Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

MS Care Center of Greenville
(CCN: 25-5252),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-913

Decision No. CR2439

Date: September 30, 2011

DECISION

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to impose civil money penalties (CMPs) against Petitioner, MS Care Center of Greenville, of $3,550 per day from May 9, 2010 through June 1, 2010 and $100 for one day of noncompliance, June 2, 2010, after the immediate jeopardy was abated, for a total CMP of $85,300.[1]

I. Background

Petitioner is a skilled nursing facility located in Greenville, Mississippi. It participates in the Medicare program, and its participation is subject to the requirements of sections 1819 and 1866 of the Social Security Act (Act), as well as implementing regulations at 42 C.F.R. Parts 483 and 488. Petitioner's hearing rights are governed by regulations at 42 C.F.R. Part 498. To participate in the Medicare program, a nursing facility must maintain

[1] CMS stated that the total CMP here is $85,000. CMS Br. at 2. However, my calculations indicate 24 days of immediate jeopardy at $3,550 plus one day of non-immediate jeopardy at $100 totals $85,300.

substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary of Health and Human Services contracts with state survey agencies to conduct surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20.

This appeal involves an elopement incident at Petitioner's facility. Petitioner reported the incident and on June 1 and 2, 2010, the Mississippi State Department of Health conducted a survey regarding the incident. Following the survey, CMS determined that Petitioner was not in substantial compliance with two requirements at the immediate jeopardy level—Tag F224 (42 C.F.R. § 483.13(c)), Staff Treatment of Residents; and Tag F323 (42 C.F.R. § 483.25(h)), Accidents and Supervision. By letter dated June 18, 2010, CMS notified Petitioner that it imposed a CMP of $3,550 per day for the period of May 9 through June 1, 2010 for the immediate jeopardy deficiencies and a CMP of $100 for one day of noncompliance after the immediate jeopardy was abated.

Petitioner timely requested a hearing of the deficiencies found and remedies imposed. I conducted a hearing in this matter on February 23 through February 25, 2011 in Jackson, Mississippi and a transcript (Tr.) of the proceedings was prepared.[2] CMS offered CMS Exhibits (Exs.) 1 through 15, which were admitted. However, CMS replaced its proposed CMS Ex. 14 with a new CMS Ex. 14 at the hearing. CMS offered a rebuttal exhibit, CMS Ex. 17, which was admitted. Tr. at 473 (no CMS Ex. 16 was ever offered). I also identified and admitted as ALJ Ex. 1 a list identifying the residents and staff by key number. Tr. at 454. Petitioner offered P. Exs. 1 through 49. Petitioner withdrew its P. Ex. 11 and replaced it with P. Ex. 11A. All of Petitioner's exhibits so offered were admitted. CMS called Surveyor Jane McNally, R.N. and Surveyor Ordenia Howzie-Warkie, R.N. as witnesses. Petitioner called Jennifer Holdeman, R.N., Petitioner's Director of Nursing, and Donna Cingolani, R.N., Petitioner's Risk Management Nurse. The testimony of Judy Pevey, R.N., Petitioner's expert witness, was taken by deposition on March 24, 2011. The parties filed post-hearing briefs (CMS Br. and P. Br.) and were given the opportunity to submit post-hearing reply briefs. Only Petitioner submitted a post-hearing reply (P. Reply).

[2] Because one of Petitioner's witnesses, Judy Pevey, was not available during the scheduled hearing, the parties agreed to take her testimony by deposition. The transcript of her March 24, 2011 deposition is cited as "Pevey Tr." to avoid confusion with the hearing transcript (Tr.).

II. Issues

The issues before me are —

- From May 9, 2010 through June 2, 2010, was the facility in substantial compliance with Medicare requirements?

- Was CMS's determination of immediate jeopardy level noncompliance clearly erroneous? and

- Is the penalty imposed—$3,550 per day CMP for the period of May 9 through June 1, 2010 and a $100 per day CMP for June 2, 2010—reasonable?

