Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Glasgow State Nursing Facility,
(CCN: 18-5363),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-08-406

Decision No. CR2199

Date: July 30, 2010

DECISION

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to impose remedies against Petitioner, Glasgow State Nursing Facility (Facility). The remedies that I sustain include civil money penalties (CMPs) at an immediate jeopardy range of $4,050 for each day of a period that began on December 30, 2007 and ran through February 19, 2008. I also sustain CMS determination to sustain civil money penalties of $150 per day from February 20, 2008 until March 9, 2008.

I. Background

Petitioner, located in Glasgow, Kentucky, is authorized to participate in Medicare as a skilled nursing facility (SNF) and in the Medicaid program as a nursing facility (NF).

On February 12, 2008, the Kentucky Division of Health Care Facilities and Services (State Agency) completed an abbreviated at Petitioner's Facility to determine if the Facility was in compliance with Federal requirements for nursing homes participating in the Medicare and Medicaid programs. The survey found that the Facility was not in substantial compliance with participation requirements. The survey further identified the following conditions at the Facility constituted immediate jeopardy:

F 281 – 483.20(k)(3)(i) – Comprehensive Care Plans;
F 323 – 483.25(h) – Accidents and Supervision;
F 333 – 483.25(m)(2) – Medication Errors; and
F 501 – 483.75(i) – Medical Director.

In addition, substandard quality of care was cited in the areas of:

F 323 – 483.25(h) – Accidents and Supervision; and
F 333 – 483.25(m)(2) – Medication Errors.

As a result of the findings of non-compliance, CMS assessed a CMP at the immediate jeopardy range of $4,050 per day, which ran from December 30, 2007 until February 19, 2008, when immediate jeopardy was removed. The CMP was then reduced to $150 per day, and ran until March 9, 2008, when the Facility achieved substantial compliance.

Petitioner timely requested a hearing before an administrative law judge (ALJ), and the case was assigned to me for hearing and decision.

I conducted an in-person hearing in Bowling Green, Kentucky, on March 10–11, 2009. CMS offered exhibits (CMS Exs.) 1 through 30, which were admitted. Petitioner offered exhibits (P. Exs.) 1 through 13, which I admitted into evidence. CMS elicited testimony from Linda Tinsley, State Agency surveyor. Petitioner elicited testimony from: Jo Ann Watson, Registered Nurse (R.N.), the Facility's shift supervisor; Cecil Wayne Thompson, the Facility's fiscal officer; and Phillip Bale, M.D., and Jeffrey Purvis, M.D., both of physicians for the Facility.

Both parties submitted a post hearing brief (CMS Brief and P. Brief, respectively), and each party received a copy of the hearing transcript (Tr.)

In the interest of judicial economy, I do not address, and make no findings or conclusions regarding, the alleged violation of F 501, 42 C.F.R. § 483.75, from the survey completed on February 12, 2008. The violations discussed hereafter provide a sufficient basis for the enforcement remedies that CMS proposed. *See Beechwood Sanitarium*, DAB No. 1824, at 22 (2002). I do not consider the deficiencies not specifically addressed as the basis for the imposition of an enforcement remedy.

II. Issues, Applicable Law, Findings of Fact, and Conclusions of Law

A. Issues

The issues in this case are:

1. Whether Petitioner failed to comply with one or more Medicare participation requirements; and

2. Whether the remedies imposed are reasonable.

B. Applicable Law and Regulations

Petitioner is considered a long-term care facility under the Social Security Act (Act) and regulations that the Secretary of Health and Human Services (Secretary) promulgated. The statutory requirements for a long-term care facility's participation are found at sections 1819 and 1919 of the Act and at 42 C.F.R. Part 483. The Act at Sections 1819 and 1919 vest the Secretary with authority to impose CMPs and other remedies against a long-term care facility for failure to comply substantially with participation requirements. Pursuant to the Act, the Secretary has delegated to CMS the authority to impose various remedies against a long-term care facility that is not complying substantially with federal participation requirements. Facilities, which participate in Medicare, may be surveyed on behalf of CMS by State survey agencies to ascertain whether the facilities are complying with participation requirements. 42 C.F.R. §§ 488.10-.28; 42 C.F.R. §§ 488.300-.335. Under Part 488, CMS may impose a per instance, or per day, CMP against a long-term care facility when a State survey agency ascertains that the facility is not complying substantially with participation requirements. 42 C.F.R. §§ 488.406, 488.408, 488.430. The 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.

