Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Trinity Hill Care Center,
(CCN: 07-5268),

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-486

Decision No. CR2658

Date: November 6, 2012

DECISION

Petitioner, Trinity Hill Care Center (Petitioner or facility), is a long-term care facility located in Hartford, Connecticut and participates in the Medicare program. Petitioner challenges the Centers for Medicare and Medicaid Services (CMS) determination that it was not in substantial compliance with Medicare program requirements for accident prevention and adequate supervision. Petitioner also challenges CMS's imposition of a per-instance civil money penalty (PICMP) of $8,500. For the reasons discussed below, I sustain CMS's imposition of the PICMP.

I. Background

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program and authorizes the Secretary of Health and Human Services (the Secretary) to promulgate regulations implementing those statutory provisions. Act § 1819 (42 U.S.C. § 1395i-3). The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain 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 contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a) (42 U.S.C. § 1395aa(a)); 42 C.F.R. § 488.20. The regulations require surveying each facility once every twelve months, and more often if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A) (42 U.S.C. § 1395i-3(g)(2)(A)); 42 C.F.R. §§ 488.20(a); 488.308.

Here, following a survey completed on March 15, 2011, CMS found that the facility was not in substantial compliance with a number of program requirements, including the participation requirement at 42 C.F.R. § 483.25(h) (Tag F323) (accident prevention and adequate supervision), which CMS determined posed immediate jeopardy to resident health and safety. CMS Exhibit (Ex.) 1; CMS Ex. 2. Based solely on the deficiency cited under 42 C.F.R. § 483.25(h), CMS imposed an $8,500 PICMP. CMS Ex. 2.

Petitioner timely requested a hearing by letter dated May 27, 2011. The case was assigned to me for hearing and decision. The parties submitted prehearing exchanges and briefs. By Order issued on March 2, 2012, I informed the parties that because neither party chose to submit written direct testimony of any proposed witness pursuant to my Acknowledgment and Pre-Hearing Order, an in-person hearing for cross-examination was not necessary, and I would issue my decision on the written record. The parties then filed their final briefs (CMS Br.; P. Br.). CMS submitted thirteen exhibits (CMS Exs. 1-13). Petitioner submitted three exhibits (P. Exs. 1-3). As explained in my January 11, 2012 Order Following Prehearing Conference (as amended by notice of January 13, 2012), and in my March 2, 2012 Order and Final Briefing Schedule, I admit CMS Exs. 1-13 and P. Exs. 1-3 into the record.

II. Issues

1. Whether Petitioner was in substantial compliance with 42 C.F.R. § 483.25(h) (Tag F-323 – accident prevention and adequate supervision); and

2. If Petitioner was not in substantial compliance, whether the remedy imposed – an $8,500 PICMP – is reasonable.

III. Discussion

My findings and conclusions are set forth in the bold italicized headings and supported by the discussions in the sections below.

A. Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h) because Petitioner did not take the reasonable measure to apprise Resident 109's physician of a consulting psychiatrist's concerns with the resident's leave of absence.

A facility is required to take all reasonable measures to protect its residents against accidents including: assessing each of its residents to determine what unique aspect of that resident's condition might cause the resident to be vulnerable to accidents and determining exactly what hazards the resident is exposed to; planning each resident's care in accordance with its assessment of the resident's vulnerabilities; and implementing the care plan that it develops for each resident. *Van Duyn & Home Hospital*, DAB No. 2368 (2011). When a resident is outside the facility, the facility should be aware of when the resident is expected to be returned to the facility and consider factors that would impact the resident's health and safety when away, such as the resident's need for medication. *Eastwood Convalescent Ctr.*, DAB No. 2088, at 16-17 (2007) (upholding an (h)(2) deficiency where a resident was missing for four and one half hours while needing medication). A facility has an obligation "to take steps to protect residents from harm when they temporarily [leave] the facility," by being aware of the circumstances of a resident's departure. *Heritage Park Rehabilitation & Nursing Ctr.*, DAB No. 2231 (2009) (rejecting assertion that a skilled nursing facility has no responsibilities as to known departures by competent residents).

