Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Pinecrest Nursing and Rehabilitation Center
(CCN: 67-5289),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-861

Decision No. CR2417

Date: August 17, 2011

DECISION

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to impose remedies against Petitioner, Pinecrest Nursing and Rehabilitation Center, consisting of civil money penalties of $6,150 per day for each day of a period beginning May 11, 2010 and running through May 14, 2010, and civil money penalties of $150 per day for each day of a period beginning May 15, 2010 and running through June 1, 2010.[1]

I. Background

Petitioner is a skilled nursing facility that is located in Tyler, Texas. It participates in the Medicare program. Its participation in Medicare is governed by sections 1819 and 1866 of the Social Security Act and by implementing regulations at 42 C.F.R. Parts 483 and 488.

CMS determined to impose against Petitioner the remedies that I recite in this decision's opening paragraph. These remedy determinations were based on noncompliance findings

[1] CMS imposed other remedies against Petitioner, including loss of authority to conduct nurse aide training and certification. Petitioner did not challenge these remedies, and, so, I do not address them in this decision.

that were made at a survey of Petitioner's facility that was completed on May 14, 2010 (May Survey). Petitioner appealed CMS's determinations, and the case was assigned to me for a hearing and a decision.

The parties agreed that the case could be decided based on their exchanges of written evidence. CMS filed 14 proposed exhibits (Ex.) that it identified as CMS Ex. 1 – CMS Ex. 14. Petitioner filed 19 proposed exhibits that it identified as P. Ex. 1 – P. Ex. 19. The parties each filed opening and final briefs. I receive all of the parties' proposed exhibits into evidence.

II. Issues, Findings of Fact, and Conclusions of Law

A. Issues

The issues in this case are whether:

1. Petitioner failed to comply substantially with Medicare participation requirements;

2. CMS's determinations of immediate jeopardy level noncompliance are clearly erroneous; and

3. CMS's remedy determinations are reasonable.

B. Findings of Fact and Conclusions of Law

The surveyors who conducted the May Survey concluded that Petitioner failed to comply substantially with numerous Medicare participation requirements. These noncompliance findings included six deficiencies that were determined to be so egregious as to constitute immediate jeopardy level noncompliance. The term "immediate jeopardy" is defined at 42 C.F.R. § 488.301 to mean noncompliance that causes, or is likely to cause, serious injury, harm, impairment, or death to one or more residents of a skilled nursing facility.

The parties agreed that this case could be decided based only on the findings of immediate jeopardy level noncompliance. In this decision, I conclude that Petitioner's noncompliance at the immediate jeopardy level with three Medicare participation requirements is sufficient to justify all of the remedies that CMS determined to impose against it. These requirements are at: 42 C.F.R. § 483.13(c), which directs a facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents; 42 C.F.R. § 483.25(h), which requires a facility to ensure that its residents' environment remains as free from accident hazards as is possible and to ensure also that each of its residents receives adequate supervision and assistance devices

to prevent accidents; and 42 C.F.R. § 483.75, which requires a facility to be managed efficiently and effectively.

I find it unnecessary to address the other determinations of immediate jeopardy level noncompliance because the determinations that I do address amply support CMS's remedy determinations. Also, these additional determinations are, for the most part, based on the same facts as are the basis for the three noncompliance determinations that I address.

I make the following findings of fact and conclusions of law (Findings).

1. Petitioner failed to comply substantially with the requirements of 42 C.F.R. §§ 483.13(c), 483.25(h), and 483.75.

CMS presented overwhelming evidence that Petitioner failed to comply substantially with these three participation requirements. In summary, this evidence proves that:

- Petitioner neglected the needs of its residents. In particular, Petitioner failed to take necessary action to prevent two of its residents who were known elopement risks from eloping the facility. Its indifference to these residents' needs was such that, not only did it allow them to elope, it failed to report or adequately investigate the circumstances of elopement.

