



**NURSING HOME DECISIONS OF THE
DEPARTMENT OF HEALTH AND
HUMAN SERVICES'S
DEPARTMENTAL APPEALS BOARD, 2007**

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Strangulation death on bedrail
\$4050 civil money penalty

Rehabilitation & Care Center of Jackson County, CR1590: Between November 2001 and March 2002, an 88-year-old resident at the Illinois nursing home fell numerous times from her bed while her bed's side rail was raised. On March 12, 2002, she "was found on the floor [uninjured] with her back against the bed, holding onto one of the half side rails with both hands, with her neck wedged between the half side rail and the mattress." A week later, on March 19, she was found in the same position, "on the floor next to her bed with her head wedged between the half side rail and the mattress," but this time, without pulse, respiration, and blood pressure. She had died of accidental strangulation. The Centers for Medicare & Medicaid Services cited the facility with failure of supervision, at the immediate jeopardy level, and with failure of assessment, at a non-jeopardy level. The Administrative Law Judge sustained both deficiencies and both remedies, a \$3050 per instance civil money penalty for the supervision deficiency and a \$1000 per instance civil money penalty for the assessment deficiency.

Leg amputation following failure to follow physician's treatment orders
\$7500 civil money penalty

Morrisons Cove Home, CR1581: A resident was admitted to a Pennsylvania nursing home May 24, 2004 for short-term rehabilitation following surgery for a fractured ankle. The nursing home failed to bring her to her surgeon's office for a follow-up visit on June 2. When the resident saw her surgeon on June 11, the surgeon determined that her wound was not healing correctly. He referred the resident to a wound specialist, who debrided the wound and ordered a culture, which identified an infection. The attending physician ordered that the resident's wound be monitored for infection and treated daily and that the resident be given an antibiotic. The staff failed to follow the physician's orders. On June 17, the resident was hospitalized; her leg was subsequently amputated. The Centers for Medicare & Medicaid Services cited the facility with a deficiency for failure to meet professional standards of care and imposed a per instance civil money penalty of \$7500. The Administrative Law Judge sustained the deficiency and the remedy.

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These are the facts, and enforcement consequences, in two of the 85 cases decided by the Department of Health and Human Services's Departmental Appeals Board in 2007. This report discusses all 85 decisions that were issued by the DAB in 2007 – 66 in the Civil Remedies Division and 19 in the Appellate Division.

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PREFACE

The federal regulatory system for nursing homes has three distinct components – the standards of care, called Requirements of Participation, that facilities must meet in order to provide high quality of care and quality of life to residents; the public survey process, which determines whether facilities comply with the federal standards of care; and the enforcement system, which imposes sanctions against facilities that are cited with deficiencies for noncompliance with federal standards. Nursing homes that voluntarily choose to be eligible to receive federal reimbursement under the Medicare or Medicaid programs, or both, agree to this comprehensive oversight structure.

Over the years, considerable public attention has been focused on whether the enforcement system is effective in ensuring that facilities provide residents with the appropriate care they need and are guaranteed by the Nursing Home Reform Law. Advocates for residents often contend that the system is too tolerant of poor care. The nursing home industry argues that the enforcement system is overly strict and punitive. For the first time since the 1987 Reform Law was enacted, Congress is considering amendments to the law's enforcement provisions.

Prior analyses have looked at deficiencies – how many are cited, how serious they are, whether survey agencies accurately code the seriousness of facilities' failures in care. But deficiencies are not the end point of the enforcement system; they are only the public statements of noncompliance with federal standards of care on which actual enforcement – the imposition of sanctions – is based.

This report is the first report to look at the enforcement actions taken against nursing homes that facilities appealed through the federal administrative process. It reviews all 85 decisions issued by the U.S. Department of Health and Human Services's Departmental Appeals Board in 2007 – 66 decisions by Administrative Law Judges at the Civil Remedies Division, 19 decisions by three-judge panels at the Appellate Division.

This report provides information about which deficiencies and remedies facilities appealed and how the administrative process dealt with those appeals – how the nursing home Requirements of Participation are really enforced. We hope this report will help inform public policy.

EXECUTIVE SUMMARY

Strangulation death on bedrail \$4050 civil money penalty

Rehabilitation & Care Center of Jackson County, CR1590: Between November 2001 and March 2002, an 88-year-old resident at the Illinois nursing home fell numerous times from her bed while her bed's side rail was raised. On March 12, 2002, she "was found on the floor [uninjured] with her back against the bed, holding onto one of the half side rails with both hands, with her neck wedged between the half side rail and the mattress." A week later, on March 19, she was found in the same position, "on the floor next to her bed with her head wedged between the half side rail and the mattress," but this time, without pulse, respiration, and blood pressure. She had died of accidental strangulation. The Centers for Medicare & Medicaid Services cited the facility with failure of supervision, at the immediate jeopardy level, and with failure of assessment, at a non-jeopardy level. The Administrative Law Judge sustained both deficiencies and both remedies, a \$3050 per instance civil money penalty for the supervision deficiency and a \$1000 per instance civil money penalty for the assessment deficiency.

These are the facts, and enforcement consequences, in one of the 85 cases decided by the Department of Health and Human Services's (HHS) Departmental Appeals Board (DAB) in 2007. The 85 decisions address survey deficiencies cited in nursing homes in 27 states. Sixty-six of the decisions were issued by Administrative Law Judges (ALJs) of the Civil Remedies Division; 19 decisions, by three-judge panels of the Appellate Division.

The 71 cases that reached the merits¹ addressed serious failures in care – elopements, amputations of limbs, development of avoidable pressure sores, failure to give prescribed medications, overmedication, and thirteen deaths.² The Centers for Medicare & Medicaid Services's (CMS) decision to cite deficiencies and impose remedies was upheld in 66 of the 71 cases, or 93%. More than half the decisions at the Civil Remedies Division level, and nearly three-quarters of the decisions at the Appellate Division, involved the most serious category of deficiencies, which are called "immediate jeopardy" deficiencies. Most of the decisions by the DAB involved only one or a small number of residents.

Most of the cases imposed civil money penalties (CMPs), usually at the low or lowest end of the permissible range of per day CMPs. Only 11 of the 71 decisions reaching the merits (seven at the

¹ Fourteen decisions did not reach the merits – 13 at the Civil Remedies Division, and one at the Appellate Division. At the Civil Remedies Division, Administrative Law Judges dismissed seven cases when CMS rescinded all of the remedies prior to the hearing; three appeals were untimely filed; one case raised unappealable issue, the effective date of a facility's recertification; one facility withdrew its appeal; and one case involved the facility's lack of authority to challenge the amount of a per instance civil money penalty. The Appellate Division affirmed an ALJ's dismissal of an untimely appeal.

² The ALJ rejected the deficiencies in two cases involving a resident's death and found the facility in substantial compliance. In 11 cases, the deficiencies were sustained. In one of the 11 decisions, although the ALJ did not record that a resident died, the resident's death was identified in the Appellate Division decision, issued in April 2008, which affirmed the ALJ's decision.

Civil Remedies Division, four at the Appellate Division) imposed CMPs exceeding \$100,000. Only two of the 11 cases sustaining the deficiencies that involved a resident death sanctioned the facility with a CMP exceeding \$100,000; CMPs in the 11 death cases ranged from \$4050 to \$269,950.

In 2007, CMS won, in whole or significant part, 48 of 53 appeals that were decided on their merits in the Civil Remedies Division, a 90% success rate; CMS won all 18 cases decided on the merits by the Appellate Division, a 100% success rate.

Recommendations

The regulatory system, unchanged for more than a decade, needs to be updated. A stronger and faster enforcement response is needed to the serious noncompliance that is cited. CMS must impose remedies for the existence of deficiencies, not just for facilities' failure to correct deficiencies. Fines must be increased to reflect more accurately the seriousness of the harm that is identified. New guidance to states should explain how to identify the appropriate duration of noncompliance. New federal remedies are needed to respond more quickly and appropriately to failures in care.

