Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Perry County Nursing Center,
(CCN: 25-5159),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-12-152

Decision No. CR2757

Date: April 17, 2013

DECISION

Petitioner, Perry County Nursing Center (Petitioner or facility), is a long-term care facility, located in Richton, Mississippi, that participates in the Medicare program. After receiving reports of irregularities concerning narcotics and other drugs, surveyors from the Mississippi State Department of Health (state agency) completed a facility survey on August 17, 2011, and two revisit surveys on September 8 and November 9, 2011. Based on their findings, the Centers for Medicare and Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare requirements and that its deficiencies posed immediate jeopardy to resident health and safety. CMS has imposed against the facility civil money penalties (CMPs) of $3,550 per day for 130 days of immediate jeopardy (April 30 through September 6, 2011) and $150 per day for 40 days of substantial noncompliance that was not immediate jeopardy (September 7 through October 16, 2011). Petitioner appeals.

For the reasons set forth below, I find that the facility was not in substantial compliance with Medicare requirements, that its deficiencies posed immediate jeopardy to resident health and safety, and that the penalties imposed are reasonable.

I. Background

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 §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. Act § 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 § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308.

Here, responding to complaints of missing narcotics and other drugs, the state agency surveyed the facility from August 3 through 17, 2011. CMS Ex. 4. Based on the survey findings, CMS determined that the facility was not in substantial noncompliance with Medicare program requirements and that its noncompliance with three of those requirements posed immediate jeopardy to resident health and safety:

- 42 C.F.R. § 483.20(k)(3)(i) (Tag F281), which requires that facilities maintain professional standards of quality;

- 42 C.F.R. §§ 483.60(a) & (b) (Tag F425), which sets requirements for pharmaceutical services;

- 42 C.F.R. § 483.75(o) (Tag F520), which mandates that the facility have in place an active quality assurance committee.

CMS Ex. 4 at 1, 8-34, 38-45. CMS also found that the facility was not in substantial compliance with two other requirements:

- 42 C.F.R. §§ 483.13(c)(1)(ii)-(iii), (c)(2)-(4) (Tag F225), which precludes the facility from employing staff with a history of mistreating residents and mandates that facilities investigate allegations of mistreatment, neglect, or abuse; and

- 42 C.F.R. § 483.75(l)(1) (Tag F514), which requires that the facility maintain clinical records in accordance with professional standards. CMS Ex. 4 at 2-8, 34-38.

Surveyors returned to the facility and completed a follow-up survey on September 8, 2011. Based on that survey, CMS determined that the facility's deficiencies no longer posed immediate jeopardy, but, citing the same five regulatory requirements, it determined that the facility remained out of substantial compliance. CMS Ex. 5. Thereafter, based on a November 2011 revisit, CMS determined that the facility returned to substantial compliance on October 17, 2011. CMS Ex. 7.

CMS has imposed against the facility CMPs of $3,550 per day for 130 days of immediate jeopardy (April 30 through September 6, 2011) and $150 per day for 40 days of substantial noncompliance that was not immediate jeopardy (September 7 through October 16, 2011), for a total penalty of $467,500. CMS Ex. 8; Transcript (Tr.) 6.

Petitioner timely requested a hearing. The parties filed pre-hearing briefs (CMS Br.; P. Br), and Petitioner filed a motion for summary judgment and memorandum in support (P. MSJ). I denied Petitioner's motion, and, on May 14, 2012, convened a video hearing from the offices of the Departmental Appeals Board in Washington, D.C. Counsel for the parties and the witness convened in Jackson, Mississippi. Ms. Leah A. Epstein appeared on behalf of CMS. Ms. Juliet Bowan Mitchell and Mr. Phillip J. Chapman appeared on behalf of Petitioner. Following the hearing, the parties filed their post-hearing briefs (CMS Post-hrg. Br.; P. Post-hrg. Br.), and CMS filed a reply brief (CMS Reply).

I have admitted into evidence CMS Exhibits (Exs.) 1-69 and P. Exs. 1-32, including P. Ex. 29A. Summary of Prehearing Conference and Order Establishing Procedures for Hearing (Summary and Order) at 3 (April 6, 2012); Tr. 7, 8.

II. Issues

I consider first the issue Petitioner raised in its motion for summary judgment, which it reiterates in its closing brief: Petitioner argues that, in August 2011, the state agency "was without legal authority" to survey the facility and is therefore not authorized to impose any penalties, notwithstanding the survey findings.

On the merits, this case presents the following issues:

> 1. From April 30 through October 16, 2011, was the facility in substantial compliance with Medicare program requirements?
>
> 2. If the facility was not in substantial compliance with program requirements from April 30 through September 6, 2011, did its deficiencies then pose immediate jeopardy to resident health and safety?
>
> and

3. Are the penalties imposed – $ 3,550 per day for 130 days of immediate jeopardy (April 30 through September 6, 2011) and $150 per day for 40 days of substantial noncompliance that was not immediate jeopardy – reasonable? (totals: $461,500 + $6,000 = $467,500)

Summary and Order at 3; Tr. 6.

III. Discussion

A. By statute and regulation, CMS and the state agency have broad authority to survey facilities in order to determine compliance with Medicare program requirements, and I have no authority to review their exercise of that authority.

The facility here has a troubled history, particularly with respect to its pharmaceutical services. *See* CMS Exs. 1-4. In January 2010, state surveyors found substantial noncompliance with the regulation governing pharmaceutical services (42 C.F.R. §§ 483.60(a) and (b)). Among other problems, they found that facility staff had "misappropriated" the residents' narcotic medications. CMS Ex. 1. The facility promised to correct the cited deficiencies. The state agency accepted the facility's plan of corrections, and, following a revisit survey in April 2010, determined that the facility had returned to substantial compliance. By notice dated April 13, 2010, the state agency so advised the facility. CMS Ex. 2; P. Ex. 3.

