**Department of Health and Human Services**

**DEPARTMENTAL APPEALS BOARD**

**Civil Remedies Division**

Avalon Place Trinity,
(CCN: 67-5900),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-974

Decision No. CR4601

Date: May 4, 2016

# DECISION

Petitioner, Avalon Place Trinity, is a long-term care facility located in Trinity, Texas, that participates in the Medicare program. Facility staff left one of its vulnerable residents unattended in the bathroom; he fell, and sustained a fatal head injury. Citing this incident and multiple other health and life safety code deficiencies, the Centers for Medicare & Medicaid Services (CMS) determined that the facility was not in substantial compliance with the Medicare program requirements and that its deficiencies posed immediate jeopardy to resident health and safety. CMS imposed civil money penalties (CMPs) of $6,550 per day for three days of immediate jeopardy (March 28-30, 2013) and $1,550 per day for 40 days of substantial noncompliance that was not immediate jeopardy (March 31-May 9, 2013). Petitioner timely appealed CMS's determination.

Petitioner does not appeal the life safety code deficiencies nor two of the health deficiencies (42 C.F.R. §§ 483.25(d) and 483.25(e)(2)) but challenges the multiple remaining health deficiencies, including those cited at the immediate jeopardy level.

For the reasons set forth below, I find that, from March 28 through May 9, 2013, the facility was not in substantial compliance with Medicare program requirements; that,

from March 28-30, 2013, its deficiencies posed immediate jeopardy to resident health and safety; and that the penalties imposed are reasonable.

**Background**

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

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

In this case, surveyors from the Texas Department of Aging and Disability Services (state agency) completed the facility's annual life safety code and health surveys on March 26 and 30, 2013. Based on their findings, CMS determined that the facility was not in substantial compliance with multiple Medicare participation requirements. Specifically:

<u>Life Safety Code violations</u>

- LSC §§ 7.1 and 19.2.1 (Tag K038 – means of egress requirements) at scope and severity level E (pattern of noncompliance that causes no actual harm with the potential for more than minimal harm);

- LSC §9.6.1.3 (Tag K054 – smoke detectors) at scope and severity level F (widespread noncompliance that causes no actual harm with the potential for more than minimal harm);

- LSC § 19.3.5 and 19.3.5.1 (Tag K056 – sprinkler systems) at scope and severity level F;

- LSC §§ 9.7.4.1 and 19.3.5.6 (Tag K064 – fire extinguishers) at scope and severity level F;

- LSC §§ 19.2.3 and 19.3.2.6 (K069 – cooking facilities) at scope and severity level F.

and

Health violations[1]

- **42 C.F.R. § 483.13(c) (Tag F224 – staff treatment of residents: prohibit neglect), at scope and severity level K (pattern of noncompliance that posed immediate jeopardy to resident health and safety)**;[2]

- **42 C.F.R. § 483.13(c) (Tag F226 – staff treatment of residents: policies to prohibit abuse and neglect) at scope and severity level K**;

- **42 C.F.R. § 483.15(a) (Tag F241 – quality of life: dignity) at scope and severity level E**;

- **42 C.F.R. § 483.15(f)(1) (Tag F248 – quality of life: activities) at scope and severity level E**;

- **42 C.F.R. § 483.15(h)(2) (Tag F253 – quality of life: housekeeping and maintenance services) at scope and severity level E**;

- **42 C.F.R. § 483.20(g) – (j) (Tag F278 – resident assessment: accuracy/coordination/certification) at scope and severity level K**;

- **42 C.F.R. § 483.20(k)(3)(ii) (Tag F282 – resident assessment: comprehensive care plans/services provided) at scope and severity level E**;

- **42 C.F.R. § 483.25 (Tag F309 – quality of care) at scope and severity level H (pattern of noncompliance that caused actual harm)**;

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[1] These are the deficiencies remaining following an informal dispute resolution. *Compare* CMS Ex. 1 *with* CMS Ex. 6.

[2] This list highlights, in bold, the deficiencies that Petitioner appealed. The parties did not address all of them. Because the deficiencies I affirm more than support the penalties imposed, I need not and do not address all of the deficiencies cited. *Perry Cnty. Nursing Ctr. v. U.S. Dep't of Health & Human Servs.*, 603 F. App'x 265, 271 (5th Cir. 2015); *Claiborne-Hughes Health Ctr. v. Sebelius*, 609 F.3d 839, 847 (2010); *Carrington Place of Muscatine*, DAB No. 2321 at 20-21 (2010); *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 6 n.5 (2010), *aff'd Senior Rehab. & Skilled Nursing Ctr. v. Health & Human Servs.*, 405 F. App'x 820, (5th Cir. 2010).

- **42 C.F.R. § 483.25(a)(3) (Tag F312 – quality of care:  activities of daily living) at scope and severity level E**;

- **42 C.F.R. § 483.25(c) (Tag F314 – quality of care:  pressure sores) at scope and severity level H**;

- 42 C.F.R. § 483.25(d) (Tag F315 – quality of care:  urinary incontinence) at scope and severity level E;

- 42 C.F.R. § 483.25(e)(2) (Tag F318 – quality of care:  range of motion) at scope and severity level E;

- **42 C.F.R. § 483.25(g)(2) (Tag F322 – quality of care:  naso-gastric tubes) at scope and severity level E**;

- **42 C.F.R. § 483.25(h) (Tag F323 – quality of care:  accident prevention) at scope and severity level K**;

- **42 C.F.R. § 483.25(*l*) (Tag F329 – quality of care:  unnecessary drugs) at scope and severity level E**;

- **42 C.F.R. § 483.25(m)(1) (Tag F332 – quality of care:  medication errors) at scope and severity level F**;

- **42 C.F.R. § 483.25(n) (Tag F334 – quality of care:  influenza and pneumococcal immunizations) at scope and severity level E**;

- **42 C.F.R. § 483.35(d)(1)-(2) (Tag F364 – dietary services:  food) at scope and severity level E**;

- **42 C.F.R. § 483.35(i) (Tag F371 – dietary services:  sanitary conditions) at scope and severity level F**;

- **42 C.F.R. § 483.6(a), (b) (Tag F425 – pharmacy services:  procedures, service consultation) at scope and severity level F**;

- **42 C.F.R. § 483.60(c) (Tag F428 – pharmacy services:  drug regimen review) at scope and severity level E**;

- **42 C.F.R. § 483.60(b), (d), and (e) (Tag F431 – pharmacy services:  service consultation, labeling, and storage) at scope and severity level F**;

- **42 C.F.R. § 483.65 (Tag F441 – infection control) at scope and severity level F**;
- **42 C.F.R. § 483.70(h) (Tag F465 – physical environment: other environmental conditions) at scope and severity level F**;
- **42 C.F.R. § 483.75 (Tag F490 – administration) at scope and severity level K**;
- **42 C.F.R. § 483.75(f) (Tag F498 – administration: nurse aide proficiency) at scope and severity level E**;
- **42 C.F.R. § 483.75(j)(2)(ii) (Tag F505 – administration: laboratory services) at scope and severity level E**;
- **42 C.F.R. § 483.75(*l*)(1) (Tag F514 – administration: clinical records) at scope and severity level F**;
- **42 C.F.R. § 483.75(m)(1) (Tag F517 – administration: disaster and emergency preparedness) at scope and severity level F**;
- **42 C.F.R. § 483.75(m)(2) (Tag F518 – administration: disaster/emergency preparedness training) at scope and severity level F**; and
- **42 C.F.R. § 483.75(o)(1) (Tag F520 – administration: quality assessment and assurance) at scope and severity level F**.

