Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Briarwood Nursing Center,	)	
	)	Date: January 8, 2007
Petitioner,	)	
	)	Docket No. C-03-112
- v. -	)	Decision No. CR 1551
	)	
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

I uphold the determination of the Centers for Medicare & Medicaid Services (CMS) to impose a civil money penalty (CMP) against Briarwood Nursing Center (Petitioner or Facility), for failure to comply substantially with federal requirements for Medicare participation. I conclude that from September 11, 2002 through October 1, 2002, Petitioner was out of compliance with program requirements, and that its deficiencies posed immediate jeopardy. I find that a CMP of $3050 per day is a reasonable remedy for each day of Petitioner's continued noncompliance with participation requirements from September 11, 2002 through October 1, 2002.

I. Procedural History

On September 11, 2002, Petitioner notified the Georgia Department of Human Resources (state agency) about Resident 1's (R1) elopement. CMS Exhibit (Ex.) 15, at 1. State agency surveyors completed a survey of the facility on September 26, 2002 (September survey). CMS Ex. 1. On September 30, 2002, Petitioner was notified by CMS that the September survey had found that the Facility was not in compliance with federal regulations, and that the conditions in the Facility constituted immediate jeopardy to resident health and safety. CMS Ex. 2, at 1. Petitioner was notified that CMS was imposing a CMP of $3050 per day until substantial compliance was achieved. *Id.* at 2.

On October 9, 2002, Petitioner was informed that an October 2, 2002 revisit (October survey) had determined that the facility had achieved substantial compliance as of the date of the October survey, and that the total amount of the CMP was $64,050. CMS Ex. 3, at 1.

By letter dated November 12, 2002, Petitioner requested a hearing challenging the findings of the state agency and the enforcement remedy imposed by CMS. On December 6, 2002, the case was assigned to me for hearing and decision. A hearing was held before me on December 16-17, 2004, in Atlanta, Georgia. At the hearing Dr. Richard E. Powers and surveyor Cora Cranford testified for CMS; Carolyn Smith-Warren Donna Huffstutler, Donna Howson, and Tracy Sargent testified on behalf of Petitioner. I admitted CMS Exs. 1 through 38 and Petitioner exhibits (P. Exs.) 1 through 39 into the record. Transcript (Tr.) 10-16. The parties filed posthearing briefs (CMS Br. and P. Br.) and posthearing reply briefs (CMS and P. R. Br.).

Based on the applicable law and regulations, the documentary evidence, and the testimony taken at hearing, the preponderance of the evidence shows that Petitioner was not in substantial compliance with federal participation requirements governing nursing homes and, therefore, the enforcement remedy may be imposed.

II. Issues

The issues to be decided in this case are:

1. Whether Petitioner was out of substantial compliance with participation requirements; and

2. Whether the CMP imposed by CMS against Petitioner is reasonable.

III. Authority

Petitioner is considered a skilled nursing facility (SNF) under the Social Security Act (Act) and regulations promulgated by the Secretary of Health and Human Services (Secretary). The statutory and regulatory requirements for participation by a SNF are found at sections 1819 and 1919 of the Act and at 42 C.F.R. Part 483. Sections 1819 and 1919 of the Act provide the Secretary with authority to impose penalties against a SNF for failure to comply substantially with federal participation requirements.

To participate in the Medicare program, a SNF 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.

Part 488 of 42 C.F.R. provides that 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; 42 C.F.R. §§ 488.300 - 488.335. If a survey reveals that a facility is not in substantial compliance with federal participation requirements, the survey agency must determine, following an onsite revisit or other means of verification, that the deficiency no longer exists for the facility to achieve substantial compliance. 42 C.F.R. § 488.440(h).

If CMS finds 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, which include imposing CMPs. *See* Act, section 1819(h). CMS is authorized to assess CMPs when a facility is not in compliance with one or more participation requirements. 42 C.F.R. § 488.430(a). CMS may impose a CMP for the number of days that a facility is not in substantial compliance with one or more program requirements, or for each instance that a facility is not in substantial compliance. 42 C.F.R. §§ 488.430(a); 488.440. The CMPs range from $50 to $3,000 per day 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. Furthermore, the CMPs range from $3050 to $10,000 per day for deficiencies which constitute immediate jeopardy. 42 C.F.R. § 488.438(a)(1)(i) and (ii).