Federal regulations allow CMS to reopen an initial or reconsidered determination within 12 months of the date of the notice of the initial determination. 42 C.F.R. § 498.30. Petitioner charges that, by conducting the August 2011 survey, the state agency (and CMS) have impermissibly "reopened" the January 2010 survey. The bases for Petitioner's claim seem to be notice letters sent by the state agency following the August survey. The state agency sent the facility a series of confusing letters that seem to characterize its survey as a "reopening" of the January 2010 action. A letter dated August 9, 2011, refers to "a partially extended complaint survey . . . to the complaint survey of January 6, 2010 . . . ." P. Ex. 1. Additional letters, dated August 12 and 19, 2011, contain similar language; they say that the "complaint investigation . . . that was conducted on 1/05 – 06/10 with a revisit date of 04/09/11 was re-opened." P. Ex. 4 at 2; P. Ex. 5 at 2.

I agree that the language in the state agency's letters was sloppy and potentially misleading. But the letters' misstatements do not create an impermissible re-opening of the January 2010 survey and do not invalidate the surveys before me. Nor has Petitioner established that it has been prejudiced in any way by the faulty language.

First, CMS corrected the state agency's errors in its notice letter of August 24, 2011. That letter contains none of the state's offending language; it characterizes the purpose of the August 17 complaint investigation survey as "to determine if your facility was in compliance with the [f]ederal requirements for nursing homes participating in the Medicare and Medicaid programs." CMS Ex. 9 at 1; *see* 42 C.F.R. § 498.20(a)(1) (providing that CMS mails notice of an initial determination to the affected party).

Second, and most critical, neither the state agency nor CMS actually reopened the earlier survey. In January 2010, CMS made determinations based on the January 2010 survey findings, and those determinations remain untouched. No additional penalties have been imposed for the period encompassed by the January 2010 survey. As CMS's letter advises the facility, the cited deficiencies and the penalties imposed began on *April 30, 2011*, well after the period covered by the January 2010 survey. CMS Ex. 9 at 1.

Moreover, state agencies (and CMS) have broad authority to survey facilities, and any determination to do so is not an initial determination that is subject to review in this forum. 42 C.F.R. § 498.3(b); 42 C.F.R. § 498.5(b). In addition to conducting the mandatory annual survey, the agencies may survey a facility "as frequently as necessary" in order to:

> (1) determine whether a facility complies with participation requirements; and
>
> (2) confirm that the facility has corrected deficiencies previously cited.

42 C.F.R. § 488.308(c). Inasmuch as facilities must, at all times, maintain substantial compliance with program requirements, they can hardly claim that they are prejudiced by the state agency's decision to survey them.

Petitioner nevertheless cites section 1819(g)(2)(B) of the Social Security Act for the proposition that the August 17, 2011 survey was not authorized by statute. P. MSJ at 6. That section provides that any skilled nursing facility found to have provided substandard quality of care "shall be subject to an extended survey." Petitioner asserts that no substandard-quality-of-care deficiencies were cited here, so the survey could not have been authorized under section 1819(g)(2)(B). Petitioner, however, disregards the next sentence in that section, which says: "*Any other facility* may, at the Secretary's or State's *discretion*, be subject to such an extended survey (or partial extended survey)." (emphasis added).

And other provisions of the statute enhance this survey authority: 1) section 1819(g)(3)(D) says that the Secretary can survey a facility and make independent and binding determinations if she "has reason to question" its compliance; and 2) section 1819(g)(4) mandates that the state agency investigate complaints. *See also* 42 C.F.R. §488.308 (authorizing the state agency to survey facilities "as frequently as necessary" to

determine compliance with participation requirements and to confirm that deficiencies have been corrected).

CMS may thus appropriately look at the facility's prior deficiencies and plan of correction to see: 1) did the facility implement the promised corrections; 2) did the corrections effectively resolve the problem; and 3) has the facility maintained substantial compliance as required. CMS's consideration of these factors does not mean that it has reopened the earlier survey.

The state agency and CMS have acted well within the bounds of their statutory and regulatory authority.

B. The facility was not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(i) (professional standards of quality), because its staff: 1) did not administer medications – including narcotics – as ordered by physicians; 2) did not document why they failed to follow physician orders; 3) did not document and report when residents refused their prescribed medications; and 4) did not count narcotics and/or accurately record the narcotic counts.[1]

Program requirements. The services provided or arranged by the facility must meet professional standards of quality. 42 C.F.R. § 483.20(k)(3)(i).

Failures to follow physician orders and to document/report medication refusals. In CMS's view, professional standards of quality – and thus 42 C.F.R. § 483.20(k)(3)(i) – dictate that staff administer medications according to physician orders. When a nurse does not administer a medication as ordered, he/she must document the reason. If a resident refuses a prescribed medication, staff must not only document that refusal, but must also inform the resident's physician that the resident refused. CMS Ex. 10 at 2, 9 (Baker Decl. ¶¶ 9, 30); CMS Exs. 11, 36, 38.

CMS cites multiple examples of the facility's failure to administer medications, notably narcotics, as ordered and its failure to document and report a resident's refusal to take prescribed medications:

Resident 1 (R1) R1 was a 76-year-old woman, admitted to the facility on May 31, 2011, whose diagnoses included chronic and acute bronchitis, congestive heart failure, dysphagia, cardiomegaly, atrial fibrillation, depression, and other impairments. CMS Ex. 12 at 1, 3. She had difficulty walking and complained of significant pain (6 on a scale of 1-10). CMS Ex. 12 at 1; CMS Ex. 10 at 3 (Baker Decl. ¶ 13). On June 15, 2011, her

[1] My findings of fact/conclusions of law are set forth, in italics and bold, in the discussion captions of this decision.

physician prescribed 7.5 mg. of Lortab every four hours for pain. Lortab combines the powerful narcotic hydrocodone with acetaminophen. CMS Ex. 12 at 1. It is a controlled substance and may be habit forming. CMS Ex. 10 at 3 (Baker Decl. ¶ 12).

R1's medication administration record (MAR) shows that, in July 2011, nursing staff failed eleven times to administer her Lortab as ordered:

- July 5 – failed to administer 5:00 a.m. dose;
- July 7 – failed to administer 1:00 a.m. dose;
- July 8 – failed to administer 1:00 a.m. dose;
- July 13 – failed to administer 1:00 a.m. dose;
- July 14 – failed to administer 1:00 a.m. dose;
- July 15 – failed to administer 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. doses;
- July 20 – failed to administer 5:00 a.m. dose;
- July 23 – failed to administer 1:00 a.m. dose.

CMS Ex. 13 at 1.

