Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	Date: August 21, 2008
Heritage Park Rehabilitation & Nursing Center (CCN: 45-5599),	)	
	)	Docket No. C-06-366
Petitioner,	)	Decision No. CR1820
v.	)	
Centers for Medicare & Medicaid Services.	)	

DECISION

Petitioner, Heritage Park Rehabilitation & Nursing Center, violated 42 C.F.R. § 483.25(h)(2),[1] as alleged by the Centers for Medicare & Medicaid Services (CMS) based upon the survey of Petitioner's facility completed January 7, 2006. A per instance civil money penalty (PICMP) of $6300 is reasonable.

I. Background

Petitioner, located in Austin, Texas, is authorized to participate in the Medicare program as a skilled nursing facility (SNF) and the Texas Medicaid program as a nursing facility (NF). On January 7, 2006, the Texas Department of Aging and Disability Services (the state agency) completed a survey of Petitioner's facility and found that it was not in substantial compliance with Medicare participation requirements. CMS notified Petitioner by letter dated February 7, 2006, that it concurred with the findings of the state agency and that it was imposing a PICMP of $6300 based upon a violation of 42 C.F.R. § 483.25(h)(2), a denial of payment for new admissions (DPNA) effective February 22, 2006, and termination of Petitioner's provider agreement effective July 7, 2006, if Petitioner did not return to substantial compliance before that date. CMS Exhibit (CMS

[1] References are to the Code of Federal Regulations (C.F.R.) in effect at the time of the survey.

Ex.) 1, at 1-3. CMS notified Petitioner by letter dated March 8, 2006, that during a revisit survey the state agency found that Petitioner had returned to substantial compliance, and the DPNA and termination remedies were rescinded. CMS Ex. 1, at 4-5; Tr. 58. On April 5, 2006, Petitioner timely requested a hearing by an administrative law judge (ALJ). The case was assigned to me for hearing and decision on April 25, 2006. A Notice of Case Assignment and Prehearing Case Development Order (Prehearing Order) was issued at my direction on April 25, 2006.

On December 12 and 13, 2006, a hearing was held in Austin, Texas. CMS offered and I admitted CMS Exs. 1, 2 (except pages 1-9 and 22-27), 3 (except pages 6-15), 4, 5, 6 (except pages 1, 3-7, 9, 16), 7 (except pages 1-11), 8 (except pages 1-11, 13-14, 17-19, 21, 25, 30, 32-34, 36-41), and 9-21. Tr. 29-30. Petitioner offered Petitioner's exhibits (P. Exs.) 1-9, 11-13, 15-16, and 18 (P. Exs. 10, 14 and 17 were withdrawn prior to the hearing). Tr. 32, 194. I admitted P. Exs. 1-3, 4 (except the bottom entry on page 2, dated January 11, 2006), 5-9, 11-13, 15 (for the limited purpose discussed at Tr. 42-46), 16, and 18. Tr. 47-48, 197-98. CMS elicited testimony from surveyors Cathy Whitis, Licensed Vocational Nurse (LVN), and Jenny Rebecca Martinez, Registered Nurse (RN). Petitioner elicited testimony from Blaise Faxique, Director of Nurses (DON), Travis Wheat, Vice President of Operations for Regency Nursing and Rehabilitation, and Michael Gutierrez, M.D. The parties submitted post-hearing briefs and post-hearing reply briefs.

II. Discussion

A. Findings of Fact

The following findings of fact are based on exhibits admitted, the transcript, and the parties' joint stipulations. Citations to exhibit numbers related to each finding of fact may be found in the analysis section of this decision, if not indicated here.

1. Resident 9, a 65-year-old male at the time of the survey, had a medical history of a cerebrovascular accident (CVA) with right-sided hemiparesis (partial paralysis of one side), senile dementia and psychosis, hypertension, hypercholesterolmenia (high cholesterol), peptic ulcer disease, gout, depression, and a seizure disorder. Joint Stipulation and Joint Statement of Issues Presented for Hearing, dated August 11, 2006. (Jt. Stip.) ¶ 8; CMS Ex. 13, at 32-33; P. Exs. 3, 5.

