Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the case of:	)	
	)	
Opp Health and Rehabilitation, L.L.C.	)	
(CCN: 01-5210),	)	Date: March 12, 2009
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-07-342
	)	Decision No. CR1921
Centers for Medicare & Medicaid	)	
Services.	)	
	)	

DECISION

Petitioner, Opp Health and Rehabilitation, L.L.C. (Petitioner or facility), is a long-term care facility located in Opp, Alabama, that is certified to participate in the Medicare program as a provider of services. On February 17, 2007, the Alabama Department of Public Health (State Agency) conducted a complaint survey in response to a tip that the facility had not reported the death of a resident found unresponsive in the facility's parking lot, partially clothed, on a winter night, who had exited the facility undetected. Based on the results of that survey and a revisit survey, the Centers for Medicare & Medicaid Services (CMS) determined that, from February 12 through March 20, 2007, the facility was not in substantial compliance with Medicare requirements, and that from February 12 through February 27, 2007, its deficiencies posed immediate jeopardy to residents. CMS imposed a Denial of Payment for New Admissions (DPNA) effective February 25 through March 20, 2007, and a civil money penalty (CMP) of $5000 per day for 16 days of immediate jeopardy and $100 per day for the 21 remaining days of substantial noncompliance (totaling $82,100). Petitioner challenges those determinations and related penalties.

For the reasons set forth below, I find that the facility was not in substantial compliance with program requirements from February 12 through March 20, 2007, and that from February 12 through February 27, 2007, its deficiencies posed immediate jeopardy to resident health and safety. I sustain CMS's imposition of the DPNA and the CMP.

I. Background

On the night of February 12, 2007, a visitor discovered an 84-year-old resident, Resident Number 1 (R1), in the facility parking lot. R1 was lying unresponsive on the asphalt between two parked vehicles, wearing only a t-shirt and socks, without vital signs, and with blood on his head and face. Petitioner's Exhibits (P. Exs.) 13-23, 25, 28-30; CMS Ex. 5, at 26. R1 had significant unexplained facial injuries to his forehead and nose, and he had abrasions on his knees and chest. The source of the injuries was unwitnessed and the unconscious resident could not explain how the injuries occurred. The visitor alerted staff, who responded immediately by calling an ambulance and attempting to resuscitate the resident. The resident was taken to the hospital and pronounced dead.

After receiving an anonymous tip, surveyors went to the facility to investigate and determined that the facility should have but did not report the incident, that the facility did not have any system in place to prevent R1 from being outside the facility, and that the facility had not provided R1 with adequate supervision. The surveyors also determined that the facility failed to follow R1's care plan and failed to prevent foreseeable accidents. CMS Ex. 1, at 1, 12, 19, 31. A revisit survey concluded that Petitioner had corrected its immediate jeopardy deficiencies but that it remained out of substantial compliance. CMS Exs. 9, 12.

CMS has imposed a DPNA and CMP of $5000 per day for 16 days of immediate jeopardy and $100 per day for 21 days of substantial noncompliance that was not immediate jeopardy (totaling $82,100). CMS Exs. 8, 12, 14.

The facility timely requested a hearing, and the matter was assigned to me. I held a hearing in Birmingham, Alabama, which began on September 9, 2008. Ms. Margaret J. Babb appeared on behalf of Petitioner, and Mr. Donald J. Calder appeared on behalf of CMS.

I admitted into evidence CMS Exs. 1-14 and P. Exs. 1-35. Transcript (Tr.) 6-7; *Order* (August 18, 2008). During the hearing I also admitted a one-page document prepared by the paramedic who attended to R1 on the night of his death as Administrative Law Judge (ALJ) Ex. 1. Tr. 266. The parties have filed opening briefs (CMS Br. and P. Br), reply briefs (CMS Reply and P. Reply), and CMS filed a response brief.

II. Applicable Law and Regulations

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program, and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act, section 1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program

requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance with program participation requirements. Act, section 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months, and more often, if necessary, to ensure that identified deficiencies are corrected. Act, section 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a), 488.308. If a facility is not in substantial compliance, CMS has the authority to impose enforcement remedies, including per day CMPs and DPNAs. 42 C.F.R. §§ 488.406, 488.408; *see* Act, section 1819(h).

Per day CMPs fall into two broad penalty ranges. 42 C.F.R. §§ 488.408, 488.438. The upper range, from $3050 to $10,000 per day, is reserved for deficiencies that constitute "immediate jeopardy." 42 C.F.R. § 488.438(a)(1). The lower range, from $50 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). "Immediate jeopardy" is defined as "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 (emphasis added).

