Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Liberty Nursing and Rehabilitation Center - Mecklenberg County,	)	Date: January 24, 2007
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-05-224
Centers for Medicare & Medicaid Services.	)	Decision No. CR1559
	)	

DECISION

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to impose a civil money penalty (CMP) against Petitioner, Liberty Nursing and Rehabilitation Center-Mecklenberg County, for failure to comply substantially with federal requirements governing participation of long term care facilities in Medicare and state Medicaid programs. The CMP of $3,050 per day from November 30, 2004 through January 12, 2005 is based on a finding of immediate jeopardy. After the immediate jeopardy was removed, a CMP of $100 per day was imposed from January 13, 2005 until February 9, 2005. For the reasons that follow, I uphold a CMP of $3,050 per day based on a finding of immediate jeopardy and a CMP of $100 per day thereafter.

I. Background

This case came before me pursuant to a request for hearing filed by Petitioner on March 2, 2005.

On February 22, 2005, CMS informed Petitioner that it was imposing the following remedies pursuant to a complaint investigation survey conducted on January 4, 2005, followed by another complaint investigation survey completed on January 14, 2005, by the North Carolina State Survey Agency (State survey agency):

- CMP of $3,050 per day effective November 30, 2004 and continuing through January 12, 2005;
- CMP of $100 per day beginning January 13, 2005 through February 9, 2005;
- Denial of payment for new admissions (DPNA) effective April 4, 2005;[1] and
- Mandatory termination effective July 4, 2005.[2]

A hearing was held on April 25, 2006 in Charlotte, North Carolina. At the hearing, CMS offered 29 proposed exhibits (Exs.), identified as CMS Exs. 1-8; 11-21; 23-25; 27; 28, at 2; 29-30; 37; 39; and 40. I received CMS's exhibits into evidence without objection. Petitioner offered 18 proposed exhibits, identified as P. Exs. 1-18. I received these exhibits into evidence without objection.[3]

Subsequent to the hearing, the parties submitted post-hearing briefs (CMS Br. and P. Br.) and reply briefs (CMS Reply and P. Reply).

Based on the testimony offered at the hearing, the documentary evidence, the arguments of the parties, and the applicable law and regulations, I find that Petitioner was not in substantial compliance on the dates determined by the State survey agency and CMS. I further find that CMS was authorized to impose a CMP of $3,050 for noncompliance from November 30, 2004 through January 12, 2005, and a $100 per day CMP thereafter until February 9, 2005.[4]

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[1] The facility returned to substantial compliance before the DPNA went into effect.

[2] The facility returned to substantial compliance before the termination went into effect.

[3] P. Ex. 18 had formerly been offered by CMS as CMS Ex. 26, but was withdrawn.

[4] Petitioner filed a Motion for Partial Summary Judgment on July 22, 2005, premised on the argument that CMS lacks authority to cite violations of the Long Term Care Requirements of Participation based solely on the facility's alleged errors in the operation of a motor vehicle used to transport residents outside its premises. I denied that

II. Applicable Law and Regulations

Petitioner is a long-term care facility under the Act and regulations promulgated by the Secretary of Health and Human Services (Secretary). The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Social Security Act (Act), and at 42 C.F.R. Part 483.

Sections 1819 and 1919 of the Act invest the Secretary with authority to impose remedies of CMPs and denial of payment for new admissions against a long-term care facility for failure to comply substantially with participation requirements.

Pursuant to the Act, the Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. The applicable regulations at 42 C.F.R. Part 488 provide that facilities which participate in Medicare may be surveyed on behalf of CMS by state survey agencies in order to ascertain whether the facilities are complying with participation requirements. 42 C.F.R. §§ 488.10-488.28. The regulations contain special survey conditions for long-term care facilities. 42 C.F.R. §§ 488.300-488.335. Under Part 488, a state or CMS may impose a CMP against a long-term care facility where a state survey agency ascertains that the facility is not complying substantially with participation requirements. 42 C.F.R. §§ 488.406, 488.408, and 488.430. The penalty may start accruing as early as the date that the facility was first out of compliance until the date substantial compliance is achieved or the provider agreement is terminated. 42 C.F.R. § 488.440.

The regulations specify that a CMP which is imposed against a facility will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMPs, of from $3,050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1), (d)(2). The lower range of CMPs, of from $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii).

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motion by Order dated September 8, 2005.

The regulations define the term "substantial compliance" to mean:

> [A] level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

42 C.F.R. § 488.301.

"Immediate jeopardy" is defined to mean:

> . . . a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

Id.