2. Resident 9 had a history of being evaluated as alert and oriented in three spheres -- person, place, and time. Jt. Stip. ¶ 9; Tr. 103; P. Ex. 4.

3. Resident 9 was assessed as moderately impaired in cognitive skills with poor decision-making. Tr. 15; CMS Ex. 13, at 7, 14.

4. Resident 9 was considered responsible for making his own health care decisions. Tr. 20; CMS Ex. 13, at 14.

5. Resident 9 was restricted to wheelchair mobility. Tr. 15; CMS Ex. 13, at 16, 21; Petitioner's Brief (P. Br.) at 3.

6. On November 30, 2005, Resident 9 left the facility unsupervised; he was assessed as an elopement risk and was moved to the second floor of the facility as a result, and his location was monitored until January 1, 2006, when that intervention was discontinued because he made no more attempts to leave. Tr. 15-16; P. Ex. 4, at 1; CMS Ex. 13, at 1, 25, 29; P. Br. at 3.

7. Resident 9 was allowed to sit on the front porch of the facility on a regular basis. CMS Ex. 3, at 2; P. Ex. 4, at 1; Tr. 236.

8. On January 3, 2006, between 8:00 p.m. and 9:45 p.m., Resident 9 left the facility through the front door without signing out or notifying staff of his departure. Tr. 13; CMS Ex. 3, at 2; CMS Ex.13, at 40; P. Ex. 6; P. Br. at 3.

9. Resident 9 left the facility property in the company of a non-family member, who was referred to as Linda. Tr. 13; P. Exs. 7, 8, 9; P. Br. at 3.

10. On January 3, 2006, at 9:45 p.m., staff noted Resident 9 was missing and began searching the facility and neighborhood for him. CMS Ex. 3, at 2; CMS Ex.13, at 40.

11. On January 4, 2006, between 7:00 a.m. and 7:30 a.m., Resident 9 was found, by a passerby at a street corner about three to four blocks from the facility, sitting in his wheelchair. Tr. 17-18; CMS Ex. 3, at 1; CMS Ex.13, at 40; P. Br. at 3.

12. When Resident 9 was discovered on January 4, 2006, he was wearing a T-shirt and boxer shorts, no socks or shoes, he was wet with urine, his skin was cold to touch, and he was shivering. Tr. 17-18; CMS Ex. 3, at 1; CMS Ex.13, at 40, 59.

13. On January 4, 2006, Resident 9 was transported to the hospital, evaluated, and treated for hypothermia as his temperature was 94.4 degrees Fahrenheit orally. Tr. 18; CMS Ex. 13, at 32; P. Br. at 3.

14. During the evening on January 3, 2006, Resident 9 did not receive medication for which he had a physician's order. CMS Ex. 3, at 4; CMS Ex. 13, at 3-5; Tr. 86.

B. Conclusions of Law

1. Petitioner's request for hearing was timely and I have jurisdiction.

2. Petitioner violated 42 C.F.R. § 483.25(h)(2) with respect to Resident 9.

3. Resident 9 suffered actual harm.

4. Petitioner was not in substantial compliance with program participation requirements based upon the regulatory violation and actual harm suffered by a resident.

5. The determination that immediate jeopardy was posed does not impact the amount of the PICMP and is not in issue before me.

6. A PICMP of $6300 is reasonable.

C. 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.

D. Applicable Law

Petitioner is a long-term care facility participating in the federal Medicare program as a SNF and in the state Medicaid program as a NF. The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Social Security Act (Act) and at 42 C.F.R. Part 483. Sections 1819 and 1919 of the Act vest the Secretary of Health and Human Services (Secretary) with authority to impose enforcement remedies against a long-term care facility for failure to comply substantially with federal 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. "*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 the Secretary through his regulations at 42 C.F.R. Part 483. 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. Pursuant to 42 C.F.R. Part 488, CMS may impose a per instance or per day CMP against a long-term care facility when a state survey agency concludes that the facility is not complying substantially with federal participation requirements. 42 C.F.R. §§ 488.406; 488.408; 488.430. The regulations in 42 C.F.R. Part 488 also give CMS a number of other remedies that can be imposed if a facility is not in compliance with Medicare requirements. 42 C.F.R. §§ 488.406; 488.408; 488.430.

