Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Harlan Nursing Home	)	Date: September 10, 2007
(CCN: 18-5166),	)	
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-06-10
	)	Decision No. CR1644
Centers for Medicare & Medicaid	)	
Services,	)	
	)	
Respondent.	)	
	)	

DECISION

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to impose a civil money penalty (CMP) against Harlan Nursing Home (Petitioner or facility) for failure to comply substantially with federal requirements governing participation of long-term care facilities in Medicare and State Medicaid programs. CMS imposed a CMP of $ 8,050 per day effective August 9 through August 17, 2005, based on a finding of immediate jeopardy. CMS also concluded that the facility remained out of substantial compliance at a less than immediate jeopardy level from August 18 through August 25, 2005, and imposed a $100 per day CMP for that period.

I. Background

This case is before me pursuant to a request for hearing filed by Petitioner dated October 13, 2005. Petitioner is a long-term care provider located in Harlan, Kentucky.

By letters dated August 17 and August 29, 2005, CMS informed Petitioner that, based on a complaint survey conducted on August 12, 2005, and a revisit survey completed on August 23, it was imposing selected remedies due to Petitioner's failure to be in substantial compliance with the applicable federal requirements for long-term care facilities. The remedies were based on an immediate jeopardy deficiency under Tags F-324 and F-490. The letter informed Petitioner that CMS was imposing the following remedies:

- CMP in the amount of $ 8,050 per day effective August 9 through August 17, 2005 based on an immediate jeopardy violation.

- Denial of Payment for New Admissions (DPNA), effective August 19, 2005.[1]

- Termination of the provider agreement, effective February 12, 2006.[2]

I held a hearing on March 13 and 14, 2007, in Frankfort, Kentucky. At the hearing, CMS offered 14 exhibits, identified as CMS Exs. 1-14. I received CMS Exs. 1-14 into evidence without objection. Petitioner offered nine exhibits, identified as P. Exs. 1-9.[3] I received these exhibits into evidence without objection. I also entered into the record Petitioner's Credible Allegation of Removal of Immediate Jeopardy dated August 12, 2005, as Administrative Law Judge (ALJ) Ex. 1.

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[1] The DPNA was no longer in effect as of September 10, 2005. CMS Ex. 6, at 1.

[2] Petitioner came into substantial compliance prior to the effective date of the termination of the provider agreement and therefore the termination was not effectuated.

[3] Petitioner Ex. 9 (Harlan Accident Investigative Report dated August 12, 2005) was offered and admitted into evidence without objection during the testimony of Ms. Kathy Hall (Harlan Corporate Director of Operations), with the parties' agreement that the sole purpose of its admission was to show that a report of investigation was submitted to the State survey agency on August 15, 2005. Tr. at 321.

Subsequent to the hearing, the parties submitted post-hearing briefs (CMS Br. and P. Br.) and response briefs (CMS Response and P. Response).

Based on the testimony offered at the hearing, the documentary evidence, the arguments of the parties, and the applicable law and regulations, I find that Petitioner was not in substantial compliance, at the immediate jeopardy level, on the dates determined by the State survey agency and CMS. I further find that CMS was authorized to impose a CMP in the sum of $8,050 per day for the immediate jeopardy violation, and a $100 per day CMP for the non-immediate jeopardy violations.

II. Applicable Law and Regulations

Petitioner is considered a long-term care facility under the Act and regulations promulgated by the Secretary of Health and Human Services (Secretary). The statutory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Act, and at 42 C.F.R. Parts 483 and 488.

Sections 1819 and 1919 of the Act invest in the Secretary authority to impose CMPs and DPNAs against a long-term care facility for failure to comply substantially with participation requirements.

Pursuant to the Act, 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. The regulations at 42 C.F.R. Part 483 provides that facilities which participate in Medicare may be surveyed on behalf of CMS by State survey agencies in order to ascertain whether the facilities are complying substantially with participation requirements. 42 C.F.R. §§ 488.10-488.28. The regulations contain special survey conditions for long-term care facilities. 42 C.F.R. §§ 488.300-488.335. Under 42 C.F.R. Part 488, a State or CMS may impose a CMP against a long-term care facility where a State survey agency ascertains that the facility is not complying substantially with participation requirements. 42 C.F.R. §§ 488.406, 488.408, 488.430. The CMP may start accruing as early as the date the facility was first out of compliance through to either the date substantial compliance is achieved or the facility's provider agreement is terminated. 42 C.F.R. § 488.408.

CMS may impose a CMP for either the number of days a facility is not in substantial compliance with one or more participation requirements or for each instance that a facility is not in substantial compliance, regardless of whether or not the deficiencies constitute immediate jeopardy. 42 C.F.R. § 488.430(a). Thus, CMS may impose a per instance CMP ranging from $1,000 to $10,000 for an instance of noncompliance regardless of whether the deficiency is at the immediate jeopardy level. 42 C.F.R. § 488.438(a)(2).

The regulations define the term "substantial compliance" to mean:

> [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.

