long as he or she wished.

According to Hillcrest, prior to admission of a resident, each respective reviewer, for instance, a discharging physician, the independent screening agency, and the accepting facility must certify that the resident is "not a danger to himself or others" and is "stable." P. PHB at 12; Tr. at 40. Hillcrest attempts to use the PASARR[26] screening process to argue that the screening reports indicated that R3, R4, R5, and R6 did not require the level of supervision CMS purports they needed. However, the Board in *Woodstock* concluded that

> "[n]either federal reimbursement practices nor the PASARR screening process relieves the facility of its responsibility to provide its residents all care and services necessary to afford them their highest practicable physical, mental, and psycho-social well-being, including insuring adequate supervision and assistance devices to prevent accidents. Notwithstanding the purported opinions or policies of any outside agency, a facility is charged with limiting its admissions to those residents for whom it is capable of providing that care and those services."

Woodstock, DAB No. 1726, at 40-41.

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[26] The Omnibus Budget Reconciliation Act of 1987 (OBRA '87) required that nursing facilities establish pre-admission screening (PAS) requirements for individuals with severe mental illness. An independent screening agency, referred to as a PASARR agent, examines the individual in order to confirm both the referring physician's diagnosis and that the individual is ready for transition to a less restrictive facility. *See* Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-2003, § 4201, 101 Stat. 1330 (1987).

Hillcrest allowed residents to leave on pass far too often to allow for proper assessment. Surveyor Steven Mott testified that typically a pass policy for new residents with mental illness would allow for a period of one or two weeks to allow the facility time to thoroughly assess the new residents before allowing them to leave the facility on pass. Tr. at 759. I agree that this time period is important for facility staff to establish a relationship with a resident and to assess a resident in order to determine intervention and treatment planning. Hillcrest's pass policy did not maintain residents in the facility long enough for sufficient assessment.

Former Clinical Director Mutterer testified that to revoke a resident's pass privileges because he or she failed to fill out all the boxes on the pass sign-out form was not within the facility's authority under federal regulations unless the resident posed imminent danger of harming themselves or another. If the resident posed a threat to themselves or others, Hillcrest "would be under obligation at that point to hospitalize them." Tr. at 1279-80. Mr. Mutterer further testified that in the situation where the resident did not fully complete the pass sign-out form, it would be considered a house rule violation and the resident would then be encouraged to comply more regularly. *Id.* at 1280. However, former Administrator Kalkowski testified that although residents generally refer to "[t]he Little Store" which is three blocks from the facility, there are also multiple stores near Hillcrest and therefore, Hillcrest staff would not specifically know where to look for a resident that had signed out to go to a "store." Tr. at 1384.

The cited incidents, regardless of whether they were accidents or not,[27] constitute valid probative evidence as to whether Hillcrest adequately supervised its residents. Residents who have the opportunity to be away from a facility unsupervised for hours at a time, with the opportunity to drive around in a vehicle drinking, are inadequately supervised to prevent accidents. Moreover, a resident who is away from a facility for 12 unaccounted hours, and has the opportunity to wander around town intoxicated and eventually become involved in a home invasion and homicide, is completely without *any* supervision, irrespective of whether the individual resident himself is involved in an actual accident or another resident in the facility sustains an accident. It was inevitable that the lack of supervision of R3, R4, R5, and R6 would likely result in serious injury.

I find Hillcrest's assertions unpersuasive. Facility staff failed to properly monitor these four residents during their pass usage and there is no contemporaneous documentation that offers a reasonable justification for why the monitoring was not performed. The record before me establishes that R4's, R5's, and R6's MDS and plan of care indicated potential

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[27] Even in the absence of "actual harm," a "widespread potential for more than minimal harm" is sufficient to sustain a CMP. 42 C.F.R. § 488.301.

for criminal behavior, psychiatric problems, ineffective coping skills, refusal and noncompliance with treatment programs. Furthermore, a review of the social services notes for February and March 2001 reveal that these residents were expressing that they had disturbing dreams, anxiety over too much freedom, and were not following pass guidelines and/or drinking when out on pass.

The crux of CMS's case is that Hillcrest failed to provide adequate supervision to these four residents. The evidence offered by CMS to support this contention is persuasive and not sufficiently rebutted by Hillcrest. The evidence establishes that Hillcrest persisted in utilizing sign-out sheets in lieu of personal supervision. I do not find Hillcrest's response to this evidence to be persuasive and I conclude that Hillcrest was in violation of 42 C.F.R. § 483.25(h)(2) when it failed to ensure that staff enforced the pass usage policy and properly monitored the use of resident day passes.

a. Hillcrest failed to properly assess residents before they left on pass.

CMS contends that Hillcrest failed to properly assess residents before they left on pass (i.e., mood state, where the resident was going when out on pass, with whom, and for how long). CMS PHB at 59.

R5

R5 was allowed to go out on a pass without an assessment of either his psychiatric state (his depression and history of serious suicide attempts), or his need for medication monitoring. A review of R5's pre-admission screening assessment completed on February 26, 2001, describes R5 as "not able to manage his bi-polar disorder," and although he had been stable at times, he was "not able to deal with stress and reverts to depression and substance abuse." CMS Ex. 403, at 20. It further states that he needs the "support and structure of an ICF [Intermediate Care Facility]." *Id.* The screening assessment identifies R5's needs for medication monitoring, mental illness education, and substance abuse education. *Id.*

On March 19, 2001, R5 complained of "having disturbing dreams" that were "causing him anxiety throughout the day," and were causing him to feel "depressed." CMS Ex. 403, at 62. However, there is no record that staff advised the psychiatrist of this complaint, or monitored R5 more carefully after his reporting this to staff. In fact, at 5:00 p.m. that same day, R5 signed out of the facility to go downtown.

On the morning of March 22, 2001, nursing notes reveal that R5 was "unable to get out of bed," complained of having the "spins . . . feeling nauseated," and that he had "dry heaves." CMS Ex. 403, at 50. The nursing notes which were documented at 2:23 a.m. further indicate that staff would "endorse day shift to monitor as Trazadone dosage has been increased." *Id.* However, at 6:25 a.m., R5 signed out of the facility, recording on the sign-out sheet that he would be "walking." He returned to the facility at 7:00, and then signed out again at 9:10 a.m. to go to the "store." *Id.* at 48. The next notation in the nursing notes on March 22 was at 9:18 p.m., which reveals that R5 had not been seen since the evening shift had started. *Id.* at 50. The sign-out sheet was checked by staff and verified that R5 had signed out, but had not returned. R5 had been allowed to go out on pass on March 22 and thus was unavailable to staff for monitoring and assessment, specifically in regard to his medication compliance. The nursing note reveals that "alcohol smell noticed" when R5 returned to Hillcrest at 9:54 p.m. *Id.*

Hillcrest argues that it assesses residents each morning, and that R3, R4, R5, and R6 were assessed on the morning of the homicide and home invasion, by the nurses who administered medications to them. However, R.N. Mary Locicero, who administered the medications to R3, R5, and R6 on the morning of March 22, testified that she spends only a couple of minutes with residents during medication administration and that she does not review resident nursing and social service notes prior to administering the medications. Tr. at 1625, 1626. R.N. Jurilla, who administered medication to R4 on March 22, testified that with just one medication to administer to him, she would take a minute "[o]r less than that." Tr. at 1667. She further testified that she does not go back and review nursing notes; rather, she relies on a shift report of what is going on with the resident. Tr. at 1668.

The evidence establishes that Hillcrest failed to properly assess these residents before their leaving on pass and after returning from their pass outing. A one-minute visit by a nurse with a resident during a morning medication pass is not sufficient for an assessment prior to that resident's going out on pass, which could last up to 10 or more hours.

Hillcrest asserts that there is nothing in the nursing records of R4 and R5 during the weeks leading up to the home invasion and homicide from which anyone could have predicted that they would act dangerously while on pass. P. PHB at 2-3. Hillcrest asserts further that on the morning of March 22, nurses gave the four residents the medications that they were taking on a daily basis, and that the four residents were not acting abnormally or in a manner such that they posed a risk to themselves or others. *Id.* Hillcrest argues that none of the four residents had a written order from a physician imposing any kind of restraint on them, as is required under 42 U.S.C. § 1396r(c)(1)(A)(ii). P. PHB at 7. Instead, all four residents had orders from their treating physicians allowing them to go out on pass. P. Exs. 7, 51, 52; CMS Ex. 403, at 36. Therefore, staff had no grounds to disregard their doctor's orders or revoke the pass privileges of R3, R4, R5, and R6 on the morning of

March 22, and, according to Hillcrest, the intentional crime committed that day by R4 and R5 was entirely unpredictable. P. PHB at 2.

At hearing, several witnesses from both CMS and Hillcrest testified that R5's symptoms on the morning of March 22 were consistent with either alcohol use or medication side effects. Tr. at 145, 350-351, 613-614, 2158, 2343, 2498-99. However, there is nothing in R5's record relative to tests performed or other actions taken addressing either of these possible causes. CMS Ex. 403, at 50. Nursing staff took R5's vital signs and then "endorse[d]" him to the next shift. *Id.*

Dr. Perraud credibly testified that an assessment of only vital signs was not sufficient. Tr. at 1217. Rather, the standards of nursing practice dictate that staff should have done a thorough assessment and explored beyond one explanation as to why R5 might be experiencing the symptoms he described. *Id.* Additionally, Dr. Perraud testified that an alcohol screening of R5 was warranted. *Id.*

R5 had signed an alcohol and drug policy which required that an alcohol screening be done if alcohol use was suspected. Outside of the initial vital signs being taken, there were no follow-up checks of R5's level of consciousness after he first reported his symptoms. R5's symptoms were first reported to nursing at 12 a.m., by a female resident indicating that R5 was not feeling well, and was unable to get out of bed. CMS Ex. 403, at 50. The nursing note at 2:23 a.m. indicated that R5 was "found lying supine" and "dry heaves were noted." *Id.* R5 was advised by a nurse to lie on left side, his vital signs were taken, and the note further indicates that "[c]lient resting comfortably at this time." *Id.* So from the one notation at 2:23 a.m., it would appear that the nurse first intervened at 12:00 a.m., and then checked R5 again at 2:23 a.m. *Id.* However, this was not sufficient. Surveyor Pettenger testified that she would have taken vital signs at least every half-hour, encouraged fluids, and instructed R5 to get up slowly as his blood pressure could drop more. Tr. at 430. She stated that she would also "keep him where I could see him, to see how he reacts to that medication . . . and call the doctor." Tr. at 430. Dr. Perruad testified that "[g]iven that [R5] was complaining of fairly extreme symptoms, I would hold the pass and call the physician and clarify it." Tr. at 1099. However, the record for R5 does not indicate that Hillcrest notified either the medical doctor or the psychiatrist of his condition. I find that Hillcrest's failure to monitor R5 after his symptoms on the morning of March 22 violated standards of nursing practice and the supervision requirement of section 42 C.F.R. § 483.25(h)(2).

R3

On March 12, 2001, R3 was transported via ambulance to the hospital after reporting severe abdominal pain, and having vomited blood. CMS Ex. 401, at 63. Upon her return to Hillcrest, R3 reported that she had a cyst on her ovaries which required medication for pain. *Id.* at 63, 64. On March 22, R3 reported that she sometimes felt depressed and asked to see her doctor. *Id.* at 64. A nursing note dated March 22, notes that "staff will continue to monitor." *Id.* However, two hours later, R3 was allowed to go out on pass. CMS Ex. 401, at 6. There is no evidence in the record that Hillcrest monitored R3 for signs of depression or that arrangements were made for R3 to speak with her doctor, or any other doctor.