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, of from $3050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). The lower range of CMP, from $50 per day to $3000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). 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 Act and regulations make a hearing before an ALJ available to a long-term care facility against which CMS has determined to impose a CMP. Act § 1128A(c)(2); 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) and 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 collected by CMS or impact upon the facility's Nurse Aid Training and Competency Evaluation Program. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i). CMS's determination as to the level of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's 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 governed by 42 C.F.R. § 488.438(e).

When a penalty is proposed and appealed, CMS must make a *prima facie* case that the facility has failed to comply substantially with federal participation requirements. "*Prima facie*" means that the evidence is "(s)ufficient to establish a fact or raise a presumption unless disproved or rebutted. *Black's Law Dictionary* 1228 (8th ed. 2004); *see also Hillman Rehabilitation Center*, DAB No. 1611, at 8 (1997), *aff'd Hillman Rehabilitation Center v. U.S. Dept. of Health and Human Services*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999). To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 143 Fed.Appx. 664 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800 (2001); *Cross Creek Health Care Center*, DAB No. 1665 (1998); *Hillman Rehabilitation Center*, DAB No. 1611.

E. Analysis

1. Petitioner violated 42 C.F.R. § 483.25(h)(2) (Tag F324)[2]

Section 483.25 of Title 42 C.F.R. requires that:

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosoical well-being, in accordance with the comprehensive assessment and plan of care.

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[2] This is a "Tag" designation as used in the State Operations Manual (SOM), Appendix PP – Guidance to Surveyors for Long Term Care Facilities. The "Tag" refers to the specific regulatory provision allegedly violated and CMS's guidance to surveyors. Although the SOM does not have the force and effect of law, the provisions of the Act and regulations if interpreted clearly do have such force and effect. *State of Indiana by the Indiana Department of Public Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991); *Northwest Tissue Center v. Shalala*, 1 F.3d 522 (7th Cir. 1993). Thus, while the Secretary may not seek to enforce the provisions of the SOM, he may seek to enforce the provisions of the Act or regulations as interpreted by the SOM.

One specific requirement is that a facility must ensure "[e]ach resident receives adequate supervision and assistance devices to prevent accidents." 42 C.F.R. § 483.25(h)(2). The regulation requires that a facility provide *both* "assistance devices" *and* "adequate supervision" to prevent accidents. In *Woodstock Care Center*, the Board considered whether the facility knew or reasonably should have anticipated the risk of the kind of events that occurred and whether any reasonable means were available to prevent them without violating the residents' rights. *Woodstock Care Center*, DAB No. 1726, at 26-27. The Board in *Woodstock* noted that, while a facility is permitted the flexibility to choose the methods it uses to prevent accidents, the chosen methods must constitute an "adequate" level of supervision and use of assistance devices given all the circumstances. What is "adequate" takes into consideration the resident's ability to protect himself or herself from harm. *See Woodstock Care Center* at 28-35; *see also Windsor Health Care Center*, DAB No. 1902, at 5, *aff'd, Windsor Health Center v. Leavitt*, 127 Fed. Appx. 843, No. 04-3018 slip op., 2005 WL 858069 (6th Cir. 2005) ("[a] facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods must constitute an 'adequate' level of supervision under all the circumstances."). 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)." SOM, App. P, Guidance to Surveyors, Tag F324, *Woodstock Care Center*, DAB No. 1726, at 4.

The surveyors allege in the Statement of Deficiencies dated January 7, 2006, that Petitioner violated 42 C.F.R. § 483.25(h)(2) because Petitioner failed to monitor resident access to the front door, which resulted in the elopement[3] of Resident 9. The surveyors allege that Resident 9 suffered hypothermia as a result of being outside the facility and unsupervised. CMS Ex. 2, at 10.