"Immediate jeopardy" is defined to mean:

> [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.

42 C.F.R. § 488.301.

In determining the amount of the CMP, the following factors, specified at 42 C.F.R. § 488.438(f), must be considered:

1. the facility's history of noncompliance, including repeated deficiencies;
2. the facility's financial condition;
3. the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404. and
4. the facility's degree of culpability.

In a CMP case, CMS must make a prima facie case that the facility has failed to comply substantially with participation requirements. To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd Hillman Rehabilitation Center v. U.S. Dep't of Health and Human Services*, No. 98-3789(GEB), slip op. at 25 (D.N.J. May 13, 1999).

The Act and regulations make a hearing available before an ALJ to a long-term facility against whom CMS has determined to impose a CMP. Act, § 1128A(c)(2), 42 C.F.R. §§ 488.408(g), 498.3(b)(12), (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).

III. Issues

The issues in this case are:

> Whether the facility was complying substantially with federal participation requirements;
>
> Whether the finding of immediate jeopardy was clearly erroneous; and,
>
> Whether the amount of the penalty imposed by CMS is reasonable, if noncompliance is established.

IV. Findings and Discussion

The findings of fact and conclusions of law noted below in italics are followed by a discussion of each finding.

> ***A. Petitioner was not in substantial compliance with federal participation requirements.***
>
> > ***1. The facility failed to provide six residents who were at risk for elopement, one of whom successfully eloped on August 9, 2005 (Resident (R)1), with adequate supervision and assistance devices to prevent accidents. 42 C.F.R. § 483.25(h)(2) (Tag F-324).***

The applicable regulation at 42 C.F.R. § 483.25(h)(2) entitled, "Quality of Care" provides that the facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.

A summary of the surveyor findings as reflected in the Statement of Deficiencies (SOD) reveals that:

> Based on observation, interview, and record review, it was determined that the facility failed to provide adequate supervision to prevent accidents for 6 of 6 residents. The facility's system for monitoring the whereabouts of 6 residents who were identified to be at risk for elopement included the use of alarms on the exit doors. The facility staff knowingly disarmed the exit door alarm system on the West unit to allow for supply deliveries without

> implementing protective measures to monitor the residents who were at risk for elopement. In addition, direct care staff members were not trained regarding use of the alarm system and were not made aware when the alarm system was disengaged to assure continued supervision of the residents.
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> Resident Number 1 exited the facility on August 9, 2005, and left the grounds without staff knowledge. The facility staff was not aware of the elopement for at least one hour after the resident was last observed by the staff to be in the facility and the time that the resident was found to be deceased in an open field behind the facility.

CMS Ex. 1, at 4-13.

R1 was admitted to the facility on September 27, 2002. CMS Ex. 11, at 1. His diagnoses included dementia (Alzheimer type), a history of schizophrenia, and chronic obstructive pulmonary disease (COPD). *Id.* The facility determined that he needed supervision at all times due to a history of elopement from his prior facility. CMS Ex. 11, at 5. After admission to Harlan Nursing Home, he persisted in his attempts to elope. *Id.* Betty Morgan, Petitioner's Minimum Data Set (MDS) coordinator stated that R1 often expressed that he was going home and she considered that he needed "constant supervision." CMS Ex. 4, at 24.

At hearing, Surveyor Burton-Brock, who interviewed Petitioner's staff members, testified that R1 frequently attempted to exit the facility through the West Wing doors, and had occasion to leave the building and head for the main road. Tr. at 10.

The following summary of events surrounding the elopement of R1 was provided by surveyor Kimberly Burton-Brock during her testimony at the hearing. Surveyor Burton-Brock based her testimony on staff interviews and personal observations during the survey.

> On August 9, 2005, R1 exited the facility but no one heard the alarm sound to alert staff that a breach had occurred. Tr. at 12. Two Certified Nursing Assistants (CNA), Summer Boggs and Madonna Ramsey, stated that they had last seen R1 sometime between 4:50 p.m. and 5:00 p.m. at a time when they were responding to a neighboring resident's call for assistance. When Ms. Boggs went to deliver R1's dinner food tray at approximately 5:10 p.m., he was not in his room. At that point, she began searching for him throughout the facility. Tr. at 19. She began to look in the areas most often frequented by the resident such as the smoking and TV rooms, but he was not there. When Ms. Ramsey realized that Ms. Boggs was no longer

assisting with delivery of the food trays, she went to find out what had happened. She encountered another nurse, Polly Napier, who indicated to her that R1 was missing and Ms. Boggs was still searching for him. Ms. Ramsey joined the search that eventually continued outside the facility, when it became evident that the resident was not inside. Tr. at 15.

When Ms. Ramsey opened the 900 hallway door in the West wing, leading to the outside, she noted that the alarm did not sound, and yelled back toward the staff member located at the nurses station that the alarm had not sounded, and proceeded to search outside. Tr. at 16. Ms. Ramsey later learned from another CNA that the alarm had been disengaged for a coke delivery that had been made during the day shift. Tr. at 17.

