Department of Health and Human Service

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	Date: May 04, 2009
Libertywood Nursing Center, (CCN: 34-5520),	)	Docket No. C-07-253
	)	Decision No. CR1945
Petitioner,	)	
v.	)	
Centers for Medicare & Medicaid Services.	)	

DECISION

Petitioner, Libertywood Nursing Center, violated 42 C.F.R. § 483.25(h)(2)[1] and was not in substantial compliance with program participation requirements from October 8, 2006 through December 19, 2006. A civil money penalty (CMP) of $3050 per day for the period October 8, 2006 through November 10, 2006, and $50 per day from November 11, 2006 through December 19, 2006, a total CMP of $105,650, is reasonable.

I. Background

Petitioner, located in Thomasville, North Carolina, is authorized to participate in Medicare as a skilled nursing facility (SNF) and in the Mississippi Medicaid program as a nursing facility (NF). On October 3, 2006, the North Carolina State Survey Agency (the state agency) completed a complaint investigation of Petitioner's facility and found that Petitioner was not in substantial compliance with program participation requirements. On December 6, 2006, the state agency completed a complaint investigation and revisit survey of Petitioner's facility and found that Petitioner continued to not be in substantial compliance with program participation requirements and that the deficiencies posed immediate jeopardy to the health and safety of Petitioner's residents.

[1] Citations to the Code of Federal Regulations (C.F.R.) are to the version in effect at the time of the survey unless otherwise indicated.

The Centers for Medicare & Medicaid Services (CMS) notified Petitioner by letter dated December 12, 2006, that based on regulatory violations found by the survey completed on December 6, 2006, CMS was imposing a CMP of $3050 per day beginning on October 8, 2006, and continuing until Petitioner returned to substantial compliance or its participation agreement was terminated; that Petitioner's provider agreement would be terminated on December 29, 2006, if Petitioner did not return to substantial compliance before that date; and that Petitioner's authority to conduct a Nurse Aide Training and Competency Evaluation Program (NATCEP) would be withdrawn. A second revisit survey was conducted on December 20, 2006, and Petitioner was found to have returned to substantial compliance as of that date. CMS advised Petitioner by letter dated January 3, 2007, that Petitioner was found to have returned to substantial compliance effective December 20, 2006, and that the termination of its provider agreement was rescinded. Petitioner did not have a NATCEP. Tr. 12.

Petitioner requested a hearing by letter dated February 7, 2007. The request for hearing was docketed as C-07-253, and assigned to me for hearing and decision on February 20, 2007. A Notice of Case Assignment and Prehearing Case Development Order (Prehearing Order) was issued at my direction on February 20, 2007. A hearing was conducted on September 25 and 26, 2007, in Greensboro, North Carolina. CMS offered, and I admitted, CMS exhibits (CMS Exs.) 1 through 27. Tr. 17. Petitioner offered, and I admitted, Petitioner exhibits (P. Exs.) 1 through 43. Tr. 19. CMS called as a witness Surveyor Kathleen Dunn. Petitioner called the following to testify: Nurse Practitioner (NP) Mary Ann Nooe; Debbie Draughn, Petitioner's Social Service Director; Certified Nurse Assistant (CNA) Connie Kindley; Don Miller, Petitioner's Administrator; and Timothy Beittel, M.D. The parties submitted post-hearing briefs (CMS Brief and P. Brief). Petitioner submitted a post-hearing reply brief (P. Reply). CMS did not submit a post-hearing reply brief.

II. Discussion

A. Issues

The issues in this case are:

Whether there is a basis for the imposition of an enforcement remedy; and,

Whether the remedy imposed is reasonable.

B. Applicable Law

The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 (for SNFs) and 1919 (for NFs) of the Social Security Act (Act) and at 42 C.F.R. Part 483. Section 1819(h)(2) of the Act vests the Secretary of Health

and Human Services (Secretary) with authority to impose enforcement remedies against a SNF for failure to comply substantially with the federal participation requirements established by sections 1819(b), (c), and (d) of the Act.[2] Pursuant to 1819(h)(2)(C), the Secretary may continue Medicare payments to a SNF not longer than six months after the date the facility is first found not in compliance with participation requirements. Pursuant to 1819(h)(2)(D), if a SNF does not return to compliance with participation requirements within three months, the Secretary must deny payments for all individuals admitted to the facility after that date – commonly referred to as the mandatory or statutory denial of payment of new admissions (DPNA). In addition to the authority to terminate a noncompliant SNF's participation in Medicare, the Act grants the Secretary authority to impose other enforcement remedies, including a discretionary DPNA, CMPs, appointment of temporary management, and other remedies such as a directed plan of correction. Act § 1819(h)(2)(B).

The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. "*Substantial compliance* means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301 (emphasis in original). A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act or the Secretary's regulations at 42 C.F.R. Part 483, Subpart B. Facilities that participate in Medicare may be surveyed on behalf of CMS by state survey agencies in order to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-488.28, 488.300-488.335. The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406.

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, $3050 per day to $10,000 per day, is reserved for deficiencies that pose 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). Pursuant to 42 C.F.R. § 488.301, "*[i]mmediate jeopardy* means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." (Emphasis in original.) The lower range of CMP, $50 per day to $3000 per day, is reserved for deficiencies that do not constitute

[2] Section 1919(h)(2) of the Act gives similar enforcement authority to the states to ensure that NFs comply with the participation requirements established by sections 1919(b), (c), and (d) of the Act.

immediate jeopardy but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii).

The Act and regulations make a hearing before an administrative law judge (ALJ) available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act §§ 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et al*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Cal Turner Extended Care*, DAB No. 2030 (2006)*; The Residence at Salem Woods*, DAB No. 2052 (2006). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e), 498.3. However, the choice of remedies by CMS or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge would affect the range of the CMP that could be imposed by CMS or impact the facility's authority to conduct a NATCEP. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i). The CMS determination as to the level of noncompliance "must be upheld unless it is clearly erroneous" (42 C.F.R. § 498.60(c)(2)), including the finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9, 38 (2000), *aff'd, Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See e.g., Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Review of a CMP by an ALJ is subject to 42 C.F.R. § 488.438(e).

The standard of proof or quantum of evidence required is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a prima facie showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *See Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd, Hillman Rehabilitation Ctr. v. U. S. Dep't of Health and Human Services*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999); *Cross Creek Health Care Center*, DAB No. 1665 (1998); *Emerald Oaks*, DAB No. 1800; *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x. 181 (6th Cir. 2005); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004).