Based on the record before me and the testimony offered at hearing, I find that Hillcrest failed to properly assess R3 and R5 before they left on pass.

b. Hillcrest's doctors' orders were ambiguous

CMS states that doctors' orders for R3, R4, R5, and R6 allowing them to go out on pass were ambiguous, and that each resident had the same general verbatim order which read:

> **MAY LEAVE FACILITY WITHOUT CONTRAINDICATION WITH OR WITHOUT MEDS.**

P. Exs. 7, 51, 52; CMS Ex. 403, at 36.

Surveyors Susan Pettenger, Daniel Pletcher, and Elaine Moore, all experienced nurses, testified that the language in the order was not clear, and they would question what the doctor meant by "with or without meds," in relation to length of time period, and what was meant by "without contraindication." Tr. at 426-427; 609; 712.

It was clear from the testimony that there seemed to be different interpretations by Hillcrest staff as to the doctors' orders in relation to pass privileges. R.N. Locicero, who administered the medications to R3, R5, and R6 on the morning of March 22, testified that she believed the order authorized a resident to leave for the day with his medications or even for a day without his medication, but she was not certain if a resident could leave for a week without his medications. Tr. at 1629. In an attempt to interpret the "with or without meds" language, Hillcrest's expert witness, Gershon H. Kaplan, M.D., testified that it was his understanding that the order meant "that if a person goes out for half an hour, he doesn't need to take meds. If he's going out all day, he should have meds with him." Tr. at 2303.

Additionally, CMS argues that the doctors' orders upon which Hillcrest relied to allow R3, R4, R5 and R6 out on pass are for April 2001, and not March 2001, which is the month at issue in this appeal. CMS maintains that Hillcrest failed to provide evidence of doctors' pass orders for the four residents that would apply to the time period prior to and up to the date of the homicide and home invasion. CMS PHB at 92-93; P. Exs. 7, 51, 52; CMS Ex. 403, at 36. CMS argues that without having the orders for the correct month, there is no way to tell how they read and what handwritten changes may have been made to them. CMS PHB at 93; Tr. at 1671-72 (Hillcrest R.N. Jurilla concurs with CMS's argument).

CMS is correct. The record before me does not include evidence of March 2001 doctors' orders allowing pass privileges for R3, R4, R5, and R6. However, even if it did, and if the March orders were identical to the April orders, I would still find that the doctors' orders were not individualized for each resident. The doctors' orders were vague and ambiguous, and staff at Hillcrest did not have a consistent understanding of how the orders were to be interpreted.

2. Hillcrest failed to ensure that R3, R4, R5, and R6 attended their group counseling sessions or received appropriate individual counseling.

CMS alleges that Hillcrest failed to provide R3, R4, R5, and R6 with the counseling services they required, and thus failed to provide them with "adequate supervision to prevent accidents." CMS PHB at 35. According to Hillcrest, a resident's failure to receive offered counseling is no reason to revoke a doctor-issued pass privilege. Hillcrest contends that facilities should encourage residents to receive group and individual counseling, but are not required to compel or force residents to receive such counseling.

Hillcrest employs a variety of interventions in dealing with a resident's failure to attend group counseling: (1) if a resident is late or absent, they are sought out by professional staff and encouraged to attend; and (2) a token reward program is a tool used to encourage residents to regularly attend planned programming. According to Hillcrest's *Supervision and Care of Residents* policy, a resident will be assigned to one of the group therapies and a psychiatric technician based upon assessment and need. The resident then receives individual sessions and attends different group meetings on topics such as anger management, socialization, managing stress, alcohol/drug dependency, social skills, and problem resolution skills. CMS Ex. 419, at 9.

a. Review of residents' care plans and counseling needs.

R3

R3's care plan identified her need for individual and group counseling sessions. CMS Ex. 401, at 58-59. It noted that she had poor affect management and when periods of stress were observed, staff were instructed to "[m]ake referrals to social service for 1:1" and "[e]ncourage attendance in therapeutic groups and activities" *Id.* In dealing with her ineffective individual coping skills, her care plan instructed social service staff to make "1:1 visits [when] depressed" and "[e]ncourage to attend Coping Sessions 1-2 times weekly." *Id.* at 59. Her care plan instructed staff to "[e]ncourage to attend Twentysomething Group 1x weekly." *Id.* at 59-61.

During her stay at Hillcrest (a total of 16 days), R3 received the following counseling services:

> (1) Three individual counseling sessions during her first week after her admission on March 6 (on March 7, 9, 12); and, from March 13 through March 22, one individual session on the morning of March 22. CMS Ex. 401, at 62.
>
> (2) R3 attended three group counseling sessions during her stay (March 7, 13, 14), but none occurred during her last eight days at Hillcrest: (1) "Coping with Depression" group which met twice weekly, R3 attended two of the five meetings and missed the two sessions held on March 19 and 21, prior to when she reported her depression on March 22; (2) one session on Women's Issues on March 13; and (3) R3 did not attend the "Twentysomething" group which met weekly. CMS Ex. 421, at 1.

A review at R3's sign-out sheet shows that she was out on pass during her last week at Hillcrest, and therefore unavailable to attend group sessions during those times.

I find that the record establishes that R3 was encouraged by the psychiatric technician to participate in group counseling during her initial placement at Hillcrest; however, from March 12 through March 21, for a total of 10 days, the record does not reflect that R3 received individual counseling, nor does the record reflect that she was prompted to attend counseling sessions. CMS Ex. 401, at 62. The social service notes indicate that a psychiatric technician encouraged R3 to attend her group sessions on the following days in which she received individual counseling: (1) March 7, 2001, when she was encouraged to participate in "Twenty-something" and "Coping with Depression" groups; (2) March 9, 2001 where she was encouraged to attend the Coping with depression group; and (3)

March 22, 2001, when she was encouraged to attend "all depression groups offered." CMS Ex. 401, at 62, 64.

R4

R4's care plan identified a need for regular group and individual counseling which required staff to "[m]ake referrals to social services for 1:1 contact during periods of stress or when observed change in mood or behavior," to "[i]ncrease 1:1 contact during periods of stress," and "[e]ncourage attendance at HRDI[28] relapse prevention group." CMS Ex. 402, at 56-57. Staff were also to deal with his ineffective individual coping skills through individual visits and to "[e]ncourage to attend Coping Sessions," and to "[e]ncourage to attend 20 Something Group" for therapeutic recreation. *Id.* at 57-58.

CMS contends that R4's chronic absences from Hillcrest contributed to the lack of individual counseling, and the failure to receive sufficient individual and group counseling made him an accident risk to himself and other residents. CMS PHB at 115. During his stay at Hillcrest (a total of 43 days), R4 received the following counseling services:

> (1) Twelve individual counseling sessions were received: six during his first week after admission (February 9, 11, 12, 13, 15 and 16); then from February 17 through March 23, six individual counseling sessions were recorded in social service notes (February 18, March 8, 9, 18, 19, 23). CMS Ex. 402, at 72-73.
>
> (2) Nine group counseling sessions which included: four of the six "Coping with Depression" group meetings during his first three weeks (CMS Ex 421, at 1-2, 19); during his last three weeks he attended two of the six meetings of this group (*Id.*); he attended one session in the "Anger Management" group which met once per week (*Id.* at 1, 20); one session of the "Twentysomething" group which met weekly (CMS Ex. 421, at 1); and one meeting of the "HRDI Sobriety Society" group. *Id.*

R4's group counseling attendance declined as did his individual counseling sessions during the last half of his stay. During the last three weeks of his stay, he had an average of one individual and one group counseling session per week. R4 attended nine group sessions during his six-week stay, and only one of those sessions was during the final two weeks of his stay.

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[28] The record before me does not provide an indication as to what "HRDI" signifies. However, the absence of this information does not effect my Findings and conclusions.

Hillcrest asserts that R4's clinical records reveal that he had "little interest in groups and activities," and "does not like to talk in groups." CMS Ex. 402, at 72 (entries dated 2/11/01 and 2/12/01). Hillcrest staff repeatedly encouraged him to attend groups sessions. *Id.* at 72-73 (entries dated 2/12, 2/13, 2/15, 3/9). Thus, in spite of his aversion, R4 attended at least nine group sessions during his six weeks at Hillcrest and 12 individual counseling sessions. Hillcrest also asserts that during those sessions he denied any suicidal or homicidal thoughts. *Id.*

CMS contends that R4 received few, if any, individual counseling sessions and was not appropriately confronted and/or counseled even when he did have direct time with Hillcrest psychiatric technicians.

R5

R5's transfer report from the inpatient hospital states as a goal that he "continue to receive treatment for his depression." CMS Ex. 403, at 13. His care plan identified a need for regular group and individual counseling. *Id.* at 59-61. To avoid his relapse into alcohol and drug dependence, R5's care plan directed staff to "[m]ake referrals to social services for 1:1 contact during periods of stress or when observed change in mood or behavior" and "[e]ncourage attendance in therapeutic groups and activities." *Id.* at 59.

During his stay at Hillcrest (a total of 22 days), R5 received the following counseling services:

> (1) On March 19, 2001, three weeks after R5's admission to Hillcrest, social services notes reveal one visit with a counselor which was initiated by R5, and two visits by counselors on March 23 following R5's return to the facility after the homicide. CMS Ex. 403, at 62.
>
> (2) R5 attended eight group sessions during his stay: (1) a "Stressbuster's" group on March 4; (2) the "Coping with Depression" group met twice per week and he attended the first five meetings, but missed the session held on March 21, which was following his self-report of having "disturbing dreams," "anxiety," and depression on March 19, 2001; and (3) the "Anger Management" group met once per week and R5 attended two of the four meetings during his stay. *Id.* CMS Ex. 421, at 1-2, 19, 20. The "Twentysomething" group met once per week and R5 did not attend any of their meetings. *Id.* at 1. R5 did not attend the "HRDI Sobriety Society" group meeting which was held at least once during his stay. *Id.*

R5 did not receive any individual counseling visits initiated by Hillcrest counselors during his stay. CMS Ex. 421, at 1-2, 19. The social service notes reveal that on March 19, R5 "sought out counselor for 1:1." *Id.* During that session, he indicated that he was "having disturbing dreams" that were "causing him anxiety throughout the day" and making him feel "depressed." *Id.* The social service notes do not indicate any additional individual counseling sessions with R5 during the next three days prior to March 22, the day of the homicide and home invasion. CMS Ex. 403, at 62. At hearing, R5's psychiatric technician testified that he did not feel the need to monitor R5 more closely after the March 19 session when R5 had told him that he was suffering from anxiety throughout the day. Tr. at 1926.

R5's clinical record reveals that he was an individual who had experienced numerous losses since February 2001. His mother died, his five-year relationship with a girlfriend ended, and he lost his job. CMS Ex. 403, at 6. On February 21, 2001, he had been admitted to a psychiatric hospital due to "acute suicidality." *Id.* at 8. On March 19, R5 reported disturbing dreams causing daytime anxiety, and then there was a noted increase in use of passes. *Id.* at 48, 62. However, R5's clinical record reveals that he did not receive individual counseling sessions initiated by Hillcrest counselors during this time.

R6

R6's inpatient hospital records indicate that he had "a very serious psychiatric history," and required placement that would "help him engage with treatment." CMS Ex. 404, at 9, 10. His care plan instructed staff to "[m]ake referrals to social services for 1:1 contact during periods of stress or when observed change in mood or behavior," and to "[e]ncourage [attendance] at HRDI Relapse prevention groups." CMS Ex. 404, at 48. As for his noncompliance and his substance abuse treatment regime, R6's care plan advised staff to "[e]ncourage to attend HRDI [relapse prevention] and [sobriety society] groups." *Id.* The care plan also instructed staff to "[m]ake referrals to social services for [1:1] during periods of stress or behavior programs," and deal with his poor anger and stress management, coping skills, and impulse control issues. *Id.* at 38, 39. As for his criminal behavior, his care plan instructed staff to "[r]efer to social services" and instructed social service staff to "1:1 visits" and "[e]ncourage to attend Anger [Management] and Depression Groups." *Id.* As for his potential for ineffective individual coping, his care plan directed staff to make "1:1 visits when [depressed]" and "[e]ncourage [resident] to attend Coping Sessions." *Id.*

During his stay at Hillcrest (a total of 35 days), R6 received the following counseling services:

(1) R6 participated in eight individual counseling sessions in total, all of which occurred during the first two weeks after his admission to Hillcrest (February16, 21, 22, 23, 26, 27, 28, and March 19). CMS Ex. 404, at 60, 61.