CMS Exs. 1, 2, 6.

Thereafter, CMS determined that the facility returned to substantial compliance on May 10, 2013. CMS Ex. 4. CMS has imposed against the facility CMPs of $6,550 per day for three days of immediate jeopardy (March 28-30, 2013) and $1,550 per day for 40 days of substantial noncompliance that was not immediate jeopardy (March 31-May 9, 2013), for a total penalty of $81,650.00 ($19,650 + $62,000 = $81,650). CMS Ex. 4.

Petitioner timely requested a hearing. It does not challenge any of the LSC deficiencies or the health deficiencies cited under 42 C.F.R. §§ 483.25(d) and 483.25(e)(2).

On August 26, 2014, I convened a hearing, via video teleconference, from the offices of the Departmental Appeals Board in Washington, D.C. Counsel and witnesses appeared in Dallas, Texas. Ms. Tangla Fudge-Bernal and Mr. Julian Treadwell appeared on behalf of CMS, and Ms. Allison Spruill appeared on behalf of Petitioner. Transcript (Tr.) at 12.

I admitted into evidence CMS Exhibits (Exs.) 1-11, 15-19, 22, 24, 25, 27-32, 34-40, 42, 43, 45-67, 69, 74, 75, 76, 80-82, 84-95, 97, 98 (as amended) and 99, which includes a supplement. I also admitted Petitioner's Exhibits (P. Exs.) 1-53. Tr. 13-14; Order Following Pre-hearing Conference at 2-3 (June 20, 2013). The parties have filed pre-hearing briefs (CMS Br.; P. Br.) and post-hearing briefs (CMS Post-hrg. Br.; P. Post-hrg. Br.).

**Issues**

Based on the uncontested issues, the facility was not in substantial compliance with Medicare program requirements from March 28 through May 9, 2013, and I must sustain a CMP of at least $50 per day for those days. 42 C.F.R. § 488.408(d).

The issues before me are:

- From March 28 – May 9, 2013, was the facility in substantial compliance with the remaining regulatory requirements;
- From March 28 – 30, 2013, did the facility's deficiencies, specifically 42 C.F.R. §§ 483.13(c), 483.20(g)-(j), 483.25, 483.25(c), 483.25(h), and 483.75, pose immediate jeopardy to resident health and safety; and
- Are the penalties imposed – $6,550 per day for three days of immediate jeopardy and $1,550 per day for 40 days of substantial noncompliance that was not immediate jeopardy – reasonable?

**Discussion**

1. ***The facility was not in substantial compliance with 42 C.F.R. §§ 483.13(c), 483.20(g)-(j), 483.25, 483.25(h), and 483.75 because its staff did not accurately assess all of its residents; did not prevent resident neglect; and did not provide vulnerable residents with the supervision and assistive devices they needed to prevent accidents.***[3]

Program requirements. 42 C.F.R. § 483.13(c) (Tags F224, F226).[4] "Neglect" means failure to provide goods and services necessary to avoid physical harm, mental anguish,

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

[4] Petitioner complains that CMS improperly cited certain neglect deficiencies under Tag F224 instead of Tag F226. The argument is irrelevant. The relevant question is whether

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

Citing a ten-year old Administrative Law Judge decision (which was not appealed), Petitioner questions whether any regulation "will support a substantive charge of generalized neglect." P. Post-hrg. Br. at 3, citing *Heron Pointe Health & Rehab. Ctr.*, DAB CR1401 (2006). Even if section 483.13(c) could "support" a charge of neglect, according to Petitioner, "one isolated allegation" is insufficient to establish that the facility failed to implement its anti-neglect policies." *Id*. Neither position has any merit.

First, the drafters of section 483.13(c) explicitly rejected Petitioner's notion that the regulation does not prohibit neglect. They emphasized that "inherent in" section 483.13(c) is the requirement that "each resident should be free from neglect as well as other forms of mistreatment." 59 Fed. Reg. 56130 (November 10, 1994).

Second, the Departmental Appeals Board has explicitly rejected the *Heron Pointe* reasoning and has repeatedly disallowed the use of a "quantitative analysis" to determine whether a facility failed to implement its anti-neglect policy. In *Avalon Place Kirbyville*, the Board explained that its focus is not on the number or nature of the instances of neglect, but on whether the facts demonstrate "an underlying breakdown in the facility's implementation of the provisions of the anti-neglect policy." DAB No. 2569 at 12 (2014), citing *Oceanside Nursing & Rehab. Ctr.*, DAB No. 2382 at 11 (2011) and *Columbus Nursing & Rehab. Ctr*., DAB No. 2247 at 27 (2009). Thus, a facility violated section 483.13(c) when its staff did not follow facility protocols after discovering a resident who was not breathing, even though the incident involved just one resident. *Avalon Place Kirbyville*, DAB No. 2569. Another facility violated section 483.13(c) because its staff failed to follow instructions for securing lift straps and catheter tubing to a single resident's wheelchair. *West Texas LTC Partners*, DAB No. 2652 at 9-10 (2015).

<u>42 C.F.R. § 483.20(g) – (j) (Tag F278)</u>. Initially and periodically, the facility must conduct "a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity." The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. The registered nurse must sign and

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the facility complied with section 483.13(c). As I have explained repeatedly (*see, e.g.*, Tr. 44-45), tag numbers are a convenience but they are not binding on anyone. The regulations are binding. Contrary to Petitioner's characterization (P. Post-hrg. Br. at 2 n.1), this is not merely my "preference"; it is the law.

certify that the assessment is completed, and each individual who completes a portion of the assessment must sign and certify the accuracy of that portion. An individual who willfully and knowingly falsifies an assessment may be subject to a civil monetary penalty

42 C.F.R. § 483.25 (Tag F309). Under the statute and the "quality of care" regulation, each resident must receive, and the facility must provide, the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. *See* Act § 1819(b).

42 C.F.R. § 483.25(h) (Tag F323). So that each resident can attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the his or her comprehensive assessment and plan of care, the "quality of care" regulation also mandates that the facility "ensure" that each resident's environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistive devices to prevent accidents. The facility must therefore eliminate or reduce a known or foreseeable risk of accidents "to the greatest degree practicable." *Del Rosa Villa*, DAB No. 2458 at 7 (2012); *Clermont Nursing & Convalescent Ctr.*, DAB No. 1923 at 9-10, *aff'd Clermont Nursing & Convalescent Ctr. v. Leavitt*, 142 F. App'x 900 (6th Cir. 2005); *accord*, *Briarwood Nursing Ctr.*, DAB No. 2115 at 5 (2007) (holding that the facility must "take all reasonable steps to ensure that a resident receives supervision and assistance devices designed to meet his or her assessed needs and mitigate foreseeable risks of harm from accidents."). A facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods must constitute an "adequate" level of supervision under all the circumstances. *Briarwood Nursing Ctr.,* DAB No. 2115 at 5; *Windsor Health Care Ctr.*, DAB No. 1902, at 5 (2003), *aff'd, Windsor Health Care Ctr. v. Leavitt*, 127 F. App'x 843 (6th Cir. 2005).

