Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Savoy Nursing & Rehabilitation Center,
(CCN: 22-5423),

Petitioner,

v.

Centers for Medicare & Medicaid Services

Docket No. C-13-795

Decision No. CR3521

Date: December 18, 2014

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) that Savoy Nursing & Rehabilitation Center (Petitioner or the facility) was not in substantial compliance with Medicare participation requirements at 42 C.F.R. § 483.25(h) relating to the prevention of accidents. I also find as reasonable CMS's imposition of a per day civil money penalty (CMP) of $350 for the period of February 11 through March 21, 2013 (39 days) for a total CMP of $13,650. CMS imposed the penalty after an elderly resident, with dementia and known tendencies to wander and elope, was able to exit and fall from a second-story window in the facility's secured unit.

I. Procedural Background

Petitioner is a long-term care facility in New Bedford, Massachusetts. It participates in Medicare as a skilled nursing facility and Medicaid as a nursing facility. On February 11, 2013, the Massachusetts Department of Public Health, Bureau of Health Care Safety and Quality, Division of Health Care Quality (State Agency) completed a complaint survey to

determine if Petitioner was in substantial compliance with federal requirements. By letter dated March 12, 2013, CMS notified Petitioner that it was accepting the State Agency's finding that Petitioner was not in substantial compliance with respect to 42 C.F.R. § 483.25(h) relating to accident prevention.

Petitioner timely requested a hearing before an administrative law judge (ALJ). The case was assigned to me for hearing and decision. I issued a prehearing order, which included a briefing schedule, and on March 5, 2014, I convened a prehearing conference with the parties. During that conference the parties agreed to the issues that I would decide, I admitted to the record without objection CMS exhibits (Exs.) 1-18 and Petitioner's exhibits (P. Exs.) 1-10, with the understanding that Petitioner would resubmit P. Ex. 11, the unsworn statements of two proposed witnesses, as sworn statements. Petitioner resubmitted P. Ex. 11, but only with respect to one witness, and I admit that amended exhibit to the record.

During the conference, the parties agreed that I decide this case on the basis of the written record after they briefed their final arguments. Before the prehearing conference, the parties filed pre-hearing briefs (CMS PH Br. and P. PH Br.). Although CMS filed a motion for summary judgment after the prehearing conference, because I am deciding this case on the full merits of the written record, there is no need to for me to decide whether summary judgment is appropriate here. I therefore treat CMS's submission as its final brief (CMS Br.). Petitioner also filed a final responsive brief (P. Br.).

II. Issues Presented

Whether Petitioner was in substantial compliance with 42 C.F.R. § 483.25(h), requiring a skilled nursing facility to ensure that the resident environment remain as free of accident hazards as is possible and requiring each resident to receive adequate supervision and assistance devices to prevent accidents; and, if so,

Whether the CMP that CMS imposed is reasonable in amount and duration.

III. Statutory and Regulatory Framework

The Social Security Act (Act) sets forth requirements for participation of a long-term care facility in the Medicare program, as a skilled nursing facility, and authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations implementing those statutory provisions. Act § 1819. [1] To participate in the Medicare program, a skilled nursing facility must maintain substantial compliance with program

[1] The Act, as amended, is available at http://www.ssa.gov/OP_Home/ssact/ssact.htm. On this website, each section of the Act contains a reference to the corresponding chapter and section in the United States Code.

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 Act authorizes the Secretary to impose enforcement remedies against a long-term care facility for failure to comply substantially with the federal participation requirements. The Secretary has delegated this authority to CMS and the states. State agencies survey facilities on behalf of CMS to determine whether the facilities comply with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335.

CMS may impose a per-day CMP for the number of days a facility is not in substantial compliance or a per-instance CMP for each instance of the facility's noncompliance. 42 C.F.R. § 488.430(a). A per day CMP, which CMS imposed in this case, may range from either $50 to $3,000 per day for less serious noncompliance or $3,050 to $10,000 per day for more serious noncompliance that poses immediate jeopardy to the health and safety of residents. 42 C.F.R. § 488.438(a)(2). If CMS imposes one or more enforcement remedies against a long-term care facility based on a noncompliance determination, the facility may request a hearing before an ALJ to challenge the noncompliance finding and enforcement remedies. Act §§ 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13).

IV. Factual Background

The following facts are undisputed unless otherwise noted. Resident 1, a 72 year-old female resident of the facility, had conditions including a history of spinal stenosis, bipolar disorder, and dementia. P. Br. at 3. On February 2, 2013, at approximately 1 p.m., family and staff found Resident 1 seriously injured on the ground outside of the facility. CMS Ex. 14 at 2; CMS Ex. 15 at 1-6. A second floor window above the area was open. CMS Ex. 14 at 2. Staff, family members, and an investigating police officer concluded that she fell or jumped from the window. CMS Ex. 14; CMS Ex. 15 at 2, 5; P. Br. at 4. Resident 1's injuries included a fractured neck, three back fractures, a fractured wrist, and a collapsed lung. CMS Ex. 13 at 2.