In five of these instances, nursing staff documented a reason for not giving the drug. At 9:00 a.m. on July 15, the responsible nurse entered "X" on the MAR, indicating that R1 was not in the facility at the time. CMS Ex. 13 at 1. At 1:00, 5:00, and 9:00 p.m. that day, the nurse entered the letter "M" on the MAR, to indicate that she failed to administer Lortab because the facility had run out of the drug. CMS Ex. 13 at 1, 2.[2] A note indicates that R1 refused her 5:00 a.m. dose on July 20. CMS Ex. 13 at 2.

This leaves six missed doses unaccounted for. Facility policy dictated that staff should document when medication is given or refused and should indicate in nurses' notes the reason a medication was not given as ordered. CMS Ex. 13 at 2. Contrary to facility policy and standard nursing practice, the responsible nurse in all six instances, Licensed Practical Nurse (LPN) Paula Malone, did not document why she failed to administer the

[2] As discussed below, it seems that prescribed medications were often unavailable. Although the facility maintained an "emergency box," from which staff sometimes requisitioned medications, including Lortab (*See* CMS Ex. 15), standard nursing practice limits the use of such emergency drugs.

narcotic. CMS Ex. 13 at 1; CMS Ex. 10 at 3-4 (Baker Decl. ¶ 14). When surveyors brought this to the facility's attention during the August survey, LPN Malone wrote a statement claiming that R1 had refused to take the scheduled medications at those times (5:00 a.m. on July 5 and 1:00 a.m. on July 7, 8, 13, 14, 23). CMS Ex. 14. I find such after-the-fact and potentially self-serving statements inherently unreliable, particularly where the person making the statement does not testify.

Facility Administrator Woodall issued a written warning to LPN Malone for violating the company policies and procedures, which required staff to document medication refusals. CMS Ex. 40.

Nor did LPN Malone properly document that she disposed of the controlled substance. CMS Ex. 13 at 1-2. Facility policy required her to flush the refused medication in the presence of a witness, who then was supposed to sign the back of the MAR, but no evidence indicates that she did so. CMS Ex. 36 at 3.

Facility nurses did not consistently administer the correct doses to R1. In orders dated July 15, 2011, her physician directed staff to administer 1½ 5 mg. tablets of Lortab at 1:00 a.m. and 5:00 a.m. that day only; thereafter, staff were to administer a 5 mg. tablet every four hours "until Lortab 7.5 mg. tablets are available." CMS Ex. 12 at 5. But staff did not then record on R1's MAR the order for the 5 mg. doses, and those doses were not administered as ordered. CMS Ex. 13; CMS Ex. 29 at 1.

Ironically, *after July 15*, nurses requisitioned 5 mg. Lortab tablets from the facility's emergency box, ostensibly for R1, even though her physician's order no longer authorized them to administer any combinations of the 5 mg. tablets. On July 16, a nurse took out 3 tablets; on July 26, a nurse took out 2 tablets; and three times on July 27, nurses took a total of 3 ½ tablets (in increments of 1 tablet, 1 tablet, and 1 tablets). CMS Ex. 15. In an employee statement dated August 3, 2011, LPN Belinda Beasley wrote that, on July 27, she gave R1 1½ tablets of Lortab, totaling 7.5 mg. She wrote that she broke a tablet in half, gave half to the resident and discarded the other half. CMS Ex. 30 at 3.[3]

Resident 3 (R3) R3 was a 58-year-old man suffering from end stage renal disease, pneumonia, cellulitis, dysphagia, and other ailments. CMS Ex. 16 at 1. Among R3's medications, his physician prescribed the sedative Ambien, every night, for insomnia. CMS Ex. 16 at 1; CMS Ex. 17 at 1. Ambien is a controlled substance that is potentially habit-forming.

[3] The Emergency Box Requisition form confirms that LPN Beasley is the nurse who signed out 1½ Lortab tablets on July 27. CMS Ex. 15.

Under standard nursing practices, nurses must transcribe physician orders carefully and accurately. They must add all medication orders, including temporary changes in orders, to the resident's medication administration record (MAR). CMS Ex. 10 at 8 (Baker Decl. ¶ 26). Staff made a mistake when they entered the Ambien order into the facility's computerized physician orders, erroneously indicating that the drug should be withheld on Sundays. CMS Ex. 10 at 5 (Baker Decl. ¶ 17); CMS Ex. 19 at 1.[4] The MARs for June and July, however, correctly reflected that the drug should be administered every day. CMS Ex. 10 at 5 (Baker Decl. ¶17); CMS Ex. 17 at 1. Nevertheless, according to the MARs for those months, staff did *not* administer the Ambien on Sundays in June and July (June 5, 12, 19, and 26; July 3, 10, 17, 24, and 31). The entry block for Sundays is blocked off with asterisks, indicating that the doses were withheld. CMS Ex. 10 at 5 (Baker Decl. ¶ 18); CMS Ex. 16 at 1; CMS Ex. 17 at 1.

In a medication error report, dated August 8, 2011, Director of Nursing (DON) Chad Tisdale acknowledged the error regarding the twelve Sunday dosages and promised to conduct daily audits of MARs and narcotics records to prevent future errors. CMS Ex. 20. The facility's administrator, Linda Woodall, issued written warnings to three LPNs, including LPN Malone, who were identified as failing to administer Ambien as ordered on those Sundays in June and July, violating company policies. The warning reports also indicate that DON Tisdale "inserviced" the employees on medication administration and documentation. LPN Malone was also apparently suspended. CMS Exs. 21, 22, 23.

Without providing any explanation, staff also failed to administer the drug on June 30 (a Thursday), July 4 (a Monday), and July 30 (a Saturday), for a total of thirteen missed doses in June and July 2011. CMS Ex. 16 at 1, 2: CMS Ex. 17 at 1.

Resident 5 (R5) R5's physician ordered Restoril (Tamezepam) and Trazadone (Desyrel) daily to treat her insomnia. CMS Ex. 25 at 1. On July 25, 2011, staff did not administer the ordered doses nor document any reason for not doing so. CMS Ex. 24 at 1.