In addition, more public information is needed about the survey and enforcement systems and about the appeals process.

At present, there is little information available to the public about enforcement actions taken against facilities that are cited with deficiencies. CMS does not publicize its enforcement activity, either at the time of imposing remedies against a specific nursing home or in a monthly, quarterly, or annual report. CMS's nursing home information website, *Nursing Home Compare*, identifies the number of deficiencies cited against facilities over a three-year period, but it identifies deficiencies solely by the regulatory provision that is cited. The website does not describe what specific problems surveyors actually found and why surveyors cited the particular deficiency. There is no link to the federal survey form, CMS 2567. In addition, *Nursing Home Compare* does not include any information about enforcement actions.

CMS also does not publicize any information about facilities' administrative appeals – their number, substance, or outcome – and it should.

BACKGROUND

In order to understand why the Departmental Appeals Board (DAB) issued only 85 decisions in 2007, when there are 15,000 nursing homes nationwide and the overwhelming majority of facilities are cited with deficiencies in their annual surveys, it may be helpful to understand the federal survey and enforcement systems and state licensure rules.

The federal survey process

Each year, the 15,000 nursing homes that participate in the Medicare or Medicaid programs, or both, are required to have a publicly-conducted survey to determine their compliance with federal law. Surveys are conducted by state survey agencies, which are usually located in the state department of health, under contract to the federal Centers for Medicare & Medicaid Services (CMS). Additional surveys may be conducted at any time in response to a complaint by a resident, family member, or other person, or an incident that is self-reported by the facility.

Surveyors identifying noncompliance with federal Requirements of Participation cite nursing homes with deficiencies, classifying the deficiencies according to the number of residents affected (scope) and the seriousness of the deficiency (severity). Deficiencies are classified as isolated (one or a small number of residents), pattern (several residents), or widespread (pervasive in the facility). Deficiencies are also identified by four levels of severity – substantial compliance, no actual harm (with potential for more than minimal harm that is not immediate jeopardy), actual harm, and, for the most serious deficiencies, immediate jeopardy.³

The federal enforcement system

Under the federal enforcement system, CMS is responsible for enforcement of federal Requirements of Participation for nursing homes⁴ that choose to be certified for participation in the Medicare program, more than 95% of facilities nationwide. States are responsible for enforcement of federal Requirements of Participation only in the small number of nursing homes that participate solely in the Medicaid program. In addition, under state licensing laws, states enforce state standards of care. These standards are applicable to all facilities in a state; they are the only standards applicable to the small handful of facilities that do not choose to participate in either Medicare or Medicaid.

The federal enforcement system gives most facilities an opportunity to correct their deficiencies before remedies are imposed. CMS's initial letter to a facility about its deficiencies advises the facility that, based on the state's recommendation, it may impose specified remedies if the facility fails to correct its deficiencies by a specific "date certain." If a revisit by the state survey agency finds that the facility has achieved substantial compliance by that date, the remedies are not imposed. The "opportunity to correct," authorized by the enforcement provisions of the State Operations Manual, but not by statute or regulations, means that the federal enforcement system

³ The regulations define "immediate jeopardy" as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. §488.301.

⁴ The Medicare program uses the term 'skilled nursing facility;' the Medicaid program, 'nursing facility.' This report uses the term 'nursing home' to describe facilities that appealed their deficiencies to the Departmental Appeals Board.

imposes remedies for failure to correct deficiencies, generally not for the citing of deficiencies. Under the federal system, many remedies that CMS proposes to impose are never actually imposed.

Even when deficiencies are cited, enforcement is generally discretionary. CMS may impose remedies but it is not required to do so. Under the 1987 Reform Law, imposition of the remedy “denial of payment for new admissions” is mandatory under two sets of circumstances. CMS must impose the remedy if a facility either fails to achieve substantial compliance within three months or if it is found to have provided substandard quality of care on three consecutive standard surveys. In all other circumstances, CMS has discretion to impose one or more remedies against facilities that are cited with deficiencies.

Although the Nursing Home Reform Law and regulations authorize states and CMS to impose a full range of remedies tailored to the scope and severity of a facility’s deficiencies, CMS’s State Operations Manual suggests that remedies should be imposed only for serious deficiencies. The undercoding of deficiencies, identified by numerous reports of the Government Accountability Office (GAO) since 1998, means that many deficiencies are identified as less serious than they actually are. Relatively few deficiencies are described as causing actual harm or immediate jeopardy to residents. As a result, relatively few deficiencies lead to the imposition of discretionary remedies.

Federal remedies include civil money penalties (CMPs), denial of payment for new admissions, directed in-service training, directed plan of correction, temporary management, and termination. All remedies other than civil money penalties may be imposed while a facility’s administrative appeal is pending.

The dollar amount of per day CMPs is based on the severity of the deficiencies. Immediate jeopardy deficiencies carry per day CMPs of \$3050-\$10,000; non-immediate jeopardy deficiencies, per day CMPs of \$50-\$3000. When immediate jeopardy is removed, the CMP is reduced to the non-jeopardy range. The total amount of per day CMPs is a function of the amount of the per day CMP and the number of days that the CMP is imposed. CMS has not given states guidance on how to identify the appropriate duration of a facility’s noncompliance. The federal regulations authorize a 35% reduction in a CMP if a facility foregoes an administrative appeal.

Per instance CMPs are \$1000-\$10,000. The full range of per instance CMPs is available for deficiencies, regardless of the scope or severity of the deficiencies, the number of days of noncompliance, or whether immediate jeopardy is cited.

Facility appeals of deficiencies

Facilities that have deficiencies cited against them may request informal dispute resolution (IDR), a proceeding in which they can challenge the factual basis of deficiencies. Some deficiencies are eliminated through the IDR process; other deficiencies have their scope or severity, or both, reduced. Although the federal regulations governing the enforcement system specify that IDR may not delay the formal administrative appeals process, in practice, facilities often use both IDR and formal appeals sequentially. They request IDR and, if deficiencies remain after IDR, they continue with their appeals.

Facilities that have remedies imposed against them may file an appeal with the DAB, an independent dispute resolution body at the Department of Health and Human Services. Facilities may appeal deficiencies only if remedies are imposed; they may not appeal deficiencies in the absence of remedies. Administrative Law Judges (ALJs) in the Civil Remedies Division of the DAB hold hearings or decide cases on the pleadings or motion.

Facilities sometimes choose not to appeal all the deficiencies cited against them. They may limit their appeals to the most significant deficiencies with the largest penalties; occasionally, they appeal only the duration of a CMP, not the underlying deficiency itself.

The overwhelming majority of facility appeals, perhaps 80% or more, are settled, often just before the administrative hearing. No information is publicly available about the number of cases that are settled or the actual terms of the settlements. Anecdotal information indicates that CMPs are sometimes reduced by more than 35% in settlements.

ALJs often address only some of the deficiencies cited by CMS. They discuss deficiencies that are sufficient to sustain the remedy(ies), not the additional deficiencies cited by CMS. Deficiencies that are not addressed are usually cited at a lower scope or severity, or both, than the deficiencies discussed in the decision, although, at times, an ALJ will address only one of a number of immediate jeopardy deficiencies.

Any party that is not satisfied with an ALJ decision – the facility or CMS, or both – may file an appeal with the Appellate Division of the DAB, which decides cases in three-judge panels. Appeals of Appellate Division are brought in federal court.

Most of the ALJ and DAB decisions address serious deficiencies for which CMPs were imposed.