A facility has a right to request a hearing before an ALJ to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. §§ 488.408(g), 498.3(b)(13); *see* Act, section 1819(h). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et al*, DAB CR65 (1990), *aff'd, Anesthesiologists Affiliated, et al v. Sullivan*, 941 F.2d 678 (8th Cir. 1991); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *The Residence at Salem Woods*, DAB No. 2052 (2006). CMS's choice of remedies or the factors it considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408; *see* 42 C.F.R. §§ 488.330(e), 498.3. CMS's determination as to the level of noncompliance, including a finding of immediate jeopardy, "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2); *Woodstock Care Center*, DAB No. 1726, at 9, 38 (2000), *aff'd, Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). An ALJ may review a CMP pursuant to 42 C.F.R. § 488.438(e).

In these proceedings, CMS must establish a *prima facie* case that the facility was not in substantial compliance. The facility must overcome CMS's showing by a preponderance of the evidence to prevail. *Emerald Oaks*, DAB No. 1800, at 4 (2001); *Cross Creek Health Care Center*, DAB No. 1665 (1998) (applying *Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd*, *Hillman Rehab. Ctr. v. U.S. Dep't of Health & Human Services*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999)).

III. Issues

The issues in this case are:

> Whether the facility was complying substantially with federal participation requirements on the dates CMS determined to impose a CMP.
>
> Whether CMS's determination of immediate jeopardy was clearly erroneous.
>
> Whether the penalty imposed by CMS is reasonable, if noncompliance is established.

IV. Discussion

A. The facility was not in substantial compliance with 42 C.F.R. §§ 483.13(c) (investigation and reporting requirements), 483.25(h)(2) (accidents), 483.20(k) (comprehensive care plans), and 483.75 (administration).

On the night of February 12, 2007, after 10:00 p.m., a visitor found a resident in the facility parking lot, dressed only in a t-shirt and socks, lying on his side between two vehicles, face down, with blood around his head. P. Exs. 13-23, 25, 28-30; CMS Ex. 5, at 26. The visitor, Dane Adams, ran to the closest door, Hall Two East, and beat on it. No one answered the door, so he went to the front door, and then to the Hall Two nurses station. P. Ex. 32, at 1; CMS Ex. 3, at 16, 38. Staff rushed out to the parking lot and began cardio pulmonary resuscitation (CPR) on R1. An ambulance was called, and the paramedics took R1 to the hospital where he was pronounced dead. Staff also called the facility's Administrator, Yvette Welch, who arrived at the facility after R1 had been taken to the hospital, and began interviewing staff about what happened. P. Exs. 13-23, 25, 28-30.

R1 had been readmitted[1] to the facility on February 7, 2007, with diagnoses including acute exacerbation of chronic obstructive pulmonary disease (COPD),[2] congestive heart failure (CHF),[3] osteoarthritis,[4] and diabetes. P. Ex. 1, at 41, 43, 45, 54. To mitigate the

---

[1] He had been in the facility several months earlier for a short period of time.

[2] Surveyor Sharon Parker testified that COPD affects memory and ability to think. Tr. 11-12.

[3] CHF causes the heart muscle to fail to circulate the blood throughout the body to the lungs. Tr. 12 (Surveyor Parker).

effects of COPD and CHF, his physician, J. Michael Stanfield, M.D., ordered that he receive oxygen through a nasal cannula, which could only be removed for short periods. P. Ex. 1, at 35, 40, 55; Tr. 389-92. Surveyor Sharon Parker noted that patients with below normal oxygen levels, like R1, are likely to experience confusion. Tr. 19-20. Dr. Stanfield testified that R1 had grown accustomed to lower levels of oxygen in his blood than most people, but also that COPD caused the resident to feel short of breath and fatigued, especially when walking.[5] Tr. 349, 389-90.

R1 had been assessed to need one-person assists with transfers, walking in his room, walking in the corridor, and toilet use. He also required assistance with personal hygiene and bathing. P. Ex. 1, at 54 (Minimum Data Set signed February 13, 2007), 112, 145 (needs help dressing and bathing, walks *with assistance*) (emphasis added). On February 7, 2007, the day of his readmission, the physical therapist assessed R1 as being at a high risk for falls.[6] P. Ex. 1, at 120 (physical therapy gait and balance tests). On February 12, 2007, Dr. Stanfield ordered six weeks of physical therapy, five days a week, in part, for progressive gait training. P. Ex. 1, at 42.

R1 was generally alert and oriented, but according to some staff and facility records, he occasionally experienced mild confusion. His speech-language pathology report shows that he had mild to moderate problems with cognition, and indicates that speech therapy services were warranted to improve R1's cognitive status for functional communication. P. Ex. 1, at 134. His "Mini-Mental State Examination" (MMSE) established that R1 suffered from mild dementia. P. Ex. 1, at 108; Tr. 569. His transfer form dated February 7, 2007, also indicates that he was occasionally confused. P. Ex. 1, at 145. His care plan directed staff to prevent R1 from eloping, in part, by maintaining alarms on exit doors and by ambulating with the resident. P. Ex. 1, at 76. Surveyor Parker testified that door alarms help prevent elopements by sounding when exit doors open, alerting staff that a resident may have exited through an open door. Tr. 50-51.