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold followed by my findings of fact and analysis.

It is alleged by the Statement of Deficiencies (SOD) dated December 6, 2006, that Petitioner violated 42 C.F.R. §§ 483.13(c) (Tag F226, scope and severity level (S/S) D); 483.15(h)(2) (Tag F253, S/S E), and 483.75(e)(8) (Tag F497, S/S D), in addition to the two deficiencies discussed hereafter. Petitioner waived any challenge to Tags F226, F253, and F497, and agreed that they provide a basis for a CMP, albeit in the lower range that applies only to deficiencies that do not pose immediate jeopardy. Tr. 9-10; P. Brief at 4 n.1.

1. Petitioner was in violation of 42 C.F.R. § 483.25(h)(2) (Tag F324) from November 10, 2006 through December 19, 2006.

A facility must ensure that "[e]ach resident receives adequate supervision and assistance devices to prevent accidents." 42 C.F.R. § 483.25(h)(2). The Board has explained the requirements of 42 C.F.R. § 483.25(h)(2) in numerous decisions. *See e.g.*, *Eastwood Convalescent Center*, DAB No. 2088 (2007); *Liberty Commons Nursing and Rehab - Alamance*, DAB No. 2070 (2007); *Golden Age Skilled Nursing & Rehabilitation Center*, DAB No. 2026 (2006); *Estes Nursing Facility Civic Center*, DAB No. 2000 (2005); *Northeastern Ohio Alzheimer's Research Center*, DAB No. 1935 (2004); *Woodstock Care Center*, DAB No. 1726, at 28 (2000), *aff'd*, *Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). Section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, but it does require that a facility 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 from accidents. *Woodstock Care Center v. Thompson*, 363 F.3d at 589 (a SNF must take "all reasonable precautions against residents' accidents"). A facility is permitted the flexibility to choose the methods of supervision it uses to prevent accidents, but the chosen methods must be adequate under the circumstances. *Id*. Whether supervision is "adequate" depends in part upon the resident's ability to protect himself or herself from harm. *Id*. Based on the regulation and the cases in this area, CMS meets its burden to show a prima facie case if the evidence demonstrates that the facility failed to provide adequate supervision and assistance devices to prevent accidents, given what was reasonably foreseeable. *Alden Town Manor Rehabilitation & HCC*, DAB No. 2054, at 5-6, 7-12 (2006). An "accident" is "an unexpected, unintended event that can cause a resident bodily injury," excluding "adverse outcomes associated as a direct consequence of treatment or care (e.g., drug side effects or reactions)." State Operations Manual (SOM), App. PP, Tag F324; *Woodstock Care Center*, DAB No. 1726, at 4.

(a) Facts.

The surveyors allege in the SOD that Petitioner violated 42 C.F.R. § 483.25(h)(2) (Tag F324) because Petitioner's staff failed to develop measures to prevent the elopement of Resident 2 from the facility on three occasions, and failed to prevent Resident 2 from hitting another resident. CMS Ex. 1, at 5. The facts related to Resident 2 and incidents cited in the SOD are undisputed. Tr. 27-28.

Resident 2 was admitted to Gaston Memorial Hospital on August 4, 2006, after being diagnosed with a sub-acute, right-sided, subdural hematoma with midline shift, apparently caused when he hit his head while drinking. He was discharged on August 6, 2006, and hit his head again, possibly while drinking, and was readmitted the same day. Due to his neurologic status, Resident 2 underwent a right-sided, frontotemporal craniotomy for evacuation of the subdural hematoma. P. Ex. 5, at 12-14; P. Ex. 6, at 9. His hospital record reflects an attempt to discharge him for rehabilitation or nursing home care, but he was readmitted due to the fact placement could not be secured. P. Ex. 5, at 2, 3.

On August 21, 2006, Resident 2 was discharged from the hospital and admitted to Petitioner with diagnoses of head injury; right subdural hematoma with midline shift; right-sided cerebral edema; delirium; and inability to perform activities of daily living. P. Ex. 5, at 1-3; P. Ex. 16, at 12. A document titled "North Carolina Medicaid FL2 Level of Care Screening Tool" provided to Petitioner by Gaston Memorial Hospital indicates that Resident 2 was oriented to person but not time or place; he did not wander, was not physically or verbally abusive, and was not a danger to himself, others, or property; he required limited assistance for ambulating, transfers, and eating; he required supervision for bathing and toileting; he was independent for dressing; he could not focus on conversation, mumbled a lot and did not make sense when speaking and could state his name only; and he was 65 inches tall and weighed 169 pounds. He was 48 years old when he was transferred to Petitioner. P. Ex. 6, at 2; P. Ex. 7 at 2. Resident 2's treating physician upon discharge to Petitioner was Dr. Timothy Beittel. P. Ex. 9. Resident 2 was assessed as being disoriented and confused but friendly at the time of admission to Petitioner. P. Ex. 10.

Behavioral problems began to manifest on the day of admission according to the evidence of record. Nurse's Notes reflect that on August 21, 2006, the resident was wandering around in his room and was found in bed with his roommate. On August 22, he was found in another resident's room; he was sexually inappropriate with staff and resisted care; he was observed massaging the back of the neck of a female resident who yelled and tried to pull away; he broke the plastic cover on the air conditioning control with his hand; he urinated in the cup holder on the medication cart; he picked up the oxygen tank and held it over the head of another resident; a nurse practitioner ordered

increasing his Risperdal and Ativan pending physician evaluation. On August 23, NP Nooe issued an order for Seroquel and a psychiatric referral. During the night of August 23, Resident 2 was in the hall with a mirror that he had ripped from the wall in his room; the mirror was taken and he was redirected to the day room. He then attempted to remove some unspecified object from the floor in the day room and was assisted back to his room. A note with the time 6:00 a.m. on August 24, 2006, indicates he was found in another room where he had pulled the covers off a resident, removed all items from the top of the dresser, and was sitting on top of the dresser. Later on August 24, he entered another resident's room, defecated on the floor in the corner, and pulled her cards off the wall. A note with the time 6:00 a.m. on August 25 states the resident was up several times during the night shift with feces spread on him and smeared in his room. He refused to wear a brief or pants; he tore the screen from the window and threw it outside; he pulled the divider curtain down; he was give an injection of Ativan at 2:00 a.m. with some effect, but continued to wander in his room. A note at 8:00 a.m. on August 25 indicates he stripped and voided on the floor in his room. A note at 1:15 p.m. on August 25 indicates the police were at the facility to remove Resident 2 to Dorothea Dix Hospital for commitment due to his behaviors. A note at 10:40 p.m. indicates that the resident was being sent back to Petitioner and that the Administrator and Social Services Director agreed to take him back. Resident 2 arrived by ambulance around midnight. A 5:00 a.m. note on August 26 indicates the resident was out of bed wandering in and out of other residents' rooms and moving furniture. A note dated August 31, at 2 p.m. indicates Resident 2 tore up his room, including his bed covers, and put his foot in his lunch tray. P. Ex. 23, at 1-6; P. Ex. 35, at 1-2.