42 C.F.R. § 483.75 (Tag F490). The facility must also be governed in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Facility policies. The facility had in place a written policy to prohibit abuse, neglect, and misappropriation of property. Although the policy focusses primarily on preventing abuse, it adopts the regulatory definition of neglect – failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness – and promises to ensure a safe environment by prohibiting neglect and abuse. CMS Ex. 30 at 2, 3; P. Ex. 3 at 2, 3.

The facility had other relevant policies that defined the "goods and services" needed so that residents would avoid physical harm:

The facility had in place policies to reduce falls. One policy provides that the facility will "assess, assist, and reduce falls by using a falling star (or other item stars/leaves) [t]o identify residents who are at high risk for falls." Among other requirements, residents must be assessed on admission and quarterly thereafter or as needed. Those with high risk assessments and/or other risk factors are considered for the "Falling Star Program." Stars are placed outside their rooms, and their participation in the program is documented in their plans of care. The policy provides that residents in the program be evaluated or re-evaluated, as needed, and that those who continue to fall "may" require more frequent evaluations and assessments "to identify additional factors to assist in determining the cause of the continued falls." CMS Ex. 24.

A separate policy, titled "Fall Risk Assessment & Management," states that the facility aims to identify, when possible, risk factors for falls and to "improve on the prevention and management of residents who fall." P. Ex. 15 at 7. The policy recognizes that, among other factors, gait and balance disorders, muscle weakness (particularly of the lower extremities), previous falls, and the number and types of medications administered can increase the resident's risk of falls. The policy sets forth basic steps that staff should follow:

1) decide whether there is a risk and, if so, what to do about it; this requires collecting and evaluating relevant information (history, signs and symptoms, medical conditions, personal habits, patterns) and then evaluating that information to identify whether the individual has a problem, and, if so, to define the nature of the problem;

2) assess and analyze the problem to determine its cause or to explain why its causes should not be identified as problems;

3) based on the information gathered, the facility should decide how best to manage the resident's condition, symptom, or situation; when causes can be identified and corrected, staff and practitioners should address them or explain why they cannot or should not do so;

4) staff should evaluate the individual's progress, consider the effectiveness of its interventions, and systematically determine what to do next;

5) the facility should use the information gathered to develop a goal with measurable approaches, using an interdisciplinary team approach; the care plan is implemented and revised at the time of admission, quarterly, and when there are significant changes, or as necessary.

The policy also lists what it calls "policy interpretation and implementation." It consists of specific factors that should be considered or included in evaluating a resident: fall

history, falling onset/increase, medical conditions, medications, functional/psychological impairments, environmental factors, monitoring, fall assessment tools, and education (which includes educating staff on the causes and risk factors for falls as well as interventions to manage the risk). With respect to those "functional impairments," the facility should evaluate factors that include ambulation, mobility, gait, balance, excessive motor activity, activities of daily living capabilities, activity tolerance, continence and cognition. P. Ex. 15 at 7-9.

The facility's policy for "activities of daily living" lists, among the basic activities of daily living: bathing, transfers, ambulation, toileting, and eating. The policy calls for the "observation and comprehensive assessment" of each resident to assure that his abilities do not diminish unless unavoidable. Assessments must be performed upon admission, quarterly, and "as deemed necessary." Staff are instructed to observe the resident for any indication of change. Nurse aides are to use the facility's computerized documentation system (referred to as the "AccuNurse process") to document the resident's involvement with "basic activities of daily living care and services rendered." A resident's deterioration should be assessed to ensure that he receives the care and services he needs. P. Ex. 2.

<u>Resident 73 (R73)</u>. R73 was an 81-year old man suffering the late effects of cerebrovascular disease and anemia. He was admitted to the facility on March 13, 2013, following a hospitalization for influenza and chronic obstructive pulmonary disease (COPD). His functioning ability with respect to activities of daily living (grooming, dressing, bathing, home management, functional mobility, home safety) was declining, related to his muscle insufficiency, balance deficits, and deficits in coordination. CMS Ex. 63 at 8, 89, 102, 104; P. Ex. 5. He required oxygen. CMS Ex. 63 at 83, 86; CMS Ex. 82 at 2 (McDaniel Decl. ¶ 4B).

As is well-documented, from the time of his admission or shortly thereafter, R73 was at risk for falls and needed assistance with toileting and other activities of daily living:

- R73's hospital transfer records, dated March 13, 2013, show that he needed assistance with all "self-care," including sitting, standing, walking, and toileting. He required a low bed and side rails. CMS Ex. 63 at 9. According to the transfer form, physical, occupational, and speech therapists were supposed to evaluate and treat him. CMS Ex. 63 at 8; P. Ex. 5 at 1.

  Pointing to one page of R73's transfer documents, Petitioner maintains that R73's admitting diagnosis did not include a history of falls. P. Post-hrg. Br. at 4. But a history of falls is not the only factor to consider in determining a resident's need for supervision. And the document that Petitioner alludes to (P. Ex. 5) is incomplete. Page 2 of the transfer form indicates that the resident requires assistance with sitting, standing, walking, and toileting. CMS Ex. 63 at 9. See

CMS Ex. 63 at 29 (R73's "admission plan of care") and CMS Ex. 63 at 15 (R73's "plan of treatment for outpatient rehabilitation"), discussed below.

- A March 13 form titled "resident-data collection" indicates that R73 ambulates with a walker and 1-person assist. P. Ex. 13 at 1, 2. But an attached "physical restraint elimination assessment" indicates that he ambulates with 2-person assistance and requires 1-person assistance to perform activities of daily living. P. Ex. 13 at 3. Still another form, titled "elopement risk assessment," says that he ambulates independently. P. Ex. 13 at 4. In fairness, because this form assesses his elopement risk, the assessor may have been considering what the resident was capable of rather than what he could do safely, which explains the discrepancy between this and the other assessments.

- R73's March 13 "admission plan of care" *directs the physical therapy department to evaluate him for safety issues*, particularly related to falls, and says that the rehab/restorative nurse will notify his physician of safety issues and "implement proper safety devices." CMS Ex. 63 at 29; P. Ex. 8 at 2; *see* P. Ex. 8 at 1 (ordering therapy evaluations and treatment).

- Physical Therapist Julius Fernandez prepared and signed a care plan for R73, dated March 13. The plan describes R73's "decline in transfers, gait, bed mobility, safety." It says that the changes are related to balance deficits, motor control deficits, incoordination, and postural deficits. According to the plan, R73 *was a fall risk*. CMS Ex. 63 at 17.

- An occupational therapy care plan, dated March 13, 2013, says "Patient will perform toileting *with supervision*." CMS Ex. 63 at 104 (emphasis added).