III. Discussion

The deficiencies cited stem from the elopement of one resident, R1, from Petitioner's facility on May 9, 2010. No one disputes that R1 eloped sometime around 7 p.m. No one disputes that R1, who was wheelchair-bound and housed on the second floor of the facility, somehow got into the elevator, rode it down to the main floor, got out the allegedly-secure exit door to a patio area, and then rolled himself through a gate, through the parking lot, and across the street to the Krystal Double Quick, an adjacent convenience store with a drive-up fast-food window.[3] No one saw him exit the building. CMS Ex. 1. By coincidence, R1 was spotted when one of the CNA staff noticed him across the street in the Krystal Double Quick parking lot when she went to move her car. P. Ex. 30 at 1 and 4. A little while later, one of the CNAs responsible for R1 was looking for him. P. Ex. 30 at 3. She looked around the building and could not find him. She then went outside and saw R1 in the parking lot of the adjacent convenience store with the other CNA. Then these two CNAs and one other attempted to get R1 back into the facility. Not more than a half hour later, R1 again got on the elevator and exited the

[3] One of Petitioner's witnesses did, however, try to contend that R1 did not exit Petitioner's premises even though R1 was found on the premises of the adjacent fast food restaurant/convenience store across the street. *See* Tr. 188-89. She contended that the property line of Petitioner's facility "even goes out into that street." Tr. at 189. I find this witness's statements in this respect disingenuous: these statements have no basis in fact or reality. She neither saw the resident outside the facility nor was even present there that day. Tr. at 190. Nor did she speak to the CNA who found R1 in the parking lot of the fast-food restaurant/convenience store. Rather, her opinions were based solely on what others told her. Tr. at 190. I find her statements to be less than objective and that lack of objectivity reduces the credibility of her testimony here. Clearly, as soon as R1 exited the building and into the parking lot without staff being aware, he had eloped.

building right behind a facility visitor and was out in the parking lot. A CNA was in reach of him and returned him to the second floor. P. Ex. 20 at 2.

1. Petitioner failed to comply substantially with Medicare participation requirements.[4]

This case addresses the level of supervision that Petitioner's staff gave to R1, whom Petitioner had identified as being at risk for eloping from the facility premises. CMS alleges that Petitioner failed to comply with two specific regulatory requirements. 42 C.F.R. § 483.13(c) requires a facility to develop and implement policies and procedures that, among other things, protect a resident against neglect.[5] 42 C.F.R. § 483.25(h) requires a facility to provide residents with adequate assistance devices and supervision to prevent accidents and to render its premises free from accident hazards.[6]

Essentially, Petitioner argues that it did develop and implement policies and procedures to protect this resident against neglect but that despite these efforts, his elopement was unforeseeable. Petitioner contends that sometimes events such as this one happen despite all the measures that a facility can put in place. Petitioner argues that even though R1 was assessed as an elopement risk and that his care plan addressed this as a problem, his elopements on May 9 were not reasonably foreseeable.

The weight of the evidence establishes that Petitioner did not comply substantially with these two requirements. Although Petitioner had developed some policies to protect its residents against the risk of elopement, it failed to implement those policies. Furthermore, Petitioner failed to protect R1 from the obvious risks and hazards associated with his eloping from the facility by not providing him with adequate supervision and whatever other protection necessary to keep him from eloping from the facility.

Petitioner admitted R1 to its facility on April 14, 2010 from an acute care facility with diagnoses of post cardiac arrest with anoxic encephalopathy (a degenerative disease of the brain caused by prolonged insufficient oxygen supply), hypertension, expressive aphasia (a defect in the ability to communicate through speech) and amputation of the leg

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

[5] Under Mississippi law, indicators of neglect by a caregiver include lack of supervision. CMS Ex. 13 at 2.

[6] Based on my *de novo* review, I find that the remedy imposed of $3,550 per day would be reasonable based solely on Petitioner's substantial noncompliance with 42 C.F.R. § 483.25(h) without even addressing Petitioner's noncompliance under 42 C.F.R. § 483.13(c). *Bedford Care Center – Monroe Hall, LLC*, DAB No. CR2229 (2010).

above the right knee. Tr. 329, 333. R1 was younger than the residents normally admitted to the facility (he was approximately 55 years old at admission). P. Ex. 19; Tr. at 329.[7] His room was on the second floor of Petitioner's three-floor facility. CMS Ex. 2 at 3. Apparently, R1 had overdosed on crack cocaine or some other drug, ended up in the hospital and "coded." As a result, he suffered anoxic brain injury. Tr. 329. He had been in the hospital for a while on a ventilator, and then started recovering some level of functioning. When he was admitted to Petitioner's facility, he was heavily sedated, in a kind of medicated coma and not really able to answer questions. Tr. 330. Consequently, at the time of his admission, he was bed-bound and showed little or no inclination to wander.