CMS's determination regarding the level of noncompliance must be upheld unless clearly erroneous. 42 C.F.R. § 498.60(c)(2). This includes instances where CMS has determined that the level of noncompliance is at the immediate jeopardy level. *Woodstock Care Center*, DAB No. 1726, at 9, 38 (2000), *aff'd Woodstock Care Center v. U.S. Dept. of Health and Human Services*, 363 F.3d 583 (6th Cir. 2003).

The Act and regulations make a hearing before an administrative law judge (ALJ) available to a SNF against which CMS has determined to impose a CMP. Act, sections 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).

When a penalty is imposed and appealed, CMS bears the initial burden of producing evidence sufficient to establish a prima facie case that the facility failed to comply substantially with federal participation requirements. Once CMS has established a prima facie case of noncompliance, the facility has the burden of proving, by a preponderance of the evidence, that it complied substantially with participation requirements. *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004); *Emerald Oaks*, DAB No. 1800 (2001); *Cross Creek Health Care Center*, DAB No. 1665 (1998); *Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd, Hillman Rehabilitation Center v. U.S. Dept. of Health & Human Services*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999).

IV. Findings of Fact, Conclusions of Law, and Discussion

I make findings of fact (Finding) and conclusions of law to support my decision in this case. I set forth each Finding below, in italics, as a separate heading. I discuss each Finding in detail.

I do not discuss herein every F-tag that was cited by the surveyors at the survey in issue. The Departmental Appeals Board (DAB) has previously approved an ALJ's discretion to exercise judicial economy and not discuss every alleged deficiency. *Beechwood Sanitarium*, DAB No. 1824 (2002), at 22; *Beechwood Sanitarium*, DAB No. 1906 (2004). Substantial noncompliance with only one participation requirement can support the imposition of a penalty. *Beechwood Sanitarium*, DAB No. 1824. In general, the F-tags I have focused on and discussed in this decision are those which sustain the immediate jeopardy level finding for the period September 11, 2002 through October 1, 2002.

A. Petitioner failed to comply substantially with 42 C.F.R. § 483.25(h)(2) (F-324).

Tag F-324 of the September 2002 Statement of Deficiencies (Statement of Deficiencies or SOD) alleges that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h)(2). CMS Ex. 1, at 4; P. Ex. 1, at 4. This regulation requires, in relevant part, that a facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.

The record shows the following:

- Before being admitted to the Facility, R1 had been living with her nephew until his death in February 2001. CMS Ex. 11, at 19; P. Ex. 7, at 1. Before R1's nephew died, R1's family members noted that R1 had periods of dementia and confusion. *Id.* After R1's nephew died, R1's dementia seemed to worsen and she started to have a wandering problem. *Id.* Sometime during August 2001, R1 left her home and was missing for more than 24 hours. *Id.* R1 was found in an abandoned apartment building several blocks from her home. CMS Ex. 14, at 2. R1 was then taken to Lakeland Regional Medical Center (Lakeland) and admitted to the psychiatric floor. P. Ex. 6, at 15. After R1's discharge from Lakeland, she was admitted to the Facility. CMS Ex. 11, at 1.

- Once admitted to the Facility, R1 continued to exhibit wandering behavior. During the week ending May 13, 2002, nursing notes state that R1 attempted to elope from the Facility and also she "question[ed] why is she in this facility in the first place." P. Ex. 27, at 34. During the week ending July 21, 2002, nursing notes state that R1 again attempted to exit the Facility by walking out the front door. *Id.* at 31. In a Resident Assessment Protocol dated August 26, 2002, the Facility noted that R1 "will wander due to her memory loss." P. Ex. 17, at 2.

- On September 11, 2002 at 8:00 a.m., a Facility staff member went to R1's room; she could not find R1. An immediate census was done to make sure that all other residents were accounted for and all exit doors were checked and found secure. An immediate search for R1 commenced. P. Ex. 28, at 1. On September 18, 2002, R1's body was found behind a shed. CMS Ex. 34, at 2.