The pertinent facts are set forth in detail in my Findings of Fact and are not restated here. There is no dispute that Resident 9 left Petitioner's facility on January 3, 2006, without staff knowledge. Petitioner cannot dispute that Resident 9 was not subject to staff supervision from approximately 8:30 p.m. on January 3, 2006, until he returned from the hospital on January 5, 2006. Tr. 209. Furthermore, Resident 9 suffered from hypothermia and had to be hospitalized and treated. Thus, Resident 9 suffered actual harm.

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[3] The term as used by the surveyors refers to Resident 9's unsupervised, unplanned, or unintended departure from the facility property. Elopement as used in this decision means a departure from facility property that Petitioner's staff and the resident's care planning team did not supervise, plan, or intend. Whether the resident planned or intended to depart is not controlling.

Petitioner argues that CMS failed to show a *prima facie* violation of 42 C.F.R. § 483.25(h)(2) because there was no accident and, if there was an accident, it was not foreseeable. P. Br. at 9-11; P. Reply at 9; Tr. 176-77. Petitioner reasons that the chain of events involving Resident 9 was not an accident because Resident 9 chose to leave the facility voluntarily with his girlfriend, and he had the right to do so. Further, according to Petitioner, Resident 9 and his girlfriend decided that he should be dropped off three to four blocks from the facility to avoid detection. P. Br. at 9, n.2; P. Reply at 9. An accident is an unexpected or unintended event that can cause, but need not necessarily cause, injury or harm to a resident. I have no difficulty concluding that there was an accident based upon the facts of this case. The regulations that govern Petitioner's participation in Medicare and Medicaid oblige Petitioner to ensure that a resident is properly assessed and a comprehensive care plan developed with professional quality care and services delivered by qualified staff in a safe environment that preserves a resident's rights and quality of life. 42 C.F.R. §§ 483.10, 483.12, 483.15, 483.20, 483.25, 483.70. Petitioner does not, and cannot, argue that Resident 9's unsupervised departure on January 3, 2006 was planned or intended as part of his plan of care or as part of Petitioner's delivery of professional quality services. Both Petitioner and CMS recognize that Resident 9 has the right to come and go from the facility. However, as part of Petitioner's plan to exercise supervision over Resident 9, Petitioner expected Resident 9 to notify staff when he wanted to leave the facility. CMS Ex. 13, at 25. Resident 9's unsupervised departure was clearly both unplanned and unintended by Petitioner. There are many potential injuries or harms associated with the unplanned and unsupervised departure, exacerbated by Resident 9's assessed poor judgment and decision-making, including his failure to adequately dress for the weather conditions and failure to receive or have a supply of his ordered medication to take at the ordered time and dose. I find no requirement in the regulation or the prior decisions of the Board or ALJs that indicates Petitioner needs to be able to foresee a specific injury or harm that might befall an unsupervised resident, only that the unexpected or unintended event could cause bodily injury.

Petitioner's argument that it could not foresee Resident 9's elopement is also problematic for Petitioner. There is no dispute that on November 30, 2005, Resident 9 left the front porch of the facility and rolled his wheelchair onto the parking lot where his further progress was prevented by a speed bump. The attempted elopement was observed by facility staff, and Resident 9 was wheeled back into the facility. CMS Ex. 13, at 1; P. Ex. 4, at 1-2. Petitioner then created a care plan to address the problem of Resident 9 leaving the facility without first signing out on pass, with the goals of continued safety for the next 90 days and no reports of elopement for the next 90 days. The care plan listed four