A Social Service Progress Notes entry dated August 24, 2006, indicates that Resident 2's inappropriate behaviors included grabbing at a CNA and a resident; taking his clothes from his closet and putting them on the floor; putting a razor in his mouth and biting it; and defecating on the floor in another resident's room and using her greeting cards to clean himself. The Social Services Director requested an emergency psychiatric evaluation. On August 25, NP Nooe gave an order to obtain commitment papers for the resident and the police transported him to Daymark Recovery Services.[3] P. Ex. 25, at 1; CMS Ex. 23, at 74. The Daymark report dated August 30, 2006, indicates that Resident 2 was delivered by police on August 25 with paper work that reflected his behavior during his week at Petitioner's facility. The report indicates that when interviewed, the resident was confused, disoriented, and smelled of feces. The resident was not able to provide a reliable report, and Petitioner's staff was called and confirmed the reported behaviors. The resident could not be fully assessed as to his risk to self or others as the resident was alone and he could not discuss the issues. However, it was noted in the report that he resisted police when they attempted to transport him. The psychiatrist directed that

[3] Daymark was a community mental health center at which the resident had to be evaluated before commitment to a psychiatric hospital. In this case, the Nurse's Notes indicate the hospital was Dorothea Dix. Tr. 161-62.

Resident 2 be sent to the hospital for evaluation of possible brain swelling before psychiatric treatment. The report further indicates that Resident 2 was sent to the hospital by ambulance as the police officer and a nurse could not get him into the police car. P. Ex. 32; CMS Ex. 23, at 117-28.

Physician's orders reflect Resident 2's prescription for Risperdal was changed and Ativan was added to Resident 2's medications on August 22, 2006. P. Ex. 19, at 1. Seroquel was added and a psychiatric evaluation was ordered on August 23, and the order included the comment that Resident 2 may need to be transferred to a facility with a behavioral unit if Petitioner's staff was unable to monitor or control him. On August 25, 2006, Haldol and an antibiotic were ordered. P. Ex. 19, at 1.

Resident 2's Minimum Data Set (MDS) with an assessment reference date of September 2, 2006 (his admission assessment), reflected no problem with communication – he only sometimes understood simple direct communication; there was some indication of depressed mood; he was noted to have socially inappropriate and/or disruptive behavior daily that was not easily altered; he was totally dependent on staff for dressing, toileting, personal hygiene, and bathing; he was incontinent of bowel and bladder; and his condition was evaluated to be unstable. P. Ex. 13. Resident 2's care plans identified as a problem that he suffered cognitive loss due to a head injury and craniotomy with secondary trouble communicating and not responding appropriately. The care plan listed three interventions: ask the resident simple questions that require yes and no answers; document responses; and monitor for improvement. P. Ex. 15, at 1. The care plan also identified as a problem that he tore things off the walls, bed, curtains; he tore things up, and he spread feces about his room. Three interventions listed to address the problem were: provide activity to occupy his hands to prevent destructive behavior; provide incontinent care every two hours, and as necessary; and notify physician of changes in behavior. P. Ex. 15, at 5.

Nurse's Notes entries show that on September 2, 2006, Resident 2 was standing in the day room in the afternoon, and he fell backward and struck his head. He was transported to Thomasville Medical Center by ambulance. P. Ex. 23, at 6. The incident/accident report indicates that he was standing in the dining area and fell straight back, hitting his head on the floor. The report indicates that nurse assistants were told to "watch this type of Resident more closely." P. Ex. 35, at 3.

On September 2, 2006, Resident 2 was admitted to the hospital for altered mentation following falling and hitting his head at Petitioner. He was started on psychotropic medications and evaluated by psychiatry. He was discharged back to Petitioner on September 13, 2006, with diagnoses of altered mentation; Wernicke-Korsakoff encephalopathy; Clostridium difficile colitis (C. diff.); dehydration; and psychosis. P. Ex. 17. Resident 2's readmission assessment dated September 13, 2006, indicates that he

was confused, required isolation precautions, he was on psychotropic medication and an antibiotic; and he was angry, combative, and noncompliant. P. Ex. 18.

The physician's order dated September 13, 2006, indicates that the resident was to be on contact isolation in his room including having meals served in his room until laboratory results were negative for C. diff. P. Ex. 19, at 3. He was reported to be confused and verbally abusive on September 15, and remained on isolation. P. Ex. 23, at 7; P. Ex. 37, at 2. On September 18, he was reported to respond inappropriately. On October 3, he refused incontinent care by CNAs, pulled the vinyl cover off his mattress, and was noncompliant. P. Ex. 23, at 8, 10. On October 8, the Progress Notes entry at 11:00 p.m. indicates that the nurse was alerted by a CNA that the resident was not in his room; the facility was searched, then it was noted that the blinds in his room were moving. Feces were found around the window, a search was conducted outside, and the resident was found in only a shirt between dumpsters. He was taken inside and bathed, no injuries were detected, and the note indicates he was to be observed to prevent elopement. P. Ex. 23, at 10. On October 11, he was found in his bathroom, naked except for a T-shirt and socks, and there were feces in a diaper besides the toilet and on his socks. A note dated October 11 at 9:15 p.m. indicates that Resident 2 was in another resident's room, he pushed the screen out of the upper window, and climbed out the window. A passing motorist reported to staff that the resident was near the street, and he was returned to the facility without further incident. On October 13, the laboratory reported that Resident 2 continued to have positive results for C. diff., and isolation precautions remained in place. P. Ex. 23, at 11-12; CMS Ex. 23, at 62, 96-97.

