Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Littlefield Hospitality,
(CCN: 67-6149),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-79

Decision No. CR4598

Date: May 2, 2016

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose the following remedies against Petitioner, Littlefield Hospitality, a skilled nursing facility:

- Civil money penalties of $6050 per day for each day of a period that began on July 30, 2015 and that ran through August 4, 2015;

- Civil money penalties of $150 per day for each day of a period that began on August 5, 2015 and that ran through September 26, 2015; and

- Denial of payment for new Medicare admissions for each day of a period that began on September 16, 2015 and that ran through September 26, 2015.[1]

[1] The $150 daily civil money penalties and denial of payment for new admissions are in part based on noncompliance findings made at a survey of Petitioner's facility that occurred on September 2, 2015. Petitioner did not challenge these findings and they are administratively final.

I. Background

Petitioner filed a hearing request to challenge the remedy determinations that I recite in this decision's opening paragraph. CMS filed a brief and 46 proposed exhibits that it identified as CMS Ex. 1-CMS Ex. 46. Petitioner filed a brief and one proposed exhibit that it identified as P. Ex. 1. The parties agreed to have the case heard and decided based on their written submissions. I receive into the record CMS Ex. 1-CMS Ex. 46 and P. Ex. 1.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues are whether Petitioner failed to comply substantially with Medicare participation requirements and whether CMS's remedy determinations are reasonable.

B. Findings of Fact and Conclusions of Law

CMS alleges that Petitioner failed to comply substantially with Medicare participation requirements contained in the following regulations: 42 C.F.R. §§ 483.13(c), 483.25(h), and 483.75. 42 C.F.R. § 483.13(c) requires a skilled nursing facility to develop and implement written procedures that prohibit mistreatment and neglect of residents. CMS alleges that Petitioner neglected residents in that it allowed them to leave its facility unsupervised without first assessing these residents for the risks that they might encounter when off-premises.

42 C.F.R. § 483.25 directs a skilled nursing facility to ensure that its resident environment remain as free from accident hazards as is possible and also to ensure that each of the facility's residents receives adequate supervision to prevent accidents. CMS asserts that Petitioner contravened this regulation in failing to assess its residents for the risks that they might encounter if they left the facility unsupervised and also by failing to develop mitigating measures to protect residents when they were off-premises.

42 C.F.R. § 483.75 requires a skilled nursing facility to be administered in a way that maximizes the efficient use of resources in order to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. CMS argues that Petitioner contravened this regulation by failing to develop policies and to implement procedures that ensure that residents were assessed to determine whether they could safely leave Petitioner's facility without supervision.

CMS contends that Petitioner's noncompliance with all three of these regulations was so egregious as to comprise immediate jeopardy for residents of its facility.

Essentially undisputed material facts determine the outcome of this case. CMS centers its arguments around the care that Petitioner gave to three of its residents, identified as Residents 1, 2, and 4. Resident 1 had diagnoses that included dementia with behavior disturbances, alcohol-induced amnestic disorder, psychosis, and antisocial personality disorder. CMS Ex. 2 at 3; CMS Ex. 7 at 1; CMS Ex. 14 at 16. The resident's impairments were so severe that he was adjudicated mentally incapacitated and a guardian was appointed to make decisions on his behalf. CMS Ex. 16 at 1. Petitioner's staff assessed the resident as having signs and symptoms of delirium and found him to be at a high risk for falling. CMS Ex. 12 at 12-13. The staff found that the resident was so impaired that he needed to be supervised when he walked. CMS Ex. 8 at 21, 31; CMS Ex. 12 at 11-13.

Resident 2 had diagnoses that included schizophrenia and drug and alcohol abuse. CMS Ex. 2 at 2, 11; CMS Ex. 24 at 1. Petitioner's staff assessed the resident as requiring 24-hour supervision. CMS Ex. 2 at 48.

Resident 4's diagnoses included traumatic brain injury that caused him to be forgetful, have short-term memory problems, and make bad decisions. CMS Ex. 2 at 18. Petitioner's staff assessed him as being at a high risk for falls due to balance issues, unsteadiness, and his tendency to lean forward as he walked. CMS Ex. 30 at 1.