(2) R6 attended a total of 12 group counseling sessions during his five-week stay. CMS Ex. 421, at 1.

For the last 22 days of R6's stay at Hillcrest, March 1-22, there was only one individual counseling session which occurred on March 19. CMS Ex. 404, at 60, 61. The clinical record notations from that session indicate that R6 was encouraged to "seek out counselors when he needs to talk," would "continue to meet with writer," and would be "referred to Dr. White's groups for ongoing therapy and monitoring." *Id.* at 60. Although R6's plan of care identified his need for individual counseling, there is no documentation of continued individual counseling after February 28, outside of the March 19 counseling session. The March 19 entry indicates that a social history was completed and a review of facility policies discussed with R6. *Id.* 60-61. However, there is no reference to any discussion by a counselor with R6 regarding the recent incident of his expressing that he was "depressed and often agitated" and described himself as "unhealthy." *Id.* at 63. However, on March 22, R6 was permitted to sign out of Hillcrest, and was later found to have spent the entire day driving around and drinking with two other residents.

I find that CMS has established a prima facie case that Hillcrest failed to provide R3, R4, R5, and R6 with the counseling services they needed as identified in their care plans. It is clear that R3's, R4's, R5's, and R6's clinical records identified certain patterns of behavior that merited precaution that the resident needed something more than to be allowed out on pass. The record established that each resident was in need of closer monitoring and more counseling than was provided. Hillcrest had ample reason to be aware of the likelihood of R3, R4, R5, and R6 encountering some incident which they could not handle. These were residents with troubled, aggressive, and impulsive backgrounds. Therefore, Hillcrest had a duty to these residents to provide the appropriate supervision to prevent such foreseeable adverse outcomes even if Hillcrest could not have predicted the specific crime that occurred on March 22.

Hillcrest maintains that it cannot force residents to participate in available counseling as they have a "right to refuse treatment," and that it encourages its residents to attend counseling by employing a token reward system and through verbal reinforcement. P. PHB at 49; Tr. at 1268, 2053. However, as evident by R3's, R4's, R5's, and R6's sign-out sheets, their access to the outside community was more motivating to them than tokens they could have earned by attending counseling sessions. Also, based on the counseling record of each of the four residents, there was insufficient individual sessions afforded to these residents to be able to provide consistent verbal reinforcement encouraging them to

attend their group counseling sessions. I find that Hillcrest did not take relevant precautions such as closer monitoring and supervision of these residents who had histories of psychiatric problems, ineffective coping skills, refusal and noncompliance with treatment programs and past criminal behavior. These would have included more individualized counseling initiated by staff and a pass system that was tied to compliance with the individual's rehabilitation needs as identified in each of their plans of care. The failure by Hillcrest to provide the needed supervision which allowed R3, R4, R5, and R6 opportunity to participate in dangerous activities resulted in immediate jeopardy to residents. Therefore, the record before me provides a preponderance of evidence that Hillcrest failed to provide adequate supervision designed to meet R3's, R4's, R5's, and R6's needs an thus failed to mitigate foreseeable risks of harm from accidents. The evidence also provides overwhelming support for a finding that Hillcrest's noncompliance was at the immediate jeopardy level.

b. Hillcrest's assertions of a resident's right to refuse treatment.

Consistently throughout the hearing, Hillcrest staff reiterated that although they encourage residents to attend counseling sessions, it is the residents' legal right to refuse treatment. Former Clinical Director Mutterer testified that "[i]f a resident chooses not to attend a group, no, we cannot force them into treatment." Tr. at 1538-39. Additionally, Mr. Mutterer testified that Hillcrest could not restrict a resident's pass usage as Hillcrest was "legally responsible to allow them to go out on pass based on the resident rights and the regulations regarding nursing homes." Tr. at 1267. Mr. Mutterer further testified that "[i]f somebody presents themselves in a manner that they are a danger to themselves or others they are immediately hospitalized in an in-patient psych unit to stabilize their symptoms." Tr. at 1462.

A resident has the right to refuse treatment, choose health care, and to make choices about significant aspects of his or her life in the facility. 42 C.F.R. §§ 483.10(b)(4); 483.15(b)(1); 483.15(b)(3). However, the regulation requires that the care plan outline the services to be provided to the resident. Any services that would otherwise be required under the quality of care requirement at 42 C.F.R. § 483.25, but could will not be provided due to the resident's exercise of his or her rights, including the right to refuse treatment, and the resident's right to choose health care must be "consistent with his or her . . . assessments, and plans of care." 42 C.F.R. §§ 483.20(k)(1)(ii), 483.15(b)(1). While there is no dispute that residents have a right to refuse treatment, Hillcrest had a countervailing duty to protect the individuals under its care against accidents. Therefore, while the regulations support a resident's right to refuse care, such right is not absolute and should be consistent with the resident's interest, assessments, and plans of care. *See Innsbruck HealthCare Center*, DAB No. 1948, at 7-8 (2004). Additionally, a resident's right to refuse treatment does not absolve a facility from a continuous effort to comply with the

regulations by use of other means – to allow this would mean facilities could permit residents to refuse treatments to the point of injury or death. *See Koester Pavillion*, DAB No. 1750, at 28 (2000). A facility is entrusted with balancing necessary care and services with a resident's right to refuse treatment.

The preamble to the implementing regulations state:

> We recognize that a facility cannot ensure that the treatment and services will result in a positive outcome since outcomes depend on many factors, including a resident's cooperation (i.e. the right to refuse treatment), and disease processes. However, we believe it is reasonable to require the facility to ensure that "treatment and services" are provided, since the basic purpose for residents being in the facility is for "treatment and services" and that is why the Medicare or Medicaid program makes payment on the residents' behalf. We also think it is reasonable to require the facility to ensure that the resident does not deteriorate within the confines of a resident's right to refuse treatment and within the confines of recognized pathology and the normal aging process.

54 Fed. Reg. 5316, 5332 (Feb. 2, 1989).

3. Hillcrest staff failed to respond properly when R3, R4, R5, and R6 returned to Hillcrest on March 22.

According to CMS, upon the return of R3, R4, R5, and R6 to the facility on March 22, 2001, Hillcrest failed: (1) to fully assess these residents for injuries; (2) to separate these residents from Hillcrest's general population; and (3) to call the police in a timely manner.

a. Hillcrest failed to fully assess R3, R4, R5, and R6.

The following was noted when R3, R4, R5, and R6 returned to the facility at 9:55 p.m. on March 22, 2001:

R4

R4 had "[a]brasions noted on right knuckle, left elbow, right forearm and blood stain in his jeans." CMS Ex. 402, at 71; CMS Ex. 414, at 29. The note further indicates that "[s]upervisor no[t]ified. Endorsed to next shift." CMS Ex. 402, at 71. The social service notes reveal that R4 "returned to the facility with intoxication, agitation and anger." CMS

Ex. 402, at 73. In addition, it was noted that R4 "got into verbal altercation which almost [led] to a fight. Counselor had to separate the res[idents] from one another. As counselor attempted to redirect res[ident], resident continued to verbalize threatening words to peer. Res[ident] left the facility in rage." *Id.* According to the police report which provides an account of R4's condition when he returned to the facility that evening, "they drove back to [Hillcrest] where they were observed by a Psychology Technician . . . [She] related that she observed [R4] with bloody knuckles, and his pants approximately halfway down from his knees were covered in blood, including bloody hand-prints." CMS Ex. 414, at 9.

R5

Nursing notes for R5 state that "alcohol smell noticed." CMS Ex. 403, at 50. The social service notes describe his condition upon his return: "Res[ident] returned to the facility with increased intoxication . . . Counselor smelled alcohol on res[ident] from 4 ft away. Counselor noticed a scratch on his forehead and asked how did it get there. Res[ident] reported that the resident and another res[ident] [were] wrestling and he accidently got scratched" . . . Counselor and nursing will continue to monitor for change in mood and behavior." *Id.* at 62.

Additionally, R4 and R5 provided inconsistent stories to Hillcrest staff as to how they obtained their injuries on the evening of March 22:

- CNA Joyce Welcher noted that R4 reported that he ran into a brick wall, and then later stated that he had been in a bar fight. CMS Ex. 410, at 6.

- R4 is reported to have told R.N. Cheryl Morelli Jacobi and R.N. Ray Sinsong that he had been in a bar fight and the other guy wasn't doing very well. Tr. at 602, 750; CMS Exs. 408, at 7; 411, at 12.

- R.N. Joy Goyano reported that R4 told her that he had tripped and fallen on the ground. Tr. at 600, 749; CMS Exs. 408, at 8; 411, at 5.

- R5 reported to Ms. Jacobi that their injuries resulted from R4 and R5 goofing around in a fighting manner. Tr. at 603; CMS Ex. 411, at 13.

R3 and R6

Nursing notes for R3 and R6 also record that "alcohol smell noticed." CMS Exs. 401, at 63; 404, at 59. Social service notes for R6 describe that he "returned to the facility and presented with anxiety, intoxication and admitted to drinking alcohol." CMS Ex. 404, at 61.

CMS argues that the four residents were not fully assessed for injuries upon their return to Hillcrest the evening of March 22. Specifically, there were no full incident reports completed and the four residents' vital signs were not taken.

Hillcrest claims that the observations recorded in each resident's record prove that R3, R4, R5, and R6 were questioned about their appearance and whereabouts, that they were carefully assessed, and that complete examinations were not warranted. P. PHB at 57; testimony of Ms. Costello, Tr. at 2084 (the nurses "examined the scratches and marks that were on them, and didn't find any need for further physical exam.")

In a written statement, Cheryl Morelli Jacobi, the R.N. on duty at Hillcrest on March 22, wrote that she "assessed all the four residents that came back that evening visually after noting the blood on one resident's jeans and that's when I realized none were hurt and the blood must have come from someone else." CMS Ex. 415. She then notes that is when she called the police. *Id.* However, in spite of R.N. Jacobi's statement as to her assessment of the four residents, a Joliet police report notes a cut on R5's chest that is not referenced at all by Hillcrest staff in R5's clinical record. CMS Ex. 414, at 15-16.

Surveyor Pettenger testified at hearing that a visual assessment is different than a head-to-toe assessment as a visual assessment involves "just looking at the person standing there." Tr. at 424. Ms. Pettenger testified further that Hillcrest should have completed a full head-to-toe assessment of each resident:

> You start at the top of the head, observing for any signs and feeling for any lumps. You do the facial for a reaction to light. You look behind the ears. You look into the mouth for any bleeding. You go into the shoulder. You go from head to toe.

Tr. at 320.

Considering the state in which these residents returned to Hillcrest that evening, I find that they should have been fully assessed for injuries. A review of the circumstances surrounding the return of R3, R4, R5, and R6 to Hillcrest the evening of March 22 would have justified the need for a complete physical exam of each resident, given that they had returned from a full-day pass intoxicated, bruised, and bloodied.

b. Hillcrest failed to separate R3, R4, R5, and R6 when they returned to the facility on the evening of March 22.

At hearing, former Clinical Director Costello testified that she decided the evening of March 22 that the residents did not need to be separated from each other or other residents:

> There was no indication that there was any need to isolate any of those residents at that time . . . . The times when we would use physical isolation on a resident would be when they seem to be at imminent risk of harm to themselves or others, and these residents presented as under the influence of alcohol but there was nothing to indicate that they were at risk to themselves or others.

Tr. at 2083, 2086.

According to Hillcrest, the police were called by staff, and each resident was assigned a staff member who monitored the resident on a line-of-sight, one-to-one supervision. P. PHB at 56. Hillcrest further contends that not even the Joliet police knew at the time that a homicide had occurred, much less that R4 had committed it. *Id.* As to R4's verbal altercation that evening, Ms. Costello stated at hearing that "[w]e can't prevent another resident from speaking to that resident or prevent R4 from speaking to another resident. When it did become a verbal altercation, the staff intervened, and that's what they were intended to do." Tr. at 2085.