Shortly thereafter, though, as he was weaned from the sedating medications, he began to get up from his bed and eventually became able to use his wheelchair; later, he would hop on his one leg down the hallway, and in and out of other residents' rooms. Tr. 341; P. Ex. 20 at 1. Nurse's Notes for April 24, 2010 state that R1 was at "elevator, trying to get on" and "keeps pulling w/c [wheelchair] alarm off." CMS Ex. 9, at 18. Because he was continually getting up and out of his wheelchair, Petitioner used a soft belt restraint but he would break these. *Id.* at 19. He also would be placed at the "nursing station where he could be watched carefully." *Id.* But within days he was again trying to tear off the soft waist restraint; on April 28 , he cut the restraint with his dinner knife. R1 continually would get up and out of his wheelchair and hop around. *Id.* at 21.

As a result of his increased agitation and activity, Petitioner reassessed R1 on May 3, 2010 as a wanderer and an elopement risk. P. Ex. 18; P. Ex. 19 at 2; Tr. 346. Petitioner updated R1's care plan to reflect that he was deemed an elopement risk and indicated that the following approaches would be employed to address this risk and problem —

- Chair alarm while up in wheelchair to alert staff he is trying to get up without assistance;
- Bed alarm while in bed to alert staff he may be trying to get up without assistance;
- Place R1 in an area where constant observation is possible;
- Redirect him when found wandering;
- Team meeting with PTA, ADON, CNA;
- Ensure he has proper ID (wristband);
- Make sure staff is aware of his wander/elopement risk;
- Place a picture of resident in elopement book;
- Family to sign LOA [leave of absence] form when taking resident out of facility;
- Elopement/Wander risk per RN; reevaluate as needed;

[7] Petitioner's witness stated that R1 was in his mid-to-late forties, but his records indicate he was born in May 1955 so at the time of admission he was just short of his fifty-fifth birthday. Tr. at 329; P. Ex. 19.

- Be mindful of his location;
- Provide diversional activities;
- Observe closely; and
- Contact family for additional support if necessary.

P. Ex. 19 at 2.

R1 also was beset with a number of conditions that placed him at great risk for injury, or worse, if he eloped. R1 was cognitively impaired, had poor decision-making skills, and had short and long term memory problems. P. Ex. 19 at 1; CMS Ex. 9 at 6, 8, 9. An addition to his care plan on May 3, 2010 indicated that he had fallen at least four times since his admission on April 14, 2010 and was at risk for further falls due to his amputated right leg, his unsteady gait, and his constant attempts at trying to get out of his wheelchair. CMS Ex. 9 at 8.

When the surveyor asked the Director of Nursing for Petitioner's elopement policy, she was given a document which states as follows —

ELOPEMENT POTENTIAL / WANDERING INSTRUCTIONS

1. An Elopement Assessment must be completed on the day of admission. If the resident is identified as an elopement risk, the resident will be care planned accordingly.
2. Elopement risk must be added to the C.N.A. care plan.
3. The supervisor will initiate Visual Checks as necessary.

CMS Ex. 14.

Despite the fact that R1's care plan required that he be placed in an area where constant observation would be possible and that staff be mindful of his location, he nevertheless eloped without anyone observing his absence or knowing his whereabouts. There is even an admission in the May 9, 2010, Nurse's Notes that staff found it impossible to keep him under constant observation, but nothing was done to remedy this obviously-dangerous situation. *See* CMS Ex. 9 at 23 (R1 "keeps going to the other hall, unable to watch him every minute and unable to keep him out of the other rooms. Few residents have complained of a onelegged man hopping in their rooms" and "that scares them. Esp. [especially] at night when they are abed.").

The notes from later that same day indicate that a CNA reported finding R1 outside in the "Krystal" parking lot in his wheelchair. Staff's only intervention to this elopement was to instruct R1 "not to get on elevator or leave floor unattended." CMS Ex. 9 at 23. Yet, only a half hour after he was returned from the "Krystal Drive Thru" parking lot, he left the floor a second time by the elevator and was escorted back to the floor by a CNA. *Id.*

But it was only after the second elopement, that Petitioner took any deliberate action to protect R1. Petitioner at that time placed R1 on one-on-one observation until such time as he could be evaluated for and transferred to a psychiatric unit. CMS Ex. 9 at 14; CMS Ex. 7 at 1.