Once the search party was outside, they inquired at a nearby hospital and a Comprehensive Care Center if they had seen R1. After looking around in these facilities, the people that had been approached indicated that they had no success in locating the resident. Tr. at 17. The search continued inside an old, abandoned "skilled unit" but the resident was still not found. They then looked in the gullies and ditches that are found in a field behind the nursing home that leads to a river, but still without success. Tr. at 21, 22. The field was described as very dense, with vegetation growth that was taller than the surveyor. Tr. at 23. When the resident was not located in the field, the search party returned to the facility, but the Director of Nursing (DON), directed them to go back to the field leading to the river and look around the river bank to be sure he didn't fall in the water. When they were by the river bank, they heard the maintenance man yell that he had spotted the resident on the ground in the field from the top of a truck he had climbed. Tr. at 24, 25. Ms. Ramsey stated that her overall search lasted about one hour and twenty minutes.

When Ms. Ramsey first saw R1 she noted that his head wasdown into the ground and his face also on the ground. His buttocks was sticking up in the air, his shoes were off one of which he was holding in his right hand. He was positioned as if he was trying to push himself up. Tr. at 25. He had removed a sweatshirt he always wore, and it was laying beside him, turned inside out. Tr. at 26.

Madonna indicated that R1's face was distorted and discolored from blood that had pooled, his nose was mashed up, his eyes were slanted, and his mouth was open. Madonna also noted a small cut on R1's forehead from which blood flowed. Tr. at 26, 27.

See also CMS Ex. 4, at 29-37.

CMS asserts that the timeline of the events that took place on August 9, 2005 can only be estimated because several different times were given by different people. This is evident from Petitioner's allegation that the total time between when the resident was last observed and the time when he was found was less than an hour. However, I find that it is not crucial for me to reconcile the time differences in order to resolve the central issue present in the deficiency under scrutiny here. That issue is whether the facility failed to provide its residents, who were at risk for elopement, with adequate supervision and assistance devices to prevent accidents. 42 C.F.R. § 483.25(h)(2).

CMS contends that Petitioner could not provide adequate supervision to R1 because it never determined what was adequate supervision for him. Although R1 always exhibited elopement seeking behavior, the facility planned for "frequent" monitoring of his whereabouts without defining the meaning of that term. Thus, Petitioner did not have a systematic method to keep track of the whereabouts of its wandering dementia residents to ensure their safety at all times. Petitioner ignored the MDS coordinator's assessment that R1 required "constant supervision," which I interpret to mean that staff was to know the resident's whereabouts at all times. CMS Ex. 4, at 24. Petitioner also disregarded an assessment dated March 16, 2005 that found R1 in need of supervision at all times due to a history of elopement from a prior facility. CMS Ex. 11, at 5. More specifically, Petitioner failed to provide adequate assistance devices to its wandering dementia residents because it voluntarily disabled and compromised the effectiveness of the door alarms that had been designed to protect these residents from elopement. CMS. Br. at 19; P. Ex. 1, at 14.

Petitioner argues that but for an isolated incident on August 9, 2005, residents with the potential for eloping were adequately supervised and protected by the facility administration and staff. P. Br. at 6. Although Petitioner acknowledges that elopement-prone residents were not adequately protected on August 9, 2005, it contends that there is ample proof in the record regarding the actions taken by the facility to prevent any wandering resident from eloping. *Id.* Petitioner adds that the facility's historical experience with the protection of wandering residents made R1's experience completely unforeseen. P. Br. 7. I disagree.

The credible evidence of the record before me reveals that the facility had a practice of disarming the door alarm for vendors providing weekly delivery services to the facility, and that several staff members were unaware of the proper operation and monitoring of

the alarm system. CMS Ex. 4, at 6, 7, 18; Tr. at 54-57, 62,132. Contrary to Petitioner's assertion, this state of affairs existed not only on August 9, 2005, but persisted until CMS determined that those deficiencies were corrected.

The facility engaged in the practice of disarming the alarms on a weekly basis on doors number one (#1) and number six (#6) to allow for deliveries, and turning them back on after delivery was completed.[4] Tr. at 132. This was confirmed through an interview of Darrin Waddle, a person who routinely made deliveries to the facility. When interviewed by William Stewart, a State investigator, Mr. Waddle, stated that on August 9, 2005 (the day R1eloped), he arrived at Harlan Nursing Home at approximately 12:30 p.m. and left at approximately 2:30 p.m. That day he backed up his truck to the door labeled #1 on Ex.14 (700 hall), and entered the facility through the laundry room door, which was always unlocked. Once inside, he went to the nurses station, and asked the person there to turn off the alarm. After the alarm was turned off, he made his trips to replenish the vending machines by going in and out through door #1. When he had finished, he went back to the nurses station to let the person there know that he was done. CMS Ex. 6, at 2, 3. Although the door alarm was disengaged (in this instance for 2 hours) during deliveries, the facility had no system to safeguard that door, nor was there increased monitoring of wandering residents while the door was disengaged for the benefit of deliverymen. Tr. at 133. My finding of noncompliance, however, is not predicated on the conclusion that R1 exited the facility during the time the alarm was turned off for the vendor while he replenished the vending machines. I do find, however, that the practice of disabling the door alarms together with the ignorance of the staff as to the manner of operation of the alarm system caused, or was likely to cause, serious injury, harm, impairment, or death to a resident. In the particular case of R1, he was able to exit the facility, and suffered serious injury and harm because the alarm was not properly reset after it had been disarmed either after the delivery man left the premises, or at some other time, because of the staff's incompetence in operating the alarm system. As will be discussed later in greater detail, that incompetence was a systemic flaw that permeated all levels of the facility administration.