The Act and regulations make a hearing available before an administrative law judge (ALJ) to a long-term facility against which CMS has determined to impose a CMP. But the scope of such hearings is limited to whether an *initial determination* made by CMS is correct. Act, section 1128A(c)(2); 42 C.F.R. §§ 488.408(g), 498.3(b)(12) and (13). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et al.*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991).

III. Issues

The issues in this matter are whether:

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

IV. Findings and Discussion

The findings of fact and conclusions of law noted below in italics are followed by a discussion of each finding.

A. The facility was not in substantial compliance with federal participation requirements from November 30, 2004 through February 9, 2005.

1. CMS established that Petitioner was not in compliance with the Quality of Care requirements at Tag F323 because Petitioner failed to ensure that the resident environment remained as free of accident hazards as possible, as required by 42 C.F.R. § 483.25(h)(1).

Based on observation, record review, staff interview, and resident interview, the facility failed to ensure that wheelchair residents were appropriately strapped in the facility's van during transport. This involved one of two facility vans that did not have the proper straps to ensure residents were secured in their wheelchairs. Immediate jeopardy was identified as occurring on November 30, 2004 when the administrator was notified of the van not having enough safety belts and instructed staff to use any type of device to secure residents in their wheelchairs during transport. Immediate jeopardy was removed on January 5, 2005, when the facility took the van out of service and completed staff in-services. CMS Ex. 3.

Resident No. 3 (R3)

On November 30, 2004, R3 voiced a concern to the facility administrator, Ms. Sharon Stiles, about residents being transported in wheelchairs that were not properly fastened down in the passenger van. In response to that concern, the facility administrator spoke with the driver by the name of Durk,[5] and instructed him to use a belt around the residents to secure them in the van. Ms. Stiles also indicated that she ordered a new van. P. Ex. 7. I infer from the action taken by the administrator that there was substance to the concern raised by R3.

In an affidavit dated January 10, 2005, Ms. Stiles stated that R3 complained to her that the driver was not fastening her down in the wheelchair in the passenger van. P. Ex. 6, at 1. However, a mere reading of the grievance report of November 30, 2004, prepared by Ms. Stiles, reveals that R3 was not solely concerned about herself not being strapped to the wheelchair. Her concern included the safety of other residents. Ms. Stiles noted her

[5] The driver's full name is Durk Dean Campbell.

concern to be that: "patients using wheelchairs that they were not fastened down while in wheelchair." P. Ex. 7, at 1. Ms. Stiles' resolution of the issue brought to her attention is further indication that R3's concern included other residents. In this regard, I note that she instructed Durk "to use a belt around patients to secure them to the van." *Id.* Another more revealing fact is that R3 was not wheelchair bound. It is evident from the Minimum Data Set (MDS) Assessment that she was ambulatory and required no assistance for ambulation. CMS Ex. 11, at 10, 11. Moreover, in a statement dated January 7, 2005, Durk Campbell indicated that R3 was able to walk and did not need to be transported in a wheelchair, but could be positioned in a seat up front with a CNA. P. Ex. 6, at 2. Thus, the issue with respect to this deficiency is not whether it can be established that R3 was transported in the facility van without her wheelchair being properly fastened and strapped, but rather, whether the facility failed to ensure that wheelchair dependent residents were appropriately strapped in the facility's van during transport.

Ms. Stiles' affidavit (P. Ex. 6, at 1), along with the testimony of Robert Powe, reveals that during the period at issue the facility had two van drivers. One was Durk (Campbell) and the other was Robert Powe. Durk quit his job unexpectedly on December 21, 2004, but Robert Powe remained in his position. Durk Campbell was the driver of an older van that had space for "maybe 5 wheelchairs, but was short one or two straps and seatbelts," as he put it. Tr. at 90. According to Ms. Stiles, at some point the facility leased another van because more transportation was needed for the dialysis residents. The leased van was driven by Robert Powe. On January 7, 2005, after the state survey team made it known to the facility that residents were being transported without the appropriate straps and seat belts to secure their wheelchairs, Ms. Stiles and her assistant reviewed the transportation logs, and found that there were several days in which Durk took three [wheelchair] patients at the same time. Thus, they asked him how he was securing the third patient since the van only had two van seat belts, and he said that he was using a wheelchair soft belt. P. Ex. 6, at 1.