State enforcement system

All states license nursing homes. As a condition of doing business in a state, a nursing home must have a state license. State licensure programs require surveys and may impose their own remedies for noncompliance with state standards. State licensure standards are often modeled on federal standards, but states may also enact state standards that go beyond federal standards in certain areas. Generally, when state surveyors conduct federal surveys, they also survey facilities for compliance with state-specific requirements.

After a survey, the state survey agency decides whether to cite deficiencies under federal law or comparable state law, or both. The states cite state deficiencies and facilities appeal state enforcement actions through the state appeals system. Some states have found that the federal enforcement system is too delayed, too cumbersome, and too limited, and have chosen to use their own state licensure system as the primary enforcement system in general or for certain deficiencies. Washington State, for example, imposes remedies for the existence of deficiencies, not for failure to correct deficiencies; California imposes fines of up to \$100,000 when a facility caused the death of a resident.

As noted above, the state enforcement system is also used for the small handful of nursing homes that choose not to participate in the Medicare or Medicaid programs, or both; these facilities are not subject to the federal Requirements of Participation or the federal enforcement system.

This report's findings

This report describes the results of a review of all of the nursing home cases decided by the Civil Remedies and Appellate Divisions in calendar year 2007 – 66 at the Civil Remedies Division and 19 at the Appellate Division. The 85 cases most often involve serious failures in care – elopements, amputations of limbs, development of pressure sores, failure to give prescribed medication, and thirteen deaths.

Number of potential facility appeals is unknown

The universe of potential facility appeals is unknown and unknowable, with currently-available public information. Although the 15,000 nursing homes participating in the Medicare or Medicaid programs, or both, are subject to surveys to determine their compliance with federal law, only facilities that have remedies actually imposed against them have the right to an administrative appeal. Most facilities are cited with deficiencies; fewer than 10% of facilities are found to be deficiency-free. However, facilities that are cited with deficiencies have no right to appeal if remedies are dismissed before their effective date. The GAO has repeatedly reported that the overwhelming majority of facilities that are cited with deficiencies are given an opportunity to correct their deficiencies. The result is that most deficiencies cited by state survey agencies and CMS never lead to any enforcement actions. Immediate jeopardy deficiencies, the subject of a large portion of the cases at the DAB, are cited in a small number of facilities; just over 2% of facilities were cited with immediate jeopardy deficiencies in 2007.

The relatively small number of cases decided by the DAB in 2007 also reflects states' reliance on state licensure systems, rather than the federal enforcement system, when state remedies are faster and easier to implement. In addition, most cases appealed to the DAB are settled, leading to few adjudicated decisions.

CMS wins most cases at the DAB

As a general matter, CMS wins the cases that nursing homes file, with ALJs and the three-judge panels at the Appellate Division sustaining all of the deficiencies and the remedies imposed by CMS. On occasion, the ALJs reject some of the deficiencies or some of the resident examples; on rarer occasions, and particularly when they reject some deficiencies or some resident examples, they reduce the CMPs. In the interests of judicial economy, ALJs may not address all the deficiencies appealed by the facility; they may consider only the deficiencies that are sufficient to sustain the remedies imposed.

In 2007, CMS won, in whole or significant part, 66 of the 71 cases (93%) that were decided on their merits at the DAB. CMS won 48 of 53 decisions that were decided on their merits in the Civil Remedies Division, a 90% success rate, and all 18 decisions that were decided on their merits by the

Appellate Division, a 100% success rate. Fourteen cases (13 at the Civil Remedies Division, one at the Appellate Division) did not reach the merits.

ANALYSIS

The Civil Remedies Division

The Civil Remedies Division of the DAB issued 66 nursing home decisions from 25 states in 2007. Fifty-three decisions reached the merits; 13 did not.⁵

Forty-eight of the 53 decisions that reached the merits affirmed decisions of CMS to cite deficiencies and impose remedies; five decisions rejected the deficiencies and remedies either because CMS had not established a *prima facie* case or because the facility had rebutted CMS's *prima facie* case. Most of the 53 decisions that reached the merits involved serious deficiencies, frequently, the most serious "immediate jeopardy" deficiencies, and only one or a small number of residents. Most of the cases imposed CMPs.

Federal standards of care that are most often cited as deficiencies in ALJ cases

Failure to provide adequate supervision of residents, 42 C.F.R. §483.25(h)(2), is the most commonly-cited Requirement of Participation in the ALJ decisions. Seventeen of the 53 cases discussed this deficiency, reflecting a variety of failures in care:

- "Elopements" (a resident leaving the facility or expected location in the facility and the facility's not knowing that the resident has left or where the resident is, or both) (nine cases)
- Residents who left the facility and killed a man in a home invasion
- Falls
- Bedrail entrapment death
- Resident smoking; resident smoking, including smoking while using oxygen tank (three cases)

Elopement death
\$64,050 civil money penalty

Briarwood Nursing Center, CR1551, involved a resident with a history of elopement who eloped through the window of her room; her body was found a week later. The Georgia nursing home had failed to implement its care plan for the resident, which required that she be monitored every two hours. A nurse falsified the midnight census report by counting the resident as present, even though she did not see the resident; the facility terminated the nurse for falsifying facility records. The ALJ sustained three immediate jeopardy deficiencies

⁵ Thirteen of the 66 cases at the Civil Remedies Division did not reach the merits. ALJs dismissed seven cases when CMS rescinded all of the remedies prior to the hearing; three appeals were untimely filed; one case was a non-appealable issue (the effective date of recertification); one facility withdrew its appeal; and one case involved the facility's lack of authority to challenge the amount of a per instance civil money penalty.

related to the resident's elopement (supervision, §483.25(h)(2); neglect, §483.13(c)(1)(i); and professional standards of quality, §483.20(k)(3)(i)); he chose not to address other deficiencies cited by the survey agency. CMS imposed a \$3050 per day CMP for the period September 11-October 1, 2002, totaling \$64,050. The ALJ sustained the deficiencies and the CMP in full.

Quality of care, 42 C.F.R. §483.25, or a specific subset of quality of care, is the second most commonly-cited standard of care discussed in the ALJ decisions, cited in 14 of the 53 cases. Deficiencies under this regulatory citation include:

- Failure to assess or plan care for a resident who lost 50 pounds in a month, at a time when he was complaining of dizziness and weakness and was showing evidence of nausea, vomiting, and gastrointestinal distress
- Failure to provide appropriate tracheotomy care to residents after the respiratory company pulled its staff from the facility
- Development of avoidable pressure sores (e.g., failure to remove an immobilizer from a resident's leg for more than a month, resulting in the resident's development of avoidable pressure ulcers)
- Failure to provide incontinence care to residents
- Giving residents unnecessary drugs
- Failure to provide pain medication to a resident for three months
- Weight loss
- Dehydration

No pain medication for three months, one of five deficiencies
addressed by ALJ out of 17 cited by CMS
\$7500 civil money penalty

Woods Edge Pointe, CR1699: The quality of care deficiency, §483.25, cited at a level of severity indicating no harm to residents, was based on the care of three residents. One resident at the Ohio nursing home, who had not been given any pain medication for three months, despite the physician's order that pain medication be administered on an "as needed" basis, cried out in pain when she was given care and stopped crying when care was completed, according to a certified nurse assistant. The facility failed to follow up on a second resident's need for dental care, identified in September 2002, at the time of the April 2003 survey. The facility failed to honor the third resident's care plan, which allowed her to self-test for blood sugar and self-administer her own insulin. For the quality of care deficiency and five other deficiencies addressed by the ALJ (out of 17 deficiencies cited by the state survey agency), CMS imposed a \$250 per day civil money penalty, totaling \$7500.