- A March 13 "fall risk assessment" scores R73 at "7" for falls. According to the form, a total score of 10 or above represents high risk. The form does not indicate what a score of 7 signifies, but the facility's (then) director of nursing (DON), Angal Biano, testified that the score means that the resident was not a high risk for falls. CMS Ex. 63 at 78; P. Ex. 9 at 1; P. Ex. 51 at 8; Tr. 130.[5] A second assessment, dated March 28, gives R73 a score of 10. CMS Ex. 63 at 57; P. Ex. 9 at 2.

- A "plan of treatment for outpatient rehabilitation" describes R73 as a "*fall risk* and unable to react safely to the challenges of balance." CMS Ex. 63 at 15, 89, 109

[5] As discussed below, Petitioner concedes that facility staff assessed R73's fall risk without input from the physical and occupational therapy departments, which buttresses CMS's position, also discussed below, that the score is inaccurate.

(emphasis added). The plan also notes that the resident "demonstrates decreased safety" in using assistive devices and "decreased awareness" of safety and risks in rising to a standing position. CMS Ex. 63 at 16, 17.

- R73's occupational therapy care plan notes his "*multiple falls*." CMS Ex. 63 at 104 (emphasis added).

- Specifically with respect to toileting, the occupational therapy plan describes "difficulty managing clothing" and "*loss of balance in standing*." CMS Ex. 63 at 18, 103 (emphasis added).

- An assessment dated March 19 indicates that R73 *requires support* for toilet use, "setup help." He requires one person assist for personal hygiene. His balance, in moving from a seated to standing position, is described as "*not steady*." CMS Ex. 63 at 81 (emphasis added).

- A series of documents titled "Daily Skilled Nurse's Note[s]," dated from March 13 through 27, confirms R73's *unsteady gait*, *balance problems*, *weakness*, and *decreased movement in his lower extremities*. P. Ex. 13 at 12, 14, 16, 18, 20, 26, 28, 30, 32, 34, 36, 38, 40, 42. The notes also indicate that, on March 16 and 17, he ambulated with a wheelchair rather than a walker. P. Ex. 13 at 35, 37.

Thus, from the time of his admission, R73 required assistance with his activities of daily living, including toileting. By March 27, his condition had deteriorated significantly:

- In a physical therapy note, dated March 27, R73 is described as "very weak" and "noted to have a struggle getting in/out of bathroom." He could not then participate in any balance or gait activities. CMS Ex. 63 at 90.

- On March 27, R73's occupational therapist, Susan Barnes, reported R73's "significant decline in functional mobility." She wrote that he called on her and other therapists multiple times throughout the day to ask for assistance to the bathroom. At one point, his lower extremity gave out as she was returning him to bed, and he ended up sitting on her lap at the edge of the bed. According to the occupational therapist, she spoke to his nurse, to the assistant director of nursing, and to multiple nurse aides about his significant decline in mobility. *She told staff that he "must have assistance at this time with all mobility."* Staff told her that they understood. CMS Ex. 63 at 101 (emphasis added).

  When interviewed by Surveyor Theresa McDaniel, Occupational Therapist Barnes confirmed that, on the day before R73's fatal fall, she told the nurses that it was not safe to leave him by himself; he required supervision. Tr. 24, 27.

In a statement dated April 1, Licensed Vocational Nurse (LVN) Andrea Bell reported that, on March 26, R73's wife asked staff to speak to the director of nursing (DON) about her husband's declining condition. LVN Bell then saw the wife enter the DON's office. The DON subsequently spoke to staff about their conversation and said that she would ask Dr. Mandel to see the resident. Thereafter, Dr. Mandel ordered an injection of Procrit, which was administered on March 27. P. Ex. 10 at 9.

According to Petitioner, Procrit significantly increases the recipient's strength and stamina and combats fatigue. P. Br. at 6. Petitioner does not offer any evidence to support its suggestion that one injection of Procrit resolved the resident's balance, motor control, and other deficits. *See* Tr. 35, 78-79 (explaining that it may take two to six weeks for the body to respond to Procrit). In any event, relying on the possibility of improvement, without further assessment, would be irresponsible and dangerous. *See* Tr. 79.

LVN Bell also wrote that, on March 27, the physical and occupational therapists told her that R73 "did not seem as strong as he had been since he had been there." P. Ex. 10 at 9.

- A nursing assessment prepared during the day shift on March 28 (the day of the accident) again describes R73's unsteady gait and balance problems. CMS Ex. 63 at 121.
- The March 28 incident report indicates that R73 had a "fall history," ambulates with "extensive assistance," and is confused at times. P. Ex. 10 at 1.
- Remarkably, a March 28 "ADL plan of care" describes the resident as independent in toileting, requiring no set up or physical help from staff. P. Ex. 1 at 7. (This was obviously prepared after R73, left to toilet himself, fell and suffered what would turn out to be fatal injuries.)
- In a discharge summary, dated March 28, Occupational Therapist Barnes reports that R73 was discharged because he was admitted to the hospital. She reiterates that he had demonstrated poor balance and "inadequate standing tolerance." His decreased muscle sufficiency affected his ability to transfer from sitting to standing. CMS Ex. 63 at 106.

<u>The incident</u>. Notwithstanding R73's well-documented need for supervision when standing, walking, toileting, and performing other activities of daily living, Brandi Ratliff, the nurse aide caring for him on the morning of March 28, left him alone in the bathroom. At about 7:15 a.m., she returned to find him lying on the bathroom floor,

urine and blood on the floor, pants down around his hips. He was bleeding from the side of his head. CMS Ex. 63 at 58, 60-61, 64, 66, 120; P. Ex. 10 at 1-3; P. Ex. 13 at 6-9, 11.

R73 suffered intracranial bleeding and a subdural hematoma. CMS Ex. 63 at 25, 34, 49; P. Ex. 10 at 1. Staff called the emergency medical services, and the EMTs transported him to the emergency room. CMS Ex. 63 at 28, 32, 58, 64, 127; P. Ex. 10 at 3, 4. But the local hospital deemed his condition too serious for treatment there and transferred him – via air-medical transport – to a regional medical center, where he died later that night. CMS Ex. 63 at 49-50; CMS Ex. 82 at 2 (McDaniel Decl. ¶ 4A); P. Ex. 10 at 12.

In a written statement, also dated March 28, Nurse Aide Ratliff wrote that, at about 7:00 a.m., she went into the resident's room to help him dress for breakfast. He said he needed to use the restroom but, according to Nurse Aide Ratliff, he did not need her help. Using his rolling walker, he took himself into the bathroom. At the resident's request, again according to Nurse Aide Ratliff, she left the bathroom door open, left the room, and closed the room door behind her. She wrote that she was away for "3 to 5 minutes." When she returned, she found R73 lying on the floor, his pants still down around his hips. CMS Ex. 63 at 66; P. Ex. 10 at 14.