Denise Ford, a quality assurance nurse employed by Petitioner, testified that it was her understanding that the door was always armed while the vendor was in the facility actually stocking the machines. Tr. at 183. She did not say, however, where that

[4] Ms. Kathy Hall, Petitioner's Corporate Director of Operations, testified that several vendors would routinely visit the facility for whom the alarms were disengaged. Tr. at 315.

understanding came from. In fact, neither the vendor in his statement to the State investigator (CMS Ex. 6, at 2, 3.), nor any staff member made reference to such practice. I, therefore, find little probative value in that assertion.

During surveyor Burton's interview of some staff members on August 10, 2005, it became evident that they were unaware of the proper operation and monitoring of the alarm system:

> • CNA Robin Rigney had been with the facility for three months, but had not been trained on the alarm system. She only checked the panel when the alarm went off, but did not know what the switches were for. CMS Ex. 4, at 7.
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> • Cindy Mefford, who had been in the facility about four years, was inserviced by Darrell (Darrell Goodin, Maintenance Supervisor). However, she only took note as to whether the alarm was activated by looking at the lights. If the red light was on, the system was armed. And if the light was green, the system was not armed. She would only look at the [switch] panel if the alarm went off.[5] CMS Ex. 5, at 8; Tr. at 136.
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> • CNA Julie Birchfield, who had been in the facility for about a year, stated that she knew how to reset that alarm, but did not know how to turn it off. She would not pay attention to the alarm [switch] panel unless the alarm went off. By looking at the [switch] panel she could determine which door was armed. CMS Ex. 5, at 10.

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[5] The facility alarm system had a green light that indicated that it was powered, and a red light to indicate that the system was armed. However, it was not possible to determine if each individual door was armed unless one looked at a switch panel that had switches that controlled the doors in each wing of the building. Thus, in order for each door to be armed, it was necessary that each of the switches controlling those doors be in the up position. It was, therefore, possible for a door to be disarmed even though the light showed the system to be armed if the switch that controlled that particular door was in the down position. I infer that those staff members that stated that they did not pay attention to the switch panel or only paid attention to the lights, meant that when checking the alarm system they did not take into account whether the switches were in the up or down position. It is logical to conclude that inasmuch as the lights could be seen from a distance to ascertain if the system was armed, it was not so easy to see which switch was in the up or down position from that same distance. This was a problem because turning an individual door off (switch in down position) did not affect the lights on the panel. Tr. 37, 38, 136, 139, 268-69, 272-73.

- The Social Services person as well as the facility administrator and the Director of Nursing (DON) were unable to inform the surveyor as to the function of the panel switches on the alarm. Tr. at 36-39, 78.

- Summer Boggs determined if the alarm was properly engaged by observing the lights. Tr. at 126.

I note that in her affidavit, Ms. Ford stated that Summer Boggs, Stacey Blas, Madonna Ramsey, and Rhonda Curtis asserted having received instruction and training during their attendance in the Nurse Aide Training Program at Harlan Nursing Home. Aside from constituting an implied admission that they did not receive that training during the new employee orientation, she provided no explanation, however, for the absence of such training regarding Robin Rigney, Cindy Mefford, Julie Birchfield, the Social Services director, the DON, and the Administrator. It is interesting to note also that although Summer Boggs allegedly received training on the alarm system during attendance at the Nurse Aide Training Program, she admitted to the surveyor that she would determine if the alarm was properly engaged by observing the lights. I have found, however, that the fact that the red and green lights were on provided no assurance that the alarm was engaged, because it was also necessary to consider the position of the panel switches. Furthermore, training on the operation of the alarm system was not part of the new employee orientation. P. Ex. 4; Tr. 61, 62. Consequently, Ms. Ford's testimony to the effect that operation of the alarm system was part of the initial orientation for new staff members is not supported by the credible evidence of record. Tr. at 183-85.