---

[4] Osteoarthritis is a weakening condition of the bones. Patients become limited in their mobility, including walking, mobility, using the hands, arms, etc. Any limitation with the musculoskeletal system is possible. Tr. 13 (Surveyor Parker).

[5] R1 frequently ambulated with a wheelchair. P. Ex. 1, at 54, 93.

[6] A separate, undated assessment included in R1's intake records and signed by Nurse Christy Bryan (fall risk assessment) indicates that he was not at a high risk for falls. P. Ex. 1, at 100. This assessment is the only one in R1's intake records that is not dated. P. Ex. 1, at 96-103. Nurse Bryan testified that on the day of his readmission, his gait was steady: when he stood up from the stretcher he had to stand for just a second, but that he walked three or four feet from the stretcher to the bed without any problems and without any assistance. Tr. 329.

1. Duty to investigate and report injuries of unknown source

Regulations require facilities to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. Facilities are required to ensure that alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, are reported *immediately* to the facility administrator and to other officials in accordance with state law. 42 C.F.R. § 483.13(c)(2) (emphasis added). A facility must have evidence that all alleged violations are thoroughly investigated. 42 C.F.R. § 483.13(c)(3). The results of all investigations must be reported to the administrator and to other officials in accordance with state law within *five working days* of the incident. 42 C.F.R. § 483.13(c)(4) (emphasis added). The Departmental Appeals Board (Board) has held that under section 483.13(c)(4), the results of the investigation should be reported to the State Agency within five days of the incident regardless of whether the investigation verified the alleged violation. *Bergen Regional Medical Center*, DAB No. 1832 (2002).

On the night of the incident, Administrator Welch began interviewing staff and asked them to write statements about what happened. Tr. 489-90. No staff members reported having observed R1 exit the building. According to Administrator Welch, Petitioner never discovered precisely how or where R1 exited the facility. Tr. 32-34, 51, 580-81; CMS Ex. 3, at 31 ("I determined that I don't know how he got out and don't know if alarm sounded or not."). Petitioner suspected that R1 exited through a door on Hall Two because the resident's room was there, which is where he was last seen, and because it was the closest door to the location where his body was found. Tr. 36, 41, 198-200, 566. Although Petitioner argues that its door alarms were functioning properly on the night of the incident, some staff members suspected that he exited from a door on Hall Two because the exit door alarms were not working at that time. CMS Ex. 1, at 28-29; Tr. 16, 198-200.

Staff also reported that audible alarms on exit doors were disabled by staff, some of whom were in the habit of entering and exiting through the doors and/or using rugs to prop the doors open. CMS Ex. 1, at 28-29. As Administrator Welch explained, though, the keypad codes were posted in the main lobby,[7] R1 knew the codes, and facility staff

[7] Petitioner's assertion that it was required to post the keypad code is not supported by its references to the Life Safety Code or Alabama law. CMS points out that Alabama law requires that panic hardware be installed on exit doors. The LSC actually requires that doors be equipped with panic hardware (including cross-bars and push-pads) with a push-type door lock release, and signage reading "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS." CMS Reply at 3 (citing LSC Ch. 7.2.1.6.1(d)).

allowed him to come and go at will.[8] Tr. 468-70, 472-74; CMS Ex. 1, at 28; CMS Ex. 3, at 31 (referring to R1's MMSE, Administrator Welch told surveyors: "I can't keep him in here, he was not demented."). If he entered the keypad code, he could walk outdoors without triggering an alarm. Tr. 528, 582.

Petitioner argues that Administrator Welch reasonably concluded after a thorough investigation that R1 died of a myocardial infarction which caused him to fall and sustain multiple injuries, and because she knew the source of the injuries, there was no reason to report the circumstances of R1's wandering alone and dying outdoors. P. Br. at 24-27; Tr. 499-500.

i. Duty to investigate injuries of unknown source

While the Administrator did conduct a cursory investigation into the events that took place on the night of R1's death, the investigation revealed very little about what happened. Petitioner discovered that R1 exited the facility and died, but the underlying cause of R1's exit and death were not determined, and the circumstances surrounding his death were unknown. Petitioner's detailed explanation of its theory regarding "air-hunger" seems plausible given R1's conditions. *See* P. Br. at 5, 25. However, this analysis is absent from any documents that have been submitted as part of the investigation, which indicates that the theory was not discovered during investigation but developed at a later point. Moreover, the explanation does not answer the question of how R1 left the facility undetected or how he sustained the injuries to his head, side, and hands. He may have sustained the injuries from a fall, or he may have sustained them from more than one fall. He may have suffered a heart attack and then fallen, or he may have fallen and then suffered a heart attack. Petitioner now maintains that R1 died and then fell, but it has not submitted any documentation showing that this was a conclusion of its investigation. *See infra* discussion Part IV.A.1.ii.

Petitioner has not submitted any documentation of its actual investigation process. At the hearing, Administrator Welch testified that P. Exs. 1-4, 6-7, 10, 12-31, 32, at 3, were part of the investigation. Tr. 501-14. But none of these documents – consisting of medical charts, maintenance notes, and witness statements – show any analysis.