Notwithstanding the overwhelming documentary evidence to the contrary, in these proceedings Nurse Aide Ratliff testified that R73 required no "special type" of fall precautions. P. Ex. 52 at 4. She claimed that he said he did not need her help, and he specifically asked her to give him some privacy, to leave the bathroom door open, to leave the room, and to shut the room door. P. Ex. 52 at 5, 6. She added, for the first time, that she reminded the resident to pull the call light and said that she would be right outside. P. Ex. 52 at 7.

I am skeptical of the nurse aide's claims regarding R73's insistence on privacy. None of his assessments or care plans, which indicate that he required assistance with toileting, suggests that he resisted assistance or demanded privacy (which would have compelled additional planning in order to keep him safe). Indeed, it seems odd that he actively sought assistance throughout the day of March 27 but refused all help the following morning. CMS Ex. 63 at 101. Nurse Aide Ratliff also claimed that R73 took himself to the bathroom, using his rolling walker. But, according to the incident report, his rolling walker was not in use. P. Ex. 10 at 1; Tr. 136-137. Further, I do not believe that the nurse aide reminded him to use the call light, a claim she did not make prior to these proceedings.

Moreover, based on the facility's computerized documentation system (*see* P. Ex. 2), it also seems that the level of assistance R73 received when toileting depended more on the nurse aide who cared for him than on his identified need for assistance. The nurse aide identified as KGW simply did not supervise him when he went to the bathroom; with one exception (when, in the middle of the night, she provided "extensive" assistance), Nurse

Aide DR did not supervise R73 in toileting. Nurse Aides TT and SJW, on the other hand, consistently assisted him. P. Ex. 1 at 2.[6]

The documentation also shows that, prior to the date of his fatal accident, Nurse Aide Ratliff had minimal contact with R73, which suggests that she would not have been familiar with his needs unless some other source informed her what they were, and, of course, the facility should have had procedures in place to convey to staff such vital information. The system entries reflect just one instance of Nurse Aide Ratliff interacting with R73 prior to the date of his accident: at 8:23 a.m. on March 26, she provided him with "setup" help for eating. P. Ex. 1 at 2.

<u>Inadequate assessments</u>. Accurate assessments are critically important because they form the bases for the care that the facility provides. *See, e.g.*, 42 C.F.R. § 483.20(d) and (k) (directing the facility to base a resident's comprehensive care plan on the results of his comprehensive assessment). The assessments must be comprehensive and must accurately reflect the resident's functional capacity.[7]

In R73's case, input from the physical and occupational therapy departments was critical to assessing accurately his functional capacity. *See* P. Ex. 50 at 16 (Stephens Decl.) (explaining the importance of an interdisciplinary approach to care); Tr. 136 (conceding that assessments from the physical and occupational therapy departments should have been part of the overall assessment). *Petitioner* maintains (and CMS agrees) that, in

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[6] The March 28 entries into the computerized documentation system are troubling. According to the toileting entry, at 7:05 a.m. on March 28, R73 was under the care of Nurse Aide KGW when he used the toilet without supervision. P. Ex. 1 at 2. But we know that Nurse Aide Ratliff, who was unassisted, was responsible for R73's care. We also know that, within minutes of the time noted (about 7:10 to 7:15 a.m.), R73 was lying injured on the bathroom floor. Petitioner now claims (without support) that Nurse Aide Kelly Williams accompanied Nurse Aide Ratliff on March 28, entering the resident's room to dress him for breakfast. P. Br. at 7; P. Post-hrg. Br. at 7. This would have justified the entries by KGW. But nothing in the record suggests that Nurse Aide Williams provided any care to R73 at that time. Indeed, Nurse Aide Ratliff denied that anyone was helping her; she testified that another nurse aide was on the same hall but that she entered the resident's room alone. P. Ex. 52 at 4; *see* P. Ex. 10 at 14-15.

[7] Petitioner gratuitously asserts that section 483.20(g) applies to the required minimum data set only. P. Post-hrg. Br. at 16. The minimum data set is just *part* of the federally-mandated process for assessing the functional capacity of nursing home residents. As the regulation reflects, the facility must also document summaries of additional assessments in care areas triggered by the findings of the minimum data set. 42 C.F.R. § 483.20(b)(1). *See also* 42 C.F.R. § 483.20(f).

assessing R73's functional status, facility staff neither had nor considered input from the physical and occupational therapy departments, even though the therapists' input would have been "critical" and "mandatory." P. Ex. 50 at 16-17, 19 ("They should have been in the chart.").[8] In taking this position, Petitioner all but concedes that its assessments of R73 could not have been comprehensive or accurate.[9]

Facility staff assessed R73's fall risk (CMS Ex. 63 at 89) without input from the physical and occupational therapy departments, and that assessment is notable for its critical omissions:

- The assessors awarded R73 no points for gait problems and none for decreased muscular coordination. CMS Ex. 63 at 78. But the nurses' notes from the time of his admission document his unsteady gait, neuromuscular weakness, and decreased movement in both of his lower extremities. P. Ex. 13 at 40, 42. According to his physical therapy treatment plan, he had "insufficient lower extremity motor control with decreased joint integrity." CMS Ex. 63 at 89; *see* CMS Ex. 63 at 15.

- According to the fall risk assessment, R73 had one to two "predisposing diseases." But his medical records show that he suffered from coronary artery disease, pain, fatigue, and weakness. He was recovering from an infection (influenza). CMS Ex. 63 at 8, 10, 12, 82; P. Ex. 5 at 1; P. Ex. 13 at 1, 40, 42; Tr. 34.

I therefore agree with CMS; had these conditions been factored in as they should have been, R73 would accurately have been assessed as at high risk for falls. Overlooking factors critical to determining a resident's fall risk creates the potential for more than minimal harm (as this case shows, substantially more than minimal harm). The facility was therefore not in substantial compliance with 42 C.F.R. § 483.20.

Petitioner's misguided attack on the facility's physical and occupational therapy departments. Notwithstanding the overwhelming documentation to the contrary,

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[8] I address below Petitioner's rationale for taking such an ill-advised position regarding the performance of its physical and occupational therapy departments.

[9] The minimum data set must include "documentation of participation in assessment." 42 C.F.R. § 483.20(b)(xviii). Here, the surveyors' copy of the minimum data set includes an unsigned signature page. CMS Ex. 63 at 85. Petitioner submits a copy that has been signed. P. Ex. 11 at 1. No one has explained why the facility did not provide the surveyors with a copy of the signed page. In any event, nothing on that signature page suggests that anyone from the physical or occupational therapy departments participated in the assessments.

Petitioner claims that R73 was not a fall risk and could independently manage activities of daily living, so facility staff justifiably did not assist him in toileting and other activities. Petitioner faults CMS for relying on "assessments," "evaluations," and "notes" generated by the facility's physical and occupational therapy departments. P. Post-hrg. Br. at 9. (quotation marks in original). Pointing to the testimonies of DON Angal Biano and Corporate Nurse Jackie Stephens, who was then director of clinical services for the 22 nursing homes owned by Avalon's parent organization, Petitioner claims that "the therapy documentation is not legitimate and should not be relied upon by anyone for any purpose." P. Post-hrg. Br. at 9; *see* P. Ex. 50 at 15-20 (Stephens Decl.); P. Ex. 51 at 9 (Biano Decl.).