With respect to whether the Facility ensured that R1 received adequate supervision and assistance devices to prevent accidents, Petitioner argues that 42 C.F.R. § 483.25(h)(2) does not "require every nursing facility to protect every resident against every conceivable hazard." P. Br. at 27. Petitioner also contends that the Facility identified the risks associated with R1 and took the appropriate steps to protect against those identified risks. Further, Petitioner argues that R1's elopement was through an unusual means and R1's previous attempts at elopement gave Petitioner no warning that she would try to elope through a window; thus, R1's elopement through a window was unforeseeable. As for the failure by the Facility to monitor R1 every two hours according to R1's care plan, Petitioner acknowledges that "two hour" checks are desirable, but contends that these checks are not mandated by the regulations or professional standards and even if strictly adhered to would not have necessarily prevented elopement nor facilitated immediate searches. P. Br. at 38-40.

The weight of the evidence in this case is that Petitioner failed to provide adequate supervision to prevent the "accident" of R1's elopement. Although it cannot be shown with 100 percent certainty that R1 eloped through her bedroom window from the Facility on the night of September 10, 2002, or during the early morning of September 11, 2002, it is far more likely than not that R1's bedroom window was used by her to leave the Facility during that period. But even if R1 did not use her bedroom window to leave the Facility on or about September 10-11, it is clear that the Facility could have done much more to ensure that R1, who had a history of elopement, would not use her bedroom window for possible escape.

R1 resided in a room with unalarmed and unsecured windows. This situation alone would seem to be inviting to someone with a proclivity for trying to elope from the facility where she resides. It is puzzling that the Facility did not address an obvious escape route for a resident with such a hazardous tendency. There are several ways that the Facility could have implemented sufficient interventions to curb R1's wandering and exit-seeking behavior. Two courses of action that the Facility could have taken to address the unalarmed and unsecured windows in R1's bedroom are: 1) the Facility could have installed windows that could not open more than eight inches; or 2) the Facility could have installed alarms on their windows.

The Facility could have followed the example of other nursing homes and installed windows in R1's bedroom that open no more than six to eight inches, thus making it more difficult for a resident to escape through a window. This could have easily been accomplished by installing some type of device above the window to effectively stop or limit the opening of the window. The use of mechanical means to limit how far a window could open in a resident's room is not a novel idea, as exemplified by the extended discussions of such mechanisms in *Sonogee Rehabilitation and Living Center*, DAB CR754 (2001); *Estes Nursing Facility Civic Center*, DAB CR1240 (2004); *Estes Nursing Facility Civic Center*, DAB No. 2000 (2005); and *Estes Nursing Facility Civic Center*, DAB CR1370 (2005). Nor is the use of such devices unknown in the nursing home industry: one of the ways that some nursing homes protect the safety of residents is to "secure all windows in resident rooms and common areas so that they open no more than 6 to 8 inches from sill." CMS Ex. 32. Any resident would have difficulty getting through a window that could only open eight inches. For a wanderer, limiting the means of escape is essential, and this option would have been both easy and quick to implement.

Petitioner alludes to the fact that in Georgia, it is unlawful for a nursing home to make or alter a resident's windows so that they cannot open. *See* Tr. 420; P. Br. at 15. While the difference is substantial between limiting how far a window can open and making it so that a window cannot open at all, the Facility could have also taken steps to either place

an alarm on R1's bedroom window or install a window with an alarm built in. It is very common and often necessary for a facility to place some type of alarm on any door that leads to entry or exit of the building. Following the same logic, it would seem that windows are sometimes used by residents who want to leave a particular facility. In fact, Ms. Donna Howson, the Facility's Director of Nursing, testified that, although unusual, she has heard of instances where residents have gone out through windows. Tr. 519. It is reasonable to assume that if a resident who wants to leave a facility realizes that it will be very difficult to leave through the most obvious of exits, a door, she will most likely try to find another way to leave, which in the case of R1, was probably through a window.

The threat of elopement through an unsecured window was foreseeable. The DAB has held that 42 C.F.R. § 483.25(h)(2) requires facilities to do everything within their power to prevent residents from sustaining foreseeable accidents. *See Woodstock Care Center*, DAB No. 1726 (2000); *Koester Pavilion*, DAB No. 1750 (2000). The DAB has stated that "a facility is not required to do the impossible or be a guarantor against unforeseeable occurrences, but is required to do everything in its power to prevent accidents." *Koester Pavilion*, DAB No. 1750, at 26. To determine what is foreseeable, one obvious thing that must be determined is whether anything similar to the actual accident has occurred in the past. R1 was known to wander before and during the time she was at the Facility, especially at night. R1's history already included an elopement where she was missing for more than 24 hours. Dr. Powers also provided convincing testimony that the Facility should have known that there was a high probability that R1 would exhibit this behavior again. Petitioner argues that even though R1 had made previous elopement attempts, R1 never had tried to elope through a window and therefore, this means of exit was unforeseeable. I disagree; although the primary means of exit from any building is usually a door, a secondary means of exit, especially if exit through a door is unavailable, would rather obviously be a window. For a resident who is trying to elope, a window is the next most likely means of exit, and thus foreseeable. As the DAB has recently stated,