Notes compiled after the survey (which appear to be Administrator Welch's) indicate that Petitioner still did not understand exactly what happened on the night of February 12,

[8] In its hearing request, Petitioner stated that R1 "was mentally competent to decide if he wanted to step outside to breathe fresh air . . . . He requested a room near an exit for this purpose when he moved into the facility; he knew the security code for the door so that he could exit and enter when needed and did not need or want to be attended at all times." Hearing Request at 2.

2007. In response to deficiency Tag F225 (42 C.F.R. § 483.13(c), failure to conduct a thorough investigation and failure to report), a handwritten note reads, "[R1] was found at the edge of the sidewalk that connected to the parking area. (Not as surveyor states.)" P. Ex. 34, at 13. None of the contemporaneous witness statements say that R1 was found at the edge of the sidewalk; almost all of the witness statements say that he was found in the parking lot. The notes also say that (apparently Administrator Welch) interviewed Glen Jowers, Paramedic, "first on the scene." P. Ex. 34, at 14. Paramedic Jowers was the first paramedic to respond, but many staff members would be able to describe the scene as it looked when R1 was found better than he would because he arrived after R1 had been moved to a CPR board and covered with a sheet. Nursing notes show that R1 took a powerful sleeping pill, Restoril, two hours before he was found dead, but there is no documentation showing that the facility considered what medications R1 had taken that night and the effects they may have had on the resident. P. Ex. 1, at 48; *see* Tr. 405 (the sleeping pill could have caused confusion).

The purpose of requiring facilities to investigate is, in part, to facilitate a determination of the cause of unknown injuries and the implementation of corrective measures to guard against repeat occurrences. Tr. 59-64, 75-77, 83. A thorough investigation of R1's elopement should have identified flaws in policies and procedures designed to prevent such events. In this case, Administrator Welch told surveyors that no corrective measures had been taken as a result of R1's exit from the facility. Tr. 63-64.

In view of the foregoing, I find that CMS has established a *prima facie* case that Petitioner failed to investigate injuries of unknown origin. Petitioner has not overcome that showing by a preponderance of the evidence.

ii. Duty to report the results of the investigation within five working days of the incident

Petitioner maintains that it did not have a duty to report because, as expert evidence shows, R1 suffered a myocardial infarction on the night of his death and died before he fell, i.e., he did not fall and then die. Petitioner says that this conclusion follows from the fact that there was little or no blood when R1 was found dead, which would indicate that his heart had stopped pumping before he fell and sustained injuries, and that he did not have defensive wounds on his hands from trying to break his fall. P. Br. at 2, 11.

However, Petitioner did not arrive at this conclusion at the time of the investigation. Petitioner asserts that on February 13, 2007, Paramedic Jowers told Administrator Welch that there was very little blood, which indicates that the heart had already stopped beating, and that R1 did not have defensive wounds from trying to break his fall. Tr. 492-94; CMS Ex. 34, at 14 (undated notes, written after complaint survey). Paramedic Jowers did not recall talking to anyone at the facility until after he had spoken with surveyors. Tr. 257-58, 291, 305.

Petitioner has not submitted contemporaneous notes of Administrator Welch's interview with Paramedic Jowers. In fact, it has submitted no documentation indicating that any assessment was made during the investigation that R1 died and then fell, that he did not have defensive wounds, or that the amount of blood was considered during the investigation. As Dr. Stanfield testified, although the facility notified him on the night of February 12, 2007, that R1 had been transferred to the hospital, the only thing he was told about the circumstances surrounding R1's death was that he was found outside.[9] Tr. 370.

Moreover, when Dr. Stanfield made his assessment, it was premised on Petitioner's assertion that there was little or no blood when R1 was found. At the hearing, he confirmed that if he was told that "there was a pool of blood or that [R1] was bleeding and there was blood on the pavement then [he] would conclude that [R1] was alive before the impact and the impact could have contributed to his death." Tr. 421. He also said that if there had been blood, he would consider whether the injuries to the head might have in some way contributed to the death. Tr. 421. Dr. Stanfield acknowledged that a heart attack was not necessarily the reason R1 fell, but that something else could have caused him to fall. Tr. 419-20. He also acknowledged that the presence of Restoril in R1's system could have impaired R1's ability to perform a defensive maneuver when he fell. Tr. 406.

Many witnesses reported a seeing a lot of blood: R1 "appeared to be bleeding from his head or upper half of his body" (P. Ex. 13, Whatley Decl.); "face down in a pool of blood" (P. Ex. 17, Foster Decl.); "his face was bloody" (P. Ex. 18, Brown Decl.); "blood on pavement" (P. Ex. 19, Thompson Decl.); "blood under resident at his head" (P. Ex. 22, Rhoder Decl.); "bleeding from his forehead" (P. Ex. 25, Rosen Decl.); "blood around face area" (P. Ex. 28, Barrow Decl.); "laying on the ground covered in blood" (P. Ex. 30, Burks Decl.); "lying . . . with his face down and blood all around." (CMS Ex. 5, at 26, Hall Decl.). Witnesses also told surveyors they saw blood. CMS Ex. 3, at 7 (blood pooled, 12' circle); CMS Ex. 3, at 24 (blood around his head, on face); CMS Ex. 3, at 38 (saw blood, some was on him); CMS Ex. 3, at 27 (the blood was coming from his head).

