Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Grenada Living Center,
(CCN: 25-5104),

Petitioner

v.

Centers for Medicare & Medicaid Services.

Docket No. C-09-396

Decision No. CR2158

Date: June 15, 2010

DECISION

I sustain the determination by the Centers for Medicare and Medicaid Services (CMS) to impose remedies against Petitioner, Grenada Living Center, consisting of the following:

- Civil money penalties of $3,550 for each day of a period consisting of January 18 and 19, 2009;

- Civil money penalties of $250 for each day of a period that began on January 20, 2009 and which ran through February 19, 2009; and

- Decertification of Petitioner's Nurse Aide Training and Continuing Education Program (NATCEP).

I. Background

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

CMS notified Petitioner that it intended to impose the remedies that I describe in the opening paragraph of this decision. CMS made that determination based on findings of noncompliance that were made at surveys of Petitioner's facility during the period running from January 22 through January 30, 2009 (January surveys).[1] Petitioner requested a hearing and the case was assigned to me for a hearing and a decision.

I held a hearing by telephone on March 29, 2010. I received into evidence exhibits offered by CMS which are identified as CMS Ex. 1 – CMS Ex. 13. I received into evidence exhibits offered by Petitioner which are identified as P. Ex. 1 – P. Ex. 46.[2]

II. Issues, findings of fact and conclusions of law

A. Issues

The issues in this case are whether:

1. Petitioner failed to comply substantially with Medicare participation requirements;

2. CMS's determination of immediate jeopardy with respect to one of its noncompliance findings was clearly erroneous; and

3. CMS's remedy determinations are reasonable.

B. Findings of fact and conclusions of law

I make the following findings of fact and conclusions of law.

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[1] There were two surveys conducted during this period. The survey findings were combined in a single report which is in evidence as CMS Ex. 1.

[2] With its post-hearing brief Petitioner offered a proffer of testimony of one of the surveyors, Ms. Donna Womble, that Petitioner asserts Ms. Womble would have given "had . . . [Petitioner's counsel] been allowed to question her further." Proffer of Donna Womble at 1. In fact, I allowed counsel considerable leeway in her questioning of Ms. Womble even though I found it necessary to instruct her several times that much of her questioning of the witness – questions directed towards the surveyor's opinion as to whether facts might or might not establish a violation of regulations – amounted to questioning the surveyor about her legal opinion and was irrelevant. I also cautioned counsel that the case was not about the surveyor's acumen or opinion as to what conclusions of law may be drawn from facts so much as it was about the facts that the surveyor unearthed during the course of the survey and her opinions as to whether Petitioner contravened professionally recognized standards of nursing care.

1. ***Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h) in that it failed to assure that electronically operated security doors were enabled and functioning.***

The regulation that is at issue here requires a skilled nursing facility to provide each of its residents with adequate supervision and assistance devices in order to prevent accidents from occurring. 42 C.F.R. § 483.25(h)(2). It has been addressed in innumerable cases before the Departmental Appeals Board and in federal courts as well.

The regulation does not impose a strict liability standard on a facility. It requires a facility to take all reasonable measures to prevent accidents. In practice, that means that a facility must assess its resident environment and individual residents in order to determine all knowable hazards. It must plan to address those hazards and it must implement the plans that it develops.

CMS alleges that Petitioner failed to comply with the regulation's requirements in that it did not assure the proper operation of its electronic door locking system. This system was intended to ensure that demented residents did not elope from Petitioner's premises. CMS contends that Petitioner and its staff knew or should have known that an electronically locked door in the facility had been disabled by a contractor's employee who was doing work in the facility but that it did nothing to assure that the door was restored to working order. As a consequence, a demented resident eloped from Petitioner's facility through the disabled door. CMS contends, additionally, that this security breach was a consequence of Petitioner's failure to assign responsibility to any of its staff to check on and to ensure the proper functioning of the door while the contractor's employees were working on the premises.