Corporate Nurse Stephens charged that the therapists and/or their staffs manufactured two-weeks-worth of assessments, treatment records, and therapy notes, which they slipped into R73's clinical record sometime after his accident but before the surveyors reviewed the chart. She testified that, upon learning of R73's death on the morning of March 29th, she personally reviewed the files and found no physical or occupational therapy documentation. P. Ex. 50 at 15 (Stephens Decl.). According to Corporate Nurse Stephens, a nurse told DON Biano that one of the therapy techs sneaked into the facility on March 29 (Good Friday, when therapy departments had the day off), generated the documents, and slipped them into the surveyors' room. P. Ex. 50 at 19. Thus, the documents were in the file when the surveyors met with facility personnel in the late afternoon on March 29, according to Petitioner. P. Ex. 50 at 16.

If this were true, the facility's problems were significantly more serious than those CMS has alleged. In claiming that its physical and occupational therapy departments did not perform ordered assessments, did not provide ordered services, did not participate in the resident's care planning, and manufactured treatment records after the resident's fatal accident, Petitioner concedes that the facility violated multiple program requirements, including 42 C.F.R. §§ 483.13(c), 483.25, 483.25(h), 483.75, 483.20(g)-(j), and 483.20(k)(3)(i) and (ii), which CMS cited as deficiencies, and section 483.45, the regulation that governs specialized rehabilitation services, which CMS did not cite because it had no reason to doubt the authenticity of the therapists' documentation.

Petitioner takes such an imprudent position because it thinks that it is not responsible for the facility's physical and occupational therapy services. Those services were provided by arrangement with a separate company rather than by the facility's own employees (even though the therapy offices were physically located in the facility). P. Ex. 50 at 13; Tr. 77, 135-136. Citing a section of the Texas administrative code, Petitioner argues that the facility cannot be held accountable for the actions of its contractors. I am not bound by any provisions of the Texas administrative code; I am bound by the federal regulations. Under those regulations, if a facility does not employ a qualified professional to provide needed services, it must provide those services by arrangement with an outside source. Such arrangements (or agreements) "must specify in writing that

the *facility assumes responsibility* for . . . (i) [o]btaining services that meet professional standards and principles that apply to professionals providing services in such a facility" and (ii) the timeliness of the services. 42 C.F.R. § 483.75(h) (emphasis added); *see* Act § 1861(w).

Elsewhere the regulations require that the services a facility provides must meet professional standards of quality, whether provided by facility staff or "arranged by the facility." 42 C.F.R. § 483.20(k)(3)(i).

Thus, if the physical and occupational therapists fabricated their assessments and clinical notes (which I doubt), the *facility* is responsible for their misconduct.

The therapists did not belatedly "manufacture" their care plans, assessments, and treatment records; the facility simply had no systematic means by which to convey their recommendations to the staff members who needed that information. If I accepted Petitioner's arguments regarding its physical and occupational therapy departments, I could find substantial noncompliance at the immediate jeopardy level without further analysis. But no reliable evidence supports Petitioner's claim that the therapists manufactured after-the-fact evidence. While the final therapy reports may not have been associated with R73's chart until after his accident, I am satisfied that the bulk of the documents – including the initial assessments and treatment notes – were genuine.

First, the physical and occupational therapy records do not stand alone. As listed above, the nursing notes, nursing assessments, and other records affirm the proposition that R73 required supervision with his activities of daily living. CMS Ex. 63 at 8-9 (hospital transfer form); CMS Ex. 63 at 29 (admission plan of care); CMS Ex. 63 at 81 (minimum data set); P. Ex. 8 (interim plan of care); P. Ex. 13 at 1-2 (resident-data collection); P. Ex. 13 at 3 (physical restraint elimination assessment); P. Ex. 13 at 12, 14, 16, 18, 20, 26, 28, 30, 32, 34, 36, 38, 40, 42 (daily skilled nurse's notes).

Second, the documents were in the resident's chart when Surveyor McDaniel reviewed it. Tr. 22, 25, 28. Under cross-examination, she was not sure when she did so, but her survey notes confirm that, by 4:40 p.m. on March 28, she had reviewed the chart. CMS Ex. 63 at 4. That timing is consistent with the rest of the record. R73 was part of her survey sample, and she was required to review his care, which includes reviewing his chart. Throughout the day of March 28, she repeatedly inquired about his status. Tr. 26. She naturally would have reviewed his chart at the same time she was asking about him. And she plainly knew which documents were missing because she noted the absence of nurse's notes for March 28 (the last nurse's note in the chart was dated March 27). She immediately brought the absence of the nurse's notes to the attention of one of the LVNs. CMS Ex. 63 at 4. At 7:15 that evening, she told Corporate Nurse Stephens that R73's chart included no orders to transfer him to the hospital and no nurses' notes for the day. CMS Ex. 63 at 4. She recognized that R73's physician had ordered physical and

occupational therapy assessments and treatment. If those records were not in the file, she'd have noted it (and likely cited a deficiency under section 483.45).

Moreover, if Petitioner's scenario were plausible (which it is not) and if the facility were not otherwise responsible for the actions of its contractors (which it is), the facility would still be deficient. R73 was admitted to the facility so that he could receive physical and occupational therapy. Tr. 135-136; CMS Ex. 63 at 17; P. Ex. 4 at 8; *see* P. Ex. 13 at 43.[10] His transfer documents, admission care plan, and admission orders call for physical and occupational therapy assessments and treatment. According to those orders, the rehab/restorative nurse was supposed to notify R73's physician of the resident's safety issues. CMS Ex. 63 at 29; P. Ex. 8 at 2. R73's minimum data set, prepared March 19, indicates that he started his occupational and physical therapies on March 13 and 14. CMS Ex. 63 at 83. If those assessments and treatment notes were missing, the facility should have found out why and then collected, assessed and disseminated that information. *See* P. Ex. 5 at 7-9 (directing staff to collect and evaluate relevant information).

Contrary to the admission orders and care plan, the rehab nurse did not notify R73's physician of the resident's safety issues. CMS Ex. 63 at 29; P. Ex. 8 at 1, 2. As Petitioner concedes, R73's physician, Dr. David Mandel, was completely unaware of the well-documented safety concerns. In a note dated April 25, 2013, he maintains that he visited the facility at about 6:30 p.m. on March 27, and "no concerns" regarding R73 were brought to his attention. He maintains, contrary to a plethora of evidence, that R73 could be left unattended in the bathroom and was independent with his activities of daily living (which he absolutely was not). P. Ex. 14.[11]

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[10] Corporate Nurse Stephens implied that R73 was in the facility so that he could be administered Procrit to treat his blood disorder. P. Ex. 50 at 14. But the Procrit was not ordered until two weeks after his admission, on March 27, when R73's wife and therapists raised alarms about his decline in function. P. Ex. 4 at 9; P. Ex. 13 at 5; P. Ex. 51 at 7 (Biano Decl.).