Petitioner's staff allowed these residents to wander off-premises as they pleased. Residents of the facility were free to leave whenever they wanted to conditioned only on their signing out. CMS Ex. 2 at 10-11. Although the facility had doors equipped with coded locking mechanisms, the codes were posted near the keypads for the doors. *Id.* at 14-15, 21.

The record is devoid of evidence that Petitioner developed interventions to protect these three residents when they were away from the facility. To begin with, Petitioner's staff did not even assess the risks and harms that the residents might encounter if off-premises and unsupervised. The staff made no plans to deal with the possibility that these residents might leave the facility. The staff failed to assess or plan for the residents' protection in spite of the obvious risks to these residents of being alone off-premises. CMS Ex. 2 at 10.

The record is replete with evidence of instances in which these three residents left the facility unsupervised and were exposed to great risk of harm. On July 30, 2015, for example, Resident 1 left the facility without signing out. CMS Ex. 6 at 1. Afterward, the facility staff received a phone call advising them that the resident was at a local grocery store and appeared to be confused. *Id.* A nursing assistant went to the store to attempt to retrieve the resident but the resident refused to return to the facility. *Id.* The staff then contacted the local police for assistance. When the police arrived at the store the resident

had left for an unknown destination. *Id.*; CMS Ex. 9 at 1. During their search, the police actually found Resident 2, who had also wandered off Petitioner's premises, and returned him to the facility. CMS Ex. 6 at 1.

Resident 1 spent the night of July 30 away from the facility, his whereabouts unknown. On the following day one of Petitioner's employees contacted Petitioner's staff to advise them that the resident was in a store in a town that is 23 miles away from Petitioner's facility. CMS Ex. 9 at 20.

This event was entirely consistent with Resident 1's history. In 2014, the resident wandered away from Petitioner's premises and was not found until two weeks later in a town located almost 80 miles from the facility. CMS Ex. 6 at 8; CMS Ex. 13 at 2.

Resident 2 wandered from Petitioner's facility more frequently than did Resident 1. In Resident 2's case the absences were often associated with the resident seeking and obtaining unlawful drugs. CMS Ex. 17 at 1; CMS Ex. 18 at 11, 13-14, CMS Ex. 25 at 1. Often, staff discovered that the resident possessed alcohol or drugs on his return to the facility. *Id.* On one occasion another resident reported that Resident 2 offered to share methamphetamine that he had brought back to the facility. CMS Ex. 18 at 12. On another occasion the resident was found passed out in the community. CMS Ex. 2 at 34; CMS Ex. 27 at 19. On multiple occasions Petitioner's staff asked local police to look for Resident 2. CMS Ex. 18 at 15; CMS Ex. 9 at 14-15.

Resident 4's falling problems were well known to Petitioner's staff. He fell multiple times while a resident at Petitioner's facility. CMS Ex. 27 at 1, 3, 5, 6, 8. Notwithstanding, the resident frequently left the facility unescorted. On various occasions Petitioner's staff would search for the resident in town or ask the police to search for him. CMS Ex. 27 at 19, 20; CMS Ex. 31 at 19, 25.

On July 6, 2015, Resident 4 left Petitioner's facility unescorted and ostensibly to make a purchase at a local convenience store. CMS Ex. 2 at 20. Later, after the store had closed, an employee of the store heard the resident yelling in an alley behind the store. CMS Ex. 2 at 20-21. It was raining and the resident was bleeding from an injury. *Id.*; CMS Ex. 35 at 2. The store employee called for assistance and an ambulance transferred Resident 4 to a hospital. CMS Ex. 31 at 8; CMS Ex. 35 at 2. Store employees reported to a surveyor that they had often witnessed Resident 4 asking customers for money, alcohol, or a ride to another town. CMS Ex. 2 at 21-22. One employee advised the surveyor that he or she had called Petitioner on more than one occasion to advise that the resident needed assistance but that Petitioner had not provided any. *Id.*