The weight of the evidence very strongly supports CMS's contentions. The purpose of an electronic door system such as the one that Petitioner employed is to serve as a surrogate for more intensive supervision by the staff of elopement prone residents. Clearly, the staff relied on that system. In light of that, it was absolutely necessary to assure that the system functioned properly. The duty to do so is heightened in the situation where third parties – not employed directly by Petitioner – have the ability to disable the system.

It is undisputed that a resident who is identified as Resident # 1in the January surveys report eloped Petitioner's premises on January 18, 2009. CMS Ex. 2 at 22. The resident, who was at the time a demented 86-year old individual, eloped through a door equipped with an electronic door lock. The electronic lock had been disabled deliberately on January 16, 2009 by a contractor's employee who was part of a group of individuals that was performing work at Petitioner's facility. CMS Ex. 6 at 8; CMS Ex. 13 at 2; Petitioner's hearing request at 1-2; Petitioner's pre-hearing brief at 3, 6. The disabled lock was not discovered by Petitioner's staff during the ensuing two days thus making Resident # 1's elopement possible.

Petitioner's staff knew that there was a strong likelihood that the door in question, or others, might be disabled by a contractor's employee. Petitioner's staff actually showed the contractor's employees how to disable the door locks and alarms by unplugging them. P. Ex. 30 at 2; *see* P. Ex. 28 at 3-4. I find that the staff's knowledge that the contractor's employees knew how to disable the electronic doors put the staff on notice that there was a potentially very serious accident hazard at the facility so long as the contractor's employees were working there. That knowledge imposed on the facility the duty to develop all reasonable measures to prevent doors from being disabled and left unattended.

However, Petitioner failed to take any meaningful measures to protect its residents from unattended and disabled electronic doors. Petitioner never directed its staff to monitor the facility's doors while the contractor's employees were present. CMS Ex. 13 at 5; P. Ex. 26.

I do not find Petitioner's defenses to be persuasive. Petitioner argues that CMS's assertions of noncompliance are a "fundamental misunderstanding" of the requirements of 42 C.F.R. § 483.25(h). Petitioner's post-hearing brief at 2. That misunderstanding, according to Petitioner, lies in CMS's failure to show how the elopement of Resident # 1 was foreseeable. In order to show that the elopement could not have been foreseen, Petitioner asserts that:

- There had never been a prior incident of the type involving Resident # 1 during the period when the contractor's employees were working at Petitioner's facility.

- The contractor had worked at Petitioner's facility for several years on various projects and there had never been a previous incident such as the one involving Resident # 1.

- Resident # 1 had never previously eloped Petitioner's premises.

- The surveyor failed to document whether the contractor's employees had ever been seen previously by Petitioner's staff disabling the lock mechanism to the electronic doors.

- The contractor's employees customarily did not use the door which was disabled. Consequently, Petitioner's staff had no reason to assume that the door in question had been disabled.

- Petitioner's staff told the contractor's employees that, if they disengaged a door mechanism, they had to man the door while the mechanism was disengaged and then, reengage it.

Petitioner also challenges the adequacy of an interview conducted by the surveyor of a certified nursing assistant (CNA). The surveyor reported the CNA as averring that she had seen a contractor's employee disengage the lock mechanism on the door on January 16, 2009 and that the facility had not instructed her or other employees to ensure that doors remained secured while workers were present. According to Petitioner, the interview was inadequate because it was brief, lasting only five minutes, and because there are no contemporaneously made notes of the interview.

I do not find Petitioner's assertions to be persuasive. They simply beg the question. Nothing Petitioner asserts derogates from these basic facts: Petitioner and its staff *knew* that its contractor's employees could disable the electronic door locking mechanisms; they *knew* that, from time to time, the contractor's employees would likely disable such mechanisms; and, despite this knowledge they failed to put into place any system whatsoever that would assure that the doors were secure. As I discuss above, the staff was well aware that the doors could be disabled and were likely to be disabled from time to time because the staff had shown contractors' employees how to disable them. Despite that knowledge, Petitioner put nothing into place to assure that a disabled door would either be guarded or reengaged. No staff member was assigned the simple task of checking the doors while the contractor's employees were on the premises.