[9] Dr. Stanfield submitted a letter dated February 20, 2007, stating his opinion that R1 died of an "Acute Myocardial Infarction and/or Pulmonary Embolus." P. Ex. 11. However, Administrator Welch acknowledged that this letter was not considered during the investigation. Tr. 510.

The only witness to say that there was no blood was Paramedic Jowers.[10] Tr. 256 ("I noticed several abrasions and cuts on him, but there was no blood anywhere, that I remember."). Paramedic Jowers arrived at the scene after facility staff had moved R1 from the pavement onto a CPR board and placed a sheet over him. Tr. 256, 271. The facility has yet to reconcile this account with all of the other accounts of R1's position when he was initially found. There were other statements and observations that should have been considered during the investigation, as well. At some point a mop was found on the back porch with blood on it. A staff member said, "we brought the mop," but no evidence shows when or where the mop was used.[11] CMS Ex. 3, at 24. Another staff member reported that she spoke with Paramedic Jowers the day after the incident and that EMS workers reported that R1's pulse was present on departure to the hospital.[12] CMS Ex. 5, at 22 (Bryan Decl.).

Regardless of whether Petitioner's conclusions as to the order of events or the amount of blood are correct or not, the argument is not valid. Even assuming that R1 died and then fell does not excuse the facility from exercising its duty to report the results of the investigation timely. The regulations allow a facility five days to investigate and report, and the facility failed to comply.

Although a cursory investigation was conducted, it was not thorough and its results were not reported to the State Agency. Petitioner should have *thoroughly* investigated the incident and reported the results of the investigation to the State Agency within five days.

In view of the foregoing, I find that CMS has established a *prima facie* case that Petitioner failed to report the results of the investigation regarding R1's accident within five working days of the incident. Petitioner has not overcome that showing by a preponderance of the evidence.

---

[10] Petitioner submitted facility notes of an interview of Dane Adams, which indicate that there was not a lot of blood. P. Ex. 32, at 1-2. However, Petitioner submitted the exhibit as "Statements of Yvette Welch." At the hearing, Administrator Welch stated that the first two pages of the exhibit were not her notes. Tr. 512-13. She speculated at the hearing that the notes were part of Nurse Bryan's statement, but the notes themselves are undated and do not indicate who wrote them. Tr. 513-14; CMS Ex. 32, at 1-2. She did not indicate that she considered these pages in her investigation. Tr. 512-14.

[11] This could explain in part why witnesses reported seeing different amounts of blood, but there are no other references to, or discussion of, the mop in the record.

[12] Dr. Stanfield testified that pulseless electrical activity may be present in a heart even after it has stopped beating. Tr. 376.

2. Duty to prevent accidents

A facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. 42 C.F.R. § 483.25(h)(2). While "a facility is not required to do the impossible or be a guarantor against unforeseeable occurrence, . . . it is required to do everything in its power to prevent accidents." *Koester Pavilion*, DAB No. 1750, at 24 (2000).

Petitioner admits that it allowed R1 to walk outdoors at will without detection or supervision. Petitioner claims that R1 was given a room near an exit door and the security code to unlock the door so that he could exit the facility whenever he wanted to without triggering an alarm. Tr. 468, 528, 582. Petitioner also acknowledged that the exit door closest to R1's room, from which Petitioner suspects R1 exited, did not allow reentry from the outside. Tr. 502. There was no keypad on the outside of the building, and the only way to open the door was by punching the code on the keypad inside the building. Tr. 42, 474.

Petitioner argues that R1 was alert and oriented, and that his MMSE score prevented facility staff from restricting him from leaving the facility at anytime. Regardless of whether R1 was alert and oriented or even if he could not be kept from leaving the facility, Petitioner had a duty to protect him and to adequately supervise him. The facility's policy on elopement and the statements of its own staff belie any argument that the facility thought that it was reasonable to allow R1 to go outside the facility alone anytime he desired. The facility's policy titled Elopements and Wandering Residents defines elopement as "the unplanned, unauthorized leaving of the facility by a resident." CMS Ex. 4, at 3. The policy recognizes that "[u]nsupervised activity outside the facility could lead to serious injury of a resident due to the many hazards such as traffic, water, storms and hot/cold temperatures." *Id*. Staff members told surveyors that residents were not allowed: to exit the facility unsupervised (CMS Ex. 3, at 9, 30, LPN Barrows); P. Ex. 35, at 15, LPN Barrows); to be outside of the facility at 10:00 p.m (CMS Ex. 3, at 8, LPN Rhoder); to smoke on the porch near R1's room (CMS Ex. 3, at 27, LPN Thompson). No staff member stated that R1 was or should have been allowed to come and go freely that late at night. As R1's treating physician noted, "I'm not surprised he died, I was surprised he was outside." CMS Ex. 3, at 34. The only person to assert the position that this was not an elopement was the facility Administrator. CMS Ex. 3, at 31.