- Petitioner failed to provide necessary protection to its elopement prone residents, despite having knowledge that these residents were not only elopement risks but that they actively sought to elope the premises.

- Petitioner's management violated Petitioner's own policy by failing to ensure that elopements were quickly and thoroughly investigated and reported to appropriate authorities. The consequence was that Petitioner's staff was under no suasion to ascertain how these residents were able to elope and why Petitioner's security measures failed to protect the residents.

The evidence supporting these conclusions relates essentially to two residents, who are identified in the May Survey as Residents #s 8 and 14. The evidence establishes a gross inattention by the facility to the need to protect these residents from their propensities to elope and a wholesale failure on the part of the facility's staff to recognize the dangers and risks that these residents were exposed to. Moreover, it shows indifference on the part of the staff to understanding the very obvious security deficiencies in Petitioner's facility. Petitioner's staff and management were manifestly incurious as to the facility's security vulnerabilities and to the reasons why residents were able to elope successfully and stay away from the premises for relatively lengthy periods of time. At bottom,

Petitioner was indifferent to the dangers of elopement and the potential consequences to the facility's residents' health and safety.

Resident # 8 was, at the time of the survey, an elderly individual who had been admitted to the facility about a month previously. Her impairments included Alzheimer's disease with dementia, anxiety, lack of coordination, and muscular wasting and disuse atrophy. CMS Ex. 1 at 14-15; CMS Ex. 5 at 37. The resident showed confusion as to time and place, and her cognitive skills and ability to make decisions were impaired. CMS Ex. 5 at 3-12. The resident was ambulatory but required support. *Id.* at 19.

Almost from the moment of her arrival at the facility, Resident # 8 was recognized to be a high risk for elopement. CMS Ex. 5 at 24. She exhibited wandering behavior and was determined to be aggressive and resistant to care. *Id.* at 5-6, 24. She was issued a Wanderguard bracelet on the orders of her physician. *Id.* at 37.

I take notice that a Wanderguard is a device that is supposed to sound an audible alarm, when a person wearing it approaches a doorway that has been rigged to respond to the device. It is utilized in nursing facilities as a means of augmenting supervision of elopement prone residents. It is not, however, a substitute for supervision. A Wanderguard will not prevent a resident from eloping, if the staff fails to respond to an alarm that it triggers.

Resident # 8 began attempting to elope Petitioner's facility within days of her arrival there. On May 1, 2010, the resident walked through a facility fire door and was retrieved by facility staff. CMS Ex. 5 at 45. There is no evidence that the staff reviewed facility security measures in the wake of that attempt, nor is there evidence that the staff intensified supervision of Resident # 8.[2]

The resident made a second elopement attempt on May 4, 2010. CMS Ex. 5 at 59. Aside from entering a cryptic comment about the attempt in the resident's record, the staff made no documentation of this second attempt. *See id.* Thus, the staff failed to investigate the circumstances of the attempt and failed to draw any conclusions from it. Nor did management or staff review the facility security measures or intensify supervision of the resident after this second elopement attempt.

Just a few days later, on May 8, 2010, Resident # 8 walked through the same fire door, as she had escaped through on May 1, and eloped Petitioner's premises. CMS Ex. 5 at 13, 43; CMS Ex. 8 at 5. Her Wanderguard sounded the alarm, but no staff member responded immediately. CMS Ex. 8 at 13-14. Only after the alarm had sounded for about a minute did a staff member respond to the alarm. *Id.* By then, the resident had

[2] Petitioner's staff had not written a plan of care for the resident.

vanished. The staff could not find Resident # 8. After an absence of about 30-45 minutes, she was returned to the facility by an unidentified individual who found the resident walking along a road in a housing development about four tenths of a mile from the facility. CMS Ex. 8 at 5, 13-14.[3]

As with the previous elopement incidents involving Resident # 8, there is no evidence that Petitioner revisited its resident security procedures in the wake of the May 1 elopement. Moreover, Petitioner violated its own elopement policy in that its staff failed to report the resident's May 1 elopement to appropriate authorities. CMS Ex. 8 at 21. The facility did not conduct a complete investigation of the May 1 elopement. As for the May 8 elopement, its staff did not interview the individual who found Resident # 8 outside of the facility and who returned her to the premises. CMS Ex. 5 at 13; CMS Ex. 8 at 12-13.