The heart of Petitioner's noncompliance is its failure to take obvious and easy protective measures despite it and its staff's knowledge that the electronic doors could be disabled. That failure was a systemic failure in the sense that it involved a general laxness on the part of Petitioner and its staff. The noncompliance does not hinge on the elopement of Resident # 1. Even had Resident # 1 not eloped, the hazard caused by the failure of Petitioner and its staff to ensure the proper functioning of the security system would still have existed. Nor was the hazard diminished by the fact that a similar event had not occurred in the past. The risk of showing the contractor's employees how to disable the electronic locks without having any system in place to check the functioning of the doors while the contractor's employees were on premises was obvious even if there had not been previous adverse incidents involving this contractor and its employees.

Telling the contractor and its employees that they were responsible for securing the doors did not relieve Petitioner and its staff of that duty. It is Petitioner, and not a third party, that owes the duty of care to its residents. Petitioner cannot avoid responsibility for negligence of a contractor's employee by contending that the contractor and its employees had been warned to maintain the security of the doors.

Finally, I do not find that this case hinges in any respect on the accuracy of the interview that was conducted of the CNA by the surveyor. Petitioner has not denied that its staff showed the contractor's employees how to disable the door locking mechanisms. Whether or not a staff member actually witnessed a contractor's employee doing so is not at all dispositive because the possibility that the locking mechanism could be disabled existed whether or not a contractor's employee was observed disabling it. Petitioner's staff had, in effect, created a hazardous situation by giving the contractor permission to disable electronic door locks and by showing employees how to do it. That put Petitioner and its staff on notice that there was a hazard and that it had to protect against that hazard.

In its pre-hearing brief Petitioner contended that it had taken "numerous meaningful measures to minimize the risk" of an elopement such as the one made by Resident # 1. Petitioner's pre-hearing brief at 3. These additional measures ostensibly consisted of the following:

- The staff checked the electronic doors at least once per week in order to assure that they functioned properly.

- The doors were also checked at the beginning of each month when security codes were reset.

- Staff members were given in-service training so that they knew that they should never leave doors unsecured.

- Newly hired employees were advised that certain residents wore Wanderguard bracelets (a bracelet that triggers an alarm if the person wearing it goes into an unauthorized area) and that security doors were kept locked to keep these residents from wandering from the facility.

- Contractor's employees were warned about the hazards associated with leaving unsecured doors unguarded.

These actions were inadequate to address the hazard that existed at Petitioner's facility. Checking the security of doors weekly or monthly was of little benefit in a situation where the contractor's employees were possessed with the knowledge and wherewithal to disable a door at any time. Training *Petitioner's* employees in the use of Wanderguards and the electronic doors may have been essential to protecting the security of the facility but it was clearly inadequate to protect against the possibility that the *contractor's* employees would breach security. All of the measures taken by Petitioner failed to address that last possibility.

2. Petitioner did not prove that CMS's determination of immediate jeopardy level noncompliance is clearly erroneous.

CMS determined that Petitioner's noncompliance with the requirements of 42 C.F.R. § 483.25(h) was so egregious as to pose immediate jeopardy for residents of Petitioner's facility. I find that Petitioner failed to prove that this determination was clearly erroneous.

"Immediate jeopardy" is defined to mean noncompliance that is so egregious that it causes or is likely to cause serious injury, harm, impairment, or death to one or more residents of a facility. 42 C.F.R. § 488.301. The evidence in this case strongly supports a finding that Petitioner's noncompliance with 42 C.F.R. § 483.25(h)(2) put residents in immediate jeopardy. The likelihood of a resident sustaining severe injuries or dying during or as the consequence of an elopement was very high.