Pursuant to 42 C.F.R. Part 488, CMS may terminate a long-term care facility's provider agreement when a survey agency concludes that the facility is not complying substantially with federal participation requirements. CMS may also impose a number of alternative enforcement remedies in lieu of, or in addition to, termination. 42 C.F.R. §§ 488.406, 488.408, 488.430. In addition to termination and the alternative remedies, CMS is authorized to impose, pursuant to section 1819(h)(2)(D) of the Act and 42 C.F.R. § 488.417(b), a "mandatory" or "statutory" denial of payment for new admissions (DPNA). Section 1819(h)(2)(D) requires the Secretary to deny Medicare payments for all new admissions to a SNF, beginning 3 months after the date on which such facility is determined not to be in substantial compliance with program participation requirements. The Secretary has codified this requirement at 42 C.F.R. § 488.417(b).

The regulations specify that a CMP imposed against a facility can be either a per day CMP for each day the facility is not in substantial compliance, or a per instance CMP for each instance that a facility is not in substantial compliance. 42 C.F.R. § 488.430(a).

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, from $3,050 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 $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy; however, they 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). There is only a single range of $1,000 to $10,000 for a per instance CMP, which applies whether or not immediate jeopardy is present. 42 C.F.R. §§ 488.408(d)(1)(iv); 488.438(a)(2).

The regulations define the term "substantial compliance" to mean "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. Non-compliance that is 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." *Id.* 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 Section 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*, DAB CR65 (1990), *aff'd*, 941 F2d. 678 (8th Cir. 1991).

A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." *See* 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e), 498.3. However, CMS's choice of remedies, 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 that CMS found if a successful challenge would affect the amount of the CMP that CMS could collect or impact upon the facility's nurse aide training program. 42 C.F.R. § 498.3(b)(14), (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 Ctr.*, DAB No. 1726 at 9, 38 (2000), *aff'd*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (Board or DAB) 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). ALJ review of a CMP is governed by 42 C.F.R. § 488.438(e).

In a CMP case, CMS must make a prima facie showing that the facility has failed to comply substantially with participation requirements. To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Hillman Rehab. Ctr.*, DAB No. 1611 (1997), *aff'd Hillman Rehab. Ctr. v. U.S. Dep't of Health and Human Servs.*, No. 98-3789, 1999 WL 34813783 (D.N.J. May 13, 1999).

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

I make findings of fact and conclusions of law (Findings) to support this decision. I set forth each finding below as a separate heading and discuss each in detail.

1. Petitioner failed to comply substantially with the requirement in 42 C.F.R. § 483.20(k)(3)(i) (F 281) that it provide services, which meet professional standards of quality.

42 C.F.R. § 483.20(k)(3)(1) requires a facility to provide services, which meet professional standards of quality. The regulation intends to assure that provided services meet professional standards of quality and that appropriate qualified persons provide the services.

CMS alleges in its February 12, 2008 statement of deficiency (SOD) that facility staff failed to obtain emergency medical services for Resident 1, after he suffered a series of falls on December 30, 2007. CMS maintains that Petitioner's failure to obtain emergency services for Resident 1 placed him in immediate jeopardy. P. Ex. 5, at 16-19.