> The requirements of this regulation [42 C.F.R. § 483.25(h)(2)] have been explained in numerous Board decisions. *Estes Nursing Facility Civic Center*, DAB No. 2000 (2005); *Northeastern Ohio Alzheimer's Research Center*, DAB No. 1935 (2004); *Woodstock Care Center*, DAB No. 1726, at 28 (2000), *aff'd, Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). Although section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, it does require the facility to take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate

> foreseeable risks of harm from accidents. *Woodstock Care Center v. Thompson*, 363 F.3d at 590 (a SNF must take "all reasonable precautions against residents' accidents"). A facility is permitted the flexibility to choose the methods of supervision it uses to prevent accidents, but the chosen methods must be adequate under the circumstances. *Id.* Whether supervision is "adequate" depends, of course, on the resident's ability to protect himself or herself from harm. *Id.*

Golden Age Skilled Nursing & Rehabilitation Center, DAB No. 2026, at 10-11 (2006).

It is clear that Petitioner did not do everything in its power to prevent accidents as is required by 42 C.F.R. § 483.25(h)(2) because it did not take the logical next step and protect against a foreseeable risk. This noncompliance is likely to cause serious harm, injury, or death to a resident.

The Facility also failed to provide adequate supervision to prevent R1's elopement by not following its own policy by monitoring every two hours those residents who are elopement risks. *See* P. Ex. 33, at 1-2; CMS Ex. 21, at 1-2. According to the Facility's policy and procedure on elopement, those residents who are designated as elopement risks are to be visually checked "in accordance with the resident's needs, but do not exceed every two hours." *Id.* at 2. R1 was determined to have the "potential for wandering/elopement" according to her Plan of Care dated August 26, 2002. CMS Ex. 11, at 12. CMS alleges that on the night of September 10, 2002, Certified Nursing Assistant (CNA) Patricia Redding checked R1's room at 11:30 p.m., did not observe R1 in her room, and observed that R1's bed was made. CMS Ex. 1, at 6. Another CNA at the facility, Carolyn Smith-Warren, testified that although she was not specifically assigned to R1, she knew R1 and observed her going to her room at about 11:00 p.m. the night of September 10, 2002. Tr. at 245. According to the Facility records, the charge nurse, Brenda Collins, claimed to have seen R1 at 2:00 a.m. the morning of September 11.[1] P. Ex. 29, at 2; CMS Ex. 1, at 6. Ms. Smith-Warren claimed to have seen R1 again at 4:30 a.m. Tr. at 245. None of the previous observations of R1 on the night of September 10 or early morning of September 11 were documented. According to an investigation report dated September 11, 2002, staff at the Facility went to R1's room to get her for breakfast but she was missing. CMS Ex. 15, at 2.

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[1] The charge nurse later stated that she did not actually see R1 in bed. CMS Ex. 1, at 6.

Even if R1 was seen at all the times stated above, as Petitioner contends, there is still a significant amount of time that passed between each sighting of R1. The Facility's policy is that each resident who is an elopement risk must be checked at least every two hours. P. Ex. 33, at 1-2; CMS Ex. 21, at 1-2. Using the times that staff claimed to have observed R1 – 11:00 p.m., 2:00 a.m., 4:30 a.m. – and 8:00 a.m. when R1 was reported missing, there are gaps of three hours, two and one-half hours, and three and one-half hours, respectively. Also, the charge nurse falsified the midnight census report and counted R1 as present at 2:00 a.m. even though she had not actually seen R1. CMS Ex. 19, at 2. The Facility's policy to check those who are elopement risks every two hours is adequate if followed; however, the Facility staff's inability to follow the policy shows that the Facility failed to ensure that each resident received adequate supervision.