On October 16, the resident was reported to be wandering in and out of other residents' rooms. P. Ex. 23, at 12; CMS Ex. 23, at 97. On October 17, Resident 2 was again reported to be wandering in and out of other residents' rooms, and, at times, was difficult to redirect. On October 18, he was again wandering in and out of other residents' rooms, stealing linen, cursing, and being argumentative and combative with staff. He opened the window in another resident's room and cussed at visitors to the building. Also on October 18, NP Nooe wrote an order for a psychiatric evaluation and recommended that Resident 2 be moved to a locked behavioral unit, and the Social Services Director called to arrange the psychiatric evaluation as soon as possible. On October 19, he was wandering in the facility. On October 21, he opened an emergency exit door and tried to go out, but was redirected and while wandering around, stepped on another resident's feet. On October 22, 23, 25, and 26, it was reported in the Nurse's Notes that he was wandering the halls and in and out of other residents' rooms. P. Ex. 23, at 13-16. A note at 4:45 a.m. on October 27 indicates that Resident 2 entered another resident's room; sat on the resident; accused the resident of wearing his clothes; stepped toward the other resident in the room with his arms stiff, yelling and cursing, and Resident 2 had to be physically redirected. A note at 5:00 a.m. on October 27 indicates that Resident 2 went into another room, opened the closet doors, stated he wanted his clothes and boots, and

had to be physically redirected. A note at 10:00 a.m. on October 27 indicates he walked into another room, the resident told him to get out of his room, and he punched Resident 2 in the head and lip, causing injury. P. Ex. 23, at 16, 18. Subsequent notes on October 27 reflect Resident 2 continued to wander in and out of other residents' rooms, sat on other residents' beds, cursed, showed inappropriate sexual and combative behavior, was verbally abusive, and opened outside doors twice. P. Ex. 23, at 17-18.

Wandering, cursing, and confrontation with other residents and staff continued on October 28 and 29. P. Ex. 23, at 18-20. Also on October 29, he demanded medication that he had already received; he threatened to hit a CNA by drawing back his arm; he rummaged through drawers of the nurse's desk; he attempted to swing at a nurse; and the resident's daughter was called and asked to come to the facility. P. Ex. 23, at 20. Nurse's Notes entries on October 30, 31, and November 1 through 9, reflect that one or more of the following behaviors occurred on one or more days: wandering the halls and in and out of other residents' rooms; urinating on another resident's bed; attempting to move oxygen tanks; rummaging through desk drawers and taking things from the desk and the crash cart; yelling at, arguing with, and cursing at staff; taking property of other residents; agitation, threatening other residents, and verbal abuse. P. Ex. 23, at 21-27; P. Ex. 37, at 6-9.

A Social Service Progress Notes entry dated October 27, 2006, indicates that the Social Services Director started sending requests to facilities with locked units to take Resident 2 and mentions a failed attempt to have the resident committed on September 3, 2006. The notes also reflect the Social Services Director made calls to several mental health facilities that were not fruitful. P. Ex. 23, at 17, 19; P. Ex. 25, at 2-3; CMS Ex. 23, at 75-76. A Social Service Progress Notes entry dated October 29 shows that the Social Services Director was called by staff and told that Resident 2 threatened to hit a CNA. Staff advised the Social Services Director that a one-time order for Ativan had been obtained and administered, and staff was one-on-one with the resident. The Social Services Director instructed staff to call the resident's daughter to sit with him if necessary and to call the police if the resident did hit anyone. P. Ex. 23, at 19; P. Ex. 25, at 3; CMS Ex. 23, at 76.

A physician order dated November 1 shows that a WanderGuard ™ was ordered for Resident 2 due to the numerous times he left the building. P. Ex. 19, at 8. On November 2, he attempted to go out the emergency exit door. P. Ex. 23, at 22. On November 7, he hit a female resident in the face three times. The Nurse's Notes entry indicates that Resident 2 was to be sent to the hospital that afternoon for a psychiatric evaluation and possible placement in another facility. However, later on November 7, the resident was returned to Petitioner in a lethargic state, having received an injection of Haldol at the hospital emergency room. P. Ex. 23, at 24. A note dated November 8, 2006, at 12:15 p.m. indicates that a CNA was doing one-on-one supervision with the resident to prevent him from hurting himself or others. However, the note also indicates that the resident's

daughter was called and told that the CNA would be leaving at 4:00 p.m. and the daughter would have to come to the facility to sit with the resident until he fell asleep. A subsequent note indicates the CNA stayed until 6:00 p.m. and continued to provide one-on-one supervision until the daughter arrived. P. Ex. 23, at 25. The CNA kept detailed notes that indicate he began one-on-one supervision of Resident 2 at 7:30 a.m. on November 8, 2006, and maintained that supervision until 6:07 p.m. when the daughter arrived to sit with Resident 2. P. Ex. 27; CMS Ex. 15. Nurse's Notes entries from 7:00 p.m. on November 8, to 7:00 a.m. on November 9, show that the resident was subject to 15-minute checks, if not constant one-on-one supervision. P. Ex. 27, at 6-7; CMS Ex. 23, at 90-91. A CNA assumed one-on-one supervision at 7:00 a.m. on November 9, that continued until 3:00 p.m. The CNA's log shows he began his one-on-one supervision again at 7:00 a.m. on November 10 and that continued until the resident was removed from the facility. P. Ex. 27; CMS Ex. 15.

On November 9, a note at 9:15 p.m. indicates that Resident 2 went into another resident's room, took a walker and hit the other resident on his legs, causing abrasions. Resident 2 was eventually returned to his room where he turned over furniture, pulled the call-light from the wall, pulled off his shirt, and attempted to get out the window. P. Ex. 23, at 26-27; P. Ex. 37, at 8; CMS Ex. 23, at 78. A late entry to the Nurse's Notes at 8:30 p.m. on November 9 indicates that Resident 2 was found outside wandering the grounds after he knocked out the screen in another room and climbed out the window. P. Ex. 23, at 28; P. Ex. 37, at 8-9. An entry at 11:30 p.m. on November 9 indicates Resident 2 was sent by ambulance with a police escort to the hospital emergency room. A note at 4:00 a.m. on November 10 indicates that Resident 2 was being returned to Petitioner. The police returned the resident and stated that the resident had been cursing, hitting, and kicking them when getting into the car. He was moved in a wheelchair with handcuffs restraining his arms behind his back. A Nurse's Notes entry at 4:00 p.m. on November 10, indicates that the resident was sent to a different emergency room for psychiatric evaluation. P. Ex. 23, at 28-29; P. Ex. 37, at 9.