Resident 1 was first admitted to the facility on January 23, 2013 from the Elder Behavioral Health Services Unit at Morton Hospital.[2] CMS Ex. 8 at 1, 3; CMS Ex. 18 at 2, 3; CMS Ex. 12 at 1. Petitioner is a small, 39-bed facility with 18 beds on its first floor and 21 beds on its second floor. P. Br. at 3. Staff admitted Resident 1 to the second floor locked unit. P. Ex. 2. Resident 1 recently eloped from her home, and staff therefore

[2] She was admitted to the Elder Behavioral Health Services Unit of Morton Hospital on December 30, 2012, after she was found wandering in the street, inappropriately clothed, and having paranoid delusions. CMS Ex. 18 at 2.

determined her to be a high safety risk. P. Br. at 3; CMS Exs. 9 at 12; 10; 11 at 4 and 7; 12; 13; and 18. Nurses' notes dated January 23, 2013, upon Resident 1's admission, state that she walks with difficulty, she is confused, delusional, and a wanderer. CMS Ex. 12 at 1. Resident 1 also exhibited wandering, disorientation and exit-seeking behavior while residing at the facility. CMS Ex. 11 at 4; CMS Ex. 12 at 2; and CMS Ex. 13 at 1, 3. On January 24, 2013, staff observed Resident 1 wandering up and down the corridor during the morning shift. CMS Ex. 12 at 1. On January 25, 2013, two days after she was admitted to the facility, staff again observed Resident 1 wandering during two nursing shifts (7 a.m. to 3 p.m. and 3 p.m. to 9 p.m.) and attempting to leave the facility several times during the afternoon and evening shift. CMS Ex. 12 at 2, 3.

Resident 1's care plan, dated January 28, 2013, indicates that she wandered and would intrude upon other residents' room. CMS Ex. 11 at 4. The care plan assessment established a goal that "Resident will wander safely on the unit and show a decrease in wandering by next review date." CMS Ex. 11 at 4. The plan's designated approaches included: monitoring Resident 1's behavior; redirecting her from unauthorized areas; questioning her motives for wandering; meeting her needs as appropriate; and monitoring her whereabouts frequently. CMS Ex. 11 at 4, 7. Her care plan also required that staff supervise her when walking in her room, the hallways, and off the unit because she was at risk for falls related to unsteady gait, cognitive deficit, impaired safety awareness, and use of psychotropic medication. CMS Exs. 10 at 8; 9 at 14; P. Ex. 4. To address Resident 1's anxiety, her care plan in effect from January 23 through April 23, 2013 again listed the requirement that staff monitor her frequently. CMS Ex. 11 at 7. A physician also ordered that Resident 1 have a bed alarm on from 3 to 11 p.m. and 11 p.m. to 7 a.m. P. Ex. 3 at 4.

On January 30, 2013, Resident 1 attempted several times to open an exit door during the afternoon and early evening shift from 3 p.m. to 9 p.m. CMS Ex. 12 at 3. Nursing records show that for all shifts on February 1-2, 2013 she walked "with constant direction/supervision." P. Ex. 10 at 1. The next day, before she fell out the window, staff last observed Resident 1 at approximately 12:30 p.m. when a certified nursing assistant (CNA) redirected her from another resident's room to a rocking chair located in the facility dining room. CMS Ex. 15 at 2, 3, and 4. Resident 1's family members arrived at the facility for a visit at approximately 12:45 p.m. CMS Ex. 15 at 3. She was not in her room. CMS Ex. 15 at 2. The CNA who redirected her earlier to the dining room told her family that she was in the dining room and that she would get her. *Id.* However, Resident 1 was no longer there. Staff initiated a search and checked every room on both floors. *Id.* When staff did not find her, two staff members checked outside. They discovered Resident 1 on the ground at approximately 1 p.m. and a second floor window was wide open. *Id.*

In April 2006, Petitioner had a similar incident when a resident eloped through a facility window. CMS Ex. 7. As a result, the facility instituted a plan of correction which

provided that: staff would identify elopement risks in care plans and review them with staff; staff would activate window stops so that window sashes could not be raised more than a few inches; and housekeeping staff would check the window stops daily. CMS Ex. 7. The facility changed ownership in July 2011, with no change of provider agreement.
P. Ex. 6; CMS Ex. 6.

V. Findings of Fact and Conclusions of Law

1. Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h).

Facilities enrolled in Medicare must "ensure that – (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents." 42 C.F.R. § 483.25(h). This provision is part of the quality of care regulation requiring that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care."