B. Petitioner failed to comply substantially with 42 C.F.R. § 483.13(c)(1)(i) (F-224).

Tag F-224 of the September 2002 SOD alleges that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.13(c)(1)(i). CMS Ex. 1, at 1; P. Ex. 1, at 1. This regulation requires, in relevant part, that a facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Neglect is defined at 42 C.F.R. § 488.301 as "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."

Petitioner argues that "[Petitioner's] abuse and neglect prevention, investigation and reporting policy included all of the elements described by CMS in its 'Interpretive Guidelines' set forth in its 'State Operations Manual,' . . . and was implemented appropriately." P. Br. at 44. Petitioner also contends that the interpretation and application of 42 C.F.R. § 483.13(c) is confusing and that the reasoning by the DAB is circular in regards to this regulation.

To make the relevant regulation, 42 C.F.R. § 483.13(c)(1)(i), as clear as possible in its application to the case at hand, a step-by-step approach follows. Elopement has an implicit risk of physical harm to a resident. R1 was known to be at risk for elopement. As previously mentioned, R1 was known to wander prior to her arrival at the Facility and once she arrived at the Facility that wandering continued. Therefore, R1 needed monitoring and supervision to prevent elopement from the Facility. R1 also needed services to address her worsening psychiatric condition, which was manifested in the wandering behavior. If R1 was not receiving the appropriate monitoring, supervision,

and services, she was being neglected according to 42 C.F.R. § 488.301 because of the implicit risk of physical harm. The Facility failed to provide services necessary to avoid physical harm to R1 because they did not implement the necessary steps to monitor and supervise R1.

The Facility failed to monitor R1 every two hours, as outlined in its own policy and care plan for R1. P. Ex. 20, at 5; P. Ex. 33, at 2. According to the Witness Interview Notes, at 11:30 p.m. on September 10, 2002, a CNA stated that R1 was not in bed and that R1's bed was made. P. Ex. 29, at 1. Even though there were reported sightings of R1, there was no documentation in the medical record of monitoring until 8:00 a.m. on September 11, 2002. P. Ex. 27, at 40. The CNA and charge nurse claim that they checked on R1 at 2:00 a.m. and 4:30 a.m. on September 11, 2002; however, that would have still been three and one-half hours that R1 went without being monitored. P. Ex. 29, at 1-2.

The Facility also failed to appropriately address R1's worsening psychiatric condition. This also shows that the Facility failed to provide services adequate to avoid physical harm to R1. The Facility had ample evidence that R1's psychiatric condition was a concern. According to the February 1, 2002 Nurses Notes, R1 was experiencing and giving clear signs of increased confusion. P. Ex. 27, at 24. Later, according to a May 13, 2002 Weekly Summary Nurses Notes, R1 attempted an escape from the Facility. P. Ex. 27, at 34. The facility noted R1's delusions which she manifested by talking to deceased family members, and noted that she then attempted elopement again. P. Ex. 27, at 36 and 38. I find Dr. Powers' testimony especially persuasive concerning the reasons behind the elopement attempts. Dr. Powers testified as follows:

> Q. In your review of the documents did you form an opinion about whether or not the facility failed to assess the causes of Resident One's wandering?
>
> A. Yes. I can find – it's clear to me that this patient had been having difficulties, was discharged from a psychiatric hospital into the nursing home, had been admitted to the psychiatric hospital, as best as I could determine, because the patient had eloped prior to that, had been gone for a day. It's clear to me based on the medications that the patient was discharged from the hospital on a dn into the nursing home that this patient had significant psychiatric problems, otherwise they wouldn't have prescribed the medications. And I don't believe based on the evidence that I have seen, that the facility made sufficient effort to manage those psychiatric problems which, in my opinion, probably produced the elopement behavior.

Q. Should you manage the causes of wandering or just manage the behavior?

A. Well, you know, the first thing that you have to do is you have to figure out why the patient is wandering and then try to minimize, mitigate, that as much as possible. Sometimes there are some patients for whom you can't figure out why they are wandering and in that instance, then, you just have to manage the specific behavior. But the assessment, the diagnosis, always starts first, then you move onto the behavior management part of it.

Tr. 64.

The Facility did not make the effort to ascertain the reasons for attempted elopement and seems instead to have focused on making elopement attempts unsuccessful by stopping the attempts when they occurred. The various reasons for R1's attempted elopements, including R1's failing to realize why she was in the nursing home, could have been key evidence in enabling the Facility to determine why R1 was such a persistent elopement risk; understanding those reasons and addressing them could have assisted the Facility in taking measures to address the root causes for R1's attempts to elope. The Facility's failure to follow its own policy made it likely that this Resident and other residents would suffer serious harm, injury, or death.