Petitioner argues that the Restoril, at least, was administered, because R5's Individual Resident's Narcotics Record (IRNR), a narcotics control sheet maintained by the facility to track its narcotics (discussed below), shows that LPN Kitchens removed the drug from its locked storage on July 25. P. Ex. 18. Petitioner concedes, as it must, that no documentation (or any other evidence) establishes that the nurse subsequently administered the drug to the resident. The facility nevertheless excuses this as a simple documentation error, not a failure to administer the medication. P. Ex. 18; P. Post-hrg.

[4] The notation "QD" means "every day"; the notation "X" means "except." Hence "QDXSUN" means "every day except Sunday." CMS Ex. 10 at 5 (Baker Decl. ¶ 17).

Br. at 10. But, without any evidence to show that the narcotic was administered, I must assume that it was not.[5]

Resident 7 (R7) R7 was a 76-year-old woman suffering from Alzheimer's disease and anxiety. She had osteoarthritis and experienced difficulty walking. Her physician prescribed Lortab, four times daily, for pain. CMS Ex. 26.

On August 5, 2011, the nurse responsible for her medications did not administer R7's midnight dose and did not document why she failed to do so. CMS Exs. 26, 27. A nurse's note entered at 9:45 that morning indicates that the resident complained that she had not been given the medication and said that that she had been in significant pain ("hurt awfully bad"). CMS Ex. 27.

Identifying the nurse responsible is not easy. CMS suggests that it was LPN Malone ("LPN #4"), the same nurse who failed to administer medications to R1. CMS Post-hrg. Br. at 6; CMS Reply at 5. LPN Malone signed R7's MAR and indicated her initial as a lower case cursive "m." Inasmuch as just she and one other nurse ("KB") signed the form, and the nurse responsible for R7's medications on August 5 entered and circled on the form initials that appear to be an "m" or double "m," CMS's presumption seems reasonable.[6] CMS Ex. 26.

Petitioner, however, identifies LPN Marquita Murdoch (LPN # 5) as the responsible nurse, and I find this more likely. P. Post-hrg. Br. at 11. She not only has the correct initials, but the facility held her responsible. When Surveyor Baker brought the medication error to the DON's attention, the DON contacted LPN Murdock, who said that she did not administer the medication because R7 was sleeping. LPN Murdock eventually entered that explanation into the nurse's notes, dating the entry August 5 at 10:55 p.m. The date and time reflect (roughly) the date and time the medication should have been administered, not the date and time LPN Murdock made the entry. Tr. 35-36; P. Ex. 19.[7] LPN Murdock explained that it had been the first night she'd worked at the facility "in a while" and "she had a lot going on." *See* CMS Ex. 27 at 1.

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[5] CMS notes that the facility has a significant and troubling history of "drug diversion." In December 2009, for example, 2,445 Lortab tablets were not accounted for. Among other irregularities, Lortab was signed out on the narcotics sheet more than 161 times without any corresponding indication on the residents' MARs that the medications had been administered. CMS Ex. 4 at 3-5.

[6] By circling her initials, she indicated that she did not administer the medication.

[7] The note immediately following this one is dated August 6 at 10:00 a.m. It is signed by DON Tisdale and says that the physician and responsible party were "made aware" that the Lortab was not administered. I find it highly unlikely that DON Tisdale wrote this

Inconsistently, a medication error report, dated August 10, 2011 and signed by DON Tisdale and LPN Murdock, says that the resident "refused her 12 midnight Lortab." It also says that "no adverse effects noted," apparently disregarding the resident's complaints. P. Ex. 20.

LPN Murdock did not testify and her inconsistent explanations for failing to administer the medication as ordered, as well as her (and DON Tisdale's) disregard for R1's complaints of pain, render her excuses not credible. I do not believe Petitioner's claim that R7 "was unable to be aroused." P. Post-hrg. Br. at 11.[8] I find it far more likely that LPN Murdoch did not even remember why she failed to administer the medication as ordered.

R7 also told Surveyor Baker that "she hurt awfully bad" that night and that she wanted to be awakened for her pain medication. Tr. 37; CMS Ex. 28.

Resident 17 (R17) was an 86-year-old woman recovering from a fractured hip. Her physician ordered one Percocet 10/325 mg. tablet every four hours for pain, as needed; and two Percocet 10/325 tablets every four hours for severe pain, as needed. CMS Ex. 31 at 4; CMS Ex. 32 at 1, 3.[9] But the facility did not obtain that strength Percocet for her. Her medication label shows that she was administered Percocet 7.5/325 mg. tablets. CMS Ex. 33.

This discrepancy between the physician order and the medication label suggests that facility staff deviated from standard nursing practices in two respects. First, obtaining the wrong medication dosage obviously compromises the facility's ability to follow the physician's medication orders. Second, standard nursing practice and the facility's own policies require that nurses check the medication label for accuracy, including the medication name and strength. CMS Ex. 35 at 1; CMS Ex. 36 at 1; CMS Ex. 10 at 8, 12 (Baker Decl. ¶¶ 27, 39). Prior to administering a medication, the nurse must compare the physician order, the MAR, and the medication label. If she finds inconsistencies or ambiguities, she must contact the physician for clarification. CMS Ex. 10 at 8 (Baker

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note prior to the time of the survey, since it was plainly written *after* LPN Murdoch wrote her note.

[8] Petitioner even suggests that LPN Murdoch was correct to disregard the physician order. It claims that administering the medication "is potentially more harmful than not giving it" because Lortab "may cause over-sedation in the elderly. . . ." P. Post-hrg. Br. at 13. If facility nurses truly saw over-sedation as a problem (which I do not believe they did), they were required to report their concerns to the resident's physician.

[9] Percocet contains oxycodone and acetaminophen. Percocet 10/325 means that each tablet contains 10 mg. oxycodone (generally the highest dose prescribed) and 325 mg. acetaminophen.

Decl. ¶ 27); *see also Premier Living and Rehab Ctr*., DAB CR1602 at 7 (2007), *aff'd* DAB No. 2146 (2008). The record does not establish, and Petitioner does not assert, that staff took any of these steps. *See* P. Post-hrg. Br. at 14 (in which Petitioner does not deny the errors but argues that they were not significant).