interventions: (1) explain to resident the risks[4] of leaving home without notifying staff; (2) redirect the resident as needed; (3) encourage the resident to notify staff when he wants to leave the facility; and (4) monitor the resident's whereabouts every hour. CMS Ex. 13, at 25. The development of the plan with specific interventions is good evidence that Petitioner foresaw the risk that Resident 9 would attempt to leave the facility unsupervised again. The plan apparently worked, as Resident 9 did sign-out on pass with his wife at least twice while the plan was in effect, and there is no evidence of any unsupervised departures. CMS Ex. 13, at 28; P. Ex. 12. Although the care plan indicated by its terms that it was to be in effect for 90 days, there is no dispute that Petitioner's staff discontinued hourly monitoring on January 1, 2006, a month after initiation, due to the fact that Resident 9 had made no attempts to leave the facility. CMS Ex. 13, at 25. Discontinuing the hourly checks based solely on the fact that Resident 9 made no further attempts is a significant error by Petitioner.

On November 30, 2005, Petitioner foresaw a risk that Resident 9 would leave the facility unsupervised. Petitioner adopted four interventions to address the risk, including hourly checks. The facts that (1) Resident 9 did sign-out twice, and (2) there were no attempts to leave unsupervised after the interventions were implemented, are good evidence that the interventions adopted were effective. A month after implementing the interventions, Petitioner discontinued the hourly checks, arguably the most restrictive intervention. Two days after discontinuing the hourly checks Resident 9 eloped. Petitioner has presented no evidence that, before discontinuing hourly checks on the resident's location, the care planning team assessed the effectiveness of the intervention and found it no longer effective or assessed Resident 9 and determined that changes in his medical condition, personal situation, or functioning had improved since November 30, 2005, when the care planning team determined that the intervention was necessary. Thus, if it was foreseeable on November 30, 2005 that Resident 9 would attempt to elope again, was it not also foreseeable that if Petitioner removed the hourly checks then Resident 9 would attempt to elope (depart without signing out and without supervision)? The question is answered by the fact that Resident 9 did elope just two days after the hourly checks were discontinued. The fact that Resident 9 had signed-out and not eloped during the 30 days, is evidence of the effectiveness of the interventions adopted, not evidence that Resident 9 had experienced a change that reduced the risk of elopement. I conclude that it was foreseeable, absent evidence to the contrary, that discontinuing the hourly checks posed the same risk for elopement as the care planning team foresaw on November 30, 2005.

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[4] The specific risks envisioned by the care planning team are, unfortunately, not listed and the evidence does not show what risks staff listed for the resident. However, it is significant that the care planning team foresaw some risks associated with unsupervised departures.

I conclude that CMS has made a *prima facie* showing of a violation of 42 C.F.R. § 483.25(h)(2).

Petitioner argues in its defense that it was not reasonably foreseeable that Resident 9's departure with Linda would pose any risk for harm to Resident 9 because Resident 9 was known to have previously left the facility on pass with Linda. P. Br. at 9; Tr. 203-04. Of course, Petitioner did not know that Resident 9 left with Linda on January 3, 2006, as Petitioner had discontinued hourly monitoring, and Resident 9 did not sign-out when he left with Linda. Resident 9 left with Linda without his medication and without proper clothing. Petitioner has not shown that either the medication or clothing were unnecessary, or that their absence posed no risk for harm to the resident. Petitioner lost supervision of the resident and therefore could not ensure he received professional quality services. Additionally, Petitioner could not supervise the resident's departure to ensure that he left with proper clothing, proper medicine, and that he would be in the protection of a specific person or persons. Petitioner should not be held accountable for Linda's conduct. However, if Petitioner had supervised Resident 9's departure with Linda, she may have been deterred from dropping the resident the next morning three to four blocks from the facility, in his underwear, soaked with urine, with no shoes or socks, and trapped in his wheelchair in cold conditions.[5] As I have already concluded, it was not necessary for Petitioner to foresee the specific injury or harm Resident 9 suffered, only that his unsupervised departure created the risk for harm.