At the time of the survey, Resident 1 was a 77-year old man with multiple ailments including, cerebral vascular accident, behavior disturbance, seizure disorder, diabetes, hypothyroidism, hypertension, and chronic obstructive pulmonary disease. CMS Ex. 11, at 5-6, 11. Resident 1 had a "do not resuscitate" directive in effect in his medical chart.

The deficiency allegation (F 281) involving Resident 1 stems from events that occurred primarily during the afternoon of December 30, 2007. The parties do not disagree on the essential facts of the case. On December 30, 2007, at about 2:00 P.M., Resident 1 was alone in his room when he fell. The charge nurse heard a call for "help" and entered Resident 1's room. The nurse found him sitting upright on the floor with a small laceration on the top of his head. CMS Ex. 11, at 208-09. At approximately 4:30 P.M., Resident 1 fell to the floor a second time behind his wheelchair. *Id*. At about 5:15 P.M., the charge nurse heard a loud noise near Resident 1's room. Resident 1 was observed lying flat on his back near his room where he had fallen a third time. *Id*.

CMS argues that it was unreasonable for facility staff not to transport Resident 1 to the emergency room after he had fallen several times and exhibited significant medical symptoms indicating that he suffered an injury. CMS Br. at 12-14. Thus, CMS asserts that Petitioner's failure to obtain emergency medical services failed to meet professional standards of quality as the regulations required pursuant to 42 C.F.R. § 483.20(k)(3)(i). *Id*.

Petitioner argues that CMS did not establish a prima facie case of non-compliance, because facts failed to support the surveyor findings. Alternatively, Petitioner asserts that it presented sufficient evidence to establish that it was in compliance with applicable regulations. P. Br. at 18.

Nurses' notes reveal that Resident 1 suffered three falls on December 30, 2007.

Fall #1

2:00 P.M. – The charge nurse entered Resident 1's room after hearing a call for "help." The nurse found Resident 1 sitting upright on the floor. An examination of Resident 1 revealed a 3 centimeter laceration on the top of his head, and his vital signs indicated a blood pressure of 171/81 and body temperature of 98.2 Fahrenheit (F). Resident 1's physician, Phillip Bale, M.D., was contacted by phone, and his power of attorney was notified. Resident 1 was given Tylenol as needed. CMS Ex. 11 at 209.

Fall #2

4:30 P.M. – The charge nurse was called to the hallway near the nurse's station, where Resident 1 was found lying on the floor behind his wheelchair. An examination of Resident 1 indicated that his pupils were equal and responsive to light. Resident 1 was assisted back in his wheelchair. CMS Ex. 11 at 208-09.

Fall #3

5:15 P.M. – The charge nurse, Anthony Walker, L.P.N., was in the hallway near the central dining room when he heard a loud noise. Nurse Walker observed Resident 1 lying flat on his back on the floor near his room. Nurse Walker noted that Resident 1 was unresponsive to verbal or physical stimuli. The Resident was turned on his left side, when a small amount of green/brown liquid expelled from his mouth onto the floor. Resident 1's vital signs were blood pressure 149/61, pulse 95, and respirations of 14. CMS Ex. 11 at 208.

5:19 P.M. – 5:25 P.M. – Nursing supervisor Jo Ann Watson, R.N. was paged to Resident 1's floor. Nurse Watson also observed Resident 1 lying on his left side in the hallway with a small amount of greenish brown emesis coming from his mouth. Nurse Watson's examination revealed that Resident 1: was unresponsive; had slurred speech, as he unable to be understood; had sluggish pupils; had a laceration to back of head – with a small amount of bleeding from laceration; had a small indentation to back of head just below laceration received earlier today; and exhibited the following vital signs – blood pressure 154/68, pulse 102, respirations 28, temperature 94 F, oxygen saturation 94%. CMS Ex. 11, at 208.