The absence or inadequacy of proper training on the facility's alarm system is significant in that the person who allegedly turned the alarm back on after the vending machine delivery man left the premises, Julie Birchfield, was not fully versed on its operation. In fact, Ms. Lorine Engle, the staff member who witnessed Ms. Birchfield reset the alarm, informed Mr. William Stewart, the State Investigator, that she saw Ms. Birchfield push a button to reset the alarm (as opposed to turning a switch). Tr. at 116, 117; CMS Ex. 6 at 6.[6] Pertinent to this is the fact that in her incident report, the facility administrator stated that when Julie Birchfield was told to reset the alarm as the "coke man" was leaving*, "the nurse aide proceeded to do as instructed and stated the system was armed as per the indicator light."* P. Ex. 9, at 4 (emphasis added). Additionally, anyone passing by the switch panel, including a resident, could simply change the position of the switches and disengage one or more door alarms. Tr. at 134, 135. In essence, the situation at the

[6] It is worthy of note that all staff members interviewed by the State Investigator denied turning off the alarm for the Vendor, nor did they observe anyone else turn it off. CMS Ex 6.

facility regarding the alarm system was chaotic, at best.[7] Thus, it is not surprising that when Ms. Ramsey exited the facility on August 9, 2005 in search of R1, the alarm did not go off. Tr. at 125. Although she went out through the door at the 900 Hall and the door deactivated for the vendor was in the 700 Hall Wing, the staff found that the alarm system was on, but not in the activated mode, meaning that all doors on that system were disarmed. Tr. at 126; CMS Ex. 4, at 1.

The record does reflect that Darrell Gooden, the maintenance supervisor, testified that when he was informed that someone was missing, he went to check the system. Tr. at 258. At that time, he heard one of the door alarms go off, and when he looked, he saw Ms. Ramsey. *Id.* He stated that he did not speak with her, nor did he have an idea what she was doing. *Id.* I find his testimony unreliable, in view of his prior statement that he went to check the alarm system when he heard that a resident was missing. Furthermore, he later admitted on cross-examination, that he did not hear an alarm go off at approximately 5:00 p.m. because he was in the kitchen working on a panel. That testimony is consistent with what he told the State investigator on November 8, 2005. At the time he stated that on August 9, 2005 he had not been in the West wing and that he had spent all day in the kitchen. He also admitted, when questioned, that he did not tell the surveyors nor the State investigator that he heard an alarm go off when Ms. Ramsey tried to exit the facility on August 9, 2005. Tr. at 265-67.

In view of the foregoing, I find that CMS has established a *prima facie* case that Petitioner did not provide adequate supervision and assistance devices to prevent accidents pursuant to 42 C.F.R. § 483.25(h)(2) (Tag F-324). Petitioner has not overcome's CMS's showing by a preponderance of the evidence.

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[7] Even after implementing an intervention regarding the alarm system by placing a plexiglass box over the alarm switches, there was confusion as to how access to the control panel would be secured. The maintenance man, Darrell Gooden, testified that access to the East Wing switch box was only possible using a key, which only he had. The box on the West Wing was bolted down and only he could unscrew it open. Tr. at 276-79. On the other hand, Ms. Ford testified that the plexiglass box was locked with a combination lock, and the nurses had the combination to the lock. Also, whereas Ms. Ford testified that the East Wing alarm could be accessed for purposes of engaging and disengaging by staff using a combination code, and the West Wing alarm could no longer be disengaged (Tr. at 236), Mr. Gooden testified that the East and West Wing alarms could still be disengaged with the key pad because they were not inside the plexiglass box that covered the switches. Tr. at 279-80.

2. The facility failed to administer its resources effectively and efficiently so as to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 42 C.F.R. § 483.75.

A summary of the surveyor findings as reflected in the SOD Tag F-490 reveals that:

> The facility's system for monitoring the whereabouts of residents with known elopement risks included the utilization of door alarms to each exit door. Facility administration indicated that it was routine facility practice for the staff to disengage the exit door alarm system for vending deliveries. The administration failed to ensure that residents with known elopement risks (Residents 1, 2, 3, 4, 5 and 6) were supervised to assure that they did not elope from the facility through unmonitored exit doors. As a result, R1 exited the facility on August 9, 2005, without staff knowledge, and was subsequently found deceased off facility grounds.

CMS Ex. 1, at 13-18. The surveyor findings cross-reference violations under Tag F-324.

Petitioner argues that CMS has put absolutely no evidence into the record regarding what the facility administration did not do or could have done differently to avoid the alleged regulatory violation. Petitioner also maintains that the surveyors never interviewed Ms. Ginger Parsons, the Administrator. Finally, Petitioner asserts that the facility had an existing policy to prevent elopement *"through assessments, alarms, code alert systems, and otherwise."* P. Br. at 15 (emphasis added).

Contrary to Petitioner's assertions there is ample evidence of the facility's failure to administer its resources effectively and efficiently. The following examples evince some of the facility's shortcomings regarding the deficiencies at Tag F-490:

- The Care Plan provided for frequent monitoring of R1 because he was an elopement risk. P. Ex. 1, at 13. However, the indication that the resident was to be monitored frequently, without specifying the interval is too vague, and overlooks the facility assessments that found he required constant supervision and that he needed to be supervised at all times. CMS Ex. 4, at 24; CMS Ex. 11, at 5. Monitoring of R1 was also questionable inasmuch as staff members had never seen a wandering resident list, and did not know that such a list existed. CMS Ex. 4, at 3, 15; CMS Ex. 5, at 8; Tr. at 59, 164.