The nurse's notes further explain that just prior to his first elopement on May 9, R1 had been sitting at the elevator for long intervals. He was moved several times but came back to the elevator soon after. CMS Ex. 9 at 23. These limited interventions are not consistent with R1's care plan which indicates he should be in an area where constant observation is possible, that staff should be mindful of his location, and that they should provide R1 with diversional activities.

The nurse's notes indicate that R1 exited the floor again and that "the laundry person stated she saw [a] visitor leaving the building" and "this pt [patient] was right behind them" and "out in the parking lot."[8] *Id.* The fact that R1 exited the building twice in such a short span of time indicates that there were other problems that the facility had not yet addressed.

Petitioner indicates that it also had facility-wide interventions in place to prevent neglect. It claims that all the stairwell doors and exit doors were equipped with magnetic locks which required a code to open from the inside. P. Br. at 12. While only staff was to have this code, apparently it was given to frequent visitors as well so that they could exit the building without staff having to let them out. Tr. at 195. But as the surveyor testified, there were no written procedures addressing the use of keypad locks, such as limitations or restrictions on who was to have access to the code, how often the codes should be changed, and how to prevent visitors from giving out the code to others, or from letting residents get out of the facility behind them. Tr. at 106. Nevertheless, R1 was able to exit the doors both times. Either he was able to access the code or he followed a visitor out the door without anyone detecting his exit. Obviously, the use of the exit codes was intended to deter residents from exiting the facility unattended, yet this intervention for preventing elopement was ineffective to say the least, especially if nearly everyone had access to the codes as seems to have been the case. The fact that the facility made daily checks to the door locks is irrelevant once it had routinely provided the access code for these locks to visitors to the facility. The door locks served as a method of augmenting its supervision of its residents by securing the facility's exit doors from residents seeking

[8] Petitioner's witness testified that R1's second attempt at elopement was thwarted because the second floor nurse saw R1 enter the elevator, called down to the laundry room and asked the laundry aide to stop R1 until the CNA arrived. Tr. at 363. However, Petitioner's own notes, contemporaneous to the actual incident, contradict this account and indicate that R1 actually exited the building a second time and was again in the parking lot. *Compare* P. Ex. 20 at 2 *with* Tr. 363.

to elope from the facility. The fact that R1 exited the facility twice in the same day unequivocally establishes that this measure failed. Yet, Petitioner does not address this other than to state that by June 1, 2010 at 4 p.m., signs were posted to all exit doors by the Administrator to alert all visitors not to let residents out of the facility and for all staff to monitor. The facility also informed staff that the gate to the patio should be closed and latched at all times and a sign was posted there as well informing visitors and staff of this. P. Ex. 42 at 24. Staff were to monitor the gate and initial the documenting sheet placed at the west patio entrance every two hours and this was done every two hours by the first-floor laundry personnel at night.

Also, at all times relevant during this period, the only monitoring of the exit doors, if any, was by use of security cameras. Tr. at 196. Petitioner indicates that it had mounted security cameras on the second floor with monitors at the second floor nursing station. [9] CMS Ex. 2 at 8. The security cameras were directed at the elevators. *Id.* Yet, at the time of R1's elopement, no one was monitoring these cameras; no one was even aware he had exited the floor on the elevator until by happenstance he was seen in the parking lot of the Krystal Double Quick, across the street from the facility. Security cameras are of little utility in preventing an elopement if no one is watching the monitors, and that is exactly what happened here. If a facility relies on devices such as key-coded door locks and security cameras with monitors as measures to assist in preventing elopements, then the facility must make sure that it has established policies and procedures for these interventions, and those policies and procedures must address how the devices will be used and who will be assigned to monitor the devices and interventions. And the facility obviously must be sure that the procedures for those devices are being properly implemented if it hopes to achieve the intended results.

Thus, if a facility such as Petitioner's expects to prevent elopement by certain means, such as security cameras directed at the elevator, key-coded door locks, and other interventions specific to an individual resident such as keeping the resident under constant observation, it must ensure that whatever means it chooses to use to prevent elopement, neglect, and to appropriately supervise its residents is functioning and being implemented by its staff correctly. Despite Petitioner's protestations, I cannot conclude that Petitioner did so here.