Petitioner argues that no standard of nursing practice requires nurses to follow physician orders for administering medication. P. Post-hrg. Br. at 2 *et seq.* This position is unsupported and unsupportable. As Surveyor Baker accurately testified, the practice of following physicians' orders is "one of the most basic and important rules of nursing." CMS Ex. 10 at 2 (Baker Decl. ¶ 9). Indeed, the facility's own written policies reflect CMS's view. Consistent with standard nursing practice, the facility's policy dictates that all physician orders be "implemented timely and carried out in a professional manner by the nursing staff." Staff are also required to "assure" that all physician orders "are transcribed properly and implemented." CMS Ex. 11. "Absent evidence to the contrary, it is 'reasonable to presume' that a facility's care policies reflect professional standards of quality." *Dumas Nursing and Rehabilitation*, L.P., DAB No. 2347 at 9 (2010), *quoting Sheridan Nursing Care Center*, DAB No. 2178 at 32 (2008); *Agape Rehabilitation of Rock Hill*, DAB No. 2411 at 7 (2011).

Because they failed to follow the physician's medication orders, nursing staff did not meet professional standards of quality, putting the facility out of substantial compliance with 42 C.F.R. § 483.20(k)(3)(i).

CMS also maintains that the facility did not meet professional standards of quality, because staff regularly failed to document the reasons for not administering prescribed medications and because staff did not report to the physician a resident's refusal to take prescribed medications. Surveyor Baker testified that, according to standard nursing practices, a nurse administering medication must document the patient's refusal and the reasons for that refusal. He/she must communicate the refusal to the attending physician and the patient's representative. CMS Ex. 10 at 9 (Baker Decl. ¶ 30). This comports with the facility's own policy, which instructs:

> If a medication is refused, or for some reason not given, notify the attending physician, record the incident on the resident's chart, or mark "R" on the resident's MAR, and sign out the ungiven medication on the back of the MAR for each time the resident refuses the medication(s).

CMS Ex. 36 at 3; CMS Ex. 38 (facility policy dictating that a resident's refusal of treatment must be "consistently documented in the resident's record" and should include "[t]he date and time the physician and responsible party [were] notified as well as the physician's response.").

Because its nursing staff did not consistently document the reasons they failed to administer prescribed medications and did not consistently inform physicians when residents refused to take prescribed medications, the facility did not meet professional standards of quality and was not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(i).

Failure to track narcotics and other controlled substances. Standards of nursing practice and the facility's policies (not to mention federal and state law) also require that nurses carefully track narcotics and other controlled substances. CMS Ex. 10 at 13 (Baker Decl. ¶ 41); CMS Ex. 37; *see Premier*, DAB No. 1602 at 7. Surveyors cited significant deficiencies with respect to the facility's shortcomings in tracking its narcotics, which I include in my discussion of the facility's substantial noncompliance with the regulation governing pharmaceutical services.[10] As that discussion shows, facility staff did not adequately account for its controlled substances, which again means that the facility failed to meet professional standards of quality and was not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(i).

C. CMS may cite a deficiency under 42 C.F.R. § 483.20(k)(3)(i), whenever facility staff fail to meet professional standards of quality; the regulation makes no exception for breaches of professional standards that involve medication errors.

Petitioner has presented little evidence and few arguments challenging CMS's factual findings with respect to staff practices. Instead, it: 1) accuses CMS of inventing standards, even though, as discussed above, those standards are contained within the facility's own policies and procedures; and 2) argues that, because the relevant professional standards of quality relate to medications, CMS may cite a deficiency under 42 C.F.R. § 483.20(k)(3)(i) *only* if it also cites a deficiency under 42 C.F.R. § 483.25(m)(1), which specifically addresses medication errors. P. Post-hrg. Br. at 3 *et seq*.

I have already rejected Petitioner's claim that CMS "invented" the professional standards of quality.

I find equally unpersuasive Petitioner's argument that CMS may not cite deficiencies under section 483.20(k)(3)(i), because it did not also cite deficiencies under section 483.25(m)(1). In support of its argument, Petitioner points to a couple of interpretive guidelines that are included in the State Operations Manual (SOM). The SOM includes

[10] As with many of the deficiencies cited in this case, the underlying facts support noncompliance findings under both sections 483.20(k)(3)(i) and 483.60(a) and (b). As a second example: CMS cited a deficiency under section 483.20(k)(3)(i), because the facility's pharmaceutical services did not assure accurate dispensing and administering of all drugs. CMS could also have cited the facility under 42 C.F.R. § 483.60(a).

useful guidance as to CMS's interpretations of applicable law, but its provisions do not constitute enforceable, substantive rules. *Beverly Health and Rehabilitation Services v. Thompson*, 223 F. Supp. 2d at 99-106 (D.D.C. 2002); *Oakwood Community Ctr.*, DAB No. 2214 at 16 (2008); *Aase Haugen Homes, Inc.*, DAB No. 2013 at 15 (2006). The regulations, on the other hand, constitute enforceable rules, and I am bound to follow them. Section 483.20(k)(3)(i) makes no exception for breaches of professional standards that involve medication errors. *See Premier Living and Rehab Ctr.*, DAB No. 2146 at 18 (2008). Thus, Petitioner's argument fails based on the plain language of the regulation.

Moreover, nothing in the language of the interpretive guidelines precludes CMS from citing a medication error under section 483.20(k)(3)(i). In *Premier Living and Rehab Ctr.*, CMS cited deficiencies under two regulations: 42 C.F.R. § 483.20(k)(3)(i) and 42 C.F.R. § 483.25(m). From this, Petitioner argues that CMS can cite a medication-related deficiency under section 483.20(k)(3)(i) *only* if it *also* cites a deficiency under section 483.25(m). Petitioner misreads the SOM and the Departmental Appeals Board's reasoning in *Premier Living and Rehab Ctr*.

An interpretive guideline under section 483.20(k)(3)(i) suggests that surveyors consider: "Are there errors in the techniques of medication administration? (Cite actual medication errors at 483.25(m).)" P. Ex. 30 at 2; *Premier Living and Rehab Ctr.*, DAB No. 2146 at 16. Elsewhere, the SOM instructs surveyors to cite under 42 C.F.R. § 483.20(k)(3) "errors in the technique of medication administration" as well as failures to carry out physician orders. P. Ex. 30 at 2. In *Premier Living*, the Board gave two reasons for rejecting the facility's contention that this language means that surveyors should not cite actual medication errors under the professional standards regulation. First, even if it agreed that the citation "required error in medication techniques, as opposed to an error in the medication administered" (which it did not), the Board found that the facility staff's techniques were, in fact, sub-par.[11] Second, the Board emphasized that it did not agree that the language in the guidelines bars surveyors from citing breaches of professional standards relating to medication errors. "Instead, we read the guidelines as merely recommending that surveyors cite the medication error regulation when applicable." *Premier Living and Rehab Ctr.*, DAB No. 2146 at 16.