5:40 P.M. – 5:45 P.M. – Nurse Watson contacted Resident 1's physician, Dr. Bale by telephone. Nurse Watson advised Dr. Bale that Resident 1 had fallen several times and that Resident 1 was unresponsive, had slurred speech, sluggish pupils, and had an indentation to the back of his head. Dr. Bale told Nurse Watson to put Resident 1 in bed, observe, and "place on clipboard" for morning rounds. Approximately five minutes later, Nurse Watson contacted Dr. Bale a second time and informed him that Resident 1's

speech had become more slurred. Dr. Bale told Nurse Watson to put Resident 1 in bed, monitor, and "place on clipboard." CMS Ex. 11, at 208, 210.

Based on the record as set forth, I find that CMS has established a prima facie case of non-compliance with 42 C.F.R. § 483.20(k)(3)(i), based on: Resident 1's multiple falls; symptoms exhibited; and Petitioner's inaction regarding necessary emergency services for Resident 1.

Petitioner contends that CMS did not set forth sufficient factual findings to support a prima facie case of non-compliance, because Surveyor Linda Tinsley's investigation of the incident was incomplete and thus unreliable. P. Br. at 9-11. Specifically, Petitioner argues that Surveyor Tinsley: did not review the incident report or Resident 1's care plan; misrepresented Resident 1's non-responsiveness to questions as a failure on the part of the Facility's nurses to investigate the cause of the falls; improperly concluded that Resident 1 needed emergency room treatment after his third fall; and improperly concluded that Facility staff was not aware of what they should do when a physician does not give an emergency transfer order. P. Br. at 10-14.

Petitioner further complains that Surveyor Tinsley failed to properly investigate the circumstances surrounding Resident 1's falls. Petitioner asserts that Surveyor Tinsley failed to ask the Facility's nursing supervisor, Jo Ann Watson, if she knew what the emergency transfer policy was. P. Br. at 10-13. Petitioner essentially attacks the quality of the survey and points out what actions Surveyor Tinsley failed to take, as well as what questions she failed to ask. *Id*. I reject Petitioner's arguments. My review of whether deficiencies existed at Petitioner's Facility is de novo. *Emerald Oaks*, DAB No. 1800 (2001). I make decisions based upon the credible evidence before me, whether CMS has made a prima facie showing that Petitioner violated applicable regulations. The issue in this case is whether the Facility was in compliance with participation requirements, not whether or not a state surveyor meticulously followed CMS instructions and guidelines. Furthermore, I have no reason to believe that the survey conducted at Petitioner's Facility was not conducted in a manner consistent with professional survey regulatory requirements. I had an opportunity to observe and hear the testimony of Surveyor Tinsley at hearing. She was clearly a highly experienced, well-educated, and practical surveyor, and I have no reason to believe she did not conduct a thorough and complete survey. Moreover, this is not a case where survey findings were solely dependent upon Surveyor Tinsley's observations and conclusions. Indeed, the record has substantial documentary evidence, as Petitioner's own nurses notes and medical records are sufficient to establish a prima facie case of non-compliance with 42 C.F.R. § 483.20(k)(3)(1).

Petitioner's arguments are unpersuasive. I find that Petitioner failed to establish by a preponderance of the evidence that it complied with 42 C.F.R. § 483.20(k)(3)(1).

The injuries that Resident 1 sustained and the severity of the symptoms he exhibited indicate that Resident 1 was in need of emergency medical services, and I find that it was