The purpose of electronic door locking mechanisms in Petitioner's facility is – as I have stated – to serve as protection in lieu of direct supervision of residents whose mental and or physical conditions made it unsafe for them to be off-premises unsupervised. There would have been no other reason for Petitioner to have installed such a system. Frail and demented individuals, such as Resident # 1, are extremely vulnerable to injury or even death if they are away from a facility unsupervised. Individuals such as Resident # 1 lack the capacity to make reasonable and safe decisions. CMS Ex. 13 at 6. Such individuals, if they are out in the open without supervision, may wander into the paths of moving vehicles and they are at risk of exposure to the elements and injuries sustained from falls. *Id.* Moreover, many demented residents of skilled nursing facilities suffer from a combination of physical and mental impairments. Such individuals could suffer injuries – such as a heart attack – if exposed to environmental stresses while away from a facility without supervision. *Id.*

Resident # 1 is a classic example of such an individual. The resident was demented at the time of his elopement and he had been assessed by Petitioner's staff as being at risk for suffering falls and uncontrolled bleeding from anticoagulant therapy. CMS Ex. 2 at 18-19. When the resident eloped on January 18, 2009 he wandered into a service driveway that was connected to Petitioner's parking lot. *Id.* at 22; CMS Ex. 6 at 4, 11. While there he was vulnerable to being struck by a moving vehicle and experiencing life-threatening injuries. CMS Ex. 13 at 6.

I am not persuaded by Petitioner's arguments that CMS's determination was clearly erroneous. Petitioner offered no evidence to dispute the evidence that I have just cited. Rather, Petitioner argues that the determination of immediate jeopardy is clearly erroneous because the surveyor who gathered the evidence on which the determination was based did not immediately recommend that Petitioner's noncompliance be assessed at the immediate jeopardy level. Petitioner places great emphasis on the surveyor's initial impression that the noncompliance was at less than the immediate jeopardy level, an

impression that was ultimately not accepted by the surveyor's supervisors. In effect Petitioner challenges the process by which CMS came to its determination that there was immediate jeopardy level noncompliance.

The determination of whether noncompliance poses immediate jeopardy to residents involves application of the law to the facts. It is an issue that ultimately I must decide in the context of a de novo hearing. A surveyor's opinion as to whether facts establish "immediate jeopardy" is an opinion as to a legal conclusion, and not relevant to my decision-making.[3] Similarly, the process by which CMS evaluated the facts in order to make its determination is irrelevant. This case in no sense involves an appellate review of CMS's determination for propriety. All that matters at this stage of the case is whether the facts of record establish immediate jeopardy level noncompliance. Those facts clearly establish such noncompliance.

In the same vein Petitioner argues that the determination of immediate jeopardy is invalid because it was not made immediately – at the survey – but was made about a week afterwards. Petitioner reasons that the determination was unmerited because immediate jeopardy mandates immediate corrective action and CMS's delay in determining to find immediate jeopardy shows indecision on its part as to whether immediate jeopardy really existed at Petitioner's facility.

This argument simply is another way for Petitioner to claim that the process by which CMS came to its determination is fatally flawed. As I have said, I am not reviewing the process of determining immediate jeopardy, I am deciding this case de novo. The overwhelming evidence is that Petitioner's noncompliance created the likelihood that a resident or resident would experience serious injury, harm, impairment or death from an unaddressed hazard.

Petitioner also argues that there was no immediate jeopardy because, in fact, Resident # 1 was not at a grave risk for falling and injury during his elopement. Petitioner's pre-hearing brief at 10. According to Petitioner, the resident had never fallen previously. I find this argument to be irrelevant. The issue here is not whether Petitioner's noncompliance posed immediate jeopardy for Resident # 1 so much as it is whether that noncompliance put *residents* of Petitioner's facility at immediate jeopardy. The failure to secure the electronic doors created a hazard for any resident who eloped, not just Resident # 1. Indeed, the noncompliance and the immediate jeopardy would have existed even if Resident # 1 had never eloped Petitioner's facility because the hazard to residents was evident even if it did not cause an adverse outcome. Furthermore, Petitioner's

[3] By contrast, a surveyor's opinion as to nursing standards of care or as to medical issues may be highly relevant. I drew that distinction repeatedly at the hearing of this case. A surveyor who is a trained nurse may, for example, express an opinion as to whether actions or inactions by a facility posed a likelihood of harm to a resident without opining on the legal questions of whether such actions or inactions constituted noncompliance with a particular regulation or posed immediate jeopardy for residents.

assertion about the lack of risk to Resident # 1 is belied by Petitioner's own assessment of the resident as being at risk for suffering falls and for uncontrolled bleeding due to his use of anticoagulant medications. CMS Ex. 2 at 18-19.