The Board also said:

> We do not read the guidance to mean that deficiencies in professional standards that cause actual harm should <u>only</u> be

[11] The Board referred to staff practices in "measuring, handling, tracking, and safeguarding" narcotics as examples of deficient techniques. Here, the evidence also establishes deficiencies in measuring, handling, tracking, and safeguarding narcotics.

> cited under the other relevant regulatory provisions, but rather that where a deficit in professional standards is bad enough to actually impact the outcome for a particular resident, it should appropriately also be cited under the particular substantive provision relating to the provision of that kind of care to the resident.

Premier Living and Rehab Ctr., DAB No. 2416 at 18. Petitioner seems to think that this language mandates a deficiency citation under the quality-of-care regulation (483.25(m)) in order to sustain a deficiency under the professional standards regulation. Of course, it does not. It just recommends that surveyors also consider citing deficiencies under any relevant substantive provision, if they find significant problems with professional standards.[12]

D. The facility was not in substantial compliance with 42 C.F.R. §§ 483.60(a) and (b) because: 1) it maintained inadequate supplies of medications; 2) it misused its emergency drug supplies; and 3) it did not adequately account for its controlled substances.

Program requirements. The facility must provide routine and emergency drugs to its residents. Its pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) must meet the needs of each resident. 42 C.F.R. § 483.60(a). To this end, the facility must employ or obtain the services of a licensed pharmacist who: 1) consults "on all aspects" of providing pharmacy services in the facility; 2) establishes a system of records showing the receipt and disposition of all controlled drugs "in sufficient detail to enable an accurate reconciliation"; and 3) determines that drug records are in order and that an account of all controlled drugs is maintained and reconciled periodically. 42 C.F.R. § 483.60(b)

The facility had in place written policies designed to assure compliance with these requirements. CMS Exs. 34 - 38. However, as the following discussion shows, its staff repeatedly failed to follow those policies, resulting in the facility's noncompliance with 42 C.F.R. § 483.60(a) and (b).[13]

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[12] In fact, the surveyors arguably did so here. They found significant problems with professional standards, and also found noncompliance with one of the more "substantive" regulations: that governing pharmaceutical services.

[13] CMS cites multiple additional examples of the facility's failure to account for its narcotics. *See, e.g.*, CMS Exs. 55, 57, 58 (showing discrepancies in the number of Fentanyl patches destroyed). Because the examples I have addressed are sufficient to justify the penalties imposed, I need not address all of these. *Claiborne-Hughes Health*

Inadequate supplies of medications. I have already discussed many of the medication irregularities that affected facility residents. As that discussion shows, on some occasions, staff failed to administer prescribed medications because the facility did not have them:

- The facility did not obtain the correct dosage of Percocet for R17. CMS Ex. 31 at 4; CMS Ex. 32 at 1, 4; CMS Ex. 33.

- On three occasions on July 15, 2011 (1:00, 5:00, and 9:00 p.m.), nurses failed to administer Lortab as prescribed to R1 because the facility had run out of the drug. CMS Ex. 13 at 1, 2.

- On July 16, 26, and 27, 2011, staff administered the wrong dosages of Lortab to R1 because they did not have the correct dosages. They requisitioned these tablets from the facility's emergency box (*see* discussion, below). CMS Ex. 15; CMS Ex. 30 at 3.

As CMS points out, the facility should not have been without R1's prescribed medication because staff knew or should have known when her supply would run out. On June 30, 2011, the facility received 60 Lortabs for her, a ten-day supply.[14] CMS Ex. 29. Yet, for reasons that the facility has not explained, no one reordered the medication until July 15, five days after her supply would have been exhausted. CMS Ex. 29. On July 15, the facility received another ten-day supply, but did not re-order until July 26, after again having exhausted her supply. CMS Ex. 29; CMS Ex. 42 at 2.

Standard nursing practice dictates that nurses ensure an adequate supply of prescribed medications. They should check supplies regularly and reorder *before* a prescribed medication runs out. CMS Ex. 10 at 12 (Baker Decl. ¶ 38). Because it did not timely reorder prescribed medications, the facility did not acquire, receive, dispense and administer necessary drugs and was not in substantial compliance with 42 C.F.R. § 483.60(a); *see Universal Healthcare/King*, DAB No. 2215 at 4-6 (2008).

Misuse of "emergency" drugs. As the above-discussion also shows, when the facility ran out of a prescription drug, nursing staff dipped into the facility's Emergency Drug Kit. But standard nursing practice and the facility's own policy dictate that those drugs

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Ctr., No. 09-3239 at 11 (6th Cir. 2010); *Carrington Place of Muscatine*, DAB No. 2321 at 20-21 (2010).

[14] Her prescription called for one tablet every four hours, or six tablets per day. CMS Ex. 12 at 1.

"should only be used for stat and/or emergency orders from the attending physician or Medical Director." CMS Ex. 34; CMS Ex. 10 at 12 (Baker Decl. ¶ 38).

Accounting for controlled substances. Nurses must track the facility's controlled substances, and the facility had in place written policies and procedures to assure that they did so. CMS cites multiple instances of the staff's failing to follow those policies, which meant that the facility was not properly tracking its narcotics:

First, facility policy directed staff to check medication labels for accuracy at the time of delivery. CMS Ex. 35 at 1. If the drugs had been ordered by means of a "Medication Order Form," the nurse was supposed to write in and sign, on the original of that form, the quantity received. The original form was then returned to the pharmacy. CMS Ex. 35 at 2. The nurse receiving the drug order was required to verify that the "count received" was correct and to add that count to the IRNR. CMS Ex. 37 at 1.

Here, the facility provided no evidence, to the surveyor or to this tribunal, establishing that its nurses followed these directives. CMS Ex. 10 at 12 (Baker Decl. ¶ 39). In fact, based on the inconsistencies between R17's physician order for Percocet (10/325 mg) and the medication label (7.5/325), we know that staff accepted medications, whose labels did not reflect the drugs ordered. CMS Ex. 31 at 4; CMS Ex. 32 at 1, 3; CMS Ex. 33.