C. Petitioner failed to comply substantially with 42 C.F.R. § 483.20(k)(3)(i) (F-281).

Tag F-281 of the September 2002 SOD alleges that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.20(k)(3)(i). CMS Ex. 1, at 1; P. Ex. 1, at 1. This regulation requires, in relevant part, that the services provided or arranged by a facility must meet professional standards of quality.

The Facility failed to provide professional standards of quality because it did not adequately supervise R1. These lapses in supervision made R1's elopement and death far more likely. As I have previously illustrated through R1's past attempts at elopement and R1's continuing psychiatric problems, the Facility should have known that R1 was a serious and persistent elopement risk.

Part of the supervision of R1 should have been that, any time R1 was not visually observed, the Facility staff would proceed as if R1 had attempted to elope. One of the primary purposes of a "visual check" protocol is that a facility can have visual proof that a staff member actually saw a resident and that the resident is indeed present and accounted for. Any time a resident is not visible, the whereabouts of that particular

resident remains in doubt. For a resident such as R1, who has made repeated attempts to elope, a policy of proceeding as if R1 had attempted to elope if not visually observed should have been implemented.

Also, the CNA who noticed that R1 was not in her bed on the night of September 10, 2002, but did not alert anyone or look for R1 herself, violated 42 C.F.R. § 483.20(k)(3)(i). CNA Patricia Redding stated that since the bed was made and there was a teddy bear on the bed, she thought that R1 was out with family. CNA Redding also stated that she did not look for the Resident and did not inform the charge nurse. CMS Ex. 1, at 6. CNA Redding did not provide adequate supervision because she failed to inform other staff that a resident with a history of elopement attempts and wandering behavior was not in her bed. Even if CNA Redding had assumed that R1 was out with her niece that night, she should have checked the log book to see if R1 had been signed out by her family. Tr. 286. The log book is provided to keep a record of residents who are out on leave. *Id.* If CNA Redding had informed someone that R1 was not seen in her bed, a search for R1 could have been started by as much as eight hours sooner than it eventually was. CNA Redding was fired shortly after the incident and the reason given for her termination was "did not report missing patient to nurse employee in probationary period." CMS Ex. 19, at 1.

The charge nurse did not meet professional standards of quality because she falsified the census report for the night of elopement. CMS Ex. 1, at 6. On or about 12:00 a.m. of September 11, 2002, the charge nurse, Brenda Collins, completed the midnight census report without actually having seen R1. *Id.* She told the Director of Nursing that her view of R1 was obscured by a privacy curtain and Ms. Collins never looked behind the privacy curtain to make sure that R1 was accounted for, but instead merely assumed that R1 was in bed. *Id.* If Ms. Collins had correctly completed the census report, the search for R1 could have started much sooner. Ms. Collins was fired shortly after the incident and the reason given for her termination was "Falsification of Facility Document." CMS Ex. 19, at 2.

The Facility did not meet professional standards of quality when it failed to manage R1's psychiatric problems properly. The Facility's staff failed to keep R1's physician abreast of the extent of her psychiatric problems or her repeated elopement attempts. During R1's stay at the facility, she repeatedly had psychotic episodes, but her physician was not adequately informed of R1's bouts with delirium and hallucinations. On November 1, 2001, at 10:15 p.m., R1 was up, fully dressed, and had a bag; she stated that she was "going to catch a bus to go out of town for the weekend." P. Ex. 27, at 17. On January 16, 2002, at 1:00 a.m., R1 was out of bed, fully dressed, and wearing her shoes; she asked "who brought her here?" and — visibly upset — she said that "someone stole her things

from her apartment and brought her here." P. Ex. 27, at 23. During the week of May 13, 2002, R1 tried to elope from the Facility and she was described as "confused, disoriented to her room, [and] anxious." P. Ex. 27, at 34. On June 6, 2002, R1 stated that "she had breakfast with her sister;" however, her sister was long-deceased. P. Ex. 27, at 35. During the week of July 21, 2002, R1 was described as having "wandering/crying episodes" and she tried to elope after telling a staff member that she did not need help to get ready for bed. P. Ex. 27, at 36.