Resident # 14 was admitted to Petitioner's facility on June 18, 2009. The resident, a relatively young individual, suffered from multiple problems that included: short and long-term memory loss and impaired decision making as a consequence of a brain injury; mood disturbances that were not easily altered; and frequent (at least daily) episodes of abusive, socially inappropriate, and disruptive behavior problems. CMS Ex. 6 at 4, 9. The resident suffered from a lack of coordination. *Id.* at 9. The resident was assessed by Petitioner's staff as being a high risk for elopement. *Id.* at 88.

On April 1, 2010, Resident # 14 eloped Petitioner's premises. She disappeared from the facility, after being left during a smoking break without one-on-one supervision. CMS Ex. 6 at 80. She was absent from the facility for about an hour before returning. CMS Ex. 8 at 21. Petitioner's management and staff did not conduct an investigation of the elopement, nor did Petitioner – as was required by its own policies – report the elopement to appropriate authorities. *Id.* Thus, Petitioner failed to do an assessment of the circumstances of the elopement and failed to reassess its security procedures.[4]

The evidence I have just discussed describes an obvious disinterest on the part of Petitioner's management and staff to find out why the facility's security was being

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[3] The resident made a fourth attempt to elope Petitioner's premises on May 11, 2010. On this occasion, she walked through an alarmed door and was apprehended shortly afterward by Petitioner's staff. CMS Ex. 13 at 5.

[4] An account of what happened during the elopement was given by the resident to a surveyor during the May Survey. According to the resident, during her elopement, she visited an Italian restaurant, a Marriott hotel, and a convenience store and was eventually given a ride by a couple. CMS Ex. 6 at 18-19. In giving this account, the resident contended that it was easy to defeat the Wanderguard, either by wrapping it with duct tape or with metal foil. *Id.*

breached so easily by its residents and to develop measures that would tighten security. How was it that two of Petitioner's residents could simply walk out of the facility and be away for extended periods? Why didn't the staff react more quickly when Resident # 8 walked out of the facility on May 8, 2010? What extra measures were needed to make as certain as possible that determined residents, like Resident # 8 and Resident # 14, could not breach the facility's security? These questions were obvious in light of the residents' elopements, yet Petitioner's management and staff made no attempt to answer them. That is obvious neglect of the residents' needs, a failure to exercise reasonable diligence at supervising residents and protecting them against evident accident hazards, and, moreover, a failure by Petitioner's management to exercise control over the situation and to identify and rectify serious security problems.

Petitioner argues that the elopements by Residents #s 8 and 14 were simply unavoidable and unfortunate events for which Petitioner bears no responsibility. Essentially, it contends that the elopements occurred in spite of Petitioner doing all that any facility could reasonably be expected to do to care for and protect these residents. In the case of Resident # 8, for example, Petitioner contends that its staff responded immediately to her elopement on May 8, 2010 and was still in the process of searching the facility premises when the resident was returned to the facility.

But, in fact, the staff did not respond immediately to the alarm that the resident triggered when she exited the premises.[5] As I discuss above, there was about a one-minute delay between the alarm's sounding and any staff member responding to it. That was enough time to enable the resident to vanish. Moreover, this resident was off premises for at least a half hour, and Petitioner's management and staff made no effort to notify the police or other responsible authorities that there was an elderly and sick resident unaccounted for and potentially out in the community.