After Durk Campbell quit, the facility returned the leased van on December 30, 2004, and Robert Powe started using the older van previously driven by Durk Campbell. Ms. Stiles remembered telling Robert that he could use a wheelchair soft belt to secure residents transported in the van. Thus, she should not have been surprised that Durk had been using the same type of restraint, because the practice was consistent with her instructions. Furthermore, Ms. Stiles stated in her affidavit that she was unaware that Robert *was not using the van seat belts*[6] until after the state survey. She must have known that on

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[6] Ms. Stiles referred to the wheelchair restraints as "van seat belts." Robert Powe described the means by which residents' wheelchairs were secured in the van with those

occasion he would use a soft belt because the vehicle was short straps and seat belts for at least one wheelchair. That is why she had instructed him to use a soft belt. This practice was also consistent with the information she obtained from Durk after reviewing the logs, and noting that on several occasions he transported one wheelchair resident for whom there was no van seat belt. On each of those occasions, he substituted a soft belt for the absent van seat belt.

Petitioner alleges confusion on the part of Ms. Stiles by pointing out that at one point in her affidavit she states that it was Mr. Powe who used a soft belt to restrain wheelchair residents in the van, while elsewhere she attributes the practice to Mr. Campbell. P. Br. at 8. I find that no such confusion exists. It is clear from her affidavit that both drivers used the soft belt to secure wheel chair residents in the facility van. I do not find Robert Powe's testimony at the hearing to the effect that he never used a soft belt to be credible. Tr. at 95. Such testimony given for litigation purposes, more than a year after the incident, does not have the probative value nor candor of the statement by the Administrator that is more contemporaneous with the events here under consideration. Additionally, at a time closer to those events, he admitted to the surveyor that he used the soft belt on residents being transported in the van on a couple of occasions. Tr. at 25, 44.

The surveyor also testified that the use of soft belts in place of van seat belts constitutes a safety hazard, and exposes residents using them in passenger vans to the risk of injury. Tr. at 27. In fact, Posey Company, a firm that manufactures those Self-Releasing Soft Lap Belts warns that they should never be used as a seat belt in a moving vehicle. CMS Ex. 14, at 3. To Robert Powe's credit, he admitted during his testimony that it would be ridiculous to use a soft belt as a seat belt in a vehicle. Tr. at 95.

Petitioner advances arguments that raise doubts as to whether R3 is a reliable source regarding the facility's alleged failure to secure wheelchair residents in the passenger van. My analysis, however, renders such arguments irrelevant to the issue here under consideration. P. Br. at 10, 11.

"seat belts" in the following way: "[i]f you're transporting a wheelchair, they're supposed to be strapped to the chair with what you call a four-point restraint, which has two straps in the front, one on each wheel, two straps in the back, one on each wheel. And it holds the wheelchair in place. And they're supposed to have a full harness seatbelt, as you would in a regular car." Tr. at 93.

In view of the foregoing, I find that CMS has established a prima facie case that Petitioner was not in substantial compliance with the requirements at Tag F323 because it failed to ensure that the resident environment remained as free of accident hazards as possible, as required by 42 C.F.R. § 483.25(h)(1). Petitioner has not overcome that showing by a preponderance of the evidence.

> *2. Staff Treatment of Resident (Tag F224). CMS established that the facility failed to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 42 C.F.R. § 483.139(c)(1)(i).*
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> *3. (Quality of Care (Tag F324). The facility failed to ensure that each resident receives adequate supervision and assistance devices to prevent accidents.*[7]

Based on medical record review, observations, and staff interviews, the facility failed to implement its elopement assessment policy and neglected to protect a resident from elopement.

Immediate jeopardy was identified as occurring on January 5, 2005, and was removed on January 13, 2005. However, the facility remained out of compliance at a scope and severity of a level "D" commencing January 13, 2005.

Resident No. 4 (R4)

Petitioner summarizes the facts pertaining to this Tag as set forth in the Statement of Deficiencies as follows:

> The Statement of Deficiencies alleges that the resident (R4) had been admitted to the Center on December 31, 2004, six days before the incident, suffering from, among other things, Alzheimer's and dementia; that she had been assessed to be at risk for wandering; that she somehow managed to ride a secured elevator from the third floor of the Center where she lived, to the lobby without triggering an alarm; that she left the Center sometime during the afternoon but was not missed

[7] I will address these Tags jointly because identical facts are alleged to support the deficiencies under the two Tags.

> until her family visited later in the day; and that she was missing until about 8:30 p.m., when a nearby neighbor called the Center and reported that she had found her.

Petitioner concedes that R4 eloped and concedes the immediate jeopardy citation. Tr. at 7; P. Br. at 16. However, Petitioner contends that it abated the immediate jeopardy by January 6, 2005, and is at a loss to know what else remained to be done after that date.[8] P. Br. at 19, 20. Thus, Petitioner disputes the appropriateness of extending the immediate jeopardy as to Tags F224 and F324 through January 12, 2005.