Petitioner also argues that the only deficiency was Resident 9's failure to properly sign-out. P. Br. at 10, 13. Petitioner's characterization is not correct. The deficiency is that Resident 9 left Petitioner's facility without Petitioner's knowledge, and without Petitioner ensuring the resident had proper supervision to avoid accidents. The evidence shows that

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[5] I recognize that if Resident 9 was with Linda, as Petitioner alleges, there is a substantial question based upon the state in which Resident 9 was discovered as to whether Linda was a safe person for Resident 9 to be with or whether she had the ability to provide a safe environment. CMS does not agree that the evidence is sufficient to show Resident 9 was actually with Linda. The surveyors made no allegation that it was unsafe for Resident 9 to be out with Linda. Accordingly, I find no reason to attempt to decide what Petitioner's responsibility was to assess whether it was safe for Resident 9 to go out on pass with Linda. Petitioner's assertion that Resident 9 had the right to do what he wanted would need to be considered in the context of Texas elder abuse laws and Petitioner's responsibilities under those laws. Petitioner acknowledges that it could have infringed Resident 9's rights if it believed he was in danger. P. Br. at 13, n.3. The evidence shows that Petitioner recognized that leaving without signing out (elopement) was unsafe. However, Petitioner does not indicate how it would assess whether Resident 9 leaving the facility with Linda was safe.

Petitioner previously assessed Resident 9 and foresaw the risk for unsupervised departure and the risk for injury. However, Petitioner discontinued the hourly checks of Resident 9 without an adequate assessment of the effectiveness of that intervention, even though the evidence shows that with that intervention in place Resident 9's elopement was prevented, he signed-out as required, and a degree of supervision of the resident was maintained.

Petitioner argues that it had a number of interventions in place to prevent elopements. P. Ex. 14-16; P. Reply at 6-7. It is not disputed that Petitioner had a number of interventions in place. The fact that those interventions were not effective to prevent Resident 9 from departing unsupervised is indisputable. Two of the interventions required observation of the front door, during business hours by a receptionist and after business hours by nurses at the nurses station located near the front door. Another intervention was a security code key pad needed to unlock the front door. Surveyor Whitis testified that the surveyors observed that facility staff was not monitoring the front door particularly after 5:00 p.m., but she agreed that before that time administrative staff could generally observe the front door from the front office. Tr. 77. She testified that the surveyors observed that frequently no one was at the front desk. Tr. 77. Surveyor Whitis concluded that Petitioner had no means for identifying residents who had the potential to wander off or elope, and a number of staff were interviewed who did not know which residents could be outside unsupervised. Tr. 77-80. Surveyor Whitis further testified that it was known that several residents had access to the code to the front door and would let other residents out. Based on the foregoing, the surveyors concluded during the survey that Petitioner's failure to ensure regular supervision of the front door posed a risk for elopement by Resident 9 and other residents at risk for elopement. Tr. 87. I find that the surveyors' observations are unrebutted. Furthermore, Petitioner asserts that on January 3, 2006, Resident 9 was sitting on the front porch when Linda pulled up and assisted Resident 9 and his wheelchair into her vehicle and drove off. However, Petitioner could not locate any witness to confirm that scenario, which gives credibility to the surveyors' observation that staff was not supervising access to or departure from either the facility or the front porch.

Petitioner argues that Resident 9 had the right to receive visitors, leave the facility, or discharge himself if he so chose. Thus, staff would not have prevented Resident 9 from leaving the facility on January 3, 2006, if staff was aware that the resident was leaving. P. Br. at 11-14. Whether staff could have prevented the resident from leaving is not the issue. If staff had known that Resident 9 was leaving, staff could have ascertained where the resident was going, how long he was to be gone, who he was with, and thus ensured

the resident went with proper clothing and medicine.[6] Staff supervision of the departure would have avoided the need to search the facility, to contact the police, and would likely have avoided Linda dropping the resident blocks away in his underwear and wet with urine.