Nor has the facility explained a significant and disturbing discrepancy in R1's narcotics count. The pharmacy delivery sheet shows that, on July 27, 2011, the facility received – and staff signed for – 120 Lortab tablets. CMS Ex. 44 at 1; CMS Ex. 46 at 1 (see label). An additional 60 tablets were signed for by LPN Malone at 3:00 a.m. on July 28, 2011, for a total of 180 tablets. CMS Ex. 44 at 2. Yet, beginning July 27, R1's IRNR shows a maximum of only 60 tablets on hand for her. CMS Ex. 46 at 1. Petitioner has not accounted for the *120 missing tablets*. I consider this a very significant problem, particularly in light of the facility's well-documented history of drug diversions.

Second, according to facility policy, which again comports with standards of nursing practice, "[c]ontrolled medications are to be signed out in the narcotic book at the time they are to be administered." CMS Ex. 37 at 1; CMS Ex. 10 at 15 (Baker Decl. ¶ 47). CMS alleges that facility staff took narcotics out of the emergency kit far in advance of dispensing them. According to the Emergency Box Requisitions form, on July 15, 2011, a nurse signed out three 5 mg. Lortab tablets for R1. She wrote in the time as 1:00 a.m. and 5:00 a.m. CMS Ex. 15. On July 16, at an unspecified time, another nurse signed out three 5 mg. tablets of Lortab for R1. CMS Ex. 15. Thus, even though her physician prescribed 7.5 mg. every four hours, these nurses signed out twice as much of the medication as needed at any given time.

Petitioner denies that the nurses signed out the medications in advance, but claims, without support, that the drugs "were simply documented at one time on one line each."

P. Post-hrg. Br. at 17. As CMS points out, if true, nurses were still violating standards of practice and facility policy, because they did not sign out the narcotics until hours *after* they removed them.

In order to account for its controlled medications, as required by the regulation, the facility directed its staff to sign out narcotics at the time they were administered. Here, staff were either taking the narcotics without timely signing for them, or they were signing them out hours before they were to be administered. Under either scenario, staff deviated from the system the facility had in place, which puts the facility out of substantial compliance with 42 C.F.R. § 483.60(a) and (b).

Third, as Surveyor Baker explained, after administering a narcotic, the facility's nursing staff should count the number of pills or measure the amount of liquid medication remaining. In this way, staff can immediately identify missing doses and other irregularities. If, instead of counting (or measuring), staff make a paper calculation, i.e., they subtract the dose administered from the number previously recorded, they risk repeating or even compounding an existing error. CMS Ex. 10 at 13 (Baker Decl. ¶¶ 42, 43). CMS Ex. 37 at 1 (policy mandating that administering nurse "check for the accuracy of the remaining count.")

CMS points to the IRNR for R17 as an example of staff's failure to count Percocet tablets as required. CMS Ex. 33. R17's IRNR is messy and filled with errors. On at least three occasions, someone has, without dating or initialing the change, visibly altered the original entry for remaining medications: the April 30 8:00 p.m. entry has been tampered with; the May 3 11:30 p.m. entry has been changed from 38 to 39; the May 7 8:00 p.m. entry was changed from 33 to 34.[15] In two instances, the amount given has been crossed out and another amount written in, again without dating or initialing the change. In any event, the numbers recorded, whether original or altered, do not add up.

- The record indicates that, on April 30 at 8 p.m., R17 had 44 tablets on hand. The nurse, S. Darby, administered two tablets, leaving 42, according to the record, although the "42" is one of the altered entries.

- The next entry is May 1 at 8:30 a.m. It indicates *43* (not 42) tablets on hand. LPN Beasley administered one tablet and wrote that 41 tablets remained.

- But the next entry, dated May 1 at 9:00 p.m., indicates 42 (not 41) tablets on hand. The nurse administered two tablets, with 40 remaining.

[15] The May 3 and May 7 changes might have been from 39 to 38 and 34 to 33, respectively, but in both cases the next nurse entering an amount recorded the numbers 39 and 34.

- Thereafter, each "amount-on-hand" entry indicates that one tablet was administered, and the "amount remaining" is decreased by one.

CMS Ex. 33. According to CMS, these entries indicate that staff were not physically counting the tablets each time they administered a dosage. Instead, they subtracted the "amount given" from the "amount on hand." CMS Post-hrg Br. at 8. Petitioner, on the other hand, claims that, on May 1 at 8:30 a.m., LPN Beasley "simply entered the incorrect count of 43 for 'amount on hand'" but then correctly recorded the amount remaining as 41.[16] Thereafter, according to Petitioner, all the other nurses recorded the correct amounts. P. Post-hrg. Br. at 15. But if that were so, the entry dated May 1 at 9 p.m. would have shown 41 tablets on hand, two administered, and 39 remaining. Instead, the entry lists *42* tablets on hand, two administered and 40 remaining. Petitioner denies that the nurse administered two tablets and claims that she administered only one. This is inconsistent with the record entries. Not only does the nurse report that two fewer tablets remain after she has administered the medication, she marks under "amount given" two parallel lines, not one. CMS Ex. 33.

In her declaration, the facility administrator, Linda Woodall, also declares that "the LPN in question entered the incorrect count for amount on hand column but the correct count of 42 for amount remaining." P. Ex. 27 at 6 (Woodall Decl. ¶16). Inasmuch as LPN Beasley entered "41" as the amount remaining, this testimony is confusing and does not accurately describe the entries on the IRNR form.