A laboratory report shows that Resident 2 continued to test positive for C. diff. from a specimen collected on October 11, 2006. The specimen collected on November 10, 2006, was negative for C. diff. P. Ex. 28, at 1, 4.

NP Nooe testified that she first evaluated Resident 2 on August 23, 2006. She added the antipsychotic, Seroquel, due to reports from staff regarding inappropriate behavior and the fact that he had an organic brain disorder. NP Nooe testified that due to his behavior and aggressiveness, she suggested that an evaluation be done of whether he was inappropriate to stay in Petitioner's facility. Tr. 134-35. She told the Social Services Director, Debbie Draughn, on August 23, that it may be necessary to transfer the resident. Tr. 144. NP Nooe explained in response to my questioning that she recommended that Resident 2 be sent to Daymark for evaluation because Daymark was the community mental health center and it could accomplish an involuntary commitment, but she and her

company could not. Tr. 161-62. She provided the resident's clinic history to Daymark by telephone. Tr. 164. She could tell from the Daymark report (P. Ex. 32) that a psychiatric evaluation of Resident 2 was done when he was seen there on August 25, 2006, but the evaluation was limited due to the resident's inability to reliably report his condition. Tr. 142-44. NP Nooe saw Resident 2 again on October 17, recommended a psychiatric consult, increased his Seroquel, and recommended that he be placed on a locked behavioral unit. Tr. 135. She was aware that Petitioner attempted the following interventions: redirection, one-on-one supervision, medication management, and he was sent out of the facility several times. Tr. 148. When Resident 2 returned to Petitioner after his hospitalization in September 2006, NP Nooe felt that medication kept him calm for a couple of weeks. Tr. 148. She opined that there was nothing more that Petitioner could have done to manage Resident 2's behavior. Tr. 149. I do not find credible or probative NP Nooe's opinion that Petitioner did all it could for reasons discussed hereafter related to a similar opinion expressed by Dr. Beittel, and as further discussed in my analysis. NP Nooe testified that she recalled that in October 2006, Petitioner was making efforts to find a better placement for the resident. Tr. 149. She testified that restraint is no longer used and she opined that use of physical restraint would only have made Resident 2 wilder. Tr. 150. She admitted that chemical restraint with Haldol and Ativan was done to a limited extent, particularly when the resident was sent out to the emergency room, but quality of life is poor when one is sedated, so chemical restraint is avoided. Tr. 150-51.

Petitioner's Social Services Director, Debbie Draughn, testified that the first attempt to have Resident 2 committed was on August 25, 2006, when NP Nooe wrote the order for her to submit the papers. Tr. 175. She felt commitment was appropriate at the time due to the resident's documented behaviors. Tr. 175. A magistrate issued orders for commitment and the police came and removed the resident to Daymark. However, the resident was returned to Petitioner. Tr. 175-76. Resident 2 received a second psychiatric evaluation at "Community General" on September 2, 2006, according to Ms. Draughn. Tr. 176. She testified that upon his return from the hospital in September, he resisted care, but 10 to 14 days later, his behaviors worsened. Tr. 177-78. Ms. Draughn testified that the resident was discussed daily at the meeting of department heads. Tr. 178-79. She testified that at the end of September or early October, she began looking for placement for Resident 2 at a facility with a lock-down unit. Tr. 180-81. She testified that the resident was sent out to the emergency room on November 9, 2006, but he was returned to Petitioner. Tr. 188. On November 10, 2006, he was sent to the Wake Forest University Baptist Medical Center emergency room; he did not return to Petitioner and Ms. Draughn believed that he was ultimately transferred to a facility named John Umstead. Tr. 188-89; P. Ex. 33. She testified on cross-examination that one-on-one supervision was not used until November 8, 2006. Tr. 191.

Petitioner's Administrator, Don Miller, testified that Petitioner's staff considered several interventions to control Resident 2's behaviors including: medication; redirection with one-on-one activities, but Resident 2 could not maintain attention; psychiatric evaluations; and, on November 8, 2006, he instructed staff to begin one-on-one monitoring of the resident. Tr. 204-06, 201-05.

Resident 2's attending physician, Dr. Beittel, testified that NP Nooe started Resident 2 on Risperdal and Seroquel on August 23, 2006, with some improvement in his mood and behavior. Tr. 231-32. However, he testified that a predictable pattern developed where medication would be adjusted to address behavior, which was effective for a day to several days, and then the behaviors would reemerge. Tr. 234. Dr. Beittel testified that unnecessary physical or chemical restraints are prohibited, but potentially harmful behavior is an exception that permits their use. Tr. 235. Ativan, a sedative, was ordered to be administered as necessary to control Resident 2, which was temporarily effective. However, Ativan is a very short-acting medication so it was not a long-term solution. Tr. 236, 268. In Dr. Beittel's opinion, Resident 2 would have been better served in a locked unit, either a dementia unit or a brain injury unit. Tr. 246.

Dr. Beittel testified that interventions included adjusting Resident 2's medications, using one-to-one supervision, interpersonal interventions, and using a WanderGuard on Resident 2 that would sound if he tried to leave through a facility door. He testified that besides these measures, they needed to keep the resident in sight as much as possible and be ready to intervene. Tr. 248-49. Dr. Beittel opined that with a resident like Resident 2, one-on-one could cause escalation of problems. Tr. 250. I do not find his opinion persuasive. The evidence shows that when one-to-one supervision of Resident 2 was done at various times on November 8, 9, and 10, 2006, there were fewer reported behavior problems. P. Ex. 23, at 25-29; P. Ex. 27; CMS Ex. 15. Dr. Beittel further opined, asserting reasonable certainty, that everything that could have been done for Resident 2 was attempted. Tr. 253. I find this opinion to be not persuasive. As already noted, when one-on-one supervision was used on November 8, 9, and 10, it was at least partially effective. Dr. Beittel testified that he was not aware that one-on-one supervision did not begin until November 8, 2006. Tr. 255-56. The evidence does not reflect that one-on-one supervision, as opposed to one-on-one activities, was considered and rejected by the care planning team prior to November 8. According to Administrator Miller, on November 8, he unilaterally decided to order the intervention of one-on-one supervision.