unreasonable for Petitioner not to obtain those services. Petitioner argues that the Facility's staff correctly implemented the Facility's policy regarding obtaining emergency treatment for Resident 1. Petitioner further maintains that the Facility properly contacted treating physician Dr. Bale, who advised them to "observe [Resident 1] and monitor him, and place him on the clipboard[1] for the next day." Tr. at 144-45. Petitioner may well have implemented its policy for obtaining emergency medical services properly. However, despite Dr. Bale's direction to place Resident 1 in bed and monitor him, the record shows that Facility staff had well-founded misgivings about Dr. Bale's instructions. Facility Nursing Supervisor Watson contacted Dr. Bale after Resident 1 fell for the third time and advised him of Resident 1's condition. Dr. Bale told Nurse Watson to put Resident 1 in bed, observe, and "place on clipboard" for morning rounds. Approximately five minutes later, Nurse Watson contacted Dr. Bale a second time and informed him that Resident 1's speech had become more slurred. Once again, Dr. Bale told Nurse Watson to put Resident 1 in bed, monitor, and "place on clipboard." Tr. at 146. Clearly, Nurse Watson, a Nursing Supervisor with over 10 years of nursing home experience, was concerned about Resident 1's declining physical condition. Nurse Watson's second call to Dr. Bale, so close in time after she made the first call, suggests to me that she had serious doubts about Dr. Bale's instructions given the poor symptoms that Resident 1 exhibited.

Dr. Bale testified at hearing and provided two reasons for his instructions not to transport Resident 1 to the emergency room. First, he testified that, because of his familiarity with Resident 1, the Facility would be able to provide better continuity of care than an emergency room physician. Second, he indicated that he believed that a hospital could be a "dangerous place" because of a patient's potential exposure to different types of bacteria and microbials." Dr. Bale appears to be a conscientious doctor who cares about his patients. However, I find that, in light of the fact that Resident 1 had three falls, which resulted in symptoms of unresponsiveness, slurred speech, sluggish pupils, vomiting and an indentation to the back of his head, the potential benefit from the care and attention from a hospital setting far outweighed any concerns Dr. Bale had relative to continuity of care and the exposure to microbials.

Petitioner's Emergency Transfer policy states that if a resident's condition is determined to be potentially life threatening, the nursing supervisor makes the decision to transfer. CMS Ex. 29 at 50-51. In light of Resident 1's poor physical condition and symptoms, Facility staff should have known that Petitioner needed emergency care and should have been transported to the hospital. Already in frail condition, Resident 1 fell three times within a 3 and a half hour period. Each fall he suffered resulted in progressively worse injuries. Resident 1 vomited an amount of greenish brown emesis from his mouth, and his injuries were so significant that he: was unresponsive to outside stimuli; had sluggish pupils; and had slurred speech – such that he was unable to be understood. The third fall was so severe that it resulted in a laceration and bleeding to the back of Resident 1's

[1] The facility utilizes the "clipboard system," whereby the nurses write down patients' names that need to be seen the next day, and the physician visits them during daily rounds.

head. In fact, on December 31, 2007, he was diagnosed with subdural subarachnoid bleeding and, on January 27, 2008, died as a result of intracranial bleeding. P. Ex. 5 at 20. It was apparent that Resident 1's injuries were life threatening and that Facility staffed erred in its decision not to seek emergency care services. Facility staff had an opportunity to observe and evaluate Resident 1's physical condition, and, thus, they were in a better position to determine Resident 1's emergency care transfer needs than was Dr. Bale. Petitioner, therefore, should have obtained emergency care services in accordance with the Facility's Emergency Transfer policy. Based on my review of all of the evidence and testimony before me, I find that Petitioner failed to comply with 42 C.F.R. § 483.20(k)(3)(i).

2. Petitioner failed to comply substantially with the requirement in 42 C.F.R. § 483.25(h) (F 323) that it provide adequate supervision to prevent falls.

42 C.F.R. § 483.25(h) requires a facility to ensure that the resident environment remains as free from accidents as possible and that each resident receive adequate supervision and assistance devices to prevent accidents. CMS alleges that facility staff did not adequately investigate or evaluate the cause of Resident 1's falls on December 30, 2007, to prevent future falls, thereby placing Resident 1 in immediate jeopardy.