R1's physician gradually took R1 off her anti-psychosis medication because he was not made aware of R1's delirium and hallucinations. When R1 was admitted to the Facility on September 10, 2001, she was taking 0.5 milligrams of Risperdal, an anti-psychosis medication, two times per day. On October 4, 2001, R1's physician reduced the dosage of Risperdal to 0.5 milligrams once a day. On April 11, 2002, R1's physician discontinued entirely her prescription for Risperdal. P. Ex. 25, at 10. The earliest date on which the evidence shows that R1's physician was informed of R1's psychotic episodes was July 2, 2002. *See* P. Ex. 27, at 38; P. Ex. 22, at 2. According to R1's doctor's notes dated July 8, 2002, there was a "report of psychosis earlier in month," and the physician stated he would start R1 back on an anti-psychotic medication if the psychosis persisted. According to R1's doctor's notes dated August 9, 2002, there was no psychosis reported, despite the fact that R1 was described in the Facility's nurses' notes as having wandering and crying episodes and had attempted to elope from the Facility during the week of July 22, 2002. *See* P. Ex. 22, at 1; P. Ex. 27, at 36.

According to Dr. Powers, "it's the responsibility of the nursing staff to provide the physician with behavioral observations and input to alert the physician because the physician is only in [the facility] once a month." Tr. 88. According to R1's doctor's notes dated May 23, 2002 and June 13, 2002, there was "no psychosis noted" even though R1 had psychotic episodes during those time periods. When R1's physician was told of R1's delirium and hallucinations, he recorded that he would prescribe the anti-psychotic medication if the psychosis persisted. Clearly, the Facility failed to keep R1's physician informed and current as to R1's mental state. Dr. Powers explained that there was a "disconnect" between the recorded behavior of R1 and what the physician was doing for R1 during the same time period. Tr. 118. Dr. Powers stated that "it is the responsibility [of the facility] to let the doctor know what's going on by the nursing service." *Id.* If R1's psychiatric problems had been addressed appropriately and if R1's physician had been accurately and completely informed of R1's episodes, then the elopement attempts could have been reduced or halted.

Actual harm to R1 and the other residents of the Facility was more likely because of the failure of the facility and its staff to comply with 42 C.F.R. § 483.20(k)(3)(i).

D. A CMP of $3050 per day for a total of $64,050 is reasonable.

CMS proposes a CMP of $3050 per day, from September 11, 2002 through October 1, 2002, for a total of $64,050. I cannot set aside CMS's determination as to immediate jeopardy unless it is clearly erroneous. 42 C.F.R. § 498.60(c)(2). CMS's immediate jeopardy determination is not clearly erroneous. Since the proposed $3050 per day CMP is the minimum prescribed by law for immediate jeopardy deficiencies, it is reasonable as a matter of law.

Petitioner has also specifically challenged the amount of the CMP. P. Br. at 52. Petitioner argues that "CMS has never made clear – and did not offer evidence at the hearing – why the CMP ran for twenty-one days." *Id.* Pursuant to 42 C.F.R. § 488.440(b), the sum of a per day CMP is the CMP multiplied by the number of days that it takes for the facility to achieve substantial compliance. CMS determined that the Facility was out of compliance on September 11, 2002 and did not achieve substantial compliance until a resurvey determined that the Facility had achieved substantial compliance on October 1, 2002. CMS Ex. 3, at 1. Usually a revisit survey is used to determine that a deficiency no longer exists and that a facility is in substantial compliance. *See Lake City*, DAB No. 1658 (1998) and *Asbury Center*, DAB No. 1815 (2002). Petitioner has offered little, if any, evidence that the Facility was in substantial compliance before October 1, 2002, and if it was in substantial compliance before that date, what specific date that it did achieve substantial compliance. Therefore, the 21-day period from September 11, 2002 through October 1, 2002 is reasonable.

V. Conclusion

For all the reasons discussed above, I uphold CMS's determination that from September 11 through October 1, 2002, Petitioner failed to comply with 42 C.F.R. §§ 483.25(h)(2), 483.13(c)(l)(i), and 483.20(k)(3)(i) and that the noncompliance constituted immediate jeopardy to Petitioner's residents. I therefore sustain the imposition of a CMP of $3050 per day, which is the statutory minimum per day CMP in an immediate jeopardy situation.

/s/
Richard J. Smith
Administrative Law Judge