Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Bibb Medical Center Nursing Home
(CCN: 01-5215),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-248

Decision No. CR2448

Date: October 11, 2011

DECISION

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to impose civil money penalties against Petitioner, Bibb Medical Center Nursing Home, of: $3,550 for each day of a period that began on October 7 and that ran through November 13, 2010; and $100 for each day of a period that began on November 14, 2010 and that ran through December 9, 2010.

I. Background

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

CMS determined to impose against Petitioner the remedies that I describe above, based on findings of noncompliance with Medicare participation requirements that were made at a survey of Petitioner's facility that was completed on November 14, 2010 (November Survey). The noncompliance findings included four findings of immediate jeopardy level deficiencies. The term "immediate jeopardy" is defined

at 42 C.F.R. § 488.301 to mean noncompliance that is so egregious as to cause, or to be likely to cause, serious injury, harm, impairment, or death to one or more residents of a facility.

Petitioner requested a hearing, and the case was assigned to me for a hearing and a decision. The parties exchanged pre-hearing briefs and proposed exhibits and, then, agreed that the case could be heard and decided based on their written submissions. I allowed the parties a final round of briefs.

CMS filed 24 proposed exhibits that it identified as CMS Exhibit (Ex.) 1 – CMS Ex. 24. Petitioner filed 15 proposed exhibits that it identified as P. Ex. 1 – P. Ex. 15. I receive all of these exhibits into the record.

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

A. Issue

Petitioner does not contest any of the deficiencies that were identified at the November Survey, nor does it dispute the duration of its noncompliance. It argues, however, that CMS's determination of immediate jeopardy level noncompliance is incorrect. Consequently, the only issues that I must hear and decide are whether:

1. CMS's determination of immediate jeopardy level noncompliance is clearly erroneous; and

2. Assuming that CMS's determination of immediate jeopardy level noncompliance is not clearly erroneous, civil money penalties of $3,550 per day are reasonable.

B. Findings of Fact and Conclusions of Law

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

1. Petitioner did not prove that CMS's determination of immediate jeopardy level noncompliance is clearly erroneous.

CMS's allegations of immediate jeopardy level noncompliance all relate to a resident who is identified in the report of the November Survey as RI #1. CMS Ex. 1. The resident was described by Petitioner's staff as being an individual who: has severely impaired cognitive abilities; requires extensive assistance from the staff for bed mobility; and is totally dependent on Petitioner's staff for all

activities of daily living. *Id.* at 4. In other words, RI # 1 is a gravely impaired individual who is completely dependent on the assistance of care givers.

The resident had a history of pressure sores. CMS Ex. 1 at 4; CMS Ex. 4 at 9, 11. Thus, Petitioner's staff knew that this resident was at risk for development of pressure sores and was on notice that special care needed to be given to her to protect her against the development of sores.

In October 2010, the resident developed pressure sores on both of her heels. The resident's deterioration became evident to Petitioner's staff on or about October 7, 2010. CMS Ex. 14 at ¶ 12; CMS Ex. 6 at 29. Despite this knowledge, Petitioner failed in important respects to provide necessary care for RI # 1. Petitioner concedes the following deficiencies:

- The staff failed to comply with their duty under 42 C.F.R. § 483.10(b)(11) to consult immediately with the resident's treating physician about the significant change in the resident's condition brought on by the development of pressure sores. CMS Ex. 1 at 2-7. The staff waited 12 days, until October 19, 2010, before advising the resident's physician about the resident's pressure sores.

- Petitioner's staff failed to comply with professional standards of quality in providing care to RI # 1, as 42 C.F.R. § 483.20(k)(3)(i) requires. The staff allowed a nonprofessional employee of Petitioner to apply wound treatments to the resident. They failed in several respects to provide wound treatment to the resident as the resident's physician had ordered. These deficiencies included failures to apply wound dressings as ordered by the resident's physician, failures to administer a medication that the physician had ordered, and failure to float the resident's heels pursuant to the physician's order. CMS Ex. 1 at 11-23.

- The staff failed to provide RI # 1 with the necessary treatment and services to promote healing of her pressure sores and to protect against the development of additional sores as 42 C.F.R. § 483.25(c) requires. These deficiencies include the failures to consult with the resident's treating physician and to follow the physician's orders that I have discussed. They also include failures to ensure that professional staff knew how to measure accurately the size of a resident's pressure ulcers, and a failure to determine why RI # 1's sponsor refused to allow the resident to be sent to a local hospital for evaluation of her pressure sores. CMS Ex. 1 at 23-52.

- Petitioner's management failed, in contravention of the requirements of 42 C.F.R. § 483.75, to ensure that the facility was administered in a manner

> that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as is evidenced by the deficient care that Petitioner's staff gave to RI # 1. CMS Ex. 1 at 61-66.

There is abundant evidence that these admitted deficiencies put RI # 1 at grave risk for serious injury, or worse. Pressure sores are a serious problem for gravely ill and dependent individuals such as RI # 1. Among the common complications of pressure sores is infection. CMS Ex. 24 at 3. Complications of pressure sores may include sepsis, chronic infection, cellulitis, and osteomyelitis. Pressure sores increase the likelihood of death in elderly patients. CMS Ex. 23 at 1, 4; CMS Ex. 24 at 4.