Failure to monitor resident's blood sugar levels,
leading to re-hospitalization with hypoglycemia four days after admission
\$38,700 civil money penalty

The Laurels at Forest Glenn, CR1681: Quality of care, §483.25, and failure to notify the resident's physician of a significant change in the resident's condition, §483.10(b)(11), were cited as immediate jeopardy deficiencies when a facility failed to adequately monitor a resident's blood sugar, contrary to the hospital's direction to monitor the resident's blood sugar carefully. The result was the re-hospitalization of the resident with hypoglycemia four days after his admission. The ALJ sustained the per day CMPs imposed by CMS – five days at \$3050 per day and 42 days at \$50 per day, totaling \$38,700.

Abuse and neglect, 42 C.F.R. §483.13(b) and (c), were cited in ten cases, including

- Abuse of residents by aide
- Failure to report and investigate reports of abuse
- Failure to investigate a resident's bruising over a four-month period
- Physical and mental abuse of residents by aides
- Choking death of a resident

Sexual assault of resident by aide and staff failure to report sexual assault;
additional deficiency cited for failure of supervision of another resident
\$12,600 civil money penalty

Franklin Care Center, CR1694: A resident was sexually abused by a certified nurse assistant and suffered post-traumatic stress disorder as a result. Neither of the aides to whom she reported the assaults reported them. The next day, the same aide was assigned to take care of the resident. She told him to leave her room and reported the assaults again, this time, to a nurse. CMS cited two immediate jeopardy deficiencies for the assault, §§483.13(b), 483.13(c). Failure of supervision, §483.25(h)(2) was also cited for another resident's repeated falls, one of which resulted in the resident's hip fracture. The ALJ sustained the per day CMPs imposed by CMS – \$3100 for three days, \$100 for 33 days, totaling \$12,600.

Choking death of resident, residents' dehydration during heat wave
\$80,000 civil money penalty

Jennifer Matthew Nursing & Rehab Center, CR1717: A resident whose care plan required that he be fed by staff, fed himself a hotdog in the dining room, choked, and died. The facility failed to provide him with appropriate care and failed to report the incident. The state also cited the facility with failing to provide residents with necessary care and services during a heat wave, resulting in residents' suffering from dehydration. The ALJ noted the facility's "abysmal" history of noncompliance and reported that eight certified nurse assistants and licensed practical nurses at the facility had been convicted of neglect and falsifying medical records just prior to the incidents at issue in the appeal. She sustained three immediate jeopardy deficiencies – neglect, §483.13(c), quality of care, §483.25, and administration, §483.75 – and \$10,000 per day CMPs for eight days, totaling \$80,000.

Accident hazards, 42 C.F.R. §483.25(h)(1), were cited in five cases, including

- Wheelchairs not correctly fastened in facility van (two cases, one involving a resident death)
- Failing to remove a cigarette lighter and smoking materials from a resident after the wanderguard attached to him was found burned off

Professional standards of quality, 42 C.F.R. §483.20(k)(3), were cited in three cases, including

- Resident elopement
- Providing unnecessary drugs
- Failure to call a physician or begin CPR on a resident
- Allowing a resident to smoke while using oxygen

10 consecutive overdoses of morphine and other medication errors
\$178,150 civil money penalty

Premier Living and Rehabilitation Center, CR1602, involved medication errors. Over the weekend of September 24-26, 2005, a hospice patient admitted to the North Carolina nursing home on September 21, 2005 received, from three nurses, 10 consecutive overdoses of morphine, each, ten times the amount of morphine prescribed by her physician. The ALJ found that nursing staff incorrectly measured the medication and failed to conduct an adequate investigation of the medication errors. She identified two additional medication errors by the facility's staff. Rejecting the facility's argument that the medication errors were attributable to "human error" rather than some systemic breakdown," the ALJ sustained two immediate jeopardy deficiencies, failure to meet professional standards of quality, §483.20(k)(3)(i), and unnecessary drugs, §483.25(l)(1). CMS imposed a \$3050 per day CMP for 58 days of immediate jeopardy and a \$50 per day CMP for non-jeopardy noncompliance. The ALJ sustained the deficiencies and the CMPs, totaling \$178,150. An appellate panel sustained the decision in its entirety. No. 2146 (Jan. 14, 2008).

The deficiencies are serious

More than half of the cases (32 of the 53 cases) reaching the merits at the ALJ level involved immediate jeopardy deficiencies. Facility failings cited as jeopardy included

- Nine cases involving residents who left the facilities without the facilities' awareness ("elopement"); two of these residents died
- Failure to assess and plan care for a resident who lost 50 pounds in a month, at a time when he was complaining of dizziness and weakness and was showing evidence of nausea, vomiting, and gastrointestinal distress
- Death by entrapment in a bedrail
- Failure to have any kind of working call system on one wing of a facility with 73 beds
- Failure of care planning, supervision, and rehabilitation of four residents who left the facility and, in a home invasion, murdered a person

- Failure to secure residents' wheelchairs properly in facility's van, resulting in two accidents; one resident died
- Failure to identify hypoglycemia in a resident, requiring his return to the hospital in four days
- Failure to provide social services to a resident, despite his escalating behavioral issues, ending with the resident's suicide with a gun
- Resident whose care plan required him to be fed choked to death when he was allowed to feed himself a hotdog in the dining room, failure to provide appropriate care to residents during heat wave; abuse, quality of care, and administration deficiencies were cited at the immediate jeopardy level

Elopement death
\$73,250 civil money penalty

Harlan Nursing Home, CR1644, involved a Kentucky nursing home's failure to provide adequate supervision for six residents, §483.25(h)(2), and failure in administration, §483.75. One resident, who had eloped from his previous facility and who was assessed as needing supervision at all times, eloped from the facility and was found outside, dead, by the maintenance supervisor. The facility's alarm system was routinely disengaged by the facility's staff to allow for vending machine deliveries and staff did not know how the alarm operated. The ALJ described the situation as "chaotic" and sustained the two deficiencies and the \$8050 per day CMP for nine days and \$100 per day CMP for eight days. The total CMP was \$73,250.

Eight cases involved the death of a resident

Eight of the 53 cases involved the death of a resident.

- Entrapment on a bedrail and strangulation death, \$4050 CMP
- Failure to consult with a resident's physician over the course of a week as the resident declined and ultimately died, \$7000 CMP
- Failure to provide CPR to a resident, \$10,000 CMP
- Elopement death, \$64,050 CMP
- Two elopements, one death, \$73,250 CMP
- Death by choking on a hotdog (and failure to provide hydration and care to residents during heat wave), \$80,000 CMP
- Failure to provide social services to resident who committed suicide, \$94,450 CMP

- Failure to secure residents' wheelchairs properly in facility's van; two incidents; one resident died, \$269,950 CMP⁶

One or a few residents are the subject of the deficiencies; fewer cases involve facility-wide deficiencies

Most of the cases involve the care of a single resident or a small number of residents; 23 of the 53 decisions discuss the care of a single resident and nine cases discuss the care of two to four residents.

Thirteen decisions discuss more than four residents:

- One decision discussed the non-functioning call system in the facility wing with 73 beds
- Two decisions discussed wheelchairs in facility vans
- Two decisions discussed Life Safety Code deficiencies
- One decision discussed housekeeping deficiencies
- One decision discussed the elopements of 10 residents
- Five decisions discussed multiple deficiencies affecting multiple residents
- One decision discussed the facility's failure to provide appropriate hydration and care to residents during a heat wave

The remaining decisions did not identify the number of residents affected by the deficiencies.

Civil money penalties are the most commonly-imposed remedies

Civil money penalties are the remedy that is most often discussed in the ALJ decisions. Forty-one decisions sustained CMPs, either alone or in combination with other remedies. In 26 of the 41 decisions, per day CMPs were imposed; in 14 decisions, per instance CMPs; and in one decision, both per day and per instance CMPs.