Considering the state in which R3, R4, R5, and R6 returned to the facility that evening, they should have been separated and counseled so that staff could ascertain their past whereabouts especially as they had been out on pass for a full day and returned intoxicated, bruised, and bloodied. As discussed earlier, R4 and R5 provided staff with different explanations as to why there was blood on their clothing.

Although Hillcrest contends that it provided one-on-one supervision to each of the residents, I find that steering residents to common rooms in which staff are present but performing other duties and watching other residents, does not equate to one-on-one supervision. It just was not apparent from the record before me that any staff member was specifically assigned to watch each of the four residents or to observe any particular resident continuously. The condition in which these residents, particularly R4 and R5, returned to Hillcrest the evening of March 22, and the discrepancies in how they sustained their bruises and the blood on their clothing, warranted closer supervision. Clearly, based on their conditions as presented that evening to staff, the residents lacked safety awareness and therefore should have been considered to possibly act in ways which would endanger themselves or another resident absent staff supervision. I find that an assignment of line-

of-sight supervision was not sufficient to meet the necessary supervision requirements. Clearly, Hillcrest failed to provide supervision adequate to protect R3, R4, R5, and R6 the evening of March 22 when the four residents returned to the facility.

c. Hillcrest staff did not fail to call police in a timely manner.

There was a 45-minute interval between the time the four residents signed into Hillcrest the evening of March 22 and the time staff phoned the police. During this time, staff assessed the residents' risk of harm to themselves and others, notified supervisors and physicians, considered the assignment for one-to-one monitoring, and then called police.

According to Joliet Police Department documents, Hillcrest staff called the police at 10:31 p.m - the parties agree that the call to the police occurred on March 22, 2001.[29] CMS Exs. 414, at 1; 422, at 1. The Hillcrest sign-out sheets for R3, R4, R5, and R6 indicate that they signed back into the facility between 9:45 p.m. and 9:55 p.m. on March 22. CMS Exs. 401, at 61; 402, at 69; 403, at 48; 404, at 57. Therefore, staff called the police at most 45 minutes after the residents signed back into the facility. Given that staff needed to interview the residents, perform assessments, and speak to the Clinical Director and Administrator, I do not find a 45-minute period before police were called to be unreasonable.

I agree with CMS that four residents returning to a facility intoxicated and with blood on their clothes would be disconcerting, but I do not agree that it prompted an immediate call to police until further investigation by staff could occur. Rather, I agree that staff needed time to evaluate the situation to determine if the residents were injured and to have an opportunity to talk with each of the residents to ascertain what may have occurred. The fact that R4 was reported as being enraged and then left the facility out the back door did not, standing alone, justify calling the police immediately. CMS Exs. 402, at 73; 414 at 9, 10. Although I have found that staff did not do comprehensive physical assessments of the residents and failed to separate them, I find that staff called the police in a timely manner once they determined there was a need for police intervention.

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[29] I take note that two of the police reports appear to be conflicting as to the date Hillcrest staff called the police to the facility. The Offense Report records the incident report date as March 23, 2001, whereas the Location Search report records the date as March 22, 2001. Since the date of the call is not in dispute, and the testimony confirms March 22 was the actual report date, I will accept March 22, 2001 as the date Hillcrest staff called the police to the facility. *See* CMS Ex. 414, at 1 compared to CMS Ex. 422, at 1.

Although I find that Hillcrest's 45-minute time interval in calling the Joliet police was reasonable, there is ample evidence before me to support CMS's determination that Hillcrest's failure to comply with the requirements of 42 C.F.R. § 483.25(h)(2) was at a level of immediate jeopardy. I conclude that CMS has established a prima facie case which Hillcrest has not been able to rebut, that Hillcrest violated the supervision requirement of 42 C.F.R. § 483.25(h)(2).

I find that the previously discussed deficiencies which the surveyors assessed at a level of immediate jeopardy are sufficient to sustain the deficiency citation under tag F324, and therefore find it unnecessary to discuss other alleged deficiencies. For instance, I will not discuss whether Hillcrest violated standards of nursing practice by:

> (1) failing to contact R4's medical doctor and psychiatrist to review his treatment plan and revisit his orders after his significant change in condition after March 17, 2001; and failing to contact R5's medical doctor and psychiatrist to revisit his orders after his significant change in condition after March 19;
>
> (2) failing to contact R4's medical doctor and psychiatrist to question whether the circumstances surrounding his return from his pass outing on March 17 constituted a contraindication;
>
> (3) failing to contact R5's medical doctor and psychiatrist to question whether his condition on the morning of the homicide and home invasion constituted a contraindication; and failing to monitor R4 more closely even after it became aware of his deceptive behavior after his return from his pass outing on March 17, 2001; and
>
> (4) failing to follow its Code White and other policies after R3, R4, R5, and R6 returned to Hillcrest after the home invasion and homicide.

CMS PHB at 102-33.

4. There is no merit to Hillcrest's other arguments.

Hillcrest raises several other arguments which I address below:

a. Section 483.25(h)(2) of 42 C.F.R. does not apply to intentional crimes committed away from the facility.

Hillcrest argues that a threshold question of law exists as to whether 42 C.F.R. § 483.25(h)(2) applies to this case. According to Hillcrest, the homicide and home invasion that occurred on March 22 did not constitutue an "accident," and the victim was not a "resident" of Hillcrest. Hillcrest additionally argues that the homicide and home invasion occurred at an apartment complex approximately four miles away from the facility, and that the homicide and home invasion was entirely unpredictable. Hillcrest states that it is a nursing home, not a law enforcement agency, and that the cited regulation simply does not apply to intentional criminal acts committed away from the facility against nonresidents.

Hillcrest further asserts that CMS reads a supervision aspect or requirement into the regulation that is unrelated to or independent from the phrase "to prevent accidents." Hillcrest asserts that the home invasion and homicide could not have been predicted or prevented. Thus, according to Hillcrest, an intentional crime against a nonresident away from the facility cannot constitute immediate jeopardy. Hillcrest claims that CMS violates due process by interjecting a requirement into 42 C.F.R. § 483.25(h)(2) that Hillcrest should have prevented the residents from committing crimes while out on pass.

It is apparent that Hillcrest focuses on the wrong issue. Although circumstances surrounding an accident could provide evidence of the inadequacy of the supervision provided to protect a resident, an event or condition that is not an accident may also provide such evidence as well. *Woodstock Care Center*, DAB No. 1726 (2000), *aff'd, Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003). Therefore, the focus when looking at section 483.25(h)(2) should be on whether the evidence demonstrates that a facility has failed to provide adequate supervision and assistance devices to prevent accidents, given what was reasonably foreseeable.

In order to comply with section 438.25(h)(2), Hillcrest and its staff were required to take all reasonable measures to provide residents with sufficient supervision to protect them against sustaining accidents. The consequences of Hillcrest's error in being lax about its supervision of day passes were foreseeable, even though the specific crime of home invasion and murder committed in this case may not have been foreseeable. The doctors' orders relative to pass privileges required clarification. Hillcrest was dealing with psychiatric residents who were on highly complicated medication regimes and yet were

authorized to leave the facility for extended periods of time without their medications. The doctors' orders relative to pass privileges for the residents at issue were vague. Hillcrest violated the supervision requirement of 42 C.F.R. § 483.25(h)(2) when it allowed its residents to leave on pass without sufficient medications and without clarification of doctors' orders.

Hillcrest had reason to know that closer supervision by staff would be necessary for R3, R4, R5, and R6. In coming to my conclusion, I considered the actions Hillcrest took to identify, remove, or protect residents and ensure their safety to the maximum extent possible. Hillcrest cannot prevail if, as I found here, it could have reasonably foreseen that its lax pass policy would create a condition that would endanger residents' safety either generally, or for a particular resident or residents, as in the cases of R3, R4, R5, and R6. When the level and kind of supervision provided to R3, R4, R5, and R6 were examined in order to determine whether they were sufficient to prevent any untoward events, I found that Hillcrest did not do everything in its power to prevent accidents. *Odd Fellow and Rebekah Health Care Facility*, DAB No. 1839, at 6-7 (2002)(quoting *Asbury Center at Johnson City*, DAB No. 1815, at 12 (2002) and *Koester Pavilion*, DAB No. 1750, at 25-26 (2000)).

A facility's duty to its residents does not cease as soon as that resident leaves the facility doors on pass privileges. Therefore, Hillcrest can be faulted for failing its obligation to care for these residents, both for its actions and inactions while the residents were in the facility and after the residents left the facility's grounds. I cannot agree with Hillcrest's rationale that it is absolved of its responsibility to care for residents as soon as they leave the facility - even if the residents have the capacity and freedom to go outside the facility pursuant to pass privileges. Hillcrest cannot abdicate its responsibility to provide supervision that is adequate and appropriate. Here, Hillcrest did not know the whereabouts of its residents for significant periods of time. Hillcrest's responsibility is to enable its residents to effectuate their choices to exercise pass privileges safely without placing them at risk. Therefore, during the period of time each of these residents was missing from the facility, Hillcrest was unable to effectuate its duty to provide these residents with the type and degree of supervision adequate for preventing accidents to them.

Even if Hillcrest's failure to comply did not harm the residents in question, this would not make the finding of a deficiency under section 483.25(h)(2) improper. The preamble to the final regulations, addressing the suggestion that "all deficiency citations made by surveyors should include what the negative outcome is," stated that "[a] violation of any participation requirement must be considered a deficiency, even if the violation caused no negative outcome to occur." 59 Fed. Reg. 56116, 56227 Nov. 10, 1994). If one or more deficiencies are severe enough to create at least the potential for more than minimal harm

to resident health and safety, enforcement remedies, including a CMP, are selected by CMS based on the scope of the deficiency (i.e. whether noncompliance is isolated, pattern, or widespread). 42 C.F.R. § 488.301; *The Windsor House*, DAB No. 1942, at 2-3, 61 (2004). However, immediate jeopardy can exist regardless of the scope of the deficiency. *See Scope and Severity Grid,* 59 Fed. Reg. 56,116, 56,183 (Nov. 10, 1994); State Operations Manual § 7500.

b. Hillcrest is not being held "strictly liable."

Hillcrest asserts that CMS is attempting to hold it "strictly liable" for the crimes any residents might commit while "off-campus." Hillcrest correctly cites to *Hermina Traeye Memorial Nursing Home*:

> A facility is not required by 42 C.F.R. § 483.25(h)(2) to assure that its residents never sustain accidents. The regulation does not impose a strict liability standard on a facility. Rather, the regulation requires that the facility provide "adequate" supervision and assistance devices to its residents as a safeguard against accidents. A facility satisfies the requirements of the regulation if it takes reasonable precautions to protect the health and safety of its residents against accidental injuries.

Hermina Traeye Memorial Nursing Home, CR756 and CR757, 12-13 (2001), *aff'd,* DAB No. 1810 (2002); *aff'd, Hermina Traeye Memorial Nursing Home v. Dep't of Health & Human Services*, No. 02-2076 (4th Cir. Oct. 29, 2003).

Hillcrest is correct in that a facility's responsibility to provide adequate supervision and assistance to its residents in order to protect them against accidents is not one of strict liability. A facility is not liable for unforeseeable events. However, a facility is responsible for identifying all accidents that are foreseeable, given each resident's condition and the facility environment, and also for taking all reasonable steps necessary to protect residents from sustaining an accident. *Koester Pavilion*, DAB No. 1750 (2000).