Petitioner argues that Resident 1's falls were not accidents under 42 C.F.R. § 483.25(h), because they were a direct consequence of Dilantin treatment. Dilantin is used to prevent the development of seizures. Petitioner points out that, on November 3, 2007, Resident 1's Dilantin doses were increased from 200 milligrams a day to 300 milligrams a day. Two weeks later, his Dilantin dose was increased from 500 milligrams a day to 600 milligrams a day. According to Petitioner, on December 30, 2007, Dr. Bale reviewed Resident 1's chart and learned that his Dilantin levels were above the normal range. Dr. Bale surmised that Resident 1's elevated Dilantin levels could have caused his difficulty walking and talking. Tr. at 231-32. Additionally, Petitioner argues that, even if I find that the falls were "accidents," the Facility provided adequate supervision.

Petitioner's arguments are unavailing. First, Petitioner's argument is made with the benefit of hind site. On December 30, 2007, after Resident 1 fell for the first, second, and third time, Petitioner staff clearly was not aware of what caused Resident 1 to fall. Nothing in the nurse's notes from December 30 indicated that Facility staff was aware of the cause of the falls or that Resident 1 fell as a result of Dilantin medication. Thus, at the time of the falls, the incidents were indeed accidents, in that they were an "unexpected, or unintentional incident, which may result in injury or illness to a resident." Second, Petitioner's response to the accidents was inadequate. The regulations and controlling case law are clear that Petitioner's staff is responsible for: (1) determining what may have caused or contributed to the fall; (2) implementing interventions to reduce hazards and risks; and (3) revising the resident's plan of care and/or facility practices as needed to reduce the likelihood of another fall. 42 C.F.R. § 483.25(h)(2); *Briarwood Nursing Ctr.*, DAB No. 2115 (2007); *Guardian Health Care*

Ctr., DAB No. 1943 (2004). A facility must anticipate what accidents might befall a resident and take steps to prevent them. Petitioner failed to take action to prevent Resident 1 from falling. For example, Petitioner could have stepped up its monitoring of Resident 1 by using an electronic monitoring device or providing more one-on-one individual attention. Clearly, after Resident 1 experienced multiple falls, Facility staff was on notice that additional measures were needed to prevent accidents. Petitioner may well have prepared incident reports and assessed Resident 1 after the falls, but this simply was not enough. Petitioner completely failed to implement interventions to reduce the risk of falls and failed to monitor for effectiveness. Therefore, I find that Petitioner failed to comply substantially with 42 C.F.R. § 483.25(h).

3. Petitioner failed to comply substantially with the requirement in 42 C.F.R. § 483.25(m) (Residents are free of any significant medication errors) (F 333).

The February 12, 2008 SOD alleges that the Facility failed to ensure the prescribed dosage and proper placement of Duragesic patch medication and failed to monitor Resident 1 for adverse effects of the narcotic**.** Specifically, Resident 1 was prescribed a Duragesic patch, which contained Fentanyl, a narcotic, which is time released continuously to provide pain relief. Tr. at 33-35. Generally, the patch is worn for three days, typically on a resident's back or shoulder, and a replacement is moved to different places of a resident's body when the old Duragesic patch is removed and discarded. *Id*. On January 25, 2008, approximately two days before Resident 1 died, Resident 1 was observed with four Duragesic patches on his body at the same time. Physician's orders prescribed one 75 microgram Duragesic patch every three days. CMS Ex. 11 at 273. Petitioner's failure to properly administer the prescribed medication in the prescribed manner exposed Resident 1 to an overdose of the narcotic administered through the patches. The evidence CMS presented establishes that Petitioner failed to keep Resident 1 free from significant medication errors and, therefore, established a prima facie case of non-compliance with 42 C.F.R. § 483.25(m). Petitioner did not contest the existence of this deficiency; therefore, I find that Petitioner failed to comply with 42 C.F.R. § 483.25(m).