In only five cases with clearly identified remedies did CMS impose remedies other than CMPs; these remedies were denial of payment for new admissions, loss of authority to conduct a nurse aide training and competency evaluation program, and termination, or a combination of the three remedies.

The per day and per instance dollar amounts of civil money penalties are generally small; total per day CMPs are also generally small

The per day and per instance CMPs are generally imposed at the lower ends of the permissible ranges. When per day CMPs are imposed, the total amounts of the CMPs are also small.

Only seven decisions involved total per day CMPs over \$100,000. Five cases were from North Carolina, one each, from Alabama and Kentucky:

⁶ The ALJ's decision did not report that one of the residents died, but the Appellate Division issued in April 2008, which sustained the ALJ's decision in its entirety, reported that the resident injured in the second incident died.

- Physical abuse; failure report allegations of abuse; failure to implement abuse policies; \$3050 for three days; then \$1000 per day for 115 days; totaling \$125,150
- Wheelchairs not secured in van and resident elopement; \$3050 for 45 days, totaling \$137,250 (then \$100 per day; total unknown)
- Resident smoking and resident elopement; \$3050 per day for 57 days, \$50 per day for 31 days, totaling \$175,400
- Unnecessary drugs for two resident; \$3050 for 58 days, then \$50 for 25 days, totaling \$178,150
- Failure to have a functioning call system on one wing with 73 beds, for 71 days; \$3050 per day CMP for 71 days, totaling \$216,550 (then \$100 per day CMP; total unknown)
- Failure to ensure a safe environment while transporting resident in facility van (one resident died); \$4000 per day for 67 days, then \$50 per day, totaling \$269,950
- 10 resident elopements; \$4050 per day for 240 days, totaling \$974,500 (non-appealed deficiencies, \$500 per day; total not specified)

Both cases involving the deaths of residents who eloped carried CMPs below \$100,000; the CMPs for the two resident deaths were \$64,050 and \$73,250.

Per day CMPs

Twenty-six ALJ cases sustained per day CMPs.

Immediate jeopardy per day CMPs

Nineteen of the 26 cases imposing per day CMPs involved immediate jeopardy. Of these 19 immediate jeopardy cases, the lowest per day CMP for jeopardy (\$3050) was imposed in 11 cases for deficiencies including

- Resident elopements
- Lack of any call system for a wing with 73 beds
- Repeated falls
- Unnecessary drugs
- Physical abuse of a resident by an aide
- Permitting a resident to smoke while using oxygen
- Failure to monitor a resident's blood sugar, leading to hypoglycemia
- Smoking and elopement
- Resident suicide

CMS generally imposed immediate jeopardy deficiencies at the lowest end of the CMP range and then reduced the CMP to the low end of the non-jeopardy range after jeopardy was removed.

The total amounts of these 19 immediate jeopardy deficiencies (depending on the number of days and levels of noncompliance) ranged from \$4150 (repeated falls) to \$974,500 (10 resident elopements)

Lack of a call system on one wing with 73 beds, July 27 - October 5
\$216,500 civil money penalty

Care Center of Opelika, CR1556, involved the lack of any type of call system on one wing of the Alabama nursing home with 73 beds, between July 27 and October 5, 2005. Although the facility's old call system had been malfunctioning for several months and broke down in July, the facility did not order a new system until September 6. The facility distributed hand bells to some residents on the wing, but did not give hand bells to all residents and did not have hand bells in the toilet and bathing areas. In late August, about a month after the call system broke, the facility assigned "bell monitors" to walk the halls listening for bells. Bell monitors were sometimes taken off the bell monitor assignment because of staff shortages. CMS found the bell system was not an adequate back-up system. The ALJ sustained an immediate jeopardy deficiency for failing to have a functioning call system, \$483.70(f), and the \$3050 per day CMP for 71 days, totaling \$216,500. (CMS also cited two non-jeopardy deficiencies and imposed a \$100 per day CMP.) On June 19, 2007, the ALJ's decision was affirmed on appeal by the Appellate Division. No. 2093.

In seven immediate jeopardy cases, the per day CMPs were imposed and sustained at higher than the minimum level. These immediate jeopardy per day CMPs ranged from \$3100 per day (residents' smoking) to \$10,000 per day (resident's choking death and failure to provide sufficient hydration and care to residents during heat wave). The total amounts of these seven immediate jeopardy deficiencies (depending on the number of days and the levels of noncompliance) ranged from \$39,250 (uncontested deficiencies in quality of care, nursing services, physical environment, and administration) to \$974,500 (failure to supervise, resulting in ten residents' elopements). The \$974,500 CMP is an outlier, nearly four times the amount of the next highest per day CMP, \$269,950 (accident hazards and administration, for failing to secure residents safely in the facility's van).

Non-jeopardy per day CMPs

CMS also set non-jeopardy per day CMPs at the low end of the range of \$50 to \$3000 per day. The seven non-jeopardy per day CMPs sustained at the ALJ level ranged from \$200 per day for four deficiencies affecting 13 residents in pressure ulcers, accommodation of residents' needs, and incontinence care, to \$500 per day in two cases. One case involved five deficiencies (care planning pressure ulcers, quality of care, supervision and assistance to prevent accidents); the other, pressure sores, unreported bruises, assessment, and dietary deficiencies.

Four deficiencies (pressure ulcers, incontinence care, call bells) involving 13 residents
\$9800 civil money penalty

Beverly Healthcare – Ingram, CR1597, sustained four deficiencies at the Alabama nursing home involving 13 residents: (1) one resident developed avoidable pressure ulcers when the facility failed to remove the immobilizer on her leg between December 9, 2005 and January 17, 2006; (2) the facility failed to place call bells within the reach of four residents; and (3) the facility failed to provide proper incontinence care to four residents (two deficiencies). The ALJ sustained the deficiencies and the \$200 per day CMP for the period January 20-March 9, 2006. The total was \$9800.

Per instance CMPs

The fourteen per instance CMPs sustained at the ALJ level ranged from \$1250 (dehydration) to two decisions imposing \$10,000 per instance CMPs (one decision cited failure of supervision when two residents who left their facility engaged in a home invasion and murder; the other decision, two Life Safety Code deficiencies).

Five cases involving resident elopements resulted in per instance CMPs of \$2000, \$3000, \$3100, \$3300, and \$7000.

Elopement; resident hospitalized with hypothermia and abrasions
\$3000 civil money penalty

Mitchell Village Care Center, CR1589: After a resident tried to elope from the Iowa nursing home on December 31, 2003, the facility did not implement any additional interventions. The resident successfully eloped on January 2, 2004 and was found outside and taken to the hospital, where she was treated for hypothermia and abrasions. The ALJ sustained the immediate jeopardy deficiency for failure of supervision, §483.25(h)(2), and the \$3000 per instance CMP.

Three of the 13 per instance CMPs involved the death of a resident. The per instance CMPs were \$4050 (\$3050 and \$1000); \$10,000 (two CMPs, each \$5000), and \$7000.

Resident death, following failure to call physician or initiate CPR
\$10,000 civil money penalty

Apollo Health and Rehabilitation Center, CR1611: A resident admitted to the Florida nursing home on March 13, 2006 died less than a week later, on March 19, 2006, when the facility failed to call the resident's physician after her condition significantly changed. The facility also failed to initiate CPR when the nurse misread the resident's chart. The ALJ described as "amazing" and flying "in the face of reality" the facility's argument that the resident did not experience significant change, saying, "By any measure or standard the resident's disorientation and death throes were significant changes that demanded physician notification." The ALJ sustained two deficiencies, neglect, §483.13(c), and professional

standards of quality, §483.20(k)(3)(i), and chose not to address other allegations of noncompliance. He sustained two per instance CMPs, each \$5000.