A facility must "take reasonable steps to ensure that a resident receives supervision and assistance devices designed to meet his assessed needs and to mitigate foreseeable risks of harm from accidents." *Briarwood Nursing Ctr.*, DAB No. 2115 at 5 (2007); *Guardian Health Care Ctr.*, DAB No. 1943 at 18 (2004). The facility must anticipate what accidents might befall a resident and take steps to prevent them. A facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods must constitute an "adequate" level of supervision under all the circumstances. *Windsor Health Care Ctr.*, DAB No. 1902 at 5 (2003).

a. Petitioner knew Resident 1 required frequent supervision because of her tendencies to wander and elope.

From the time of her admission, Petitioner knew Resident 1 was an elopement risk because she eloped from her own home just a few weeks earlier. Petitioner also assessed Resident 1 as an elopement risk upon her admission. CMS Ex. 8. She also demonstrated exit-seeking behavior within two days of her admission to the facility. CMS Ex. 12 at 1-2. Petitioner was also aware of Resident 1's wandering behavior. Within the first days of her admission, facility staff noted Resident 1 wandering up and down the corridors and in and out of other residents' rooms. CMS Ex. 12 at 1-2.

Petitioner addressed Resident 1's wandering behavior as an issue in her care plan. CMS Ex. 11 at 4. This care plan established as a goal that Resident 1 would wander safely on the unit and show a decrease in her wandering by the next review date. *Id.* To reach this

goal and to ameliorate this problem all staff were to "monitor resident's whereabouts frequently." *Id.* The care plan did not specifically elaborate upon this frequent monitoring requirement.

On a resident assessment and care screening form dated January 30, 2013, staff noted that Resident 1's wandering placed the resident at significant risk of getting to a potentially dangerous place such as stairs and outside of the facility. CMS Ex. 9 at 12. That form also indicated she required supervision when walking in her room, in the hallways, and when she was off her unit. *Id.* at 15. On January 30, 2013, Resident 1 attempted several times to open an exit door during the afternoon and early evening shift from 3 p.m. to 9 p.m. CMS Ex. 12 at 3. In the days immediately preceding Resident 1's accident, staff provided constant supervision to address her behaviors. A nursing flow sheet recorded, that for all shifts on from February 1 through February 2, 2013, Resident 1 walked "with constant direction/supervision." P. Ex. 10 at 1. The next day when she fell from the window, however, staff lost track of Resident 1 at approximately 12:30 p.m. after staff redirected her from another resident's room to a rocking chair located in the facility dining room. CMS Ex. 15 at 2, 3, and 4.

b. Petitioner did not adequately supervise Resident 1 because she was able to move unnoticed from the facility dining room to a bedroom and out through the second floor window.

Considering Resident 1 was able to leave the dining room at approximately 12:30 p.m., enter another resident room, and exit from the window without any staff observing or stopping her demonstrates that facility staff was not adequately supervising her and that she was not being "monitored frequently" as her care plan and escalating behavior required. Petitioner's staff had no idea of the whereabouts of Resident 1 after a CNA redirected her to a rocking chair in the dining room at 12:30 p.m. It was not until her family arrived at approximately 12:45 p.m. and could not find her that Petitioner's staff was aware that she was missing. It was only after an unsuccessful search of the entire building when staff searched outside and found her at around 1 p.m. sprawled out injured on the ground.

Petitioner contends that because Resident 1 was assessed as an elopement risk, it ensured she was assigned a room on the second-floor locked unit to minimize the risk of her elopement because Resident 1 would have to exit through two locked and alarmed doors to make it outside of the facility. P. PH Br. at 7; P. Ex. 11. Petitioner also contends that while Resident 1 was assessed an elopement risk, she never attempted to exit through the windows previously, so it could not have foreseen that Resident 1 would have eloped from the second floor.

I do not find this argument persuasive, however, because Petitioner knew that Resident 1 had been hospitalized for and suffered from paranoid delusions and visual and auditory

hallucinations, that she was had dementia, and was extremely anxious. CMS Exs. 8; 9 at 19; 11. Thus, it was conceivable given her recent delusional episodes and escalating wandering that an unsecured window might pose a foreseeable danger and an elopement risk.