Regarding the use of restraints, Dr. Beittel testified that there was a standing order for nursing staff to administer a 10 milligram dose of Haldol as often as twice a day, as necessary, to control the resident. Although nursing staff had the discretion to administer Haldol as they deemed appropriate, it was not desirable to knock out the resident with drugs to keep him in bed all day. Tr. 260-61. Dr. Beittel testified that C. diff. is fairly contagious, resistant to most antibiotics, and readily transmitted in long-term care facilities and hospitals. Isolation, good hand-washing and universal hygiene or universal

precaution measures are necessary to reduce the risk of transmission to staff and other residents. Infection control is a concern with an elderly resident population in a long-term care facility because the frail, elderly, and physically compromised are susceptible, and C. diff. could even be fatal in such a population. Tr. 265-66.

(b) Analysis.

CMS argues that Petitioner violated 42 C.F.R. §§ 483.25(h)(2) and 483.75 beginning about October 8, 2006, the date Resident 2 first exited through a facility window, and the violation and immediate jeopardy continued until December 19, 2006, when Petitioner returned to substantial compliance with program participation requirements. Tr. 22-23. The parties agreed at hearing that the issue before me is whether Petitioner took appropriate steps or implemented appropriate interventions to address Resident 2's behaviors. Tr. 27-28. Petitioner argues that Resident 2 should never have been admitted to Petitioner and he was admitted only because the hospital that discharged him to Petitioner did not reveal his true condition; that Petitioner's staff made heroic efforts to protect Resident 2 and other residents from his behaviors; that Resident 2 was essentially abandoned at Petitioner's facility by the healthcare system; that staff and Resident 2's physician and nurse practitioner were fully aware of the resident's condition and were actively involved in attempting to control his behaviors; and that Petitioner was not able to transfer the resident until it could locate a suitable placement. P. Brief at 4-5, 7-9, 12-15.

A facility is obliged by the regulation 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 from accidents. A facility is permitted the flexibility to choose the methods of supervision it uses to prevent accidents, but the chosen methods must be adequate under the circumstances. Whether supervision is "adequate" depends in part upon the resident's ability to protect himself or herself from harm.

The evidence shows that on August 23, 2006, within two days of admission to Petitioner, Resident 2 was assessed by NP Nooe as requiring a locked behavioral unit due to his behavior. NP Nooe added psychotropic medication to sedate him and control his behavior. The evidence shows that on August 25, 2006, Petitioner attempted to have Resident 2 committed to a state psychiatric hospital, but the resident was returned to Petitioner. Haldol was ordered in a further attempt to control him with medication on August 25. I conclude that not later than August 25, 2006, Petitioner knew of Resident 2's behaviors, and the risk of harm to him or other residents due to accidents was foreseeable based on that knowledge.

On September 2, 2006, Resident 2 fell and hit his head and was hospitalized. On September 13, 2006, Resident 2 was released from the hospital and returned to Petitioner. His diagnoses included C. diff. and isolation precautions were ordered. Thus, it was foreseeable, considering Resident 2's behavioral problems, that he posed a risk for harm to other residents by accidental infection with C. diff., if proper isolation precautions were not implemented.

A care plan dated September 2, 2006, was developed for Resident 2. The evidence shows that the interventions listed on the care plan were never effective to control the resident. Indeed, review of the Nurse's Notes should have revealed to the care planning team that the interventions were not effective even before the care plan was formally adopted. Furthermore, the care plan is not helpful evidence for Petitioner as there is no evidence that the original care plan dated September 2, 2006, was amended or updated by the care planning team with new interventions. P. Ex. 15; CMS Ex. 23, at 110-16; Tr. 42.

The clinical records of Resident 2 that were admitted as evidence show that Petitioner's staff attempted other interventions not listed on the care plan. However, the evidence also shows that the other interventions were largely ineffective to control the resident. For example, one-on-one activities were ineffective due to the resident's inability to maintain attention; the WanderGuard was ordered, and, I assume implemented, but was of little effect, for when the resident left the facility, it was through his or another resident's window. There was no dispute the windows did not have the WanderGuard alarm system installed. Further, as Dr. Beittel testified, medication adjustments were only effective for a brief period before behaviors reemerged. It is also apparent from the evidence that throughout the period of September 13, 2006 through November 10, 2006, Resident 2 continued to wander around the facility and in and out of other residents' rooms, and I conclude that the isolation that was ordered was not effectively implemented. Sedation did work to control behaviors, but as Dr. Beittel testified, chemical restraint is to be avoided. One-on-one supervision was not implemented until November 8, 2006. Petitioner argues that the one-on-one supervision agitated Resident 2, even more. I do not find Petitioner's argument credible. My review of the Nurse's Notes entries (P. Ex. 23, at 25-29) and the one-on-one supervision log (P. Ex. 27) reveals that during the period of one-on-one supervision, Petitioner's staff had better control of the resident than without the supervision. The evidence does show that during the evening of November 9, 2006, Resident 2 hit another resident with a walker, causing injury, and that Resident 2 climbed out a window, but the evidence does not show he was subject to one-on-one supervision during either incident. I also find not credible or weighty for reasons already noted, the testimony of Dr. Beittel and NP Nooe to the extent it is construed to be that Petitioner did all it could to control the resident. P. Brief at 15.

Resident 2's behaviors continued from his readmission on September 13 until he departed the facility on November 10, 2006. Throughout this period, Petitioner's evidence shows that he climbed out of windows and left the facility unsupervised three times (October 8, 11, and November 9, 2006); he struck other residents three times causing injury each time (October 27, November 7, and November 9, 2006); and he continued to test positive for C. diff. from a sample collected on October 10 and did not test negative until November 10, 2006. The evidence shows that Resident 2 was at risk for harming himself and other residents due to his lack of supervision except when he was sedated or under one-on-one supervision. Petitioner's rationalization that one-on-one supervision caused greater agitation is not consistent with the evidence. Petitioner has not shown why one-on-one supervision was not implemented as early as September 13, 2006, to control Resident 2's behavior and to maintain proper isolation to prevent the spread of the C. diff. infection.