3. Petitioner also failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h) in that its staff failed to report a malfunctioning bed alarm.

CMS alleges additional noncompliance by Petitioner with the requirements of 42 C.F.R. § 483.25(h) albeit at a level of noncompliance that is less than immediate jeopardy. The allegation centers on the failure of a CNA to report a non-functioning bed alarm. On November 7, 2008 a resident who is identified as Resident # 9 sustained a fall, resulting in fractured bones, after she got out of bed and attempted to use the bathroom unassisted. CMS Ex. 5 at 33-43. The resident was equipped with a bed alarm which was supposed to sound when she exited her bed. The obvious purpose of the alarm was to warn Petitioner's staff when the resident – who was at risk for falling and being injured – attempted to leave her bed unassisted. In other words, the alarm was intended to protect against precisely what happened on November 7, 2008. However, when the resident exited her bed on that date the alarm did not sound. *Id.*

During the January surveys the CNA who was on duty that night told a surveyor that on November 7, 2008 the resident's bed alarm appeared to be broken and was not operating in the hours prior to the resident's fall. CMS Ex. 11 at 3-4. However, the CNA failed to report the inoperative alarm to a supervisor and, consequently, no efforts were made by Petitioner to replace or repair it prior to the resident's fall. *Id.*

This evidence plainly establishes noncompliance with the requirements of 42 C.F.R. § 483.25(h). The bed alarm supplied to Resident # 9 was an assistance device that was supposed to substitute for personal supervision of the resident. Petitioner's staff knew that the resident was vulnerable to falling. It was incumbent on them either to keep the resident under continuous observation in order to prevent falls or to substitute an effective device such as an alarm for continuous observation. The fact that the staff relied on the alarm, but then failed to assure that it worked, is noncompliance.

Petitioner argues that the fall sustained by Resident # 9 was unforeseeable and unavoidable. Petitioner argues that no one at its facility really knew whether the resident's alarm was functioning properly in the hours before the resident's fall. Essentially, Petitioner challenges the credibility of the CNA's statement as reported to the surveyor who interviewed her. Petitioner's pre-hearing brief at 13-17. Petitioner argues that the CNA was awakened by the surveyor, that she was confused, that her memory of events now is muddled as compared to what she told the surveyor, and that, consequently, anything that she may have said is not believable.

I find that the CNA's declaration, to the extent that it is an effort to weaken or blunt her earlier admission, is simply not credible. It was made many months after the fact and has a self-serving tone. P. Ex. 36. Although she now claims not to remember whether the alarm was malfunctioning throughout her shift on November 7, 2008, the CNA does not deny telling the surveyor that the alarm was malfunctioning during the shift. Moreover, the surveyor does not explicitly aver that the alarm functioned properly. She admits that there appeared to be a broken clip on the alarm. P. Ex. 36 at 2.

4. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.35(g) in that it failed to provide a special eating utensil to a resident who needed it.

A skilled nursing facility must provide special eating equipment and utensils to those of its residents who need them. 42 C.F.R. § 483.35(g). CMS contends that Petitioner did not comply substantially with this requirement, at a non-immediate jeopardy level of scope and severity, because it failed to provide a weighted spoon to Resident # 6 notwithstanding the assessment of Petitioner's staff that the resident experienced hand tremors and needed such a spoon in order to eat. CMS Ex. 4 at 18-22; CMS Ex. 12 at 2. CMS's allegations are based on the observations of surveyors who saw the resident attempting to eat at three meals without the benefit of a weighted spoon. CMS Ex. 12 at 2. The allegations are based also on the staff's acknowledgment that the resident should have been provided a weighted spoon, but was not, due to miscommunications between Petitioner's dietary staff and occupational therapists and nurses. *Id*. at 2-3. The risk of harm to the resident was that the resident was less likely to eat due to the difficulty of feeding herself without a weighted spoon.