[11] Although Petitioner relies on the physician's opinion, it did not call him as a witness. Instead, Petitioner points to a paragraph, written by Dr. Mandel almost a month after R73's death. In it, he describes a short hallway interaction he had with R73 on March 27, claims that no one brought "any concerns" to his attention "at that time," and concludes that the resident could be left unattended in the bathroom and was independent with his activities of daily living. P. Ex. 14. He does not mention any of the nursing, physical therapy, or occupational therapy notes to the contrary and seems unaware that he had ordered therapy assessments and treatment. Nor does he explain why he ordered Procrit, a powerful drug with significant side effects (*see* P. Ex. 6 at 12), for someone about whom he had no concerns.

Nor was Dr. Mandel without fault. He ordered the physical and occupational therapy assessments but, apparently, did not ask to review them, even after R73's wife expressed her concerns about her husband's functional decline, for which he ordered an injection of the medication, Procrit. P. Ex. 4 at 8; P. Ex. 10 at 9; P. Ex. 13 at 5; Tr. 143.

Petitioner makes much of a "clarification" of the physician's March 13 telephone order for occupational therapy, written by Occupational Therapist Barnes. According to Petitioner, the "clarified" order undermines Occupational Therapist Barnes's March 28 assessment and establishes that R73 was "<u>self-care</u> in his [activities of daily living]." P. Post-hrg. Br. at 16 (emphasis in original), *referring to* P. Ex. 4 at 8. But the document in question does not establish that R73 was independent in his activities of daily living. Because the therapists had not yet assessed R73, neither Occupational Therapist Barnes nor anyone else would not have been in a position to assess R73's functional abilities, much less pronounce him independent in activities of daily living.

Moreover, the clarified order simply does not say what Petitioner claims it says. It calls for occupational therapy evaluation and treatment five times a week for 60 days, "for ther[apeutic] ex[ercises], ther[apeutic] activities, neuro re-ed[ucation], self-care [in]" activities of daily living. P. Ex. 4 at 8; Tr. 33-34. In other words, the therapist was supposed to *train* R73 in self-care. Self-care was not the starting point. This interpretation is consistent with the March 13 occupational therapy care plan, which lists – as short-term goals – the resident to improve his abilities to perform activities of daily living with minimal assistance, and – as long term goals – to perform such tasks with "modified independence." CMS Ex. 63 at 104. Significantly, the order suggests that R73 would never achieve the complete independence that Petitioner claims he had before even starting his therapies.

The facility's problem was not that it contracted with rogue therapists, but that – as DON Biano admitted – it had no reliable systems in place to ensure that all direct-care staff understood and followed the therapists' critically important recommendations. Tr. 145-146. This put the facility out of substantial compliance with its own policies, which require staff to gather and evaluate "relevant information" and, using an "interdisciplinary approach," develop a plan with measurable goals, and then educate staff on the causes and risk factors for falls, as well as interventions to manage the risk. P. Ex. 15 at 7-9; *see also* P. Ex. 2.

Because the facility did not convey – in a consistent and reliable way – critical information that direct-care staff needed in order to provide necessary services to vulnerable residents, staff did not provide R73 with the services he needed to avoid physical harm. This represents a serious breakdown in the facility's implementing its anti-neglect and other policies, and puts the facility out of substantial compliance with 42 C.F.R. § 483.13(c).

Further, the facility staff did not provide R73 with the supervision he needed to prevent his fatal accident, which puts the facility out of substantial compliance with 42 C.F.R. §§ 483.25 and 483.25(h).

Resident 24 (R24). R73 was not the only resident put in jeopardy by the facility's failing to provide the care and services residents needed to attain or maintain their highest practicable physical, mental, and psychosocial well-being and to prevent accidents.

R24 was a 93-year-old woman when admitted to the facility on March 13, 2013. CMS Ex. 51 at 15; P. Ex. 37 at 1. She suffered from duodenitis (inflammation of part of the small intestine), dementia, and acute and chronic back pain. CMS Ex. 51 at 28, 29, 93, 107. She required assistance (one person) to transfer and to ambulate. CMS Ex. 51 at 91. She was at high risk for falls, scoring 16 on her fall assessment; any score of 10 or above represents high risk. CMS Ex. 51 at 97, 130.

I see no evidence that the facility addressed her fall risk at the time of her admission, except in a most general – and inadequate – way. CMS Ex. 81 at 11, 25 (Hennington Decl.). A document titled "Admission Plan of Care" identifies R24's potential for falls related to her new admission. It calls for physical therapy screening and authorizes the charge nurse to "utilize emergency measures if necessary," such as mattress to the floor, bed/chair sensors, and fall mats "to assure resident safety." P. Ex. 37 at 1. No evidence suggests that the facility implemented such measures at that time. An interim care plan says that she requires extensive assistance from staff for personal hygiene, toileting, eating, and mobility. P. Ex. 37 at 2.

Petitioner justifies its failure to address R24's fall risk by pointing out that its formal care plan was not due until 7 days after her assessment was completed, and the assessment was not due until 14 days after her admission. P. Post-hrg. Br. at 21; *see* 42 C.F.R. §§ 483.20(b)(2); 483.20(k)(2)(i). But protecting residents from accidents is a requirement that knows no time line. From the moment of her admission, the facility was charged with keeping her safe. It was free to choose its methods, but those methods had to include an adequate level of supervision. *Briarwood Nursing Ctr.*, DAB No. 2115 at 5.

R24's fall. On March 25, R24 attempted to get out of bed and fell on the floor. She had removed her pants and her brief and had "an incontinent episode on [the] floor." CMS Ex. 51 at 126. Thereafter, staff placed an alarm on her bed and a fall mat next to it. CMS Ex. 51 at 127, 128, 131. A care plan, dated March 27, instructs staff to "test and re-apply bed or chair alarm." CMS Ex. 51 at 141, 142, 143; *see* CMS Ex. 81 at 11 (Hennington Decl.). Thereafter, however, staff did not ensure that R24's bed and chair alarms were in place. CMS Ex. 6 at 88. Specifically, on March 26 at 11:00 a.m., surveyors observed R24 "on the edge" of her mattress, attempting to get out of bed. No alarm was attached.

When questioned, nurse aides told the surveyor, incorrectly, that R24 required an alarm only when up in her wheelchair (an alarm was on her wheelchair, which was near the door). CMS Ex. 10 at 201; CMS Ex. 6 at 100; CMS Ex. 80 at 9 (LeBlanc Decl.). At 12:20 p.m. on March 28, however, Surveyor Jamietra Hennington observed R24 sitting in the dining room in her wheelchair without a chair alarm in place. CMS Ex. 81 at 25.

Because the facility did not provide this exceptionally vulnerable resident with the supervision and assistive devices she needed to prevent falls, it was not in substantial compliance with 42 C.F.R. § 483.25(h).

Failing to administer ordered pain medication. Among her admissions orders, R24's physician ordered a Duragesic patch, 25 mg., transdermal, every three days. CMS Ex. 51 at 16. *See* CMS Ex. 51 at 16, 33-34; P. Ex. 45 at 6-9 (describing significant improvement in pain level as a result of the medication). Yet, no one applied the patch until March 25, almost two weeks after it was ordered. CMS Ex. 51 at 74, 75, 78; CMS Ex. 81 at 19 (Hennington Decl.) (describing medication administration record showing no patch from March 15 through 21. CMS Ex. 51 at 75; P. Ex. 37 at 7.