Petitioner also contends that it was not in violation of the accident prevention standards considering there was only an approximate fifteen-minute interval when Resident 1 "was last seen by our staff and the time she went missing." Petitioner argues generally that an ALJ found there was still adequate supervision in another case when there was an approximate hour period between the time a resident was last seen and the time he eloped through a window. P. Br. at 8. However, even assuming Petitioner's characterization of that finding is accurate, the case Petitioner references, in contrast to the case here, did not involve a resident assessed as a wanderer, elopement risk, or as previously showing exit-seeking behavior. *See Country Hills Health Care*, DAB CR 2291 (2010) at 15-16. Here, Petitioner was required to assess and address the particular needs of Resident 1. Even assuming it was only fifteen minutes between the two events, the undisputed fact that Resident 1 was able to move unnoticed from the dining room at midday to another resident's room does not persuade me that she was adequately supervised. Ultimately Resident 1 lay seriously injured outside on the ground in the winter weather[3] for another estimated fifteen minutes while her whereabouts was still unknown. Without any compelling evidence to persuade me that this was some unusual or otherwise unforeseeable occurrence, the supervision here did not comport with any reasonable interpretation of her individualized care plan's requirements for "frequent supervision."

c. Petitioner did not mitigate a foreseeable risk of harm because Resident 1 exited through a second floor window that Petitioner did not ensure was equipped with an activated safety device to prevent elopements.

The facility had a reasonable basis to foresee that the windows in its facility could serve as an exit route for a resident seeking to elope because a resident eloped through an unsecured window in 2006. CMS Ex. 7. As a result, Petitioner initiated a plan of correction that provided that its window stops would be activated to prevent window sashes from being raised more than a few inches, and housekeeping staff would conduct daily checks to ensure all window stops were activated if a resident was an elopement risk. CMS Ex. 7.

Petitioner argues that it changed ownership after the development of this plan of correction. However, Petitioner does not dispute that when there is a change of ownership, the existing provider agreement is automatically assigned to the new owner.

[3] Petitioner reported that the weather forecast for New Bedford on February 2, 2013 was between 19 to 28 degrees Fahrenheit. P. Br. at 4.

See 42 C.F.R. § 489.18(c). An assigned provider agreement is subject to all applicable statutes and regulations, the terms and conditions under which it was originally issued, and any existing plan of correction. *See* 42 C.F.R. § 489.18(d)(1), CMS Br. at 7. When Petitioner bought the facility in 2011 and assumed the provider agreement, it was subject to any ongoing plan of correction, yet its Administrator and Maintenance Supervisor was unaware of the 2006 incident and the plan of correction requiring that staff activate window stops and check them daily. P. Ex. 11, at 2. Petitioner also argues that during its last life safety code survey, in April of 2012, State Agency surveyors did not cite its windows as a deficiency with regard to program safety requirements. P. Br. at 10; P. Ex. 11, at 2. However, the windows themselves were not the impetus of the previous plan of correction, rather the focus was the activation of safety stops to prevent the window from fully opening and daily checks to ensure staff activated the safety stops. Petitioner has not provided any testimony or other evidence to support a finding that its staff properly activated the window's safety stop, or had recently checked to see that it was functioning, on the date that Resident 1 fell from the second story window. Rather, Petitioner has conceded that it was unaware of this precaution.

2. The civil money penalty of $350 per day for 39 days is reasonable.

CMS must consider several factors when determining the amount of a CMP (factors an ALJ considers de novo when evaluating the reasonableness of the CMP that CMS imposed): (1) the facility's history of noncompliance; (2) the facility's financial condition, i.e., its ability to pay the CMP; (3) the severity and scope of the noncompliance, the "relationship of the one deficiency to other deficiencies resulting in noncompliance," and the facility's prior history of noncompliance; and (4) the facility's degree of culpability. 42 C.F.R. §§ 488.438(f), 488.404(b), (c).

CMS explained it imposed the $350 per day CMP for a 39-day period starting with the survey date and continuing through the date the survey agency accepted that the facility completed all corrective measures. CMS Exs. 4, 5; P. Ex. 7. The amount of the per day penalty is modest and at the low end of the $50-$3,000 range that is applicable for non-immediate jeopardy findings. *See* 42 C.F.R. § 488.408(d)(iii). The duration is within CMS's discretion to impose a CMP for the number of days of noncompliance until the point when the facility can demonstrate substantial compliance.

Considering the harm Resident 1 suffered from falling from her second floor window, I would expect a CMP in the immediate jeopardy range of $3,050 - $10,000 per day. However, an ALJ or the Board properly presumes that CMS considered the regulatory factors and that those factors support the amount imposed. *See, e.g., Pinecrest Nursing & Rehab. Ctr.*, DAB No. 2446 at 23 (2012). Thus, CMS does not need to present evidence regarding each regulatory factor. Instead, the burden is on Petitioner "'to demonstrate, through argument and the submission of evidence addressing the regulatory factors, that a

reduction is necessary to make the CMP amount reasonable.'" *Id.* (quoting *Oaks of Mid City Nursing & Rehab. Ctr.*, DAB No. 2375 at 26-27 (2011)).

Petitioner does not challenge the reasonableness of either the amount or duration of the CMP imposed, and it does not contest any of the factors set forth in the regulation that would affect my consideration of the amount of the penalty. I find that the modest CMP imposed is more than reasonable given the seriousness of the noncompliance and Petitioner's culpability in the incident.

/s/
Joseph Grow
Administrative Law Judge