During the relevant time period, Resident 109 (R109) was a 60-year old man whose diagnoses included cerebrovascular accident (CVA or stroke), with left-side hemiparesis; hypertension (HTN); acute kidney injury; and cardiomyopathy secondary to cocaine and alcohol abuse. CMS Ex. 8, at 1; CMS Ex. 10, at 56. He received antipsychotic medication three times per day, pain medication, and other medications. CMS Ex. 9, at 4-24; CMS Ex. 10, at 46. He was admitted to the facility on September 28, 2010, and he gradually made significant progress. By March 2011, R109 was preparing for discharge with an independent leave of absence (LOA) from the facility in order to search for an apartment.

On January 24, 2011, R109's physician provided that R109 may go on an independent LOA three times a week for a three-hour period, except weekends, and that R109 would undergo a urinalysis upon return to assure that he remained free from illicit drugs and alcohol. CMS Ex. 9, at 6, 8. That order was later modified on February 18, 2011, to include an independent LOA for a three-hour period (between 9:00 a.m. and 12:00 noon) on Wednesdays and Fridays. CMS Ex. 9, at 12. On Wednesday, March 2, 2011, R109

left the facility on an authorized independent LOA to view an apartment. CMS Ex. 13, at 4. R109 did not return to the facility by noon as required by the doctor's order, nor did he contact the facility to inform them of his whereabouts. P. Br. at 5. It was not until 9:36 a.m. on March 3, 2011, approximately 24 hours after R109 left the facility, that Petitioner's staff eventually located him at a gas station. R109 explained that he stayed overnight at a friend's house and was in the process of returning to the facility. Petitioner's staff transferred R109 back to the facility and then sent him to the emergency room for evaluation and assessment where he tested positive for cocaine use.

Petitioner argues it acted reasonably when authorizing the LOA because, "Resident #109 was a competent, discharge-ready resident who was able to meet his minimum basic needs and was legally entitled to take leaves of absence in order to prepare for his anticipated discharge from the Facility." P. Br. at 2.

However, I find Petitioner authorized R109's LOA without taking the reasonable measure to apprise R109's physician of a consulting psychiatrist's concerns with the LOA. Specifically, a psychiatrist's assessment on January 21, 2011 indicated that R109 was a poor historian and responded to simple questions. The assessment indicated that in the psychiatrist's opinion R109 had significant neurological/psychological impairments from the CVA, and - due to the resident's disabilities - R109 was not capable of an independent LOA and would need a chaperone if he were to leave the facility. CMS Ex. 1, at 9 (as set forth by the SOD). The facility later failed to notify R109's attending physician of this assessment prior to recommending and obtaining the attending physician's order for an independent leave of absence. R109's attending physician indicated that he was not aware of the psychiatrist's recommendations, and if he were aware of them he would not have given an order for R109 to have an independent LOA over the telephone. Instead, he would have evaluated the resident on his next visit to the facility. CMS Ex. 1, at 11-12 (as set forth by the SOD).

After the LOA and the state survey, the consulting psychiatrist provided a written statement, dated April 6, 2011, which Petitioner presented as evidence. P. Ex. 1. In this statement the psychiatrist emphasized that when making his recommendation he tried to "err on the side of safety," and the state surveyors did not interview him. *Id.* He also explained he only met the patient once, he did not comprehensively assess R109, and "[t]here would have been no major effect or harm from [R109] having missed 2 dosages of his [antipsychotic medication] while away from the facility." P. Ex. 1. Nonetheless, I find Petitioner offered no acceptable explanation why Petitioner did not take the reasonable precaution to share the psychiatrist's valid and safety-conscious concerns with the attending physician so that he could make a fully informed decision regarding R109's independent LOA.

B. Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h) because Petitioner did not comply with its own Missing Resident Policy regarding Resident 109's leave of absence.