- The alarm system was disengaged on a weekly basis for vending machine service people, and no monitoring of the unarmed doors was in place during that period of time. On occasions prior to R1's elopement, an individual who replenished the vending machines was allowed to disengage the alarm system. Tr. at 62,132-34.

- The facility had no policy or instructions regarding door or alarm checks, nor was any documentation done by staff on the door system, according to Denise Ford, the corporate quality assurance nurse. Tr. at 59. An interview with Amy Wilson and Robin Rigney confirmed that they did not document checks on the alarm system, nor were they ever oriented or trained to do so. Tr. at 60-61; CMS Ex. 4, at 7.

- The person in charge of training the new staff, Patty Lester, admitted that she provided no training on the alarm panel to new staff. She only showed a film on the use of the Wander-Guard, but covered nothing regarding the exit doors or alarm panel. In fact, the orientation checklist did not include the alarm panel as one of the items covered. Tr. at 61, 62.

The implication advanced by Petitioner that CMS cannot establish that the facility failed to utilize its resources effectively and efficiently without having interviewed the administrator is baseless. Moreover, the record does reflect that the surveyor spoke with the administrator during an inquiry regarding the alarm system on August 10, 2005. At that time, the administrator was unable to answer the surveyor's questions regarding the basic operation of the alarm system. It is not surprising that the administrator was ignorant of the functioning of the alarm in view of her lackadaisical attitude when informed that R1 was missing as she was leaving for the day. Rather than turn back and exercise leadership in dealing with an extremely serious emergency, she simply responded: "you better find him," and went home. Tr. at 29, 30.

Petitioner's assertion that the facility had an existing policy to prevent elopement *"through assessments, alarms, code alert systems, and otherwise"* is also without substance. P. Br. at 15 (emphasis added).

The items mentioned by Petitioner cannot be deemed to take the place of facility policies and procedures, but rather can be considered useful when applied correctly following acceptable policies and procedures. It has been established that the facility had alarms and Wander-Guard bracelets for wandering residents. Nonetheless, the staff was ill-trained in the operation of the alarm, and made use of the system in a way that placed wandering residents at risk of elopement.

I find that CMS established a *prima facie* case under Tag F-490. Petitioner has not overcome that showing by a preponderance of the evidence.

B. CMS's finding of immediate jeopardy was not clearly erroneous.

Immediate jeopardy exists where a 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." 42 C.F.R. § 488.301. For a finding of immediate jeopardy, it is not necessary to show that the noncompliance caused serious injury, harm, impairment, or death; it is sufficient to show that the noncompliance was likely to cause serious injury, harm, impairment, or death. *Fairfax Nursing Home, Inc.*, DAB No. 1794, at 14 (2001).

In this case, there is strong prima facie evidence of immediate jeopardy level deficiencies inasmuch as vulnerable residents were placed at risk of likely suffering serious injury, harm, impairment, or death. The credible evidence of record establishes that R1 suffered serious injuries and actual harm. He was found to have fallen with his head down into the ground; his face distorted and discolored from blood that had pooled; blood flowing from a cut on his forehead; and his nose mashed up and eyes slanted. As reported during the hearing, R1 had removed his sweater which he wore indoors, but once outdoors, in the dense brush, he collapsed during a hot August day.[8] Tr. at 25-27.

Although the Coroner did not conclude that the resident died from the intense psychological and physical trauma to which he was subjected, the record reflects that he was not being monitored for any acute condition, nor did he require special care for a life threatening condition. CMS Ex. 9; CMS Ex.11, at 55. In spite of the Coroner's failure to order an autopsy,[9] there is nothing in the record pointing to any reason to conclude that the resident was likely to die at approximately 6:00 p.m. on August 9, 2005, had he not been allowed to exit the facility undetected and unsupervised. No departure from his medical baseline appears in the record, except the fact that he was tormented by the desperation of being lost in a dense weed field on an hot August summer day in Harlan, Kentucky at the

[8] The Harlan County Coroner's investigation report noted that the temperature was in the upper 80s. CMS Ex. 9, at 3.

[9] The record does not indicate that the Coroner took the facility to task, as he should have, for having moved the body after determining that he had expired.

age of 75, where his face appeared to be crushed into the ground where he fell. However, even if I were to find that the resident's demise was not in any way related to the elopement, there is still irrefutable evidence that the elopement was not only likely to cause serious injury, harm, impairment, or death, but did in fact cause him actual harm.[10]

Petitioner should have foreseen that the practice of disarming the door alarms for vendors providing weekly delivery services to the facility without monitoring the exits on those occasions, and staff members' unawareness of the proper operation and monitoring of the alarm system could result in the elopement of wandering residents. I have already found that CMS has established a *prima facie* case that Petitioner did not provide adequate supervision and assistance devices to prevent accidents. Furthermore, Petitioner's failure to adopt and implement appropriate policies and procedures to protect elopement-prone residents created a window for R1, as well as others similarly situated, to successfully exit the facility without detection or supervision.