**Resident death, failure to consult with physician
\$7000 civil money penalty**

Topeka Presbyterian Manor, CR1707: A resident who was found on the floor on January 3, 2005 and told staff of his Kansas nursing home that he had fallen out of wheelchair was sent to the hospital that day, returned to the facility four hours later, and declined over the course of the next several days, dying in the facility on January 10. The facility never contacted his physician and his physician never saw the resident before his death, despite the fact that the emergency room physician specifically ordered that the resident's physician be consulted. The ALJ sustained the deficiency for failure to consult with the physician following a significant change, §483.10(b)(11), and the \$7000 per instance CMP.

The resident's strangulation death on her bedrail, which resulted in two per instance CMPs totaling \$4050, was discussed at the beginning of this report.

Cases involved 25 states

The 66 ALJ decisions involved nursing homes in 25 states, with each state having one to seven cases:

Eight cases: North Carolina

Seven cases: Illinois

Six cases: Oklahoma

Five cases: Texas

Four cases: Iowa

Three cases: Alabama, Florida, Kansas, Kentucky, New Jersey, Ohio

Two cases: Connecticut, New York, Pennsylvania, Washington

One case: Arizona, Arkansas, California, Georgia, Idaho, Louisiana, Mississippi, Missouri, New Mexico, South Carolina

ALJs held hearings and decided cases on motion

ALJs decide cases by holding hearings or ruling on motions. Summary judgment decisions are issued when no material facts are in genuine dispute. Motions to dismiss reflect untimely appeals or appeals where CMS had previously dismissed all remedies.

The 66 ALJ cases were decided by:

- Hearings in 37 cases⁷
- Other methods in 30 cases:
 - Summary judgment: 6
 - Written record: 7

⁷ One case had both a partial summary judgment decision and a second decision based on a hearing.

- Motions to dismiss: 13
- Stipulation: 1
- Motion for summary affirmance: 1
- Appeal withdrawn: 1
- Written exchanges: 1

Time elapsed between surveys and ALJ decisions

The 2007 ALJ decisions reflected surveys that occurred between 2001 and 2007:

2001: 1 survey
 2002: 2 surveys
 2003: 9 surveys
 2004: 8 surveys
 2005: 14 surveys
 2006: 23 surveys
 2007: 5 surveys

No survey date was identified in four decisions.

Cases that were decided by motion or on the written record were decided more quickly than those involving a hearing before the ALJ; only three cases decided by motion were based on surveys in 2003 and 2004. Cases decided by hearing included one survey in 2001, two surveys in 2002, eight surveys in 2003, six surveys in 2004, ten surveys in 2005, and eight surveys in 2006.

The time between hearing and ALJ decision ranged from two to 40 months.

Cases where the ALJ rejected the deficiencies

In five of 53 cases decided on the merits, two of which involved the death of a resident, the ALJ rejected the deficiencies cited by CMS. The ALJ found either that CMS failed to establish a *prima facie* case of noncompliance or that the facility rebutted CMS's *prima facie* case by a preponderance of the evidence. As a consequence, the ALJs also dismissed the remedies that CMS imposed.

IHS of Kansas City, CR1585, rejected the immediate jeopardy quality of care deficiency, §483.25, cited against the Missouri for failure to identify the decline of a resident, who died. While describing the resident's care as "not perfect," the ALJ found that the facility's staff acted reasonably, "given the Resident's complex medical situation." The ALJ found the facility in substantial compliance and rejected the \$10,000 per instance CMP.

Bloomfield Health Care Center, CR1610, rejected the deficiency for failure to provide one resident at the Connecticut nursing home with proper hydration, in violation of §483.25(j). The ALJ acknowledged that the facility's assessment and care plans for the resident were not models and were not "perfectly documented or executed." Nevertheless, he rejected the deficiency, relying on two physicians, who testified that the resident's hospitalization was precipitated by an episodic manifestation of mesenteric ischemia, which mimics dehydration.

The ALJ found the facility in substantial compliance with Requirements and rejected the per instance CMP of \$1000.

Sheridan Health Care Center, CR1641, rejected three deficiencies, including a quality of care deficiency, §483.25, cited at the Illinois nursing home at the immediate jeopardy level, involving the care of a resident who fasted to death in the exercise of his religious beliefs. The ALJ found that the facility's staff was attentive and accommodating to the resident during his 5½-year stay, even though some of the entries in the resident's record were late and not perfectly documented. He described the case as "extremely unusual and difficult," found that the facility had rebutted CMS's *prima facie* case, and rejected the \$3050 and \$200 per day CMPs that totaled \$27,600.

Haven Health Care of Windham, CR1656, rejected the deficiency cited against the Connecticut nursing home for failure to notify a physician of a significant change in a resident's condition, in violation of §483.10(b)(11). The ALJ found that CMS did not present any expert medical testimony to establish that any change in the resident's condition was either life-threatening or a clinical complication. Finding that CMS had not established a *prima facie* case of noncompliance, he rejected the deficiency and the \$2000 per instance CMP.

Crestview Acres, CR1718, rejected two deficiencies, a jeopardy-level failure of supervision, §483.25(h)(2), and abuse, §483.13(b), cited against an Iowa nursing home for the sexual assault of a female resident by a male resident. The ALJ found that the facility had no reason to "expect, or fear, or anticipate" that the resident would commit a sexual assault when his prior relationships with three female residents were consensual and non-sexual. The facility documented that it counseled the male resident about these prior relationships; used anti-psychotic medications and female hormone replacement medication to decrease the resident's libido; made hourly checks of the resident; and promptly discharged him to a hospital and then permanently discharged him after the sexual assault. The surveyor originally assigned to investigate the complaint testified, on behalf of the facility, that the survey agency appeared to want her to substantiate the complaint and that she was removed from the case after she told her superiors in the state survey agency that she had found the facility in substantial compliance. The ALJ found that the facility rebutted CMS's *prima facie* case and rejected the \$10,000 per instance CMP.

The Appellate Division

The Appellate Division of the Departmental Appeals Board issued 18 nursing home decisions from 11 states in 2007. All 17 decisions that reached the merits affirmed decisions of CMS, in whole or in part, to cite deficiencies and impose remedies; one case affirmed the ALJ's dismissal of an untimely appeal. Like the ALJ decisions at the Civil Remedies Division, most of the cases at the Appellate Division involved serious deficiencies, frequently, the most serious "immediate jeopardy" deficiencies, involving one or a small number of residents. Most of the cases imposed CMPs.

Panel decisions frequently began with a discussion of legal issues – whether the ALJ applied the correct legal standard and burden of proof, whether the ALJ properly conducted the hearing and

gave appropriate weight to the witnesses' testimony. The Appellate Division decisions generally included fewer facts about the cases and the deficiencies.

Federal standards of care that are most often cited as deficiencies in Appellate Division cases

The same deficiencies were addressed in the Appellate Division decisions as in the Civil Remedies Division decisions.

Failure to provide adequate supervision of residents, 42 C.F.R. §483.25(h)(2), was cited in six cases; four decisions involved resident elopements; one decision, two residents' smoking (one resident eloped; one burned himself); and one decision, the facility's failure to take any action when the husband of a resident did not return his wife to the facility after dialysis.

Smoking with oxygen, elopement
\$163,700 civil money penalty

Century Care of Crystal City, No. 2076: The facility had a smoking policy for residents, but was lax and inconsistent in its implementation of the policy. One resident, who had a history of "confusion, delirium, and unsafe behaviors, including unsafe smoking behaviors," burned himself while smoking when using oxygen; he was treated at the emergency room. A second resident who smoked, whose history included wandering and elopement, eloped from the facility, unobserved by staff; a doctor's office called the facility to report her presence. Staff did not document or report the second resident's elopement and the facility learned of the elopement two months later from surveyors who were investigating a complaint about the first resident's smoking incident. CMS cited the facility with failure of supervision, §483.25(h)(2), and administration, §483.75, both at the immediate jeopardy level. The ALJ sustained both immediate jeopardy deficiencies (the facility did not appeal the non-jeopardy deficiencies) and the CMPs, \$3050 per day for 52 days and \$150 per day for 34 days, totaling \$163,700. An appellate panel affirmed the decision.