Petitioner contends that it was diligent in addressing whatever problems were presented by residents' elopements. However, it offers no evidence that it modified any of its security protocols in response to the elopements, nor does it offer evidence that it assessed the needs of Resident # 8 or heightened security measures for this resident after her several elopement attempts and her May 8, 2010 elopement. Petitioner offers only evidence that its staff made amendments to Resident # 14's care plan after she eloped on

[5] Petitioner cites the testimony of Ms. Joleann Beene as support for its contention that the staff responded immediately to the alarm triggered by Resident # 8's elopement. P. Ex. 1 at 5-6. I do not find Ms. Beene's testimony to be persuasive. Ms. Beene was not an eyewitness to any of the events that are at issue in this case, nor does she provide direct care at Petitioner's facility. Her assertion that the staff responded immediately disregards the statement by the staff member who actually responded to the alarm that was triggered by the resident's elopement. That staff member (LVN "G") stated that he waited about a minute after the alarm sounded before responding to it. CMS Ex. 8 at 13-14.

April 1, 2010. Principally, the staff was directed to monitor Resident # 14 at 15-minute intervals. P. Ex. 8 at 1. Additionally, Petitioner's staff intervened on several occasions when the resident became aggressive or disruptive. Petitioner's Final Brief at 9-10 (and exhibits cited therein).

I do not find this to be persuasive evidence that Petitioner appropriately dealt with the risks relating to possible elopements by its residents. As I have discussed, there is no evidence that Petitioner modified the care that it gave to Resident # 8, despite evidence that she was determined to elope the premises and, on one occasion, made good on her determination. Increasing surveillance of Resident # 14 may have been better than nothing, but it failed to get at the root of the problem at Petitioner's facility, a security system that was so porous as to allow residents to elope through unguarded exit doors. A resident who is monitored at 15-minute intervals has ample time between checks to elope if the facility's security system is ineffective.

Petitioner has not offered any proof that its management and staff attempted to determine and rectify the weaknesses in Petitioner's security. There is no evidence, for example, that Petitioner ever investigated how it was that residents were able to slip through exit doors despite being monitored. Nor is there any evidence showing that Petitioner ever investigated why Wanderguard-triggered alarms were not responded to instantly when a resident breached the facility's security. Finally, Petitioner has pointed to no analysis or assessment of whether 15-minute monitoring was sufficient to assure that Resident # 14 was being adequately supervised.

Petitioner asserts that it was not under any obligation to report the elopement of Residents #s 8 and 14. According to Petitioner, that obligation is triggered only when there are circumstances that place the resident's health, safety, and/or welfare at jeopardy, and those circumstances are simply not present in the case of these residents' elopements. I categorically disagree with this contention. Petitioner's management staff should have reacted instantly to the discovery of these residents' elopements by reporting them to appropriate authorities. These residents are both extremely vulnerable individuals. Both residents suffer from significant mental limitations. Resident # 8, for example, suffers from Alzheimer's dementia. Both residents have physical problems. Facility staff concluded that Resident # 8 should not be permitted to walk unassisted. Both residents exited Petitioner's premises into a public area that contained roads and highways, businesses, and residences. The risks to these residents were obvious, ranging from exposure to the elements, the possibility of being struck by a vehicle, to events related to the residents' individual illnesses.

Much of Petitioner's argument seems to be constructed with the benefit of hindsight. Its reasoning appears to be that neither of the two residents suffered significant physical harm during their elopements, and, thus, Petitioner was under no compulsion to report or investigate the events. That is a kind of "no harm, no foul" analysis that avoids dealing

with the fact that these residents were under great risk throughout the time that they were away from the premises unsupervised. That they suffered no harm is fortuitous, but it offers no excuse for Petitioner's failure to discharge its obligations.

2. CMS's determination of immediate jeopardy is not clearly erroneous.

Petitioner's assertion that there was no immediate jeopardy level noncompliance is premised, essentially, on its argument that Resident # 8 and Resident # 14 experienced no actual harm during, or as a consequence of, their elopements. However, the presence of actual harm is not a prerequisite for a finding of immediate jeopardy. The likelihood of serious injury, harm, impairment, or death is the standard. 42 C.F.R. § 488.301. And, here, the likelihood that either of these residents would suffer harm from her elopement was very high. As I have discussed, Resident # 8 and Resident # 14 each suffers from physical and mental impairments that put them at great risk if let out in the community unsupervised.