CMS, on the other hand, contends that the facility remained out of substantial compliance at the immediate jeopardy level through January 12, 2005 because the corrective action Petitioner attempted to implement after the elopement was not sufficient to keep other residents from harm. CMS Br. at 17. Specifically, CMS argues the following reasons for Petitioner's noncompliance:

- It had not in-serviced the receptionist on how to respond to alarms;
- It had not in-serviced all of its staff on how to respond to alarms;
- Staff failed to respond to an alarm on the elevator on January 13, 2005;
- The facility's front outside doors did not lock when approached by a Wanderguard;
- The facility did not implement any additional monitoring of its front door after the incident; and
- People other than nursing staff had access codes for the elevators, rendering its system of locking the doors ineffective.

CMS Reply at 11.

The facility had more than one receptionist, and at least one had been in-serviced. Tr. at 69, 70. Inasmuch as not all of the staff members that were assigned to monitor the main exit doors were receptionists, it cannot be concluded that those doors were being monitored by receptionists that had not been in-serviced. However, it is also true that

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[8] The steps allegedly taken by Petitioner are itemized at P. Ex. 18.

during the day, the receptionist monitoring the main entrance was assigned the performance of other tasks. I, thus, infer that during the daytime the staff member who was stationed at the reception desk could not provide undivided attention to the main entrance doors. Petitioner argues that a 24-hour watch was immediately posted at the front lobby doors until the staff was satisfied, several days later, that the alarm system functioned appropriately. P. Br. at 18. The facility's plan of correction further indicated that monitoring of the front lobby and side door areas would be in effect 24 hours a day until the alarm system was operable. CMS Ex. 25. Nonetheless, as indicated earlier, I find that it would not appear feasible that the receptionist could handle other duties at the reception desk and simultaneously monitor the front doors. The desired surveillance would be even less likely if the receptionist was also required to monitor the side area door. Thus, Petitioner's assertion that "a 24 hour watch was immediately posted *at the front lobby doors*" is not supported by the credible evidence of record.

Petitioner also admits that it was not until January 11, 2005 that in-service of staff on Wanderguard documentation and monitoring was completed. Furthermore, the plan of correction dated January 14, 2005 made no mention of in-service on responding to alarms. The staff's lack of appropriate response to alarms was made evident on January 13, 2005, when staff failed to respond to the elevator alarm. It should be noted here, that the alarm on that occasion was triggered by a visitor who was given access to the elevator code by facility staff. CMS Ex. 2, at 4.

Petitioner also argues that CMS places too much emphasis on the fact that the alarm system was not completely "fine tuned" until after the survey was completed on January 14, 2005. P. Br. at 18. However, what the facility's plan of correction asserted was that, as of January 14, 2005, the alarm system was not yet "completely operable." CMS Ex. 25. The facility planned to make up for this shortcoming by having staff monitor the exits on a 24-hour schedule, but as I discussed above, that monitoring was inadequate. Moreover, the facility did not report the lobby doors to be operable until January 24, 2005. CMS Ex. 2, at 1.

Based on Petitioner's Plan of Correction, it was determined that immediate jeopardy was abated as of January 13, 2005 in that:

- The facility agreed to have a dedicated staff member monitor the front and side lobby doors twenty four hours a day until the system was operable;

- The facility agreed to have the doors automatically lock at 9:00 p.m. and reopen at 6:30 a.m.;

- The alarm vendor would continue to work on the lobby doors until the system was completely operable;
- All staff would be in-serviced on how to respond to alarms;
- The facility once again changed the codes on the elevators and alerted staff not to give codes to any visitors or volunteers; and
- It finally in-serviced all of its receptionists.

CMS Reply at 14; *see also,* P. Ex. 2, at 1-2, 12-13, 20-21.

Petitioner's contention that the immediate jeopardy was removed as early as January 6, 2005 is not supported by the evidence. In view of the foregoing, I find that Petitioner was not in substantial compliance at the immediate jeopardy level as to Tags F224 and F324 through January 12, 2005.

B. CMS's finding of immediate jeopardy was not clearly erroneous (Tag F324).[9]

I have already found that CMS has established a *prima facie* case that Petitioner was not in substantial compliance with federal requirements for skilled nursing facilities participating in the Medicare and Medicaid programs regarding Tag F324. Petitioner has not overcome CMS's showing by a preponderance of the evidence. Furthermore, I sustain CMS's finding that Petitioner's level of noncompliance constitutes immediate jeopardy.