The facility's undisputed noncompliance with its own Missing Resident Policy demonstrates that the facility was not taking reasonable steps to protect its residents from harm. I may reasonably rely on the facility's protocol as evidence of professional standards of quality, as well as evidence of the facility's "own judgment as to what must be done to attain or maintain its residents' highest practicable physical, mental and psychosocial well-being, as required by section 483.25." *Agape Rehab. of Rock Hill*, DAB No. 2411, at 7, 18 (2011); *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 (2010), *aff'd, Senior Rehab. & Skilled Nursing Ctr. v. Health & Human Svcs.*, 405 F. App'x 820 (5th Cir. 2010) (*quoting Sheridan Health Care Ctr.*, DAB No. 2178, at 15 (2008)); *Spring Meadows Health Care Ctr.*, DAB No. 1966, at 18 (2005) (holding that "it is reasonable to presume that the facility's policy reflects professional standards of quality, absent convincing evidence to the contrary").

When the incident at issue occurred, Petitioner had a Missing Resident Policy that enumerated steps that the facility staff must take once a resident fails to return from an approved LOA. CMS Ex. 6. If a resident failed to return from an authorized LOA within two hours of the designated time of return without calling, the following relevant provisions in the policy were to be immediately implemented:

> 4. The Supervisor will notify the Administrator and the [Director of Nursing Services (DNS)].
>
> * * *
>
> 8. If the resident is still not located the supervisor will notify the local Police Department, Administrator and DNS. The Administrator is responsible to **immediately** notify their Regional Director of Operations and the DNS is responsible to notify the Chief Clinical Officer.
>
> 9. The Nursing Supervisor will notify the attending physician, and the responsible party. The responsible party and/or family will be questioned as to where they think the resident may have gone.
>
> 10. While waiting for the police to arrive, the person in charge will direct staff in a search of the facility's grounds.
>
> 11. A picture of the resident, if available, will be given to the police upon their arrival. The police will also be made aware of whether

the resident has been deemed capable of meeting his/her minimal needs outside of the facility or is cognitively impaired and of any applicable special medical needs (e.g., insulin).

12. The Administrator is responsible to coordinate the facility off grounds search. The Administrator will assign staff to drive to specific locations to search for the resident.

    - Off duty staff will be called in to assist with off site search
    - Department Heads will participate in off site search
    - Area hospitals will be notified of missing resident
    - Area shelters will be notified and visited and given a picture/description of the missing resident

13. When the resident is found and returned to the facility, the responsible person and attending physician will be notified (as well as the police, if they did not locate the resident).

14. The Nurse Supervisor or charge nurse will assess the resident for any evidence of injury or distress and take appropriate action.

15. If the resident has been deemed capable of meeting his/her minimal needs outside of the facility, and has not returned to the facility or been located within 24 hours of the time he/she was deemed missing, the resident will be discharged [against medical advice].

CMS Ex. 6, at 1-3. (Emphasis in original).

In this case, when R109 failed to return at 12:00 noon, according to its own policy, Petitioner should have waited until no later than 2:00 p.m. to implement proper notifications, beginning with the charge nurse notifying her supervisor. However, the charge nurse (LPN1) did not even recognize that R109 failed to return until about three hours after he was due to return. Rather than immediately notifying her supervisor in accordance with Petitioner's policy, LPN1 simply informed the oncoming charge nurse (RN1) that R109 was missing but otherwise took no other action. RN1 then failed to immediately contact his supervisor, again violating the policy. Rather, RN1 attempted to reach a family member during the 3-11 p.m. shift, where he made "several attempts" to contact R109's family at a number that was "out of service." CMS Ex. 12, at 11.

It was not until the end of his shift, at about 10:30-11:00 p.m., when RN1 finally began to follow the missing resident protocol and notified his nursing supervisor. Finally, over eight hours after the facility's emergency protocol should have been instituted, the facility initiated its procedure and contacted R109's family, physician, area hospitals, and police. CMS Ex. 2, 3-4; CMS Ex. 5, at 3, 12; CMS Ex. 7, at 4-11; CMS Ex. 12, at 11. The facility's Administrator, however, was not notified at the same time as the DNS, according to facility policy. Instead, the DNS did not notify the Administrator until 7:42 a.m. the following morning that R109 remained missing. CMS Ex. 7, at 4-5.