Moreover, Petitioner conceded the likely harm that would result from either of these residents eloping, when it designated these residents as elopement risks. In doing so, the staff concluded that these residents were *not* safe or trustworthy if unsupervised. That is the whole point of designating a resident as an elopement risk and of subjecting the resident to special security measures, such as putting a Wanderguard on that resident.

3. CMS's remedy determinations are reasonable.

CMS determined to impose civil money penalties of $6,150 per day against Petitioner for each day of the period that began on May 11, 2010 and that continued through May 14, 2010, premised on its determination that Petitioner manifested immediate jeopardy level noncompliance throughout this period. It then imposed civil money penalties of $150 per day against Petitioner for each day of the period that began on May 15, 2010 and that continued through June 1, 2010, based on its determination that, although Petitioner had abated immediate jeopardy by May 15, it remained substantially noncompliant through June 1.

I find these determinations to be reasonable. The seriousness of Petitioner's immediate jeopardy noncompliance amply supports the penalty of $6,150 per day. Indeed, Petitioner's noncompliance was sufficiently egregious that I would have sustained the penalty amount even if Petitioner had manifested only one of the three immediate jeopardy level deficiencies that I find in this decision. The penalties of $150 per day are minimal and are supported by Petitioner's residual noncompliance.

Regulations prescribe that an immediate jeopardy level penalty must fall within a range of from $3,050 to $10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). There are regulatory factors that govern where within this range an immediate jeopardy level penalty should

fall. These include: the seriousness of a facility's noncompliance; its culpability; its compliance history; and its financial condition. 42 C.F.R. §§ 488.438(f)(1) – (4); 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)).

The penalties that CMS determined to impose fall at about the midpoint of the immediate jeopardy range. CMS relies on the seriousness of Petitioner's noncompliance as support for the penalty amount. I agree with CMS that Petitioner's noncompliance was very serious. As I have discussed, Petitioner's failure to provide adequate protection to its residents put them at a great risk for serious injury or worse.

Petitioner's noncompliance transcends its failure to protect Residents #s 8 and 14. The failure by Petitioner's management and staff to recognize that there were serious problems with Petitioner's security system, their failure to investigate the nature of the problems, their failure to notify appropriate authorities, and, above all else, their failure to develop ways to better protect the residents put not only Residents #s 8 and 14 at risk, but all residents of Petitioner's facility who were at risk of elopement. The seriousness of the noncompliance is more than sufficient to justify the penalty amount.

Petitioner again argues that the noncompliance was not serious essentially because no one suffered serious injury as a result of it. I have addressed this argument previously and will not reiterate my analysis here. Petitioner also asserts that CMS failed to offer evidence about any of the regulatory factors aside from the issue of seriousness. But, the regulations do not require CMS to prove the existence of any particular factor to justify a penalty amount. Evidence relating to any of these factors may justify a penalty.

Petitioner also argues that CMS failed to take into consideration Petitioner's financial condition. However, CMS is under no obligation to prove a negative. It does not have to offer proof that a facility is financially capable of paying a civil money penalty. If a facility wants to argue that its financial condition precludes payment of a civil money penalty, it has that right to make that argument as an affirmative defense. But, that burden rests on the facility exclusively.

As I have discussed, the $150 per day penalties that CMS imposed after immediate jeopardy was abated are minimal, and Petitioner has not challenged this amount. Neither has Petitioner challenged the duration of its noncompliance. It has not argued, for example, that it affirmatively cured its noncompliance on a date that was earlier than CMS determined to be dates of abatement and compliance.

/s/
Steven T. Kessel
Administrative Law Judge