I find the Administrator's testimony disingenuous and irrelevant. Petitioner argues that because R1 was free to come and go as he pleased, he did not elope. Assuming that R1's exit was not an elopement because the facility allowed him to leave, Petitioner was still required to supervise him. Even for a resident who is lucid and alert and has freedom to leave the facility, the freedom cannot be exercised unchecked. The facility should know where the resident is going and when to expect him back. One reason for this is that a resident may need to take scheduled medications. For R1, he was supposed to be on

oxygen. Another reason is that the time of day may affect dangers posed to a resident. R1 was leaving at a late hour in the dark. Another reason to require some supervisory check is that residents may not be dressed properly for the weather and activity. If R1 had been required to sign out at a register, facility staff would not have allowed him to leave the facility dressed as he was. R1 had also been assessed to be at a high risk for falls, which may have prompted staff to have him use an exit door without stairs or other obstacles.

Petitioner presented no evidence that it used a register or any other system to track when people exited or entered the facility. The fact that many of the doors, particularly the one from which R1 is believed to have exited, did not allow reentry into the building is especially disturbing. If R1 had, as Petitioner speculates, exited the building in a panic to relieve COPD symptoms and decided to go back inside, he would have needed to walk around to the front of the facility, nearly naked, to get back in. As Surveyor Parker testified, the area outside the facility presented hazards such as steps, stairs, and a busy parking lot. Tr. 55-56.

Regardless of the amount of freedom Petitioner gave R1, the facility was required to supervise him and to have a reasonable accounting of his whereabouts.

CMS argues that Petitioner had many doors and alarms that did not work properly. CMS Br. at 8. Many staff members noted that some doors did not close and lock completely. When some doors were opened and allowed to close slowly, they got stuck in the door frame which prevented the magnetic locks from engaging. Staff stated that some alarms did not sound when they should.[13] Petitioner attempts to rebut these arguments by claiming that surveyors and its own facility staff members did not understand the alarm systems.

Petitioner's claim does not help its case. First, whether or not the doors or alarms functioned properly is of minimal relevance to the facility's supervision of R1. If he had the keypad code, as Petitioner asserts, an alarm would not have sounded when he exited

[13] Donna Gordon and Derinda Whatley told surveyors that a button at the nurses station could be used, as it was on February 12, 2007, to disable (silence) the alarm on Hall Two exit doors. CMS Ex. 3, at 39, 41. CNA Robbie Flowers, CNA Whatley, and CNA Burks told surveyors they were aware of staff silencing alarms so that they could enter and exit through the doors. CMS Ex. 3, at 16, 41, 43. Activity Director Debra Inabinette said that she was aware of rugs being used to prop exit doors open. CMS Ex. 3, at 47. Petitioner did not call these individuals as witnesses, so I may infer that they had no intention of recanting their remarks.

the building.[14] The staff expected door alarms to be effective tools to help monitor residents. CMS Ex. 3, at 28 (LPN Rhoder).

Second, claiming that alarms worked properly but that staff did not understand the alarm systems does not show that the alarms were useful to staff for monitoring residents. Staff gave many conflicting accounts to surveyors of whether the door alarms worked in general or on the night of February 12. CMS Ex. 3, at 16 (CNA Robbie Flores), 22 (Maintenance Staff, Batchelor), 27 (LPN Thompson), 39 (CNA Gordon), 41 (CNA Whately). Petitioner asserts that these staff members did not understand that entering a keypad code would silence the alarms. Staff members did not know which doors staff were allowed to use. CMS Ex. 3, at 16 (LPN Robbie Flowers, a staff member uses the 2E door), 23 (LPN Brown, staff are supposed to use the front door or door by break room), 37 (CNA Johnston, CNAs do not use the Two Hall East door at all). There were accounts that staff turned off one of the alarm systems for various reasons and that staff occasionally propped doors open with rugs. CMS Ex. 3, at 47; Tr. 199. Staff members' accounts show systemic failures by the facility to supervise residents and to educate its staff on how the alarms function and how to use them to monitor residents.

Petitioner should have had a system in place to ensure that staff detected R1's exiting the facility, and it should have recognized this as a systemic failure and corrected it after R1's death. The facility has not proven that it was required to post the keypad codes,[15] but if it were, it should have had other systems in place in addition to door alarms to prevent elopements.

CMS established a *prima facie* case that Petitioner failed to ensure that each resident receives adequate supervision and assistance devices to prevent accidents. Petitioner has not overcome that showing by a preponderance of the evidence.