Petitioner contends that the finding of immediate jeopardy is not warranted because the facility was at all times in substantial compliance with the regulatory requirements of F-324 and F-490. However, I have rejected Petitioner's arguments that it provided R1 with adequate supervision. Petitioner's argument that the facility properly assessed the resident for elopement/wandering risk and safety does not absolve it of liability. Instead, it shows that the facility was well aware that R1 was a high risk for elopement and that he was not to be left unsupervised. In fact, R1 had been known to actually exit the building on more than one occasion. Tr. at 92, 93. Thus, it was well know that if given a window of opportunity, R1 would elope. Petitioner's indication in R1's care plan that he would be frequently monitored was vague and gave no indication that facility staff knew his whereabouts at all times.

Additionally, I must uphold CMS's determination as to immediate jeopardy unless it is clearly erroneous. 42 C.F.R. § 498.60(c)(2). Petitioner has not met its burden of showing that CMS's determination of immediate jeopardy is clearly erroneous.

C. The amount of the CMP is reasonable.

When an ALJ finds that the basis for imposing a CMP exists, the ALJ may not: (1) set a penalty of zero or reduce the penalty to zero; (2) review the exercise of discretion by CMS to impose a CMP; and (3) consider any factors in reviewing the amount of the penalty other than those specified by regulation. 42 C.F.R. § 488.438(e). I have found that a basis exists for CMS to impose a CMP because I have found that Petitioner was not in

[10] The staff did indicate to the surveyor that they feared going into the dense vegetation in search of R1, especially in light of their concern that snakes were present in the area.

compliance with 42 C.F.R. § 483.25(h)(2) and 42 C.F.R. § 483.75 . I must, therefore, review de novo whether the amount of the CMP is reasonable by considering the four factors specified in 42 C.F.R. § 488.438(f). These four factors are: (1) the facility's history of noncompliance, including repeated deficiencies; (2) the facility's financial condition; (3) the scope and severity of the deficiencies, the relationship of one deficiency to other deficiencies, a facility's prior history of noncompliance with reference to the deficiency at issue (factors specified in 42 C.F.R. § 488.404); and (4) the facility's degree of culpability.

CMS imposed a $8,050 CMP for each day of noncompliance at the immediate jeopardy level from August 9 through August 17, 2005. CMS also imposed a $100 per day CMP for deficiencies at the less than immediate jeopardy level from August 18 through August 25, 2005. The CMP was reduced to $100 per day effective August 18 for noncompliance based on the results of a revisit survey conducted on August 23, 2005. At that time, removal of the immediate jeopardy was verified, but it was determined that deficiencies at the less than immediate jeopardy remained. CMS Ex. 3.

There is no evidence in the record regarding one of the regulatory factors: the facility's financial condition. Therefore, the factors that I can consider in reviewing the reasonableness of the CMP are the scope and severity of the deficiency, the facility's degree of culpability, and the facility's prior history of noncompliance. In this case, Petitioner failed to ensure that R1 received adequate supervision and assistance devices to prevent accidents, and such failure resulted in his leaving the facility unsupervised, not only placing him at risk of serious injury, harm, impairment, or death, but in fact, causing serious injury and harm. Additionally, other wandering residents were equally placed at risk of serious injury, harm, impairment, or death. These circumstances demonstrate that the deficiency was serious and that the facility bears a certain degree of culpability. Therefore, the penalty imposed is appropriate, given the circumstances of this case, where Petitioner's systemic failure to adopt and implement policies and procedures to provide adequate supervision and assistance devices to prevent accidents, and to administer its resources effectively and efficiently so as to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, placed said residents' health and safety at risk.

Kathy Hall, Petitioner's Corporate Director of Operations, testified that the facility's past history of noncompliance included a citation for an immediate jeopardy violation, two citations for actual harm deficiencies, and an undetermined number of deficiencies that caused no actual harm, but had the potential for more than minimal harm. No description by either party was provided as to the nature of the deficiencies. Thus, I am unable to determine whether the facility's prior history of noncompliance bears any relationship to deficiencies here at issue. Tr. at 343, 344. Notwithstanding, in light of the factors

discussed above, a CMP of $8,050 is not unreasonable for the immediate jeopardy violation. The $100 per day CMP for the non immediate jeopardy violations, which is at the lower end of the permissible range, is also reasonable. Moreover, the onus is on Petitioner to come forward with evidence, consistent with 42 C.F.R. § 488.404, to show that the amount of the CMP is unreasonable. Petitioner has failed to do so.