The Board has stated that it is not necessary for an accident to actually have occurred to a resident for a facility to be out of compliance with this requirement, but that the issue is "whether the quality of supervision . . . was such that residents were subject to the risk of injury from accidental causes in their daily activities." *Woodstock*, DAB No. 1726, at 35. Further, "[o]ccurrences that do not themselves constitute accidents may well be evidence that the supervision provided was not adequate to prevent accidents." *Id.* Providers are

not strictly liable as insurers or unconditional guarantors of good outcomes in the delivery of services to residents. Rather, the quality of care provisions of section 483.25 impose an affirmative duty upon the provider to deliver services designed to achieve the best possible outcomes to the highest practicable degree. *Id.* at 25.

Although section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, it does require the facility to take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm to residents from accidents. *Woodstock Care Center v. Thompson*, 363 F.3d. 583, 590 (6th Cir. 2003). Although a facility can choose the method of supervision it uses to prevent accidents, the method chosen needs to be "adequate." *Id.* To determine if the supervision is "adequate," we look at the resident's ability to protect himself or herself from harm. *Id.*[30]

A central reason for housing a resident in an intermediate care facility is to provide the resident with care, including supervision, which the resident is unable to provide for himself or herself, or that the resident's family is unable to provide at home. Under the applicable regulation, that duty includes doing whatever is within the facility's capability to provide the resident with supervision and assistance. It is within the realm of possibility that there might be instances where a facility decides reasonably that it had done all that it was able to do and an incident or accident still occurs.

Compliance with section 483.25(h)(2) requires a facility to assess its residents' status continuously so as to be able to confront problems as they develop and to evaluate the efficacy of measures instituted to deal with residents' needs and problems. If treatment methodology is ineffective, a facility is obliged to attempt new measures until it either develops an approach that works or exhausts all possible avenues of protection.

Therefore, the issue here is whether Hillcrest failed to provide its residents with adequate supervision to prevent accidents. Although the regulation does not make Hillcrest strictly liable for every accident that occurs on or off its premises, as discussed above, it does require Hillcrest to do everything within its power to protect residents against accidents that are foreseeable. The clinical records for R3, R4, R5, and R6 were replete with documentation warning of their behavioral propensities and manifestations so that Hillcrest could have predicted that without proper monitoring and supervision of these

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[30] The Board has articulated a facility's requirements under 42 C.F.R. § 483.25(h)(2) in the following Board cases: *Estes Nursing Facility Civic Center*, DAB No. 2000 (2005); *Northeastern Ohio Alzheimer's Research Center*, DAB No. 1935 (2004); *Guardian Health Care Center*, DAB No. 1943, at 17-18 (2004); *Woodstock Care Center*, DAB No. 1726, at 28 (2000), *aff'd, Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003).

residents there would be adverse outcomes. Additionally, Hillcrest fell short of what could reasonably be considered adequate supervision under the circumstances, even after it was clear that its practices were wholly ineffective for these residents.

The evidence before me establishes that Hillcrest failed to provide the necessary supervision and protections that the regulation requires. That is the basis for Hillcrest's deficiency.

C. Hillcrest was cited for a violation of 42 C.F.R. § 483.45(a)(1) - (2) - (tag F406, Specialized Rehabilitative Services).

The regulation requires that specialized rehabilitative services (i.e. physical therapy, occupational therapy, speech therapy and mental health rehabilitative services for mental illness) as required by a resident's care plan must be provided by a facility or obtained from an outside resource. 42 C.F.R. § 483.45(a)(1) and (2). According to the April SOD, Hillcrest failed to consistently implement crisis intervention for two residents, R4 and R5.

Hillcrest was cited by IDPH surveyors during the April Survey under tag F406 as allegedly failing to provide specialized rehabilitative services, such as timely crisis intervention, for R4 and R5. CMS Ex. 1, at 20-22. It is not necessary for me to address tag F406, at scope and severity level of E (no actual harm with the potential for more than minimal harm), as I find the deficiency cited at tag F279, Resident Assessment, fully supports the DPNA remedy imposed by CMS. *See Batavia Nursing and Convalescent Inn*, DAB No. 1911, at 22-24 (2004).

D. Hillcrest was out of substantial compliance with the participation requirement at 42 C.F.R. § 483.75 - (tag F490, Administration).

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psycho-social well-being of each resident. 42 C.F.R. § 483.75. A finding that a facility's administration was out of substantial compliance may be derived from findings that the facility did not achieve and maintain substantial compliance in other areas. Where a facility has been shown to be so out of compliance with program requirements that its residents have been placed in immediate jeopardy, the facility was not administered in a manner that used its resources effectively to attain the highest practicable physical, mental, and psycho-social well-being of each resident. *Asbury Center at Johnson City*, DAB No. 1815, at 11 (2002).

The evidence before me strongly supports a conclusion that the residents whose care is at issue needed to be supervised closely by Hillcrest's staff. However, Hillcrest staff allowed residents to leave on pass which enabled these residents to be out of the facility sometimes for extended periods of time without supervision. Hillcrest had not developed procedures which contained criteria for determining which residents could receive passes. Nor did it enforce its policies and procedures to ensure that residents did not abuse drugs or alcohol even though it was aware that certain residents had known destructive behaviors and known or suspected alcohol abuse.

As previously discussed, I conclude that Hillcrest's quality of care deficiency findings at tag F324 posed immediate jeopardy to resident health and safety, and thus, justifies the finding that the facility was not in substantial compliance with 42 C.F.R. § 483.75.

VII. June Surveys

A revisit and complaint survey was conducted on June 6, 2001, which revealed that Hillcrest still had not achieved and maintained substantial compliance with participation requirements. Two repeat deficiencies were identified: a violation of 42 C.F.R. § 483.20(k) at tag F279 (Resident Assessment); and a violation of 42 C.F.R. § 483.25(h)(2) (Quality of Care) at tag F324. The deficiencies resulted in the imposition of a CMP of $200 per day, effective June 6, 2001.

A. Hillcrest was cited for violating 42 C.F.R. § 483.20(k)(Resident Assessment) at tag F279 - a repeat deficiency.

1. Hillcrest failed to care plan R9's assaultive behavior.

Hillcrest was found in violation of the quality of care regulation at section 483.20(k) because R9's care plan made no mention of his tendencies toward verbal or physical abuse. CMS Ex. 613, at 5-17. Specifically, after R9's hospitalization for assault on March 28, 2001, his care plan was not revised to address his physically abusive behavior. Rather, R9's care plan notes that he has the "potential for anxiety." *Id.* at 5. R9 is also noted as weighing approximately 130 pounds; suffering from weakened extremities; very "spastic" and prone to seizures; mobile via a wheelchair; and able to transfer from chair to bed, but requiring staff assistance to ambulate to the bathroom. CMS Ex. 613, at 8, 14, 15, 20.

During the relevant time period at issue, R9 was 29 years old. CMS Ex. 613, at 18-19. He was admitted to Hillcrest on January 5, 2001, and his clinical record indicates diagnoses of unspecified psychosis and bipolar affective disorder. *Id.* at 3. His MDS, which was completed on the date of his admission to Hillcrest, states that R9 resists care and demonstrates verbally abusive behavioral symptoms. *Id.* at 25.

A review of R9's clinical record reveals the following notations related to incidents of his aggressive behaviors:

> (1) A nursing note indicates that he was counseled on January 9, 2001, for threats he made toward his roommate. CMS Ex. 613, at 31.
>
> (2) On February 22, 2001, staff met with R9 to discuss "recent conflicts with [his] roommate." CMS Ex. 613, at 31.
>
> (3) On March 8, 2001, when staff approached R9's door to his room which was closed, he was physically blocking the door from staff access to his room. He was reported as being agitated and was "screaming profanities." CMS Ex. 613, at 31.
>
> (4) On March 22, 2001, R9 was reported as being "agitated and anxious," and it is noted that he had thrown his snacks on the floor, and "made a fist sign towards the CNA [Certified Nurse Aide]." CMS Ex. 613, at 34.
>
> (5) On March 28, 2001, R9 was noted as being physically abusive, that he had shoved an individual and then hit both a resident and a housekeeper. CMS Ex. 613, at 34. R9 was promptly hospitalized that same day due to his behaviors, and then later readmitted to Hillcrest on April 6, 2001. *Id.* at 3, 34.
>
> (6) On May 3, 2001, R9 was noted as expressing concern over his cigarettes being stolen which, according to the note, appears to have been the cause of his conflicts. CMS Ex. 613, at 31. The note further states that he "continues to display aggressive behavior this quarter . . . Resident has also been verbally abusive towards staff." *Id.*
>
> (7) On May 12, 2001, it is noted that when handed a milkshake by a nurse, R9 threw it onto the floor. CMS Ex. 613, at 31.

The evidence is clear that R9's MDS did reflect his verbally abusive behavior symptoms; however, it did not address any incidence of physical abuse. CMS Ex. 613, at 25. Additionally, the MDS was not updated to reflect his assaultive behavior. *Id.* Neither was R9's care plan updated. *Id.* at 33-35. Therefore, I find that Hillcrest did not properly care plan R9's assaultive behavior which, on at least one occasion as described above, resulted in his emergency hospitalization. Given this, R9's care plan failed to place Hillcrest staff on sufficient alert as to his potential problem behaviors and failed to outline intervening approaches as required by the regulation.

Accordingly, I conclude that Hillcrest's failure to care plan R9's assaultive behavior tendencies so that staff could appropriately monitor and supervise him was a violation of 42 C.F.R. § 483.20(k).

2. Hillcrest failed to adequately care plan R10's wandering and elopement tendencies.

During the time period at issue, R10 was a 55-year-old female with diagnoses of obsessive-compulsive disorder and schizophrenia. CMS Ex. 614, at 4. While at the facility on June 5 and 6, 2001, surveyors were presented with a list of residents who were at risk for elopement. R10's name was on the list. However, R10's care plan, dated May 21, 2001, did not address R10's wandering and elopement tendencies. CMS Exs. 2, at 2-3; 614, at 14-18.

At hearing, former Clinical Director Mutterer testified that R10's wandering behaviors constituted either authorized visits to the thrift shop at the local hospital across the street from Hillcrest to purchase items, or inconsequential rummaging in other residents' rooms. Tr. at 1289-90. Mr. Mutterer stated that R10 had a doctor's order allowing her to go out on pass unsupervised. *See* P. Ex. 60, at 1 (dated 1/10/2001).[31] Hillcrest argues that there is a distinction between R10's wandering behaviors and her elopement tendencies.

A review of R10's clinical record reveals the following notations regarding incidents related to her wandering and elopement tendencies:

> (1) On January 24, 2001, R10 insisted that she no longer wished to reside at the facility and was planning on leaving. This behavior resulted in R10 receiving an intra-muscular injection of Ativan "for agitation." CMS Ex. 614, at 5.
>
> (2) On January 25, 2001, R10 attempted to leave the facility at 2:14 a.m., which resulted in an intra-muscular injection of Haldol. CMS Ex. 614, at 5.
>
> (3) On February 6, 2001, R10 was transferred to a hospital due to her tendency to wander outside the facility. CMS Ex. 614, at 6.

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[31] I note for the record that CMS raised an issue of prejudice in relation to the admission of P. Ex. 60. P. Ex. 60 contains a doctor's order allowing R10 unsupervised pass usage. CMS argues that P. Ex. 60 was not disclosed until January 2004. At hearing and in its post-hearing brief, CMS argued that the admission of this exhibit was prejudicial to its case and requested that the exhibit and all references to it be struck. However, I admitted P. Ex. 60 as I found that the probative value of the evidence outweighs any potential for prejudice to CMS.

(4) On February 28, 2001, R10 was noted as being "very agitated" and wanting to leave the facility. An intra-muscular injection of Haldol was administered to R10. CMS Ex. 614, at 6.

(5) On March 7, 2001, R10 attempted to leave the facility and was counseled. She later left the facility, appeared at the emergency room at the hospital across the street, and was escorted back to Hillcrest. CMS Ex. 614, at 12.

(6) On March 15, 2001, R10 was hospitalized due to a change in mental status (record noted R10 as being "delusional"), and her habit of wandering outside the facility. CMS Ex. 614, at 6.