I find that the evidence overwhelmingly supports CMS's allegations of noncompliance both as to substance and as to egregiousness. Petitioner was stunningly lax in providing supervision to residents who clearly should never have been allowed to leave Petitioner's

facility without supervision or other assistance. These residents are individuals who suffered from dementia, schizophrenia, and substance abuse problems. Yet, Petitioner allowed them to come and go from the facility as they pleased without even determining where they were going and when they would return. Petitioner performed no meaningful assessments of these residents' abilities to be off-premises unsupervised, no assessments of the risks that these residents might encounter while off-premises, and developed no measures to protect the residents. There were no effective security systems in place at Petitioner's facility that prevented demented and mentally impaired residents from disappearing from the premises. Residents were found wandering miles from Petitioner's premises days after they'd disappeared from the facility. Petitioner made no meaningful efforts to trace these residents or retrieve them. Residents returned to Petitioner's facility under the influence of alcohol and illegal controlled substances and, on at least one occasion, a resident returned to Petitioner's facility with an illegal controlled substance and offered to share it with other residents.

Petitioner's noncompliance was certainly so egregious as to comprise immediate jeopardy for its residents. The likelihood of serious injury, harm, or death to these residents was overwhelming. Residents with serious mental and physical problems were allowed to wander off-premises, unaccounted for and sometimes for days, exposing them to a myriad of risks and hazards. One resident suffered an injury during the course of his wandering that required hospital care. Residents with substance abuse problems were allowed to go into an environment where unlawful drugs were available and to obtain them.

Petitioner does not dispute that it allowed its residents to roam the community at will. It does not deny CMS's assertions that it failed to assess the risks and possible harm that the residents might experience if away unsupervised. It doesn't deny that it failed to develop interventions to protect its residents when they were not on the facility's premises. Nor does it disagree that some of these residents had serious mental and physical impairments or that they had substance abuse disorders and were using their trips away from the facility to obtain drugs and alcohol.

Petitioner's sole defense is that these residents had the right to leave the facility as they pleased and that it could not lawfully interfere with the residents' exercise of that asserted right. Petitioner analogizes the residents' wandering in this case to residents who refuse medical care that is ordered on their behalf and it contends that these residents had just as much right to wander, as other residents might have to refuse a specific medication or treatment.

That argument fails, first, because Petitioner made no showing that it actually attempted to protect its residents from the likely effects of their wandering off premises. This is not a case in which residents left the premises despite being counseled by Petitioner's staff not to go. It is not a case where residents wandered off despite the facility's best efforts

to protect them. As I have stated, there is no evidence to show that the staff developed any measures – including counseling – to protect its residents. The evidence establishes that Petitioner's staff let residents come and go as they pleased, despite the palpable risks to the residents, and that the staff never attempted to stop the residents from doing so.

Second, skilled nursing facilities – contrary to Petitioner's assertion – have a duty to take all reasonable measures to prevent mentally impaired and disabled residents from wandering away. A skilled nursing facility is not a boarding house or a hotel. It owes a duty of care to its residents. As a condition for receiving Medicare reimbursement, a skilled nursing facility must assess its residents for the risks that result from their unique problems and conditions. It must develop plans to protect its residents. It must attempt to assure that residents are not exposed to foreseeable risks and hazards. And, it must do all of these things *even if* a resident or residents ultimately refuse assistance from the facility. *Van Duyn Home and Hospital*, DAB No. 2368 at 7-13 (2011).

Petitioner did none of those things. There is nothing in the record to show that Petitioner assessed Residents 1, 2, and 4 for the risks that they would encounter while away from the facility. There is no evidence to show that the staff developed interventions to protect these residents. In fact, evidence plainly shows that the staff simply ignored its own assessments of the residents' conditions and problems. In the case of Resident 2, for example, the staff determined that the resident needed 24-hour supervision. Yet, it let the resident wander away from the facility at will. In the case of Resident 1, the evidence establishes that the resident could not walk safely unsupervised. Yet, Petitioner completely disregarded that evidence and made no attempt to protect Resident 1 when he was away from the facility.