RI # 1 not only developed pressure sores that Petitioner was deficient in caring for, but she developed pressure sores that were quite serious. The pressure sore that the resident developed on her right heel measured 7.5 x 6 cm. The pressure sore on her left heel measured 3 x 2 cm. CMS Ex. 4 at 13. The sore on the resident's right heel had developed a necrotic area (eschar), and the resident's physician described the resident's wounds as being unstageable. CMS Ex. 6 at 66; CMS Ex. 14 at ¶ 31; CMS Ex. 4 at 85.

The evidence establishes a pattern of mistreatment of RI # 1's condition, and it evidences something more. The slipshod care that Petitioner's staff gave to the resident shows a fundamental misunderstanding by Petitioner and its staff of Petitioner's obligations to protect highly vulnerable residents, such as RI # 1, from the development and complications of pressure sores. The evidence leads to the inescapable conclusion that the staff was simply not prepared to handle its obligations to: assess residents for their vulnerabilities; stay vigilant to protect residents against developing pressure sores; and be aggressive and diligent in following prescribed protocol and physicians' orders in treating pressure sores.

I do not view the deficiencies at Petitioner's facility as being an isolated event. There was, as I have described, a whole series of failures to provide care to RI # 1. This series of failures establishes a pattern of noncompliance, and it leads me to find that Petitioner's management and staff were generally deficient in their treatment of residents who were vulnerable to the development of pressure sores, or who had developed sores. That the evidence that CMS offered focuses on RI # 1 does not mean that she was the *only* resident who was at risk at Petitioner's facility. The pattern of noncompliance is so egregious here that I infer that *any* resident of the facility who was at risk for developing pressure sores was equally at risk for being cared for deficiently.

Petitioner's argument that CMS's determination of immediate jeopardy is incorrect is mainly that RI # 1's sores eventually healed without the resident encountering any of the complications that a resident who has pressure sores might experience. Thus, according to Petitioner, there could not be a likelihood of serious injury, harm, impairment, or death, because none of these outcomes occurred.

I find this argument to be unpersuasive. Petitioner simply has not shown that CMS's determination of immediate jeopardy is clearly erroneous. The fact that RI # 1's pressure sores ultimately healed does not derogate from the risks that she faced while she had those sores. Nor does it suggest that Petitioner's *overall* competence at caring for residents who were at risk for developing, or who had, pressure sores was any better than I have found it to be. As I have discussed, Petitioner and its staff's deficient treatment of RI # 1 demonstrated an overall misunderstanding of their roles and responsibilities for dealing with vulnerable residents. That clearly demonstrated incompetence put more than RI # 1 at risk.

Boiled down to its essence, Petitioner's argument reduces to the kind of "no harm, no foul" contention that facilities sometimes make when found to be deficient. Essentially, Petitioner is saying that there was no likelihood of a bad outcome here because the resident eventually got better. But, that analysis fails to address the very real risks – of infection, of osteomyelitis, of increased chances of mortality – that RI # 1 faced while she suffered from pressure sores.

Petitioner also argues that its staff did many of the things for RI # 1 that were ordered for her by her physician. For example, Petitioner acknowledges that the staff failed to administer all of the medications that were prescribed but asserts that, at least, the staff administered some of them. That is no basis for me to find CMS's determination of immediate jeopardy to be clearly erroneous. Even a few omissions to provide care would have caused a likelihood of serious injury or worse, given RI # 1's vulnerable condition.

However, this is not a case of one or two missed administrations of medication or one or two missed treatments. To the contrary, the record establishes egregious failures by Petitioner's staff to provide care. The staff waited 12 days to consult with the resident's physician about her development of pressure sores in October 2010, even though the governing regulation calls for *immediate* consultation. They failed for more than two months to administer a Hypercolloid dressing to the resident's right heel, despite a prescription for that dressing by the resident's physician. CMS Ex. 1 at 11. They failed for four consecutive days to float the resident's heels, even though the resident's physician had ordered that care. *Id.* at 12.

2. Civil money penalties of $3,550 per day are reasonable.

Daily civil money penalties for immediate jeopardy level noncompliance must fall within a range of from $3,050 to $10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). Deciding where within that range an immediate jeopardy level penalty should fall depends on the presence of evidence that addresses the following regulatory factors: the seriousness of a facility's noncompliance; its compliance history; its culpability; 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)).

Here, the immediate jeopardy level penalties of $3,550 per day that CMS determined to impose fall near the bottom of the immediate jeopardy level range. I find them to be justified because Petitioner's noncompliance was very serious. As I have discussed, RI # 1 was an extremely vulnerable individual, and Petitioner's failure to identify and treat her pressure sores put her at great risk. Furthermore, and as I have also discussed, the level of incompetence demonstrated by the evidence put more than just RI # 1 at risk.

Petitioner did not challenge the $100 per day civil money penalties that CMS imposed for the period of non-immediate jeopardy level noncompliance that was manifested by Petitioner, and, so, I do not address them here.

/s/
Steven T. Kessel
Administrative Law Judge