Taken as a whole, I find that Petitioner has not rebutted the evidence presented by CMS. That evidence establishes that Petitioner failed to develop and implement policies and

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[9] Since R1 was housed on the second floor, the surveyor only reviewed the camera and monitors on the second floor, although there is some indication that there were also cameras mounted on the third floor. As to whether there were cameras directed at the exit doors, Petitioner's witness seemed to indicate there were but her testimony is not clear. She was asked whether anyone monitored the exit doors and she answered, yes with the cameras. Tr. at 196.

procedures that, among other things, protected R1 against neglect and failed to provide R1with adequate assistance devices and supervision to prevent accidents, namely elopement from the facility.

2. CMS's determination that the facility's noncompliance posed immediate jeopardy to resident health and safety is not clearly erroneous.

Immediate jeopardy exists if a facility's noncompliance has caused, or is likely to cause, "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a heavy burden to show no immediate jeopardy and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1962, at 11; *Florence Park Care Center*, DAB No. 1931, at 27-28 (2004).

There is no question that Petitioner's noncompliance placed R1 and other elopement-risk residents in immediate jeopardy. I find that the CMS assertion that the facility's lapse created a situation of immediate jeopardy was not clearly erroneous. Here, Petitioner failed to implement its procedures to protect R1 from neglect by failing to adequately supervise him and to provide assistance devices and the kind of supervision necessary to prevent R1's elopement from the facility. As a result of the elopement, the movements and whereabouts of R1 went unnoticed. While it is true that R1suffered no actual harm, that benign outcome was merely fortuitous. But a finding of immediate jeopardy does not require a finding of actual harm, merely a finding that there was or is a likelihood of serious injury, harm, impairment or death. Clearly, the likelihood of serious harm or death to R1 was great due to his cognitive impairment, his history of falls, and his lack of safety awareness. Once he eloped from the facility, he was at risk for falling or being struck by a motor vehicle.

3. The penalty imposed is reasonable.

CMS imposed a penalty in the amount of $3,550 per day from May 9, 2010 through June 1, 2010, when the immediate jeopardy was abated and $100 for June 2, 2010 for one day of noncompliance after the immediate jeopardy was abated.

In order to determine whether the CMPs are reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f), which are: (1) the facility's history of noncompliance; (2) the facility's financial condition; (3) factors specified in 42 C.F.R. § 488.404; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for

resident care, comfort, or safety. The absence of culpability is not a mitigating factor. The factors listed in 42 C.F.R. § 488.404 include: (1) the scope and severity of the deficiency; (2) the relationship of deficiency to other deficiencies resulting in noncompliance; and (3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

In reaching a decision on the reasonableness of the CMP, I must consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiency found, and in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Center*, DAB No. 1848, at 21 (2002).

CMS has imposed a penalty of $3,550 per day, which is at the low end of the penalty range for situations of immediate jeopardy ($3,050-$10,000). CMS does not cite facility history as a factor that justifies a higher CMP and Petitioner does not argue that its financial condition affects its ability to pay the penalty.[10] I have considered the remaining necessary factors. The facility here is culpable for the deficiency because it did not properly supervise its staff to determine whether its own policies and procedures intended to prevent elopements were being implemented as required. This measure of culpability, taken into consideration together with the finding of immediate jeopardy, is sufficient to sustain the CMP at $3,550 per day for the period of May 9, 2010 through June 1, 2010. I further conclude that the CMP of $100 for June 2, 2010, is reasonable because while Petitioner had abated the immediate jeopardy by that date, prior to this date the facility was still not monitoring the security cameras and gates. [11]

Therefore, I find the penalties imposed reasonable.

IV. Conclusion

For the reasons discussed above, I find that Petitioner's facility was not in substantial compliance with the Medicare requirements, and that its noncompliance posed immediate

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[10] CMS cites to other incidents of elopement at Petitioner's facility which preceded the elopement here, but that alone without reference to findings of substantial noncompliance for those elopements is not what I would necessarily consider to be evidence of the facility's past noncompliance.

[11] The surveyor testified that on June 1, 2010, she observed that staff was not always monitoring the security cameras and that justified the additional day of noncompliance at the non-immediate jeopardy level. CMS Br. at 17; Tr. 127-28.

jeopardy to resident health and safety. I affirm as reasonable the penalties imposed.

/s/
Richard J. Smith
Administrative Law Judge