(7) On April 1, 2001, R10 did not return from her pass to church. A Missing Persons police report was filed. On April 2, 2001, R10 called the facility to advise them of her intent to move into a hotel for a month. CMS Ex. 614, at 7, 8; Tr. at 1376.

Mr. Mutterer testified that R10's son, who is also her legal guardian, wanted R10 to continue her visits to the thrift store, but had decided that due to a change in her condition that "he did not want her going out unsupervised." Tr. at 1293. Her son expressed his preference that "she go out on supervised passes with either himself or facility staff members." *Id.* According to Mr. Mutterer, it was after this conversation that R10's name was placed on the facility's June 5 and 6 Elopement Risk List, and R10's supervision was increased as a condition of her pass privileges. CMS Ex. 608, at 27; Tr. at 1291-94, 1377-78.

A review of R10's care plan reveals that it does not address her wandering and elopement tendencies. CMS Ex. 614, at 14-26. Whether Hillcrest prefers to call her departures wandering or elopement is not relevant. Based on R10's demonstrated behaviors as outlined above, Hillcrest should have care planned for these tendencies. Hillcrest characterizes R10's wandering as harmless and occasioned by her obsessive-compulsive disorder. Hillcrest argues that R10 had a doctor's order allowing her to go out on unsupervised visits. In reviewing P. Ex. 60, I agree with Hillcrest that the doctor's order for February 2001 clearly states "[m]ay leave facility without contraindications with or without meds." *Id.* at 1. However, given R10's tendencies of wandering, and, specifically the expressed wishes of R10's son and legal guardian, R10's doctor should have been made aware of her tendencies and the son's preferences. The doctor's order should have been amended. Based on the record before me, I do not see where R10's doctor was informed of the wishes of R10's son and legal guardian.

I conclude that Hillcrest's failure to care plan R10's wandering and elopement tendencies so that staff could appropriately monitor and supervise her departures was a violation of 42 C.F.R. § 483.20(k).

3. Hillcrest adequately care planned R11's elopement tendencies.

The parties disagree as to whether R11's departures from the facility constituted actual elopements, or unauthorized departures. A review of R11's nursing notes reveal:

> (1) R11's first departure in question was on April 15, 2001. Tr. at 228. He was found on a main street attempting to hitchhike, was retrieved by staff and instructed to stay at the facility. Tr. at 446. However, he subsequently left and walked to a bar. Tr. at 228. Staff retrieved him and recorded in the nursing notes that R11 had "broken facility rules after signing [a] contract three days prior" and "would not be able to leave on pass without proper supervision until behavior was stabilized." CMS Ex. 615, at 27.
>
> (2) Subsequent to this entry, there is no intervening documentation in the nursing notes regarding R11 leaving the facility.
>
> (3) A May 31, 2001 nursing note entry indicates that R11 was due for a quarterly review. Several incidents are recorded outlining R11's interactions with peers and staff within the facility, but there is no reference to his leaving the facility unsupervised. CMS Ex. 615, at 28. The entry also notes that R11 "has resisted nearly every attempt at intervention that has been made" and that he "is difficult to re-direct, often refusing to comply with staff's requests that he discontinue his problematic behavior." *Id.*
>
> (4) In early June of 2001, Hillcrest determined that R11 presented as an elopement risk and, therefore, included his name on the facility's Elopement Risk List. CMS Ex. 608, at 27.

R11's plan of care shows an entry, dated June 1, 2001, which states:

> Resident is restless at times and may attempt to leave the facility unsupervised. Requires supervision with outside passes. Resident may at times become resistant to staff interventions and or redirection. Resident will at times become argumentative with staff.

CMS Ex. 615, at 17.

R11's March, April, and May 2001 doctor's orders note that R11 "[m]ay leave facility without contraindication with or without meds." P. Ex. 61, at 1-3.[32] I find that R11's departure on April 15, 2001, was not an elopement. I find persuasive Hillcrest's argument that as of April 15, 2001, R11 was not yet identified as an elopement risk. I also find that Hillcrest staff intervened appropriately by attempting to use a less restrictive method with R11, and the record establishes that there were no other documented attempts by R11 to exit the facility without supervision. I find that Hillcrest re-evaluated the scope of R11's pass privileges after his second exit from the facility on April 15, 2001, determined that the supervisory restrictions were needed and implemented them immediately. CMS Ex. 615, at 27. When R11 demonstrated his resistance to staff intervention and re-direction as noted in the May 31, 2001 nursing note entry, Hillcrest adequately care planned R11's elopement tendencies on June 1, 2001,[33] and included his name on the elopement list in early June 2001. I conclude that Hillcrest adequately care planned R11's elopement tendencies.

4. R11's updated care plan was not accessible to Hillcrest staff.

On the morning of June 6, 2001, Surveyor Pettenger asked for R11's care plan. Former Clinical Director Michael Mutterer presented to Surveyor Pettenger with R11's care plan which was dated May 25, 2001. CMS Ex. 615, at 4-9. The care plan did not include any reference to R11's elopement behaviors. CMS Exs. 3, at 3; 601, at 1; 615, at 4-9.

During the survey, and prior to Mr. Mutterer handing Surveyor Pettenger a hard copy of the care plan, Charge Nurse Genevieve Skiparnia was unable to access R11's updated care plan from Hillcrest's computer. Additionally, Nurse Skiparnia was unable to identify which residents were at risk for elopement when asked by Surveyor Pettenger. CMS Exs. 2, at 3-

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[32] P. Ex. 61 was received by counsel for CMS on January 6, 2004. CMS has objected to the admission of this exhibit claiming prejudice. CMS claims that had it subpoenaed the doctor, clarification may have been obtained as to the actual intended scope of the order. However, the wording on R11's doctor's orders is the same as all other orders for Hillcrest residents who have pass privileges. CMS repeatedly questioned the wording of those orders as well, and yet failed to request a subpoena for the doctor for clarification as to the intended scope of those orders. Additionally, the hearing was reconvened from March 1-4, 2004. This extra time afforded CMS ample opportunity to solicit the information it needed. I do not find that CMS was prejudiced with the admission of P. Ex. 61. However, even if CMS could establish it was prejudiced, I find that the probative value of the evidence outweighs any potential for prejudice to CMS.

[33] I do not find a basis for CMS's inference that the updated care plan at issue was possibly inserted by staff on June 6 rather than June 1. CMS PHB at 164.

4; 601, at 1; 608, at 38. Less than two hours later, Mr. Mutterer presented Surveyor Pettenger with a version of the care plan which did include R11's elopement behaviors. CMS Ex. 615, at 17. This care plan was noted as having been updated on June 1, 2001. CMS Exs. 2, at 3; 601, at 1; 615, at 17.

CMS has established that R11's care plan was inaccessible to staff the morning of June 6, 2001. The daytime charge nurse failed in her attempt to bring up R11's care plan on the computer. The only copy then available to staff for reference would have been the unrevised care plan which did not indicate the supervisory restrictions for R11. Also, CNA Darlene April indicated to the surveyors that the DON's office, which houses hard copies of all care plans, is not always open to staff. CMS Ex. 607, at 14.

I find that Hillcrest has not overcome CMS's showing by a preponderance of the evidence that R11's care plan was inaccessible to staff the morning of June 6, 2001.

B. Hillcrest was cited for violating 42 C.F.R. § 483.25(h)(2) (Quality of Care) at tag F324 - a repeat deficiency.

1. Hillcrest failed to maintain its first floor doorway free from debris.

Hillcrest was cited for failing to maintain a first floor east doorway free from debris. CMS Ex. 2, at 7. This doorway leads to the outside of the facility. The debris noted during the survey consisted of "a broom handle" and "a branch approximately 2 inches in diameter." Additionally, the doorway was noted as being "cluttered with paper bags and leaves." *Id.*

Former Administrator Kalkowski testified that the door at issue was not used as an exit or entrance, and on the advice of life safety surveyors, the exit sign which originally hung over the doorway was removed to ensure that the door would not be misconstrued as an emergency exit. Tr. at 1369, 1370. Also, Hillcrest contends that the door in question faces a large forest preserve which can result in leaves and, occasionally, branches accumulating. P. PHB at 88-89. Hillcrest maintains a landscape contract which requires bi-weekly cleaning of any debris on the grounds, including raking of leaves. Tr. at 1367.

Although Hillcrest had taken measures by contracting with a landscape company to ensure the perimeter of the building was free from debris, removed the exit signs so that residents did not mistake it for an exit, and locked the door from the exterior, residents still could exit from the door to go outside. The door is not locked from the inside and therefore can be used as an exit. Given this, I agree with CMS that a risk still remains. Therefore, the area must be kept clean from debris at all times. Although Hillcrest did explain that the paper

bags noted by the IDPH surveyors are used to collect the leaves and debris that accumulate in that area, the paper bags should have been removed once full and not allowed to remain near the door where they could obstruct clear access. I conclude that the violation was correctly cited by IDPH surveyors.

2. Hillcrest did not violate 42 C.F.R. § 483.25(h)(2) as regards to R9's fall on May 12, 2001.

On May 12, 2001, while crossing the threshold between the second floor doorway and patio, R9's wheelchair tipped over. CMS Ex. 613, at 35. R9 did not sustain any injuries. *Id.* DON Tierney testified that R9 fell in the doorway, and that there was a quarter-inch ridge which consists of a normal threshold for a doorway. Tr. at 1826.

Hillcrest argues that R9 had successfully negotiated this threshold on other occasions and that the May 12, 2001 recorded fall was more likely intentional, and an attention-seeking incident. P. PHB at 89-90. CMS states that the condition of the doorway threshold is hazardous, and the facility should have assessed the safety of its doorway, or should have provided R9 with a monitor to supervise his passage through the doorway. CMS PHB at 170, 171.

I note that IDPH surveyors cited Hillcrest under the quality of care deficiency, and as CMS has not cited any authority indicating that a quarter-inch threshold is a hazard, I will only address the supervision aspect of this violation.

DON Tierney testified that R9 had had other falls in the facility, although not on that threshold. She further testified that although R9 is susceptible to falls, "he also uses that as a means of acting out." Tr. at 1829. A review of R9's clinical record reveals that he has a history of falls, was on psychoactive medications, has a general weakness in all extremities, but was able to transfer independently to and from his wheelchair. CMS Ex. 613, at 11, 15, 17. The crux of CMS's argument seems to be on the safety of the threshold. However, As previously noted, CMS does not cite any authority to establish that the threshold was a safety hazard. CMS also suggests that Hillcrest should have provided R9 with a monitor to ensure safe passage through the doorway. However, CMS has not persuaded me that such a requirement was necessary in R9's case, given that his care plan establishes that R9's proclivity for falls is related to his psychiatric diagnoses. CMS Ex. 613, at 11. Additionally, R9's clinical record establishes, and his MDS assesses his ability to move between locations in his room and around the residential floor as not requiring physical assistance from staff. *Id.* at 20.

IDPH surveyors cited Hillcrest under section 485.25(h)(2), which requires that a facility provide each resident with adequate supervision and assistance devices to prevent accidents. I find credible Hillcrest's argument that R9's fall on May 12, 2001, more likely was attributed to his proclivity toward temper tantrums and throwing himself out of his wheelchair. Therefore, I conclude that the violation, specific to lack of supervision was not correctly cited by the IDPH surveyors.

3. Hillcrest failed to secure an outside doorway prior to deactivating the door alarm.

Hillcrest has a dual alarm system where two alarms are triggered whenever an outside door is opened. Tr. at 1305. Former Clinical Director Mutterer testified that the first sound is a very loud and distracting siren which is turned off by using a key box situated at the door itself. Tr. at 1305. The second alarm is a buzzing alarm and is connected to a light box at the second floor nurses station. *Id.* This alarm is turned off by staff at the second floor station. Tr. at 1305-06. Mr. Mutterer further testified that the internal stairwell doors on the first, second, and third-floor east hallways had a different alarm mechanism where a button adjacent to the actual exit door could be used to turn the alarm off. Tr. at 1306-08.