Abuse and neglect, 42 C.F.R. §483.13(b) and (c), were cited in four cases for

- Failing to provide services to a resident
- A massive fire ant attack on a resident
- Failing to follow facility policy on abuse (the facility appealed only the duration of the deficiency, not the deficiency itself)
- Failing to investigate an injury of unknown origin (two cases)

Failure to investigate injury of unknown origin
\$16,800 civil money penalty

Rosewood Care Center of Inverness, CR2120: On November 16, 2005, a resident told staff at her Illinois nursing home that she had injured her right shoulder when she bumped against the bathroom door frame. An x-ray was negative. On November 21, she told staff that she had pain in her right side and an irregular heartbeat. The hospital where she was admitted

that day advised the facility that the resident had congestive heart failure and a fractured right clavicle. The facility failed to investigate the cause of the resident's fractured clavicle until the surveyor told the facility on December 27 that the resident said she had been pulled by the arms by a member of the facility's staff. CMS cited the facility with failure to investigate an injury of unknown origin, §483.13(c)(3), and failure to ensure adequate supervision, §483.25(h)(2), and with five additional deficiencies. CMS imposed a \$300 per day CMP for the period January 6-March 2, 2006, totaling \$16,800. The ALJ found that the negative x-ray for injury to the resident's shoulder on November 16 did not excuse the facility's failure to investigate the resident's broken clavicle, which was identified by the hospital on November 21. He granted summary judgment on the investigation deficiency and sustained the CMP. An appellate panel affirmed the decision in its entirety.

Professional standards of quality, 42 C.F.R. §483.20(k)(3), was cited in three cases:

- A nurse's administering the wrong medications to a resident
- Failure to ensure that 22 of 174 nursing staff members were timely recertified in CPR, after the facility failed to provide CPR to a resident, who died
- Failure to investigate when a husband failed to return his wife to the facility following dialysis

Medication errors by contract nurse
\$3100 civil money penalty

Daughters of Miriam Center, CR2067: A contract nurse at the New Jersey nursing home reported to her supervisor that she had injected a resident with an antibiotic, contrary to the physician's order that the antibiotic be given by mouth. After the nurse reported the incident, the facility discovered that the nurse had made a second medication error on the same shift. She gave two medications that were prescribed for a resident to that resident's roommate, who had also refused the insulin injection ordered for her roommate. CMS cited the facility with violating professional standards of nursing practice, §483.20(k)(3), at the immediate jeopardy level, and imposed a per instance CMP of \$3100. The ALJ found that CMS had not established a *prima facie* case of immediate jeopardy and reduced the CMP to \$1000. Reversing the ALJ's decision, an appellate panel reinstated the \$3100 per instance CMP.

Failure to provide CPR to resident who died
\$53,200 civil money penalty

John J. Kane Regional Center – Glen Hazel, No. 2068: A resident in cardiac distress, who was not transferred to the hospital or given emergency treatment, including CPR, in violation of §483.25, died at the facility. Surveyors determined that the facility did not ensure that 22 of 174 nursing staff were timely recertified in CPR, in violation of §483.20(k)(3)(ii). The ALJ reduced the per day CMP from \$1500 to \$700 for 76 days, totaling \$53,200. The panel affirmed the ALJ's decision.

Quality of care, 42 C.F.R. §483.25

- Failure to provide appropriate catheter care, pressure ulcers
- Failure to provide CPR

Accident hazards, 42 C.F.R. §483.25(h)(1)

- Restraints, seat belts in van
- Handroll, finger amputation

Amputation of finger
\$5000 civil money penalty

Lutheran Home at Trinity Oaks, No. 2111: Staff at the North Carolina nursing home gave a resident a handmade handroll, whose elastic strap was old and loose. Staff repeatedly saw the resident with the handroll wrapped around her fingers. One morning, the handroll was found wrapped around one of the resident's fingers, which had become necrotic and had to be amputated. CMS cited the facility with failing to maintain the environment free of accident hazards, §483.25(h)(1), and imposed a \$5000 per day CMP for one day. CMS also imposed a \$250 per day CMP for additional deficiencies, which were not identified in the decision. The ALJ rejected the facility's argument that the accident was unprecedented, calling the incident a reasonably foreseeable hazard. She sustained the deficiency and remedy. The panel affirmed the ALJ's decision.

Pest control, 42 C.F.R. 483.70(h)(4), involved fire ant infestations in two facilities.

Fire ant attack on resident
\$79,300 civil money penalty

Lake Mary Health Care, No. 2081: On August 10, 2003, fire ants were seen in the room of a bedfast, totally dependent resident. On August 20, at 4:30 a.m., she was found in her room "with a large number of ants on her face and upper body and with numerous ant stings." The facility was cited with two immediate jeopardy deficiencies – neglect, in violation of §483.13(c)(1)(i), and environment, in violation of §483.70. The ALJ sustained the deficiencies, finding that the facility did not follow its own pest control policy and did not respond adequately to repeated sightings of ants in 2003. He sustained per day CMPs – \$3050 for 26 days, totaling \$79,300 and \$100 thereafter (total number of days, not identified). An appellate panel affirmed the ALJ's decision in full.

The deficiencies are serious

Nearly three-quarters of the cases (13 of 18) reaching the merits involved immediate jeopardy deficiencies. Facility failings cited as immediate jeopardy included

- A contract nurse's administering the wrong medication to two residents
- Failure to provide CPR to a resident, who died

- Resident elopements (five decisions), one ending in the resident's death
- Pest control deficiencies (two decisions), including a massive fire ant attack on one resident
- Failure to provide appropriate supervision to two smokers; one eloped; one burned himself
- Failure to develop a care plan and provide services to a resident, who died
- Failure of supervision and administration, by failing to investigate when a resident's husband did not return her to the facility following dialysis
- Failure to have a functioning call system
- Restraints used as seat belts in facility van
- Failure to provide a safe environment; staff gave the resident a handroll with loose elastic that she repeatedly wrapped her finger, leading to necrosis and amputation of her finger
- Failure to follow facility policy on abuse, following the rape of a resident by an aide
- Failure to investigate a resident's injury of unknown origin after the hospital reported that the resident had a broken clavicle

Failure to plan care for neurogenic bowel condition of resident
admitted for respite care; resident died
\$120,000 civil money penalty

Britthaven of Havelock, No. 2078: A 45-year-old man with quadraplegia, who was admitted to the North Carolina facility on June 25, 2002 for short-term respite care while his mother had surgery, died on September 2 when the facility did not develop a care plan for his neurogenic bowel condition, did not follow-up on the attending physician's note and August 9 x-ray showing a bowel obstruction, and did not inform the physician when the resident refused the ordered treatment. The facility with cited with neglect, §483.13(c), for failing to develop a care plan or provide the resident with services to avoid physical harm. The State had recommended a \$10,000 per instance CMP; CMS changed the remedy to two \$5000 per day CMPs for the period August 10-September 5. The ALJ sustained the deficiency, but held that the facility's noncompliance ended on September 2, the date of resident's death. He sustained the two \$5000 per day CMPs for 24 days, totaling \$120,000. The panel affirmed the ALJ's decision in full.

Three decisions involved the death of a resident

Three of the 17 cases reaching the merits involved the death of a resident.

- Failure to provide CPR to a resident who died, \$53,200 CMP
- Elopement, \$64,150 CMP
- Failure to develop a care plan or provide services, \$120,000 CMP

One or a few residents are the subject of the deficiencies; fewer cases involve facility-wide deficiencies

Ten cases involved a single resident; three cases involved two residents.