Petitioner concedes, "[w]ithout a doubt, some of the Facility's employees made mistakes and failed to follow all of the Facility's internal policies." P. Prehearing Br. at 2. I agree considering the facility did not even notice that R109 had not returned until approximately three hours after he was due to return, and that two charge nurses, on two successive shifts, failed to promptly respond and follow the facility missing resident policy. Petitioner's failure to follow its own policy designed to protect its residents in the vulnerable position of independent leaves of absence, including R109, is sufficient to show that Petitioner failed to take all reasonable steps to protect R109 from accidents and hazards, in violation of 42 C.F.R. § 483.25(h).

Petitioner argues, "[e]ven if the Facility's employees had started actively searching for Resident #109 at 12:01 p.m., there is no reason to believe that they would have had a better chance at locating him, nor is there any reason to believe that he would have been in less danger at that time than at a later time." P. Br. at 15. This argument does not reconcile with the facility's establishment of a Missing Resident Policy. The fact that the facility failed to follow its own protocol designed for such circumstances, without good reason, shows that it failed to take those reasonable measures.

C. The $8,500 PICMP is reasonable.

To determine whether a CMP is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): 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 in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the 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.

I 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 deficiencies found and in light of the section 488.438(f) 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 Ctr.*, DAB No. 1848, at 21 (2002); *Cmty. Nursing Home*, DAB No. 1807, at 22 *et seq.* (2002); *Emerald Oaks*, DAB No. 1800, at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638, at 8 (1999).

Unless a facility contends that a particular regulatory factor does not support the CMP amount, the ALJ must sustain it. *Coquina Ctr.*, DAB No. 1860 (2002). Here, Petitioner has not alleged or offered evidence that its financial condition affects its ability to pay the CMP. Further, Petitioner's history of non-compliance includes a G-level deficiency identified during a January 22, 2009 survey. CMS Ex. 3.

In its brief, Petitioner minimizes the seriousness of the deficiencies and questions CMS's determination of immediate jeopardy, arguing that the circumstances surrounding the LOA did not, and were not, likely to cause serious harm to the resident. As previously explained during my January 10, 2012 telephone prehearing conference and in my January 11, 2012 Order Following Prehearing Conference, Petitioner has no right to review of CMS's immediate jeopardy determination. Scope and severity is only reviewable if a successful challenge would affect the range of the CMP that CMS could collect or the resulting loss of a nurse aid training program.

Here, CMS imposed a PICMP where there is only one range allowable. In contrast, amounts of per-day CMPs which CMS may impose are divided into two ranges; an upper range from $3,050 to $10,000 per day for deficiencies that constitute immediate jeopardy and a lower range from $50 to $3,000 per day for deficiencies at lower levels of scope and severity. 42 C.F.R. § 488.438(a). Only a single range of $1,000 to $10,000 applies to per-instance CMPs, whether or not immediate jeopardy is present. 42 C.F.R. § 488.438(a)(2). Consequently, where, as here, the only CMP imposed is a per-instance CMP, a successful challenge to the immediate jeopardy determination would not affect the range of CMP amounts that CMS could collect. *Fort Madison Health Ctr.*, DAB No. 2403, at 12-13 (2011). Further, Petitioner does not have a nurse aid training program that could be affected. CMS Ex. 4, at 1. Accordingly, Petitioner's challenge of CMS's immediate jeopardy finding remains out of my purview.

Despite my limited standard of review in considering the scope and severity of the penalty, I agree with CMS that this was a significantly serious deficiency in considering the amount of the penalty. I find the facility culpable in its disregard for its own policy and for not sharing an adverse psychiatrist's recommendation with R109's physician before the physician ordered R109's LOA. Although Petitioner contends that R109 did not suffer actual harm, I find it highly concerning that R109 returned so late to the facility's care with cocaine in his system, especially considering his known substance abuse issues, treatment for cardiomyopathy, and weakened and enlarged heart. Further, not following the facility's LOA policy not only affected R109 but also any other resident subject to it.

IV. Conclusion

I find Petitioner did not take all reasonable measures in its assessment sharing and policy compliance to protect R109 with regard to his independent LOA. Therefore, I find Petitioner was not in substantial compliance with Medicare participation requirements at 42 C.F.R. § 483.25(h). Furthermore, the $8,500 PICMP that CMS imposed is reasonable.

/s/
Joseph Grow
Administrative Law Judge