Petitioner attempts to use residents' rights to shield it from responsibility for its loss of supervision of Resident 9. P. Br. at 11; P. Reply at 10-12. Two points are significant. First, when Petitioner sought to participate in the program, it was clearly on notice of its obligation to respect resident rights under the regulations (42 C.F.R. § 483.10) and the need to provide supervision to protect its residents against accidental injury (42 C.F.R. § 483.25(h)(2)). Petitioner is obliged to do the balancing required. Section 483.25(h)(2) does not provide that residents must be protected from accidents "except when protection would infringe a right." Similarly, section 483.10 does not contain a specific exception for a situation where there is a risk for harm due to accidents.[7] Second, but most significant, I infer from the fact that Petitioner implemented the intervention of checking Resident 9's location hourly on November 30, 2005, that Petitioner resolved any perceived conflict between Resident 9's rights and the need to protect him from accidental injury, in favor of the latter. Petitioner attaches great significance to the fact that Resident 9 was able to manage his own care and that his physician did not impose any restrictions upon his ability to leave the facility with a companion. P. Reply at 5. The fact that Petitioner attempts to avoid is that Resident 9's physician had determined at some time that Resident 9 needed skilled care in a long-term care facility. Thus, while Resident 9 might manage his care, he was incapable of providing all his own care. Further, the fact that his physician had not imposed restrictions upon Resident 9's sitting on the front porch or going on pass is no defense for Petitioner. The regulation imposes upon Petitioner, not the physician, the obligation to protect its residents from foreseeable risks of accidental injury or harm.

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[6] Staff might also have been able to assess whether Linda could properly care for Resident 9 and provide a safe environment or whether she was a danger. I do not attempt to resolve whether staff could prevent a departure if staff determined that Linda was unsafe or what Petitioner's responsibilities might have been in that regard under Texas elder abuse laws. I have no evidence that the incident was ever reported or treated by Petitioner or the state as an incident of elder abuse.

[7] However, section 483.10(n) does provide that the right to self-administer drugs is limited by whether an interdisciplinary team has determined that it is safe for a resident to do so.

I conclude that Petitioner has failed to show that it provided adequate supervision to prevent accidental injury to Resident 9. Accordingly, Petitioner violated 42 C.F.R. § 483.25(h)(2). The declaration of immediate jeopardy is not subject to review as it does not impact the enforcement remedy proposed by CMS.

2. A PICMP of $6300 is reasonable.

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 PICMP. CMS is authorized to impose a PICMP from $1000 to $10,000. The PICMP CMS proposes in this case is slightly above the middle of the range authorized by the regulation. The range of the PICMP that may be imposed is not affected by CMS's declaration that there was immediate jeopardy. Thus, whether there was immediate jeopardy is not subject to review.

Pursuant to 42 C.F.R. § 488.438(e), because I have found there is a basis for imposition of a CMP, my authority on review of the reasonableness of the CMP is limited: (1) I may not set the penalty at or reduce it to zero; (2) I may not review either CMS's or the state agency's decision to use a CMP as an enforcement remedy; and (3) I may only consider the factors specified at 42 C.F.R. § 488.438(f). 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 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.

I have received no evidence of prior noncompliance, and Petitioner has not offered any evidence showing an inability to pay. Where either party fails to take advantage of its opportunity to submit evidence of a facility's financial condition, that opportunity is waived. *Community Nursing Home,* DAB No. 1807, at 15-16 (2002); *Emerald Oaks*, DAB No. 1800.

I find Petitioner's failure to provide supervision to Resident 9 to be a serious failure on the part of Petitioner. A central reason for housing a resident in a long-term care facility is to provide the resident with care, including supervision, which the resident is unable to provide for himself or herself, or that the resident's family is unable to provide at home. Resident 9 did not receive the supervision he required, and he suffered actual harm as a result. I conclude that Petitioner was culpable for the violation of 42 C.F.R. § 483.25(h)(2).

I further conclude that the $6300 PICMP is reasonable.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner violated 42 C.F.R. § 483.25(h)(2) with respect to Resident 9 on January 3, 2006, and that violation caused the resident actual harm. Therefore, Petitioner was not in substantial compliance with program participation requirements, and there is a basis for the imposition of an enforcement remedy. I further conclude that a PICMP of $6300 is reasonable.

/s/

Keith W. Sickendick
Administrative Law Judge