Five cases involved more than four residents:

- One decision affirmed three deficiencies – catheter care, three residents’ pressure ulcers, and quality of food
- One decision reversed the ALJ’s decision overturning the determination of five deficiencies; the panel sustained two of the five deficiencies (restorative dining for one resident, care planning for three residents)
- Pest control deficiency
- Failure to have functional call system
- Staff failure to follow facility’s policy on abuse

Civil money penalties are the most commonly-imposed remedies

All but one case involved CMPs; one case affirmed a termination.

The per day and per instance dollar amounts of civil money penalties are generally small; total per day CMPs are also generally small

Per day CMPs

Fifteen decisions involved per day CMPs; 11 of the 15 decisions involved immediate jeopardy deficiencies and CMPs.

Four decisions involved total per day CMPs over \$100,000. Three of the decisions involved North Carolina nursing homes, one, an Alabama facility.

- Failure to develop care plan for resident, admitted for short-term respite care, who died; \$5000 per day for 24 days, totaling \$120,000
- Failure of supervision for two residents who smoked (one resident burned himself while smoking and using oxygen; the other resident eloped); \$3050 per day for 52 days, followed by a \$150 per day CMP for 34 days, totaling \$163,700
- Failure of supervision, with elopement of resident who had eloped many times before by deactivating the same switch; \$3500 per day for 60 days, totaling \$210,000 (\$100 per day CMP; total number of days unknown)
- Failure to have a functional call light system for a wing with 73 beds for 71 days; \$3050 per day, totaling \$216,550 (\$100 per day CMP; total number of days unknown)

Immediate jeopardy per day CMPs

Eleven decisions imposed per day CMPs for immediate jeopardy deficiencies. Five of the 11 decisions imposed the minimum immediate jeopardy per day CMP, \$3050:

- Accident hazards (restraints used as seat belts in facility van), neglect, resident elopement, \$3050 per day for one day for three immediate jeopardy deficiencies, then \$100, total not specified
- Elopement resulting in resident death, three immediate jeopardy deficiencies, \$3050 per day for 21 days, total \$64,150 (facility appealed only duration of CMP, which panel affirmed in full)
- Massive fire ant attack on one resident, two immediate jeopardy deficiencies for abuse and pest control; \$3050 per day for 26 days (total \$79,300); then \$100 per day
- Failure of supervision for two residents who smoked (one eloped; one burned himself), \$3050 per day for 52 days; \$150 per day for 34 days; total \$163,700)
- Failure to have functional call light system for wing with 73 beds, \$3050 per day for 71 days, total \$216,550

Six decisions imposed immediate jeopardy per day CMPs above the minimum:

- Resident was given loose and ill-fitting handroll by staff, which she repeatedly wrapped around her finger, ultimately leading to amputation of her finger, \$5000 per day for one day, \$250 per day for other deficiencies, total CMP not specified
- Failure to provide supervision to or find resident whose husband did not return her to facility following dialysis, \$4000 per day for two days, total \$8000, then \$250 per day
- Staff failure to follow facility policy after aide raped a resident, \$4150 for five days, total \$20,750, then \$50 per day for unknown number of days
- Pest control deficiency, \$8500 per day for 6 days, total \$51,000
- Failure to develop care plan for resident, admitted for short-term respite care, who died, \$5000 per day for 24 days, total \$120,000
- Elopement of resident who had eloped many times before by deactivating the same switch, \$3500 per day for 60 days, total \$210,000, then \$50 per day, total unknown

Non-jeopardy per day CMPs

Three decisions addressed non-jeopardy per day CMPs:

- Failure to investigate injury of unknown origin after hospital reported that resident had broken clavicle, \$300 per day for 56 days, total \$16,800
- Two quality of care deficiencies (catheter, pressure ulcers for three residents); food deficiency, \$400 per day for 48 days, total \$19,200

- Failure to provide CPR to resident, who died, \$700 per day for 49 days, total \$53,200

Per instance CMPs

Two decisions involved a per instance CMP. The panel reinstated the \$3100 per instance CMP imposed by CMS, which the ALJ had reduced to \$1000, when a contract nurse gave wrong medications to two residents and the first error was reported by the nurse, not identified by the facility. A per instance CMP of \$3050 was imposed for an elopement.

Cases involved 11 states

The 18 Appellate Division decisions involved nursing homes in 11 states, with each state having one to six cases:

Six cases: North Carolina

Two cases: Florida, Illinois

One case: Alabama, Georgia, Michigan, New Jersey, Ohio, Pennsylvania, Virginia, Wisconsin

ALJs held hearings and decided cases on motion

- Hearings were held in 14 cases
- Other methods in four cases:
 - Written record: 1
 - Summary judgment: 2
 - Motion to dismiss: 1

Time elapsed between surveys and ALJ decisions

The 2007 Appellate Division decisions reflected surveys that occurred between 2002 and 2006.

2002: 3 surveys

2003: 3 surveys

2004: 6 surveys

2005: 4 surveys

2006: 1 survey

One decision did not identify the date of the survey.

DISCUSSION AND RECOMMENDATIONS

A review of the 85 decisions issued by the DAB in 2007 demonstrates that deficiencies cited in nursing homes across the country are serious. State survey agencies and CMS identify extreme failures of care that, in many instances, led to unnecessary pain, injury, trauma, and death.

Despite the seriousness of the harm that residents suffer, the enforcement system imposed remedies that were modest at best. States and CMS generally imposed per day CMPs at the lowest end of the permissible range and total CMPs were almost always small, if not trivial, in comparison to the harm endured.

When nursing homes appealed these serious deficiencies and modest penalties, they lost their appeals.

What do these findings mean?

First, the regulatory system, unchanged for more than a decade, needs to be updated. A stronger and faster enforcement response is needed to the serious noncompliance that is cited. CMS must impose remedies for the existence of deficiencies, not just for facilities' failure to correct deficiencies. Fines must be increased to reflect more accurately the seriousness of the harm that is identified. New guidance to states should explain how to identify the appropriate duration of noncompliance. New federal remedies are needed to respond more quickly and appropriately to failures in care.

Second, more public information is needed about the survey and enforcement systems and about the appeals process.

At present, there is little information available to the public about enforcement actions taken against facilities that are cited with deficiencies. CMS does not publicize its enforcement activity, either at the time of imposing remedies against a specific nursing home or in a monthly, quarterly, or annual report. CMS's nursing home information website, *Nursing Home Compare*, identifies the number of deficiencies cited against facilities over a three-year period, but it identifies deficiencies solely by the regulatory provision that is cited. The website does not describe what specific problems surveyors actually found and why surveyors cited the particular deficiency. There is no link to the federal survey form, CMS 2567. In addition, *Nursing Home Compare* does not include any information about enforcement actions.

In November 2007, CMS began to publicize its Special Focus Facility (SFF) Initiative. This Initiative requires state survey agencies to conduct an additional survey each year in facilities whose three-year survey history identifies them as providing exceptionally poor care. In April 2008, CMS began to identify SFFs on *Nursing Home Compare*. CMS's limited disclosure of poor care in a small number of facilities (134 facilities in April 2008) provides some new information, but may also have an unintended consequence of suggesting to the public that facilities without the SFF designation provide acceptable care.

CMS also does not publicize any information about facilities' administrative appeals – their number, substance, or outcome – and it should.

CONCLUSION

The federal deficiencies cited by state survey agencies and the remedies imposed by CMS reflect serious failures in care for residents – amputations, dehydration, overmedication, undermedication, elopements, and deaths. These serious failures in care are not matched by significant penalties. The enforcement consequences of poor care are generally modest. Despite the limited enforcement response to poor care, nursing homes appeal the remedies imposed against them. Almost always, these appeals do not succeed.