Petitioner does not dispute these facts but contends that there was no risk of more than minimal harm to Resident # 6. According to Petitioner, the resident sometimes was able to eat without the benefit of a weighted spoon and could communicate her needs and wants. Petitioner's pre-hearing brief at 20. But, these assertions, assuming them to be true, do not counter the evidence offered by CMS. Petitioner has not offered any evidence to prove that the resident had requested not to use a weighted spoon at the meals when she was observed by the surveyors. Nor has Petitioner offered anything to refute the admissions by Petitioner's staff that the failure to supply the resident with a weighted spoon was due to a communications failure between members of the staff.

Petitioner also argues that its staff determined on January 12, 2009 to no longer take weekly weights of the resident because her weight was stable. But, assuming that to be true, that does not derogate from evidence showing that, between January 22 and January 30, 2009 the resident was deprived of a utensil that she needed in order to feed herself. Nor can one reasonably predict whether the resident's weight would have remained stable given that she was deprived of the use of the weighted spoon.

5. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.35(i) in that it failed to store and prepare food under sanitary conditions.

The regulation that is at issue here requires a skilled nursing facility to store, prepare, distribute, and serve food under sanitary conditions. 42 C.F.R. § 483.35(i)(2). CMS alleges that Petitioner manifested, in the following respects, a non-immediate jeopardy level failure to comply with regulatory requirements.

- Personal belongings such as jackets, purses, and a sweater, were left lying on top of canned food in a storage room, thus exposing the surfaces of the cans, and their contents, to possible transfers of bacteria, fungi, mold, or viruses. CMS Ex. 12 at 3-4.

- Petitioner's refrigerator contained unlabeled pudding. *Id.*

- Petitioner's facility had a dirty refrigerator that Petitioner's dietary manager acknowledged needed cleaning. *Id.*

If not rebutted these allegations are certainly sufficient to establish noncompliance. The evident risk to residents caused by putting food in contact with items of clothing, by not labeling stored food as to date, or by having a dirty refrigerator, was that these practices would result in bacterial or other foreign substance contamination of food and could cause residents to become ill.

I do not find that Petitioner rebutted this evidence. It asserts that the cans on which clothing items were placed were dented cans that were not intended for consumption by residents. I do not find this assertion to be plausible because Petitioner has not explained how allegedly dented cans of food came to be placed among items that clearly were intended for consumption or how staff knew to place their garments and personal items only on the dented cans and not on others.

Petitioner asserts that the pudding was unlabeled because it had just been prepared and that staff intended to serve it soon to the residents. The problem with this explanation is that, although it may account for the unlabeled container, it does not account for the *practice* of not labeling stored food. Petitioner does not explain how its staff could distinguish an unlabeled container of food for immediate consumption from an unlabeled container of expired food. Essentially, Petitioner is saying that one must trust the memory of its staff members absent any labeling system for protecting residents. I find that not to be a credible defense.

6. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.75(f) in that a CNA failed to provide competent incontinence care to a resident.

The regulation that is at issue here requires a facility to ensure that its CNAs are able to demonstrate competency in skills and techniques that are necessary to care for residents' needs. CMS asserts that Petitioner failed to comply with this requirement, at a non-immediate jeopardy level of noncompliance, because one of its CNAs failed to provide appropriate incontinence care to a resident. Specifically, CMS offers evidence to show that a CNA did not properly rinse soap from the genital area of a resident after the resident was cleaned up following an episode of incontinence. CMS Ex. 10 at 2-3.

The evidence cited by CMS, if unrefuted, is sufficient to establish noncompliance with the regulation's requirements. Soap not rinsed off sensitive tissue can cause painful rashes and other complications. CMS Ex. 3 at 7-10.