Citing the September 8, 2011 statement of deficiencies and its own plan of corrections, Petitioner claims that its position was "verified by audit conducted on 8/5/11 during the survey and validated by the [s]tate." (emphasis in original) P. Post-hrg. Br. at 15; P. Ex. 27 at 7 (Woodall Decl. ¶16) (claiming that "on August 5, 2011, DON Chad Tisdale conducted a 100% audit on all narcotics for [R17] to ensure all medications were accounted for and counts accurate. No additional discrepancies were noted as a result of these audits."). Petitioner offers absolutely no reliable evidence of the audit findings. Petitioner provides no audit report and no declaration from DON Tisdale. It seems that no one independently counted the number of Percocet tablets remaining. Indeed, the statement of deficiencies, upon which Petitioner relies, indicates that this so-called "audit" was extremely limited. DON Tisdale told surveyors that he could not verify that

[16] I note that, if, in fact, LPN Beasley's May 1 "amount on hand" entry was correct, and 43 tablets (not 42) remained after April 30 at 8:00 p.m., the subsequent numbers would make more sense. LPN Beasley would have started with 43 tablets, administered one, and 42 would remain, as reflected in the next entry (May 1 at 9:00 p.m.). Then, at 9 p.m. on May 1, two are administered and 40 remain. Of course, that would mean an earlier, unexplained error.

the Percocet administration was wrong, because he did not have the medication card for review. He could only compare the narcotic sheet to the MAR. CMS Ex. 6 at 19.

The multiple unexplained irregularities surrounding R17's Percocet establish that facility staff were not carefully tracking her narcotic medication, which puts the facility out of substantial compliance with 42 C.F.R. § 483.20(k)(3)(i).[17]

The record does not contain R17's MAR for May 2011, so I could not compare its entries to the IRNR. I note that R17's MAR for April is in the record, but staff did not record most of the Percocet administered to R17 in April. According to the MAR, LPN Malone administered one tablet on April 28 and someone else administered two tablets on April 30. CMS Ex. 32 at 1, 3. The MAR does not reflect the multiple other occasions the narcotic was given. *Compare* CMS Ex. 32 *with* CMS Ex. 33.

As an over-arching response to all of these tracking errors, Petitioner argues that they are not deficiencies because they are "mere documentation errors." I am not aware of any method by which a facility can track its narcotics that does not involve careful documentation. The regulation requires it. 42 C.F.R. §§ 483.60(b)(2) and (3). As its policies demonstrate, this facility relied on documentation as the primary method by which it tracked its narcotics. *See, e.g.*, CMS Ex. 37. Its staff's repeated documentation errors, which Petitioner does not even seriously dispute, confirm that it was not keeping adequate track of its narcotics and was therefore not in substantial compliance.

E. CMS's determination that, from April 30 through September 6, 2011, the facility's deficiencies posed immediate jeopardy to resident health and safety is not clearly erroneous.

Immediate jeopardy exists if 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. CMS's determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c)(2). The Departmental Appeals Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy, and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy

[17] The deficiencies cited under 42 C.F.R. §§ 483.20(k)(3)(i) and 483.60(a) and (b) more than justify the penalties imposed. *Claiborne-Hughes Health Ctr.*, No. 09-3239 at 11 (6th Cir. 2010); *Carrington Place of Muscatine*, DAB No. 2321 at 20-21 (2010). I therefore decline to address the deficiency cited under 42 C.F.R. § 483.75(o), although I recognize that the facility's long-standing and serious deficiencies regarding its pharmaceutical services raises questions about the effectiveness of its quality assurance committee.

exists." *Barbourville Nursing Home*, DAB No. 1962 at 27-28 (2005), *citing Koester Pavilion*, DAB No. 1750 (2000); *Daughters of Miriam Center*, DAB No. 2067 at 7, 9 (2007).

Petitioner attempts to isolate each individual error, declare that error "insignificant," and then move on to the next purportedly "insignificant" error. But, as the evidence discussed above establishes, the facility's pharmaceutical problems were systemic. Multiple staff members repeatedly disregarded standard practices and the facility's own policies. Taken as a whole, these errors establish that the facility was not ensuring that its pharmaceutical services met resident needs. If the facility cannot account for its residents' narcotics, those drugs will not be available when the resident needs them (as happened here). If the facility cannot assure that the correct medication – particularly powerful narcotic medications – are administered according to physician orders, its deficiencies are likely to cause serious harm. Indeed, the record contains at least one documented instance of actual harm – the pain suffered by R7 on the night of August 5. Where, as here, the evidence establishes a systemic problem of staff failing to follow physician orders, the Board has found "ample reason" to conclude that a nurse's medication errors would likely cause death or serious harm to residents. *Agape Rehabilitation of Rock Hill*, DAB No. 2411 at 19-20, *citing Daughters of Miriam Ctr.*, DAB No. 2067 at 12.

Petitioner complains that CMS erroneously began the period of immediate jeopardy on April 30, 2011. The evidence, however, establishes that the facility's significant problems with administering and accounting for medications began at least that early and were ongoing. On April 25, 2011, staff accepted the wrong Percocet dosage for R17. CMS Ex. 32 at 1; CMS Ex. 33. Their errors in tracking her narcotics began on April 30 or possibly even before then. CMS Ex. 33. Throughout June and July, staff failed to administer R3's Ambien as ordered (CMS Ex. 16 at 1); 120 Lortab tablets went missing in July (CMS Exs. 44, 46); and, throughout July and August, nurses repeatedly failed to administer medications as prescribed.[18]

Finally, aside from arguing, generally, that its deficiencies did not pose immediate jeopardy, Petitioner has not specifically challenged CMS's determination that the

[18] Aside from arguing the findings of substantial noncompliance and immediate jeopardy, and, thus the imposition of any penalty, Petitioner has not challenged the amounts of the penalties imposed. In any event, at $150 and $3,550 per day, the CMPs are at the very low ends of the penalty ranges for substantial non-compliance ($50-$3,000) and immediate jeopardy ($3,050-$10,000). 42 C.F.R. §§ 488.408(d) and (e). In light of the facility's dismal history, particularly with respect to its medication errors and pharmaceutical services, the amounts are more than justified. *See* 42 C.F.R. § 488.438(f); CMS Exs. 1, 3.

immediate jeopardy ended effective September 7, which, in any event, seems consistent with the rules governing duration. 42 C.F.R. § 488.454(a).

IV. Conclusion

From April 30, through October 16, 2011, the facility was not in substantial compliance with Medicare program requirements, notably 42 C.F.R. § 483.20(k)(3)(i) (professional standards of quality) and 42 C.F.R. §§ 483.60(a) and (b) (pharmaceutical services). From April 30 through September 6, 2011, those deficiencies posed immediate jeopardy to resident health and safety. The penalties imposed, which are at the very low end of the penalty ranges, are reasonable.

/s/
Carolyn Cozad Hughes
Administrative Law Judge