3. Development of comprehensive care plans

Facilities must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment and that describes the services to be provided to the resident. A facility must ensure that the services provided

---

[14] The facility posted the keypad code in the front lobby, so all residents had access to the keypad code, except maybe the residents on the Alzheimer's Unit. Tr. 468-69, 472-74, 603-05. Any resident who entered the keypad code could exit the facility without triggering an alarm. Tr. 528, 582.

[15] In fact, Administrator Welch testified that Petitioner stopped posting keypad codes inside the facility. Tr. 549. Petitioner never asserts that it violated the LSC by doing so.

or arranged by the facility are provided by qualified persons in accordance with each resident's written plan of care. 42 C.F.R. § 483.20(k)(3)(ii).

R1's care plan indicated that R1 required assistance with Activities of Daily Living (ADLs), and listed 19 approaches, including assist/prompt to toilet. R1's care plan provided several approaches to his potential for elopement, including alarm system in place, check functioning per schedule, ambulate with resident, and assist resident to bathroom. P. Ex. 1, at 76.

Petitioner argues that what CMS refers to as R1's care plan was actually only a generic temporary care plan used for all new residents and that consequently it could not be held to the same standard as an individualized care plan envisioned by the regulations. Petitioner further argues that "many of the approaches in the temporary care plan make no sense as applied to [R1] individually," such as elopement. P. Br. at 28.

However, facility staff wrote notations on several pages of the care plan, tailoring parts of it to R1's needs. P. Ex. 1, at 64, 66, 71, 74, 75. For the facility to assert now that staff were not expected to follow temporary care plans is nonsensical. Moreover, at the hearing, Administrator Welch agreed that Petitioner's staff was obliged to effectuate the resident's care-planned interventions for elopement-related risks of harm. Tr. 574-75.

The care plan's interventions were useless if, as Petitioner asserts, it purposefully allowed R1 to walk outdoors without supervision. Petitioner never reconciled its care-planned use of door alarms to monitor R1's whereabouts with the freedom given him to possess and use keypad codes.

I find that the facility was not in substantial compliance with the requirement to develop a comprehensive care plan for each resident.

CMS established a *prima facie* case that Petitioner failed to comply with the provisions at 42 C.F.R. § 483.20(k)(3)(ii) regarding care plans. Petitioner has not overcome that showing by a preponderance of the evidence.

4. Effective administration

Facilities must be administered in an effective manner that promotes its residents' highest practicable levels of physical well-being. 42 C.F.R. § 483.75.

Petitioner did not recognize that allowing residents to possess keypad codes would render one of its systems for preventing elopements and otherwise monitoring residents ineffective.

The fact that no corrective measures had been taken as a result of R1's exit from the facility by the time of the first survey would support a finding that the facility was not administered effectively. During the first survey, Administrator Welch told surveyors she had not initiated any in-services in response to R1's exit. CMS Ex. 1, at 28.

CMS established a *prima facie* case that Petitioner failed to comply with the provisions of 42 C.F.R. § 483.75. Petitioner has not overcome that showing by a preponderance of the evidence.

B. CMS's determination that the facility's deficiencies posed immediate jeopardy to residents is not clearly erroneous.

Immediate jeopardy means a situation where a facility's noncompliance "has caused, *or is likely to cause*, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301 (emphasis added). CMS's determination as to the level of a facility's noncompliance, including immediate jeopardy, must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has held repeatedly that the "clearly erroneous" standard places a "heavy burden" on facilities to show that immediate jeopardy did not exist, and it has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1962, at 11 (2005) (citing *Florence Park Care Center*, DAB No. 1931, at 27-28 (2004) (quoting *Koester Pavilion*, DAB No. 1750)).

Here, the evidence shows that R1 exited the facility late at night, undetected by staff, and was discovered lying nearly naked in a pool of blood in the parking lot, not by facility staff but by a visitor. P. Ex. 17 (Foster Decl.). Petitioner failed to anticipate, plan for, and prevent the very foreseeable risk that residents might exit the facility undetected, which created a situation that was likely to cause serious injury or death to a resident. Petitioner's own elopement policy made clear that unsupervised activity outside the facility could lead to a resident being seriously injured.

This failure posed particularly foreseeable risks to R1 given his practice of coming and going from the facility at will, his episodes of mild confusion, and the fact that on the night of his death, approximately two hours before he was found dead, he had been given a powerful sleeping pill. Moreover, R1 had been assessed as being at a high risk for falls; the terrain outside the facility would be especially dangerous for someone like R1.

Petitioner's violation of 42 C.F.R. § 483.25(h)(2) alone would justify a finding of immediate jeopardy, but it also failed to report the incident to the State Agency or to acknowledge that it had any obligation to do so, and it disregarded R1's care plan. CMS's finding that the facility's deficiencies posed immediate jeopardy to resident safety

was not "clearly erroneous." Moreover, Petitioner has not met its burden of showing that CMS's finding of immediate jeopardy is clearly erroneous.

C. The amount of the CMP – $5000 per day from February 12 through February 27, 2007, and $100 per day from February 28 through March 20, 2007 – and the duration of the CMP are reasonable, and CMS is authorized to impose a DPNA.