In the meantime, treatment notes reflect the resident's suffering. On March 14, she complained of pain in her back. CMS Ex. 51 at 42. A note dated March 15 says that the pain medications given "did not seem to be helping," and staff called her physician for additional orders. But the resident continued to complain of back pain and "was tearful." CMS Ex. 51 at 44. On March 16 and 17, she continued to complain of back pain. CMS Ex. 51 at 46, 47.

On March 20, R24's physician *again* ordered a Duragesic patch for her back pain. CMS Ex. 51 at 55. A social service progress note dated March 20 says that she was taken off her Duragesic patch and "this is in the process of being added to her current medication list." CMS Ex. 51 at 136. But I see no record that the original order was discontinued. A second note, dated March 22, says that she has been on the patch for "a couple of days." CMS Ex. 51 at 136. Again, no medical record supports this claim. And, a nurse's note, dated March 21, describes R24 as moaning and crying out, saying "my back, my back." CMS Ex. 51 at 58.

Surveyor Hennington asked DON Biano why the patch was not administered as ordered. DON Biano conceded that the patch was ordered on March 13, but said that the facility did not have a triplicate narcotic prescription, which was required, so did not obtain the medication until March 20. CMS Ex. 81 at 21 (Hennington Decl.); *see* CMS Ex. 51 at 12.

Because the facility did not provide R24 with the necessary care she needed to attain her highest practicable physical, mental, and psychosocial well-being, it was not in substantial compliance with 42 C.F.R. § 483.25.[12]

Administration. A finding of substantial noncompliance in the facility's administration may derive from findings of substantial noncompliance in other areas.

> [W]here 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 psychosocial well-being of each resident.

*Asbury Ctr. at Johnson City*, DAB No. 1815 at 11 (2002); *Odd Fellow & Rebekah Health Care Facility*, DAB No. 1839 at 7 (2002); *Stone Cnty. Nursing & Rehab. Ctr.*, DAB No. 2276 at 15-16 (2009). As discussed below, I find that the facility's deficiencies posed immediate jeopardy to resident health and safety, which, by itself, justifies the finding that the facility was not in substantial compliance with 42 C.F.R. § 483.75.

Moreover, as the above discussion establishes, the facility did not have in place a reliable method for conveying necessary treatment instructions to direct care staff, which is an administrative responsibility. The facility was therefore not administered in a manner that used its resources effectively to attain or maintain the highest practicable physical, mental, and psychosocial well-being of its residents and was not in substantial compliance with 42 C.F.R. § 483.75.

***2. CMS's determination that the facility's substantial noncompliance with 42 C.F.R. §§ 483.13(c), 483.20(g), 483.25(h), and 483.75 posed immediate jeopardy to resident health and safety is not clearly erroneous.***

Immediate jeopardy. Immediate jeopardy exists if a facility's noncompliance has caused or is likely to cause "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy

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[12] Failing to administer ordered medication also puts the facility out of substantial compliance with 42 C.F.R. § 483.25(m)(1).

exists." *Barbourville Nursing Home*, DAB No. 1931 at 27-28 (2004), citing *Koester Pavilion*, DAB No. 1750 (2000); *Daughters of Miriam Center*, DAB No. 2067 at 7, 9 (2007).

Here one vulnerable resident was seriously injured and died as a result of the facility's noncompliance. Petitioner argues that, because R73 died, no "future or prospective" harm for any other specific resident was likely. P. Post-hrg. Br. at 24. This argument is legally unsound and factually unsupported. First, under the plain language of the regulation, if the facility's noncompliance *has caused* a resident's death, the facility's deficiencies pose immediate jeopardy to resident health and safety, and it is well-settled that a facility's ongoing noncompliance remains at the level of immediate jeopardy until the facility affirmatively demonstrates that it has removed the immediate jeopardy. *Life Care Ctr. of Elizabethton*, DAB No. 2367 at 16-17 (2001); *Premier Living & Rehab Ctr.*, DAB No. 2146 at 23 (2008); *Lake City Extended Care*, DAB 1658 at 12-15 (1998). Second, the facts of this case establish that others were at risk of serious harm, injury, or even death. Staff did not heed – or perhaps were not aware of – the assessments and instructions from the facility's physical and occupational therapists. The facility had no reliable means for conveying that critical information. This was a systemic problem that put every vulnerable resident at risk of injury.

And R73 was not the only resident jeopardized by the facility's failures to provide adequate supervision and assistive devices. R24 was also at a very high risk for falls. Yet, initially, the facility took minimal, if any, precautions to keep her safe. After she suffered a fall, her care plan finally called for concrete interventions – bed and chair alarms. Yet staff did not consistently follow the plan's instructions, making it likely that she would suffer additional serious injury.

Because the facility's serious deficiencies caused the most serious harm and were likely to cause additional serious harm to other vulnerable residents, CMS's determination that the deficiencies posed immediate jeopardy to resident health and safety is not clearly erroneous.

***3. The penalties imposed are reasonable.***

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

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

Here, CMS imposes penalties of $6,650 per day for each day of immediate jeopardy, which is in the mid-range for a per day CMP ($3,050 to $10,000). 42 C.F.R. §§ 488.408(e)(1)(iii), 488.438(a)(1)(i). For the period of substantial noncompliance that was not immediate jeopardy, CMS imposes a penalty of $1,550 per day, which is also in the middle of the applicable penalty range ($50 to $3,000). 42 C.F.R. § 488.408(d)(1)(iii), 488.438(a)(1)(ii). Considering the relevant factors, these penalties are reasonable.

CMS does not argue that the facility's history justifies a higher CMP. Petitioner does not claim that its financial condition affects its ability to pay the CMP.

With respect to the remaining factors, I consider *all* of the facility's deficiencies, including those that the facility does not contest. The facility concedes that it was also not in substantial compliance with five life safety code requirements. Four of the deficiencies were widespread (scope and severity level F). Petitioner also concedes its substantial noncompliance with two quality of care requirements at scope and severity level E. Based on these uncontested deficiencies, I find it reasonable to impose penalties that are above the lowest ranges.

Add to these the serious problems discussed above. For this elderly and infirm population, failing to supervise a resident can – and, sadly, in this case, did – have serious, even fatal consequences. Yet, physical and occupational assessments, along with nursing assessments and other instructions designed to keep the residents safe, were not disseminated to staff, or, if they were disseminated, staff did not regard them. For this, the facility is culpable and the penalties imposed are reasonable.

**Conclusion**

For all of these reasons, I find that: 1) from March 28 through May 9, 2013, the facility was not in substantial compliance with Medicare program requirements; 2) from March 28 through 30, 2013, its deficiencies posed immediate jeopardy to resident health and safety; and 3) the penalties – $6,550 per day of three days of immediate jeopardy and $1,550 per day for 40 days of substantial noncompliance that was not immediate jeopardy – are reasonable.

/s/
Carolyn Cozad Hughes
Administrative Law Judge