On June 5, 2001, IDPH surveyors activated the door alarm for two separate drills (11:50 a.m. and 5:55 p.m.). CMS Ex. 608, at 37-38. Surveyors noted that staff failed to check the area at or near the door before staff turned off the alarm sound at the second floor nurses' station. CMS Ex. 2, at 8.

Hillcrest's Door Alarm Policy states that "*[u]pon triggering of an alarm*, personnel . . . *must immediately report to the door* with sounding alarm. Responding personnel must complete a thorough check of the immediate area outside the door." CMS Ex. 606 (emphasis added).

I find that the policy does not direct staff to first turn off the alarm and then go to the door with the sounding alarm, rather, staff are to immediately report to the door with the sounding alarm. Therefore, contrary to Hillcrest's assertions, and according to the Door Alarm Policy, staff do not have the discretion to decide whether they will first turn off the alarm before searching the door area where the alarm has sounded.

Granted, failure by a facility to comply with a facility policy is not a failure to comply with a participation requirement where the policy does not comport with a professionally recognized standard of care and where the participation requirement does not direct a facility to follow each of its internal policies. *Lake City Extended Care Center*, DAB No. 1658, at 18 (1998). CMS is prohibited from relying on a facility's failure to follow its own policy or standard because a facility's policy or standard may exceed the regulatory

requirements and professionally recognized standard of care. *Haverhill Care Center*, DAB CR522 (1998). However, Hillcrest presented no evidence here to show that its policy exceeded the professionally recognized standard of care. The policy merely articulated the applicable standard of care, and ample evidence in the record supports this finding. Thus, I find Hillcrest failed to secure the doorway prior to deactivating the door alarm.

4. Hillcrest was not in violation of 42 C.F.R. § 483.25(h)(2) when it disarmed the backyard door to the smoking patio during business hours and did not secure 50-pound paving blocks in the enclosed fenced area.

Hillcrest's Door Alarm policy states that:

> The second floor back yard door may also be unalarmed during regular business hours. This area is enclosed with a security fence and appropriately prohibits residents from coming and going from this area.

CMS Ex. 606.

CMS claims that this allows residents free access to an unsupervised area where the patio in the area had heavy paving blocks which are laid to form the path. These blocks, which were estimated to weigh approximately 50 pounds each, were not affixed to the ground. The concern was that these blocks would be moved or lifted by residents. CMS Exs. 2, at 8; 608, at 38; Tr. at 1709. CMS asserts that the loose paving stones created a potential hazard for residents to trip over, especially those with a compromised sense of balance and who were susceptible to falls. CMS PHB at 176; CMS Ex. 608, at 38. Additionally, CMS contends that a resident could possibly pick up a loose paving stone and brandish it as a weapon. CMS PHB at 176.

The arguments CMS presents are unpersuasive. I find it reasonable for Hillcrest to disarm the backyard door during regular business hours for residents to freely access the back patio to smoke. The area is secured with a fence. Tr. at 1709. I also do not find sufficient evidence in the record before me to determine whether the paving blocks which are two-to-three feet in diameter and weigh 50 pounds each, posed a tripping hazard to residents, or that there existed a risk that a resident would brandish one of the blocks as a weapon. I conclude that there is no basis for Hillcrest being cited for failure to maintain the door alarm to the backyard smoking patio or failing to secure the 50-pound paving blocks in the enclosed fenced area.

5. Hillcrest was in violation of 42 C.F.R. § 483.25(h)(2) when it failed to secure an unattended metal attic cover near the second floor south exit doorway.

The June SOD states that when the second floor south exit door was opened, surveyors observed a 10-foot ladder leaning against a wall and an open area in the ceiling, approximately 4 feet by 4 feet, and a piece of sheet metal approximately 2.5 feet by 2 feet laying on the floor. CMS Ex. 2, at 9. Hillcrest avers that there was repair work being done which necessitated use of the ladder. Tr. at 1324. CMS conceded this fact. CMS PHB at 172. However, CMS states that the unattended metal attic cover did pose an accident hazard. *Id.*

Hillcrest avers that staff turned the alarm in that area off to avoid its activation, and the maintenance man had just ascended to the roof and was in the process of securing the area when the surveyor approached. P. PHB at 90-91. Hillcrest contends that the metal attic cover was secured within moments following the surveyor's appearance, and thus did not constitute any hazard. *Id.* Although I am persuaded that the metal attic cover was quickly removed by the maintenance person, I find that it still posed a safety hazard. The exit door was unalarmed and the metal attic cover was unattended, even if just for a short period of time. Therefore, I conclude that the IDPH surveyors correctly cited Hillcrest for the unattended metal attic cover as a safety hazard.

6. Hillcrest did closely supervise R1 during an episode of agitation resulting in R9 being hit on the head.[34]

R1's clinical record reveals a diagnosis of schizo-affective schizophrenia. CMS Ex. 612, at 6. Her MDS reveals that she has persistent anger with self and others. *Id.* at 21. Her care plan reveals "severe mood swings" and "impulsive behavior." *Id.* at 13. On April 16, 2001, R1 weighed 246 pounds. *Id.* at 15.

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[34] At hearing, Maureen Lacy, PsyD testified as an expert witness on behalf of Hillcrest. CMS objected to Dr. Lacy's testimony about R1 and the events of May 23, 2001, at the hearing and renewed its objection in its post-hearing brief. CMS PHB at 177 n. 65. CMS claims that it was prejudiced by Dr. Lacy's testimony since it had insufficient warning as to the scope of her testimony. *Id.* At hearing, I ruled that the synopsis of Dr. Lacy's testimony, as provided by Hillcrest in its Amended Witness List of September 2003, was sufficiently broad to have included reference to incidents involving R1 and R9. *See* Tr. at 2418. Dr. Lacy was available for CMS to cross-examine, and I do not find that CMS has been prejudiced as a result of Dr. Lacy's testimony. However, I note CMS's renewed objection for the record.

On May 23, 2001, while walking down a hallway, R1 struck R9 on the top of his head while R9 was waiting for his shower. Prior to this incident, R1 was involved in an argument with her roommate and expressed a desire to "scratch her roommate's eyes out and kick her." CMS Ex. 612, at 8. A social service note written the same day as the incident reveals that:

> Resident presented with increased agitation and anger. Res was upset about her roomate [sic] making derogatory statements about her. Res was becoming increasingly agitated. Resident was not redirectable. Res was referred to nurisng [sic] for PRN, then res went back to her room. Res then spoke with clinical supervisor N. Williams. During this conversation, resident walked out of her room and slammed the door. Res then walked down the hall, striking another resident as she passed. Resident was then escorted to the psych tech office to be monitored . . . . Resident did not respond well to counseling, and was still upset the entire time she was in the office. Resident's Psychiatrist was contacted and arrangements were made to send resident out of inpatient psych tx [psychology treatment]. Res will be monitored in the office until transportation arrives.

CMS Ex. 612, at 12.

At the hearing, Jeffrey Baker, psychiatric technician at Hillcrest, testified about the May 23, 2001 incident with R1 and R9. Mr. Baker testified that after consultation with R1's physician, an order was placed for R1 to be transferred to Grant Hospital. CMS Ex. 612, at 8. After 30 to 45 minutes of counseling R1 in the psychology office, former Clinical Supervisor Najat Williams and Mr. Baker escorted R1 to her room so she could obtain her personal belongings in preparation for her hospitalization. Tr. at 1857, 1958, 1959. R1 did not exhibit any incidents of acting out toward staff or peers on her way to her room. Tr. at 1959. Once in the room, R1 "sat down in the rocking chair and started rocking." Tr. at 1959. While Ms. Williams continued to counsel R1, Mr. Baker remained in the hallway outside of R1's room to assist another staff member with R9's shower preparation as R9 was exhibiting challenging behaviors at the time. Tr. at 1857. After voluntarily agreeing to take her medication that would "help her feel better," R1 suddenly arose abruptly, walked past Ms. Williams to exit her bedroom, slammed her bedroom door, and proceeded into the hallway. Tr. at 1960. Ms. Williams testified that she opened R1's bedroom door and proceeded to step into the hallway where she observed Mr. Baker with R9 who was seated in a wheelchair near the shower room. Tr. at 1960. It was at this time that Ms. Williams observed R1 walk by R9 and Mr. Baker, and slap R9 on the back of the head with an open hand. Tr. at 1960, 1962.

CMS avers that there were inconsistencies between the clinical notes, staff interviews with IDPH surveyors, and testimony at hearing as to timing and specific services provided to R1 before and after her hitting R9. CMS PHB at 184-87. Specifically, CMS takes issue with the extent of Mr. Baker's involvement with counseling R1, and why he did not remain in the room while the Clinical Supervisor was counseling R1. Tr. at 1857, 1862.

Although the parties disagree as to the supervision that R1 received while she was being counseled, and before she struck R9, I find CMS's allegations that R1 was not appropriately supervised on May 23, 2001, not supported by the credible evidence of record. In fact, prior to the incident when staff realized that R1's agitation had the potential to escalate, they took measures to follow through with the plan of care, obtain a PRN from nurses, and contact Dr. Lacy who then authorized that R1 be transferred to a psychiatric setting. I find that immediately preceding the incident of R1 striking R9, R1 was under close supervision at all times and actually received constant one-on-one monitoring. CMS postulates that R1's hitting R9 could have been prevented had staff kept R1 in the psychiatric technician's office until the ambulance arrived to transport her to the hospital. CMS PHB at 195. However, I find it reasonable that R1 was escorted back to her room so that she could ready her personal belongings in preparation for her upcoming hospitalization. Tr. at 1904.

CMS has not established that R1 was alone in her room unsupervised. Rather, the evidence clearly shows that R1 was being counseled by the clinical supervisor when she walked out of the room, slammed the door, and struck R9 who apparently was being assisted by Mr. Baker and the certified nurse aide (CNA). I find Mr. Baker's testimony credible when he stated that R9 was sitting in a wheelchair facing him, "being combative with the CNA who was trying to give him care," and that he assisted the CNA in trying to calm R9 as well as assisting the CNA with showering R9. Tr. at 1863. I find that Mr. Baker's testimony as to why he felt the need to assist the CNA in calming R9 to be credible in light of the evidence of R9's behavioral issues and physical challenges. Tr. at 1857, 1862-63. I also find Ms. Williams' recitation of the events that occurred immediately prior to R9 being hit by R1 to be credible. Based on the evidence, I conclude that Hillcrest staff did closely supervise R1 before she struck R9.

CMS further alleges that Hillcrest failed to take precautionary measures regarding R1's care prior to May 23, 2001, that may have prevented R1 from striking R9. CMS contends that Hillcrest staff should have: (1) explored more aggressively any causal relationship between R1's habit of "cheeking"[35] her medications as a possible instigator of her violence; (2) monitored and intervened with R1's roommate situation; (3) expedited R1's transfer to

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[35] A resident "cheeks" medication when he or she holds the medication between the cheek and gum, pretending to swallow the medication, then spits it out later.

the hospital; (4) removed R9 from the hallway before escorting R1 to her room; (5) given R1's history of aggression toward peers and her large size, had another staff member with Ms. Williams in R1's room; or (6) called a "Code White"[36]in order to de-escalate R1. CMS PHB at 194-203.

Based on the parties' arguments and the record before me, I find that: (1) R1's noncompliance with medication administration is sufficiently recorded in both her care plan and her social service notes; (2) changing roommates may have been a viable option; however, there was be no guarantee that R1 would not get agitated with another roommate; (3) the Certificate of Involuntary Admission was completed at 3:30 p.m. that day (CMS Ex. 612, at 43) and the ambulance to transport R1 arrived at Hillcrest at 8 p.m.; thus an estimated 4.5 to 5.5 hours passed between the time Hillcrest decided to hospitalize R1 and the arrival of the ambulance; (4) Hillcrest credibly maintains that it has no control over how quickly a hospital can send an ambulance; (5) R9 was not removed from the hallway before R1 was escorted to her room because at the time staff did not have any indication that she would be aggressive toward staff or peers; (6) R1 remained under 1:1 supervision during the time period at issue and her striking R9 was an impulsive act on her part.