I agree that a skilled nursing facility may not lock up a mentally competent resident against his or her will. If a skilled nursing facility is not a boarding house or a hotel, neither is it a prison. But, a facility that houses mentally incompetent residents owes a duty of care to the residents that may include not acceding to the residents' demands if those demands are not consistent with professionally recognized standards of care or the wishes of the residents' guardians. In this case at least one of the three residents, Resident 1, had been adjudicated as mentally incapacitated. That resident had a court-appointed guardian. Given that, the resident no longer had the legal right to decide on his own that he could wander from the facility. And, if he attempted to do so the facility had the duty immediately to consult with the resident's guardian to determine what course the guardian wished the facility to take. There is nothing in the record to show that Petitioner's staff did that. Nor is there evidence to show that the staff took into account the obvious evidence of mental impairment of Residents 2 and 4 when it acceded to these residents' demands to leave the premises.

The remedies imposed by CMS are more than reasonable given the gravity of Petitioner's noncompliance. And, as I discuss in more detail below, I find that Petitioner has not shown that it lacks the wherewithal to pay the civil money penalties that CMS determined to impose.

Petitioner has not disputed the duration of its noncompliance, either at the immediate jeopardy level or at the non-immediate jeopardy level. Consequently, I do not address it here. I find that Petitioner's immediate jeopardy level noncompliance extended from July 30 through August 4, 2015 and that its non-immediate jeopardy level noncompliance extended from August 5 through September 26, 2015.

Civil money penalties in daily amounts of between $3050 and $10,000 may be imposed where immediate jeopardy exists. 42 C.F.R. § 488.438(a)(1)(i). For non-immediate jeopardy level deficiencies the permissible range for daily amounts is between $50 and $3000. 42 C.F.R. § 488.438(a)(1)(ii). The immediate jeopardy level penalties imposed of $6050 per day and the non-immediate jeopardy level penalties imposed of $150 per day fall within the permissible ranges.

Exactly where within a range a penalty amount should fall depends on factors set forth at 42 C.F.R. §§ 488.438(f)(1)-(4) and 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)). These factors include the seriousness of noncompliance, a facility's culpability and its compliance history. They may also include a facility's financial condition.

The seriousness of Petitioner's noncompliance strongly supports both the $6050 daily immediate jeopardy level penalties and the $150 daily non-immediate jeopardy level penalties. Petitioner's noncompliance was, as I have said, egregious. Indeed, Petitioner's staff utterly disregarded the risks that Petitioner's residents were exposed to notwithstanding obvious evidence that these residents were in real jeopardy when they were away from the facility unsupervised. It should have been patently clear to the staff that Residents 1, 2, and 4 were at risk of grave injury or death when they wandered away from the facility and yet the staff simply ignored the evidence that was staring them in the face.

Petitioner now argues that it would be an unsustainable hardship if it were required to pay the full amount of the penalties ($44,250) that CMS determined to impose. In support of its contention Petitioner offers the affidavit of one of its owners, Kristi D. Porter, R.N., and a balance sheet that purports to show Petitioner's financial condition as of December 31, 2015. P. Ex. 1. I do not find this evidence to be persuasive proof that it would be an unreasonable hardship on Petitioner if it were compelled to pay the penalties imposed by CMS.

The balance sheet shows that as of December 31, 2015 Petitioner had net income of just over $1.8 million. P. Ex. 1 at 4-5. It shows expenses of roughly the same amount as its income. *Id.* at 7. From this, Petitioner argues that its operating margin is so thin that it could not be expected to pay the civil money penalties without jeopardizing its ability to continue to function.

However, while the facility's income and expenses may be in almost perfect balance, that does not mean that Petitioner lacks the wherewithal to pay civil money penalties in the amount at issue here. The evidence offered by Petitioner shows that, in fact, Petitioner has substantial reserves and assets from which it could pay the penalties. At the end of 2015 Petitioner had cash in its checking and savings accounts in excess of $900,000. And, it had other, unspecified assets of more than $2.3 million. In short, Petitioner has reserves that are more than sufficient for it to pay the penalties. Moreover, Petitioner has not offered any evidence concerning its creditworthiness.

/s/
Steven T. Kessel
Administrative Law Judge