Remaining Tags

Because I have sustained CMS's deficiency findings F 281, 42 C.F.R. § 483.25(k)(3)(1), F 323, 42 C.F.R. § 483.25(h) (both immediate jeopardy), and F 333, 42 C.F.R. § 483.25(m) (non-immediate jeopardy), I will not discuss the remaining deficiency tags. It is not necessary that I make a finding concerning these additional alleged deficiencies, inasmuch as their presence or absence will add nothing to my decision in this case. The applicable regulations authorize the imposition of a CMP if a provider is found to be out of substantial compliance with even a single program requirement. 42 C.F.R. §§ 488.406, 488.408, 488.430. In addition, I have discretion to exercise judicial economy and not discuss every alleged deficiency. *Beechwood Sanitarium*, DAB No. 1824 at 22; *Western Care Mgmt.*, DAB CR1020 (2003).

4. The amount of the CMP imposed by CMS is reasonable.

In determining the amount of the CMP, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of non-compliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404; and (4) the facility's degree of culpability.

The regulations specify that a CMP that is imposed against a facility from $3,050 per day to $10,000 per day is reserved for deficiencies that constitute immediate jeopardy, to a facility's residents.

CMS seeks to impose a CMP of $4,050 a day from December 30, 2008 through February 19, 2008, at the immediate jeopardy level, and a CMP of $150 per day from February 20, 2008 through March 9, 2008, for a total civil money penalty of $213,450.

Petitioner denied the existence of deficiencies at F 281 and F 323 at the immediate jeopardy level but did not argue that substantial compliance was achieved at any earlier date than CMS alleged. Petitioner did not contest the existence of a deficiency at F 333 at the non-immediate jeopardy level. I make no finding with respect to the alleged deficiency at F 501. However, Petitioner argues with respect to the deficiencies at F 281 and F 323 that it was in compliance with applicable regulations and that the amount of the CMP will have a "disastrous" effect upon the facility. P. Br. at 17-18.

I disagree. The deficiency determinations at F 281, F 323, and F 333 support a $4,050 per day immediate jeopardy CMP imposition, and a $150 per day non-immediate jeopardy CMP. The record shows that Petitioner failed to obtain emergency medical services for Resident 1 after he sustained three serious falls with injuries and failed to provide adequate supervision and assistance devices to prevent future falls. Resident 1 suffered serious injuries, including subdural subarachnoid bleeding; thus Resident 1 suffered actual harm as a result of the deficiencies. The $4,050 per day CMP is reasonable, since it is in the lower range of penalties for deficiencies that constitute immediate jeopardy ($3,050 minimum); additionally, the $150 per day CMP is reasonable, since it is in the lower range of deficiencies that do not constitute immediate jeopardy ($50 minimum), but either cause actual harm to residents or cause no actual harm, but have the potential for causing more than minimum harm. No compelling evidence was presented that persuaded me that Petitioner was not culpable, and no facts indicated that Petitioner's culpability was in any way diminished, which would warrant the reduction of the CMP amount in this case.

Petitioner offered the testimony of its fiscal officer Wayne Thompson, who testified that the imposition of a CMP totaling $213,450 will have "disastrous" effect on the Facility. Tr. at 178-79. No doubt that a CMP in this amount will have an effect on the Facility's financial condition; however, despite its claim that the Facility was operating at a

$40,000 deficit, Petitioner did not present any financial statements to support its claim. Nor did Petitioner suggest that, as a state run and financed facility, it would be put out of business as a result of the CMP. Neither party has contended that Petitioner's compliance history should impact the penalty amount. No evidence demonstrates that Petitioner has a history of noncompliance other than during this survey cycle. Based on my review of the evidence presented relative to the regulatory factors I must consider, I find that the CMP that CMS imposed in this case is reasonable.

III. Conclusion

Based on my review of all of the evidence and testimony in this case, I conclude that Petitioner was not in substantial compliance with participation requirement. Thus, I find that a basis exists for imposing a CMP of $4,050 for each day of a period that began on December 30, 2007 through February 19, 2008. I also find that a basis to impose CMPs of $150 per day from February 20, 2008 until March 9, 2008. The evidence establishes that the CMPs imposed in this case are reasonable.

/s/
Alfonso J. Montano
Administrative Law Judge