The regulation at issue requires that a facility provide each of its residents with adequate supervision and assistance devices to prevent accidents. A facility has a duty to take all measures that are within its power to prevent accidents that are reasonably foreseeable. *Madison Health Care, Inc.*, DAB CR1325 (2005). But, the duty of care owed by a facility to its residents is not one of strict liability. A facility is not *per se* liable for every accident that occurs on its premises. I conclude that on May 23, 2001, Hillcrest staff took reasonable measures to secure R1's safety and that of other residents.

Although in its post-hearing brief CMS questions the adequacy of R1's care plan, Hillcrest was not cited for a problem with R1's care plan, so I do not address CMS's allegation that R1's care plan was deficient. CMS PHB at 181-82. Additionally, CMS alleges that R9's nursing and social services notes did not reveal any documentation of R9 being struck by R1 or any follow-up of the incident. CMS Ex. 2, at 7. However, IDPH cited Hillcrest under tag F324 for a supervision deficiency and not a deficiency in documentation; therefore, I do not find it necessary to address the issues CMS raises regarding R9's nursing and social service notes.

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[36] The purpose of the "Code White" policy is "to alert ALL staff to a psychiatric emergency, in order to protect residents and staff from physical harm . . . [i]f physical contact has been established, an automatic code white is called." CMS Ex. 419, at 15 (emphasis in original).

7. Staff were not aware of which residents were on the elopement list.

On June 5, 2001, several staff (E-2, E-4, E-21, E-14 and E-16) were interviewed by IDPH surveyors. CMS Ex. 601 (employee key). The Hillcrest staff who were interviewed indicated that there were no residents at the time identified as elopement risks, or that they could find out by calling downstairs for an elopement list. CMS Exs. 2, at 10; 607, at 13-14; 608, at 6, 9, 24, 31. None of the staff indicated to the surveyors that there was a list at the nursing station. CMS Ex. 2, at 10. On June 5, 2001, the surveyors were presented with the list of residents at risk for elopement, and the list included: R10, R11, R12, R13, and R15. On June 6, the surveyors were presented with another elopement list that included the following residents: R10, R11, R13, R15, R17, and R18. CMS Ex. 2, at 10.

Former Administrator Kalkowski testified that there were elopement lists available to staff at the nurses' station, and that staff knew where the lists were; however, they just needed to know where to look. Tr. at 1344. Former Administrator Kalkowski also testified that he didn't know if the elopement list was in the computer. *Id.* Former Clinical Supervisor Williams testified that the elopement list was part of the pass list that is maintained at Hillcrest. Tr. at 1971-72. Ms. Williams also testified that Hillcrest does not require staff to memorize the list of residents who may be at risk for elopement. *Id.* at 1972.

I find that Hillcrest has not been able to overcome CMS's showing that on June 5, 2001, staff were unaware of which residents were on the elopement list, nor has Hillcrest been able to satisfactorily explain why on June 5, 2001, the elopement list did not include R17 and R18, whose names then appeared on the June 6, 2001 elopement list.

VIII. Imposition of Remedies for April and June Surveys

CMS determined to impose remedies consisting of: a DPNA for residents admitted from May 14, 2001 through August 30, 2001; a per instance CMP in the amount of $10,000 for an immediate jeopardy finding; and a $200 per day CMP from June 6, 2001 through August 30, 2001.[37]

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[37] As previously noted, Petitioner underwent an August Survey and, as a result of a deficiency finding, CMS continued the imposition of the $200 per day CMP from August 31, 2001 through September 4, 2001, when Hillcrest was found to have achieved substantial compliance. However, as previously discussed in this decision at n.2, Hillcrest chose not to appeal the August Survey findings and remedy. Therefore, as my review is limited to the findings and subsequent remedies relating to the April Survey and the June Survey only, I do not address the continuation of the $200 per day CMP through September 4, 2001.

Hillcrest argues that (1) the alleged deficiencies resulting from the April Survey did not constitute immediate jeopardy, and, at most, presented a potential risk of more than minimal harm; and (2) that the findings in the June Survey presented, at most, a potential risk of minimal harm. Hillcrest also contends that CMS does not have the authority to impose per instance CMPs because the Act does not allow it to. I have previously addressed in this decision the legislation allowing CMS to impose sanctions against Medicare providers who are found to not be in substantial compliance with Medicare program requirements and therefore I do not re-address this issue here. *See* Act § 1819(h); 42 C.F.R. §§ 488.406; 488.430; 488.433(a); 488.438(a)(2); 488.440.

A. The $10,000 per instance CMP imposed against Hillcrest is reasonable.

Having found a basis for imposing a CMP, I now consider whether the $10,000 per instance CMP imposed is reasonable, applying the factors listed in 42 C.F.R. § 488.438(f), which include: (1) the facility's history of noncompliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404; and (4) the facility's degree of culpability. It is well-settled that, in reaching a decision on the reasonableness of the CMP, I may not look into CMS's internal decision-making processes. Instead, I consider whether the evidence presented on the record concerning the relevant regulatory factors 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 other factors involved (financial condition, facility history, and culpability). 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 Center*, DAB No. 1848, at 21 (2002); *Community Nursing Home* DAB No. 1807, at 22 (2002), *et seq.*; *Emerald Oaks*, DAB No. 1800, at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1683, at 8 (1999).

Applying the four factors listed in 42 C.F.R. § 488.438(f), I find that the quality of care deficiency identified as tag F324 was significant. R3, R4, R5, and R6 had known histories of behavior disorders, depression, drug and alcohol abuse, mental illness, poor impulse control, suicide attempts, and varied criminal behaviors. Hillcrest's failure to adequately supervise them to prevent accidents allowed them unsupervised access to the community at a time when they needed closer supervision; thus, they had the opportunity to become involved in inappropriate, or even illegal activities while out on a day pass. Both R4 and R5 were subsequently arrested and formally charged. R3's and R6's clinical records reveal they were traumatized by their involvement in the homicide, necessitating their hospitalizations. Due to the egregious nature of the violation, I am, therefore, not able to find unreasonable the imposition of a $10,000 per instance CMP.

First, in regards to the facility's history of noncompliance, I note that prior to the April Survey, Hillcrest underwent a Life Safety Code survey on March 7, 2001, and then a standard health and certification survey on March 9, 2001where deficiencies were noted. Several deficiencies were noted following a partial extended complaint survey conducted from March 26, 2001 to April 19, 2001, and two remedies were imposed. During the April Survey Hillcrest was found to have not achieved and maintained substantial compliance with several participation requirements. Hillcrest was cited for five deficiencies, the most serious of which resulted in an "immediate jeopardy" finding at tag F324, a violation of the Quality of Care regulation at 42 C.F.R. § 483.25(h)(2). The June Survey revealed that Hillcrest still had not achieved and maintained substantial compliance with several participation requirements. Two repeat deficiencies were identified, a citation under 42 C.F.R. § 483.20(k) at tag F279 (Resident Assessment); and a citation under 42 C.F.R. § 483.25(h)(2) (Quality of Care) at tag F324. Therefore, Hillcrest's history of continued noncompliance since March 9, 2001, particularly in regards to the Quality of Care regulation, lends support to CMS's determination to impose a per instance CMP.

Second, while an ALJ may consider a facility's financial condition in determining whether the amount of a CMP is within a reasonable range, the facility must initially raise that issue as a basis for disputing the reasonableness of the amount of the CMP; otherwise, the ALJ can properly exercise his discretion in excluding it. *Community Nursing Home,* DAB No. 1807, at 21, 26 (2002). Where either party fails to take advantage of its opportunity to submit evidence of a facility's financial condition, that opportunity is waived. *Id.* at 15-16; *Emerald Oaks*, DAB No. 1800 (2001). In this case, the record is silent as to Hillcrest's financial solvency, and Hillcrest has not claimed that its financial condition makes the amount of the CMP unreasonable.

Third, the seriousness of Hillcrest's immediate jeopardy level deficiency provides strong support for the $10,000 per instance CMP that CMS determined to impose. The failure of Hillcrest to adequately supervise residents' pass privileges, and to fully assess R3, R4, R5, and R6 upon their return to the facility on March 22, 2001, had serious consequences.

Fourth, Hillcrest's culpability for its deficiencies was high. Hillcrest staff should have known that its pass privilege systemand the sign-out sheets which served to document residents' pass usage were not working. It was clear that these residents required close supervision. Nonetheless, Hillcrest's lax supervision of these residents in connection with their pass privileges extended over a lengthy period of time – for the duration of R3's, R4's, R5's, and R6's placement at Hillcrest – and revealed a systemic inability on Hillcrest's part to cope with the residents' needs. I conclude that the various measures Hillcrest took, including the interventions that it made on behalf of some of its residents, do

not counterbalance Hillcrest's systemic failures to provide its residents with necessary supervision. Nor do they excuse Hillcrest's consistent failure to consider providing residents with close supervision in the face of overwhelming evidence that increased supervision was necessary.

There is only a single range of $1,000 to $10,000 for a per instance CMP. 42 C.F.R. §§ 488.408(d)(1)(iv); 488.438(a)(2). I find that based on the weight of the evidence before me the $10,000 per instance CMP imposed against Hillcrest is reasonable.

B. There was a basis for CMS's imposition of the DPNA for residents admitted from May 14, 2001 through August 30, 2001.

The record clearly supports CMS's determination that Hillcrest was not in substantial compliance with all program participation requirements. It is not necessary that every deficiency alleged against Hillcrest be sustained, as long as those actually sustained are sufficient to establish a reasonable basis for the remedy imposed. CMS is authorized to impose a DPNA based on a facility's failure to comply substantially with a single participation requirement. *Northern Montana Care Center*, DAB No. 1930 (2004). Hillcrest has failed to meet its burden of showing it came back into compliance prior to August 30, 2001. Therefore, CMS is authorized to impose a DPNA for each day of a period that began on May 14, 2001, and which ran through August 30, 2001, against Hillcrest.

C. CMS's determination to impose a CMP of $200 per day for each day Hillcrest was not in substantial compliance, from June 6, 2001 through August 30, 2001, is unreasonable. I find that a CMP of $100 per day is a reasonable amount.

Having found a basis in the June Survey findings for imposing a CMP, I now consider whether the $200 per day CMP imposed is reasonable, applying the factors listed in 42 C.F.R. § 488.438(f).

Where there is no immediate jeopardy alleged, a CMP may be imposed within a range from $50 – $3,000 per day for each day of continued noncompliance. 42 C.F.R. § 488.438(a)(1)(ii). "The per day [CMP] may start accruing as early as the date that the facility was first out of compliance, as determined by CMS or the State." 42 C.F.R. § 488.440(a)(1). "The per day [CMP] is computed . . . for the number of days of noncompliance until the date the facility achieves substantial compliance. . . ." 42 C.F.R. § 488.440(b).

Based on the testimony offered at the hearing, the documentary evidence, the arguments of the parties, and the applicable law and regulations, I concluded that from May 14, 2001 through August 30, 2001, Hillcrest was out of substantial compliance with Medicare

program participation requirements. However, I found that R10 did not elope at any time from June 6 through August 20, 2001, and that CMS did not prove a *prima facie* case that Hillcrest staff failed to closely supervise R1 during an episode of agitation resulting in R9 being hit on the head on May 23, 2001. I conclude, therefore, that a $100 per day CMP from June 6, 2001 through August 30, 2001 is reasonable.

IX. Conclusion

For the reasons discussed above, I affirm CMS's determination to impose a per instance CMP in the amount of $10,000, and a DPNA for residents admitted from May 14, 2001 through August 30, 2001. I do not find the proposed $200 per day CMP from June 6, 2001 through August 30, 2001 reasonable; rather, I find a per day CMP of $100 per day to be reasonable for that period.

/s/

Alfonso J. Montano
Administrative Law Judge