I understand that one-on-one supervision is extremely burdensome upon a facility such as Petitioner. However, the burden of providing one-on-one supervision does not outweigh Petitioner's obligation to protect its residents from the risk of accidental injury from residents who are infected or that manifest inappropriate or aggressive behaviors. One-on-one supervision may have been facilitated and made less onerous by simply moving the resident to a room closer to the nurse's station, an intervention that does not appear in the evidence before me. I also recognize that Petitioner made efforts to have Resident 2 transferred to another facility that could appropriately care for the resident beginning within days of his arrival in August 2006. However, I do not consider Petitioner's attempts to transfer Resident 2 to be an effective intervention to protect Resident 2 or the other residents from a foreseeable risk for harm from Resident 2.

Accordingly, I conclude that Petitioner failed to take all reasonable steps to ensure Resident 2 received the supervision necessary to meet his assessed needs and mitigate the foreseeable risk of accidental injury to himself and other residents due to his behaviors and infection with C. diff. Petitioner violated 42 C.F.R. § 483.25(h)(2) from the date alleged by CMS, October 8, 2006, to the date Petitioner achieved substantial compliance, December 20, 2006.

2. Petitioner did not violate of 42 C.F.R. § 483.75 (Tag F490).

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 psychosocial well-being of each resident. 42 C.F.R. § 483.75. The surveyors allege in the SOD that Petitioner's "administration failed to develop measures to prevent the elopement of" Resident 2 and "failed to prevent" Resident 2 "from hitting another Resident." CMS Ex. 1, at 30. The surveyors alleged that immediate jeopardy began on October 8, 2006, that it was identified on December 5, 2006, and was "ongoing." CMS

Ex. 1, at 30. The surveyors cross-reference the allegations under Tag F324 of the SOD. In its post-hearing brief, CMS states simply that it relies upon the SOD to establish the violation. CMS Brief at 13.

As alleged by the surveyors and argued by CMS, the alleged violation of 42 C.F.R. § 483.75 derives from Petitioner's violation of 42 C.F.R. § 483.25(h)(2). The Board has concluded in prior cases that the citation of a violation of 42 C.F.R. § 483.75 that is derivative of another deficiency allegation is acceptable. *See e.g. Cross Creek Health Care Center*, DAB No. 1665 (1998) and *Eastwood Convalescent Center*, DAB No. 2088 (2007).

Based upon the allegations of the SOD and the facts of this case, I conclude that the evidence does not show that Petitioner was not administered in a manner that enabled the use of resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of its residents. The gist of the allegations of the SOD are that: (1) Petitioner failed to create and implement effective interventions to prevent Resident 2 from eloping; and (2) Petitioner failed to create and implement effective interventions to prevent Resident 2 from hitting another resident. CMS Ex. 1, at 30. The SOD does not specifically allege how the two alleged failures, also the basis for the alleged violation of 42 C.F.R. § 483.25(h)(2), show that Petitioner was not effectively administered. The evidence does not show a failure of Petitioner's administration to act to address the needs of Resident 2 or other residents. Rather, the evidence shows Petitioner's administration acted, albeit ineffectively, to address the issues posed by Resident 2, whose presence as a resident at Petitioner's facility, it is not disputed, was an anomaly. The evidence shows that assessment and care planning occurred in the case of Resident 2 and that Petitioner attempted interventions to control the resident. There is no allegation that Petitioner did not have or had not implemented required policies. Petitioner had a policy for unmanageable residents, which the evidence shows was followed in the case of Resident 2. CMS Ex. 23, at 16. Although it is alleged under Tag F324 that staff did not follow all the requirements of Petitioner's policy regarding elopement, that allegation is not restated in Tag F490. Even if staff failed to follow all the requirements of Petitioner's elopement policy, I do not find a single failure as described under Tag F324 to establish a systemic failure of the policy or Petitioner's administration. Accordingly, I conclude that Petitioner did not violate 42 C.F.R. § 483.75.

3. The finding of immediate jeopardy was not clearly erroneous.

4. Immediate jeopardy was abated when the resident was transferred.

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 includes its immediate jeopardy finding – must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy, and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1962, at 11 (2005), citing *Florence Park Care Center*, DAB No. 1931, at 27-28 (2004) (citing *Koester Pavilion*, DAB No. 1750 (2000)).

In this case, CMS determined that the deficiencies under Tags F324 and F490 posed immediate jeopardy to Resident 2 and other residents, and that immediate jeopardy began on October 8, 2006, and was ongoing until Petitioner returned to substantial compliance on December 20, 2006. I conclude that Petitioner's failure to implement appropriate and timely interventions to supervise Resident 2 posed immediate jeopardy to Resident 2 and other residents. Although no resident suffered serious injury or death as a consequence of Resident 2's behaviors, the potential for serious physical harm or death was present. Petitioner did not meet its burden to show that immediate jeopardy did not exist so long as Resident 2 was in the facility.

Additionally, the evidence shows that Resident 2 was infected throughout most of his stay at Petitioner's facility with the bacteria C. diff. According to Dr. Beittel, C. diff. is a bacteria that is most typically associated with a gastrointestinal infection, causing watery diarrhea, cramping, and bloody stools. Tr. 265. Dr. Beittel stated that C. diff. is "fairly contagious and resistant to most antibiotics except a couple selected ones . . . and can particularly be transmitted in an institutional setting so long term care facilities, hospitals and others like that, you have a lot of attention directed to it." Tr. 265. To reduce the risk of transmission to staff and other patients, Dr. Beittel stated that isolation, good hand washing, and other universal precaution measures should be observed. Tr. 265. Dr. Beittel testified that C. diff. is problematic for the frail and elderly, and otherwise physically compromised people, and that there is in rare instances a risk of death, which is higher with compromised populations. Tr. 265-66. In his infected state, Resident 2 had repeated instances of spreading his feces around, not only in his room, but in other residents' rooms. Thus, each time Resident 2 wandered, unsupervised and unmonitored, into other residents' rooms, there existed a risk that he would spread the infection to those other residents, potentially endangering their lives.

Given the evidence, I cannot conclude that Petitioner has met its burden of showing the immediate jeopardy finding was "clearly erroneous." I therefore uphold CMS's immediate jeopardy determination for Tag F324. Because I found that the evidence did not show a violation of Tag F490, immediate jeopardy is not at issue related to that alleged violation.