Petitioner also maintains that the duration of the immediate jeopardy was unreasonable and that if immediate jeopardy existed, it was removed by August 10, 2005[11]. The basis for that contention is the allegation that beginning August 9, 2005, all facility staff were inserviced regarding the policy of not disarming the alarm doors, and no one was allowed on the floor until they received training. P. Br. at 17. In spite of Petitioner's claim that staff was inserviced on the operation of the alarm system on August 9, 2005, several staff members that were on duty on August 10, 2005, admitted to the surveyors never having received such training. One of those staff members who was ignorant as to the operation of the alarm system was the administrator.

According to Patty Lester (Medicare coordinator), the person who conducted the inservice, she was given a 10 to 15 minutes orientation by Denise Ford (Corporate Quality Assurance Nurse) in preparation for her presentation to the staff of a few of the items that were to comprise the overall training. Those items included: the wandering residents, the elopement bracelet, the door alarms, and making sure that everybody knew where the panels were and how to set the alarms. Tr. at 291. Furthermore, it was Ms. Lester's testimony that it only took her 20 to 30 minutes to make the presentation to the staff covering the aforementioned items. Tr. at 292.

It is evident that the facility's emphasis was not on helping the staff cope with the psychological impact of the tragic event, or reaching out to R1's family for support and comfort, but to do damage control. Thus, the hastily put together training fell short of resolving the serious systemic problems that resulted in immediate jeopardy. Moreover, at the hearing, Ms. Lester showed that she was still ignorant as to the operation of the alarm system. This became obvious when she stated that if the lights on the alarm panel were lit up, everything was alright. It has been established, however, that the condition of the lights was no indicator as to whether the doors were properly armed . Tr. at 203; *see also* n.5, supra.

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[11] Petitioner alleges that it began to remove the immediate jeopardy on August 9, 2005, and concluded removal on August 10, that is, two days prior to being notified by the State survey agency that its facility was in immediate jeopardy.

More importantly, Petitioner's argument that it removed the immediate jeopardy on August 10, 2005, is negated by Ms. Lester's testimony to the effect that the next day and as the days went on, new items were added to the inservice list. Tr. at 293. Although Ms. Lester could not recall all of the items that were covered on the days following August 10, 2005, she did mention that the additional training included inservicing the nurses and supervisors on how to evaluate a resident for wandering. Tr. at 293. A review of ALJ Ex. 1, which purports to include the facility's Credible Allegation of Removal of Immediate Jeopardy reveals that the sign-in sheets which cover the alleged training provided August 10-12, 2005, do not include the additional instruction referable to evaluation of wandering residents. That subject was covered, to a certain degree, only on August 18, 2005. CMS Ex. 13, at 10.

Ms. Ford confirmed that the immediate jeopardy was not removed until August 17, 2005. She stated that at 8:05 p.m. on Friday, August 12, 2005, the surveyors informed the facility of the immediate jeopardy finding. The staff wanted to submit an incomplete Credible Allegation of Removal of Immediate Jeopardy that same night, but it was approximately 11:15 p.m. and the surveyors would not wait anymore. Tr. at 197, 198. Consequently, the facility sent a facsimile of the Allegation of Removal of Immediate Jeopardy on August 15, 2005. ALJ Ex. 1, at 58.[12] On August 17, 2005, the State survey agency returned the facility's submission and asked for further clarification. Tr. at 204. Ms. Ford stated that the clarifications were submitted on August 17, 2005, but the Credible Allegation of Removal of Immediate Jeopardy is dated August 18, 2005. Tr. at 205; CMS Ex. 12.

On August 29, 2005, CMS notified Petitioner, in essence, that as a result of an August 23, 2005 revisit survey, it was determined that the immediate jeopardy had been removed, but that the facility continued to be out of compliance with participation requirements. Thus, a CMP of $100 per day was imposed effective August 18, 2005. Petitioner has not shown that it returned to substantial compliance on a date earlier than determined by CMS.

In view of the foregoing, I find that there is a basis for the length of the immediate jeopardy violation established by CMS, and that the amount of the CMP is not unreasonable.

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[12] There was an amended transmission of the same documents, but with a transmission date of August 16. ALJ Ex. 1. The documents, provided by way of facsimile to CMS, on those occasions contained 5 pages. They were comprised of pages 2-4 of ALJ Ex. 1, and a cover sheet. The cover sheets are found at ALJ Ex. 1, pages 57 and 58. ALJ Ex. 1, page 1 is a purported cover sheet that allegedly accompanied the transmission of ALJ Ex. 1, pages 2-11. It is unclear when those documents were transmitted.

V. Conclusion

I conclude that CMS correctly determined that Petitioner was not complying with federal requirements governing participation of long-term care facilities in Medicare and State Medicaid programs at the immediate jeopardy level, and that the imposition of an immediate jeopardy CMP of $ 8,050 per day from August 9 through August 17, 2005 is appropriate. I also find that CMS was justified in the imposition of a CMP in the sum of $100 per day for violations at the less than immediate jeopardy violation from August 18 through August 25, 2005.

/s/
José A. Anglada
Administrative Law Judge