Regulatory criteria provide guidance for determining whether a CMP is reasonable. The criteria include: the seriousness of a facility's noncompliance; its history of noncompliance; its financial condition; and its degree of culpability, including neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. §§ 488.438(f), 488.404 (incorporated by reference).

CMS has imposed a $5000 per day CMP for the period of immediate jeopardy, which is in the low to mid-range of immediate jeopardy penalties ($3050 to $10,000 per day). It imposed a $100 per day CMP for the remaining days of noncompliance, which is at the low end of permissible penalties for non-immediate jeopardy level deficiencies ($50 to $3000 per day). 42 C.F.R. § 488.438(a)(1). Facilities bear the burden of proving any claim that they achieved substantial compliance on a date earlier than that determined by CMS. *The Windsor Place*, DAB No. 2209 (2008) (citing *Kenton Healthcare*, DAB No. 2186 (2008)).

I find that an immediate jeopardy level penalty from February 12 through February 27, 2007, of $5000 per day is reasonable applying the regulatory factors. A resident exited the facility undetected, during the night, in the cold, wearing only a t-shirt and socks. Petitioner is highly culpable for its conscious decision to let R1 freely come and go from the facility at anytime without notifying staff and without supervision. This practice exposed R1 to grave danger. He exited the facility late at night, at a time when he was more exposed to injury, and it was more difficult for him to summon help. Petitioner's culpability is heightened by its response to R1's death: it did not change any of its policies, even though the risk of residents exiting the facility undetected (when a keypad code is used alarms do not sound) was known. The seriousness of the noncompliance, which arguably contributed to R1's injuries and possibly death, and Petitioner's culpability justify a penalty of $5000 per day.[16]

[16] CMS insinuates that the anonymous tip that sparked the complaint investigation suggests that the facility may have been trying to conceal the circumstances surrounding R1's death. I make no findings as to whether Petitioner deliberately attempted to conceal the circumstances, but if such attempts to deceive were proven, a much higher penalty would be justified.

During the revisit survey, concluded on March 7, 2007, Petitioner was found to be out of compliance with 42 C.F.R. § 483.13 because it had in-serviced staff with information that was, in part, outdated. CMS Ex. 9, at 1-5. To prove that it had in-serviced staff with correct information, it sent the material it used to train staff to the State Agency. One of the forms submitted was dated 2001. The State Agency immediately notified the facility that the form was outdated and had been replaced in 2005. On March 1, 2007, the State Agency faxed the correct form to the facility. CMS Ex. 9, at 3; Tr. 211-12; *see* CMS Ex. 10, at 11-12. During the revisit survey, the facility presented the outdated form as part of its training material.

Petitioner argues that it inadvertently submitted the outdated training form to the State Agency but that it actually used the new form in the training. With no evidence other than the Administrator's testimony at the hearing, I reject Petitioner's argument and uphold the duration of the CMP. The difference in the forms is critical to Petitioner's noncompliance – the new form emphasizes and clarifies facilities' obligation to report injuries of unknown origin. After the facility was found to remain out of substantial compliance with 42 C.F.R. § 483.13(c) on March 7, it submitted a plan of correction and requested a revisit. Petitioner alleged that it conducted an in-service with the new form on March 21, 2007, which is the date it was found to have returned to substantial compliance.[17]

CMS is authorized to deny payment for new Medicare admissions for the 24 days that ran from February 25 through March 20, 2007. CMS has the discretion to deny a facility payment for new Medicare admissions anytime the facility is not complying substantially with Medicare participation requirements. 42 C.F.R. § 488.417(a). Here, the DPNA is justified because Petitioner was not in substantial compliance with Medicare participation requirements during the 24-day period.

State agencies are required to withdraw a facility's authority to conduct a Nurse Aide Training and Competency Evaluation Program (NATCEP) for a period of two years when CMS imposes a CMP over $5000 or when CMS imposes a DPNA. 42 C.F.R. §§ 483.151(b)(2), (e)(1). Here, both situations occurred. Thus, withdrawal of Petitioner's authority to conduct a NATCEP is required.

[17] During the hearing, Administrator Welch made reference to Petitioner's installation of door lock keypads outside the facility, which occurred on February 21-22, 2007. Tr. 503, 547-49; *see also* P. Ex. 5. She also mentioned that the facility changed its keypad codes and no longer posted keypad codes in the lobby, but did not mention when this was done. Tr. 549.

V. Conclusion

I conclude that CMS correctly determined that Petitioner was not complying with federal requirements governing participation of long-term facilities in Medicare and state Medicaid programs from February 12 through March 20, 2007. Petitioner's noncompliance was at the immediate jeopardy level from February 12 through February 27, 2007, and the imposition of a $5000 per day CMP is reasonable. I also sustain the CMP of $100 per day from February 28 through March 20, 2007.

/s/
José A. Anglada
Administrative Law Judge