The regulations define immediate jeopardy as a situation in which a provider's non-compliance 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. A finding of immediate jeopardy does not require "a finding of present harm, but also encompasses a situation that is [likely to cause] harm." *Britthaven, Inc., d/b/a/ Britthaven of Smithfield*, DAB No. 2018, at 22 (2006) (*quoting Hermina Traeye Memorial Nursing*

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[9] I need not discuss CMS's determination that the facility was not in substantial compliance from January 6, 2005 through January 12, 2005, inasmuch as Petitioner has conceded the deficiency that was the basis of CMS's finding of noncompliance. I have discussed, however, the factors considered by CMS to determine the duration of the deficiency.

Home, DAB No. 1810, at 10 (2002)). CMS's determination of immediate jeopardy must be upheld unless it is clearly erroneous. 42 C.F.R. § 498.60(c)(2). The burden rests on the provider to prove that CMS's determination of immediate jeopardy is clearly erroneous. Petitioner has not met that burden here.

Petitioner contends that the immediate jeopardy Tag under F324 was not warranted because there is no reliable evidence to support the allegation that the facility transported residents in wheelchairs without proper safety restraints. Specifically, Petitioner asserts that R3 did not complain that she was never was properly strapped, but rather that other residents were not properly strapped. Furthermore, Petitioner contends that there is no record that other residents ever complained or corroborated R3's complaint regarding the facility's failure to properly strap residents in wheelchairs being transported in the passenger van. Moreover, adds Petitioner, R3's mental status made her an unreliable historian. As I have discussed above, R3's reliability is not relevant here in light of the facility staff's admission that residents were in fact transported in the passenger van without the proper safety restraints. I have also pointed out that the facility gave credence to R3's complaints and immediately began to take action (albeit inadequate), to correct the safety shortcomings based on her grievance.

Petitioner should have foreseen that transporting residents in wheelchairs in an unsafe manner in its passenger van was likely to cause serious injury, harm, impairment, or death. I should add that the statistical analysis submitted by Petitioner at P. Ex. 8, regarding *Wheelchair Users Injuries and Deaths Associated with Motor Vehicle Related Incidents*, cannot serve as a basis for ignoring the facility's duty to transport its wheelchair residents in its passenger van in a safe manner, regardless of whether the number of those who have lost their lives being so transported is few.

C. The amount of the penalty imposed by CMS is reasonable.

Petitioner contends that CMS failed to specifically provide any basis for a finding of immediate jeopardy that justifies the imposition of a $3,050 penalty from November 30, 2004 through January 5, 2005. I have already discussed the basis for a finding of noncompliance. Indeed, there is not only a prima facie case of noncompliance here, but the preponderance of the evidence is that Petitioner was not complying substantially with the regulatory requirements under 42 C.F.R. § 483.25(h)(2). Furthermore, Petitioner has not met its burden of showing that CMS's determination of immediate jeopardy is clearly erroneous. Moreover, the CMP of $3,050 per day is the minimum CMP that may be imposed for noncompliance at the immediate jeopardy level.

I also conclude that CMS satisfied the criteria for imposing remedies at the less than immediate jeopardy level from January 13 through February 9, 2005.

By letter dated February 22, 2005, CMS notified Petitioner that it was imposing a $3,050 per day CMP from November 30, 2004 through January 12, 2005, and a $100 per day CMP effective January 13, 2005 until the facility returned to substantial compliance. CMS Ex. 1. Subsequent to a February 10, 2005 survey, CMS determined that the facility had not achieved substantial compliance and raised the per day CMP to $500 commencing on that date. That determination was noticed to Petitioner in a letter dated March 8, 2006. However, Petitioner did not appeal the additional CMP period beginning February 10, 2005, nor has it refuted CMS's finding that its facility continued to be out of substantial compliance through February 9, 2005. Thus, Petitioner has not satisfied its burden of showing that it eliminated the noncompliance on any date prior to February 9, 2005. I therefore find that in addition to the immediate jeopardy CMP noted above, CMS was also justified in imposing a $100 penalty from January 13, 2005 through February 9, 2005. This CMP is at the low end of permissible penalties for a deficiency at the less than immediate jeopardy level.

V. Conclusion

Based on the testimony offered at the hearing, the documentary evidence, the arguments of the parties, and the applicable law and regulations, I find that Petitioner was not in substantial compliance at the immediate jeopardy level from November 30, 2004 through January 12, 2005, and that the imposition of a $3,050 per day CMP is reasonable. Additionally, I conclude that a CMP of $100 per day is reasonable for deficiencies at the less than immediate jeopardy level based on Petitioner's noncompliance from January 13, 2005, through February 9, 2005.

/s/

Jose A. Anglada
Administrative Law Judge