Petitioner's defense to this evidence is not persuasive. It does not deny the accuracy of the surveyor's observations. It contends, however, that the incident in question was only a single and isolated event from which it is impossible to generalize. Moreover, according to Petitioner, the CNA whose care is at issue had an exemplary record and had received relevant training only months prior to the observed episode.

However, and Petitioner's assertions notwithstanding, it is possible to conclude from the episode that the CNA used poor judgment and techniques and put the resident at risk. That calls into question the CNA's competence, notwithstanding her past performance record or her training.

7. CMS's remedy determinations are reasonable.

a. Civil money penalties of $3,550 for each day of the period beginning January 18 and ending January 19, 2009 are reasonable.

CMS determined to impose penalties of $3,550 for two days of immediate jeopardy level noncompliance beginning on January 18 and ending on January 19, 2009. Penalties for immediate jeopardy level deficiencies must fall within a range of from $3,050 to $10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). Precisely where within that range a penalty ought to fall must be based on factors which may include: the seriousness of a facility's noncompliance; its compliance history; its culpability; and its financial condition. 42 C.F.R. §§ 488.438(f)(1) – (4); 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)).

Petitioner argues that, even if there was immediate jeopardy level noncompliance, that noncompliance existed only on one day – January 18, 2009 – and did not persist thereafter. Therefore, according to Petitioner, an immediate jeopardy level penalty for January 19, 2009 is impermissible. I am not persuaded by this assertion. Petitioner's staff was not given in-service training regarding door checks until January 20, 2009. Consequently, CMS's determination that immediate jeopardy persisted for one additional day after January 18, 2009, the date when Resident # 1 eloped, is reasonable.[4]

As for penalty amount, I find that to be amply justified by the seriousness of Petitioner's noncompliance. The risks to residents resulting from Petitioner's failure to secure its electronically operated doors were real and it very substantial. As I have stated, there was a likelihood of very serious injury or worse to residents. In light of that, $3,550 per day, which is at the bottom end of the immediate jeopardy range, is eminently reasonable.

b. Civil money penalties of $250 for each day of the period beginning January 20 and running through February 19, 2009 are reasonable.

Penalties for non-immediate jeopardy level deficiencies must fall within a range of from $50 to $3,000 per day. 42 C.F.R. § 488.438(a)(1)(ii). The same factors for evaluating penalty amounts apply to non-immediate jeopardy level deficiencies as apply to immediate jeopardy level deficiencies. 42 C.F.R. §§ 488.438(f)(1) – (4); 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)).

There is ample support for CMS's determination to impose non-immediate jeopardy level penalties against Petitioner, both in terms of duration of noncompliance and penalty amount. As to duration Petitioner has not offered evidence showing that it attained compliance with all participation requirements on a date that is earlier than February 20, 2009. Petitioner did not certify that it attained compliance with the requirements of 42 C.F.R. §§ 483.35(g) and 483.75(f) until February 20. CMS Ex. 1 at 17, 21.

A penalty amount of $250 per day is minimal, constituting less than ten percent of the maximum allowable non-immediate jeopardy level penalty amount. I find it to be amply supported by the relative severity and by the quantity of the non-immediate jeopardy level deficiencies established in this case.

[4] Indeed, Petitioner is the beneficiary of CMS's determination not to begin assessing an immediate jeopardy level penalty until January 18, 2009. The door lock was disabled on January 16 and Petitioner and its staff did not detect the disabled lock – due to failure to police the security doors – until January 18. The evidence, therefore, would clearly justify beginning the penalty two days earlier than January 18, 2009.

c. Petitioner's loss of NATCEP was mandatory.

As a matter of law, CMS must revoke Petitioner's NATCEP for a period of two years. Revocation must occur where a facility has been subject to an extended survey or where civil money penalties of $5,000 or more have been imposed. Act § 1819(f)(2)(B)(iii)(I)(a), (b).[5] Here, both of these statutory criteria were met and consequently, loss of NATCEP was mandatory.

/s/
Steven T. Kessel
Administrative Law Judge

[5] An extended survey is made where a facility has been found to manifest substandard quality of care and that term includes findings of immediate jeopardy.