Petitioner argues that, if there was immediate jeopardy, it ended when Resident 2 was discharged to another facility, on November 10, 2006. P. Brief at 23; P. Reply at 6-7. I agree with Petitioner that once Resident 2 left Petitioner's facility, immediate jeopardy was abated. It was Resident 2's behavior and his C diff. infection that posed a risk for serious injury or death to himself and other residents. The evidence does not show that Petitioner had other resident's with similar problems or that there was a possibility that Petitioner would admit a resident with similar problems. When Resident 2 was removed and did not return, the risk of serious injury or death was eliminated. Accordingly, the period of immediate jeopardy at Petitioner's facility ran from October 8, 2006 through November 10, 2006.

Petitioner has not shown, however, that it returned to substantial compliance prior to December 19, 2006, the date it alleged completion of its plan of correction. CMS Ex. 1, at 5. The revisit survey determined Petitioner was in substantial compliance effective December 20, 2006, consistent with Petitioner having completed its plan of correction on December 19, 2006. I also conclude that from November 10 through December 19, 2006, the risk for more than minimal harm remained until staff training was completed related to Petitioner's policies on elopement; resident-to-resident and staff-to-resident abuse; staff response to anger, frustration, and threats from residents; investigation processes; dealing with mental status changes in residents, and falls; and until Petitioner completed the other corrective actions listed on its plan of correction. CMS Ex. 1, at 5-19.

5. There is a basis for the imposition of an enforcement remedy.

6. A CMP of $3050 per day is reasonable for the period October 8, 2006 through November 10, 2006, and a CMP of $50 per day is reasonable for the period from November 11, 2006 through December 19, 2006, a total CMP of $105,650.

I have concluded that Petitioner violated 42 C.F.R. § 483.25(h)(2). Hence, there is a basis for the imposition of an enforcement remedy.

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, including a CMP. CMS may impose a CMP for the number of days that the facility is not in compliance or for each instance that a facility is not in substantial compliance. 42 C.F.R. § 488.430(a). There are two ranges for per day CMPs. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP from $3050 per day to $10,000 per day is 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 CMP from $50 per day to $3000 per day is for deficiencies that do not

constitute immediate jeopardy, but either cause actual harm to residents or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). The $3050 per day CMP proposed by CMS is at that low end of the range of CMPs authorized for a deficiency that poses immediate jeopardy.

In determining whether the amount of the CMP is reasonable, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of non-compliance, 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. *Emerald Oaks*, DAB No. 1800, at 10 (2001); *CarePlex of Silver Spring*, DAB No. 1683, at 16-17 (1999); *Capitol Hill Community Rehabilitation and Specialty Care Center*, DAB No. 1629 (1997).

In its notice dated December 12, 2006, CMS stated that it was imposing a CMP of $3050 per day effective October 8, 2006, that would continue until substantial compliance was achieved. In its correspondence dated January 3, 2007, CMS advised Petitioner that a revisit conducted on December 20, 2006, found that Petitioner was in substantial compliance effective December 20, 2006. CMS Ex. 27. CMS proposed to impose a CMP of $3050 per day for the period October 8, 2006 through December 19, 2006. However, as discussed above, I have determined that the period of immediate jeopardy was shorter than that alleged by CMS, and ran from October 8, 2006 through November 10, 2006. I further find that Petitioner remained in noncompliance at the non-immediate jeopardy level during the period November 11, 2006 through December 19, 2006.

The presence of immediate jeopardy, even as to one resident, requires the imposition of a CMP in the highest range of authorized CMPs – $3050 per day to $10,000 per day. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). CMS proposed to impose the minimum authorized, $3050 per day. I conclude that a CMP of $3050 per day for the period of immediate jeopardy, October 8, 2006 through November 10, 2006, is reasonable.

I concluded that immediate jeopardy was abated effective November 11, 2006. Thus, a daily CMP in the upper range of CMPs is not authorized or reasonable, for the period November 11, 2006 through December 19, 2006. The regulations authorize a CMP in the range of $50 to $3000 per day for deficiencies that do not pose immediate jeopardy. 42 C.F.R. § 488.438(a)(1)(ii). I have considered the remedial purpose to be served and the factors specified by 42 C.F.R §§ 488.404 and 488.438(f). I have received no evidence showing that Petitioner had a history of noncompliance. I find that Petitioner was culpable. Petitioner submitted its current financial statements and asserted that the documents show substantial operating losses and negative equity. P. Ex. 43. CMS has not questioned the accuracy of Petitioner's financial statements.

The minimum authorized CMP amount for non-immediate jeopardy level deficiencies is $50 per day. Given Petitioner's financial condition and the other required factors, I conclude that $50 per day for the period November 11, 2006 through December 19, 2006, is a reasonable CMP.

Accordingly, I conclude that a CMP of $3050 per day is reasonable for the period of immediate jeopardy from October 8, 2006 through November 10, 2006, a period of 34 days at $3050 per day which amounts to a CMP of $103,700 for the period. I further conclude that a CMP of $50 per day is reasonable for the period from November 11, 2006 through December 19, 2006, a period of 39 days at $50 per day which amounts to a CMP of $1950. The total CMP is $105,650.

7. The burden of persuasion does not affect the outcome of this case.

8. Review of the reasonableness of the proposed enforcement remedy was de novo and review of how CMS considered the regulatory factors when proposing an enforcement remedy is not relevant to my review.

Petitioner attempts to preserve two additional issues for appeal. Petitioner argues that the allocation of the burden of persuasion in this case according to the rationale of the Board in the prior decisions cited above violates the Administrative Procedures Act, 5 U.S.C. § 551 *et. seq.*, specifically 5 U.S.C. § 556(d). Petitioner's Prehearing Brief at 16-17. Because the evidence is not in equipoise, the burden of persuasion did not affect my decision, and Petitioner suffered no prejudice.

Petitioner also argues that the Medicare Act is violated, and Petitioner is deprived of due process if CMS is not required to submit evidence to prove it considered the regulatory criteria established by 42 C.F.R. §§ 488.404 and 488.438(f). Petitioner's Prehearing Brief at 17. I reviewed the evidence related to the regulatory factors de novo and perceive no prejudice to Petitioner because I did not require CMS to submit evidence related to its consideration of the regulatory factors.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner violated 42 C.F.R. § 483.25(h)(2). I further conclude that a CMP of $3050 per day for the period October 8, 2006 through November 10, 2006, and $50 per day from November 11, 2006 through December 19, 2006, is reasonable.

/s/
Keith W. Sickendick
Administrative Law Judge