Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Methodist Health and Rehabilitation Center,
(CCN: 04-5413),

Petitioner,

v.

Center for Medicare & Medicaid Services.

Docket No. C-14-194

Decision No. CR3352

Date: August 28, 2014

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose the following remedies against Petitioner, Methodist Health and Rehabilitation Center:

- Civil money penalties of $3150 per day for each day of a period that began on July 26, 2013 and that ran through August 13, 2013; and

- Civil money penalties of $150 per day for each day of a period that began on August 14, 2013 and that ran through August 29, 2013.

I. Background

Petitioner, a skilled nursing facility, requested a hearing to challenge the remedies that I recite in the opening paragraph of this decision. I held a hearing by video teleconference on June 4, 2014. I received into evidence from CMS exhibits that are identified as CMS Ex. 1 – CMS Ex. 78 and CMS Ex. 80. I received into evidence from Petitioner exhibits that are identified as P. Ex. 1 – P. Ex. 43.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues are whether: Petitioner failed to comply substantially with Medicare participation requirements; CMS's determination of immediate jeopardy level noncompliance was clearly erroneous; and CMS's remedy determinations are reasonable.

B. Findings of Fact and Conclusions of Law

CMS alleges that Petitioner failed to comply substantially with regulations that govern the participation of skilled nursing facilities, such as Petitioner, in the Medicare program. CMS Ex. 5. These regulations include: several subsections of 42 C.F.R. § 483.13(c), including (c)(1), (2), and (4), which govern a facility's duty to investigate and report allegations of neglect or abuse of residents; the overall requirements of 42 C.F.R. § 483.13(c), which impose on a skilled nursing facility the duty to develop and implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents; and 42 C.F.R. § 483.25(h)(1) and (2), which require a facility to ensure that its resident environment remains as free of accident hazards as is possible and which require further that each resident of a facility receives adequate supervision and assistance devices to prevent accidents from occurring. CMS's allegations of noncompliance include the assertion that Petitioner's noncompliance with 42 C.F.R. § 483.25(h)(1) and (2) was so egregious as to cause residents of Petitioner's facility to be in immediate jeopardy.

I find it to be unnecessary to decide CMS's allegations of noncompliance with 42 C.F.R. § 483.13. As I explain below, the remedies in this case are supported entirely by my findings that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h)(1) and (2).

A skilled nursing facility is obligated by the requirements of 42 C.F.R. § 483.25(h)(1) and (2) to take all reasonable measures to protect its residents from foreseeable accidents. In the case of an elopement prone resident a facility must assess the risk of that resident eloping. It must determine what possible avenues of escape the resident may attempt to utilize as well as the circumstances under which the resident is prone to elope. And, it must assess its premises – its entrances and exits – in order to determine their vulnerabilities to an elopement prone individual. Finally, a facility must react to events by taking appropriate measures to beef up security when that is called for and to plug holes that are evident in its existing security system.

The gravamen of CMS's allegations concerning 42 C.F.R. § 483.25(h)(1) and (2) is that Petitioner failed to ensure that residents of its facility – residents who were known elopement risks – did not elope. CMS asserts that on several occasions residents got out

of the facility apparently by defeating or evading Petitioner's alarm system and that Petitioner failed to react, both in the cases of individual residents, and generally. CMS asserts that Petitioner did not improve and tighten its security system in order to protect residents against future elopements.

The evidence offered by CMS paints a picture of a facility that resorted to ad hoc and obviously ineffective measures to deal with elopements by its residents. In the cases of two eloping residents, Residents #s 1 and 6, Petitioner failed to investigate comprehensively the causes of their elopements, it failed determine the actual reasons for these residents getting out of the facility, it failed to follow its internal anti-elopement policies, and it failed to consider or to implement additional protective measures in order to keep the residents secure. The consequence was that the gaps in Petitioner's security system remained unfilled. That had obvious negative results in the case of Resident # 1, who eloped for a second time just three days after escaping from Petitioner's premises, and who sustained injuries as a consequence.

Petitioner equipped its elopement-prone residents with electronic bracelets that are part of an alarm system known as Watch Mate. The system is supposed to alert Petitioner's staff whenever a bracelet-equipped resident attempts to exit the facility because, in theory, that individual cannot pass through an exit doorway without his or her bracelet triggering an alarm.

Resident # 1 was, as of June 2013, 94 years old, and she suffered from a variety of impairments and illnesses that included Alzheimer's disease. CMS Ex. 21 at 1; CMS Ex. 9 at 2. She was one of the residents of Petitioner's facility who wore a Watch Mate bracelet. However, on June 13, 2013, the resident eloped the facility even though she was wearing a bracelet at the time. CMS Ex. 18 at 1. It is unclear how long the resident was outdoors because Petitioner did not record that information. CMS Ex. 11 at 7.

The resident was able to elope on June 13 because one of Petitioner's exit door alarms was disabled. CMS Ex. 11 at 7. Petitioner speculates that a contractor disabled the door. Petitioner's pre-hearing brief at 18. But, Petitioner did not provide evidence that proves this assertion.

The actual reason for the door being disabled remains unknown. Petitioner did not systematically investigate to determine why the door was disabled and thus, remained clueless as to how it happened. CMS Ex. 18; Tr. at 38. Moreover, Petitioner did not follow its own elopement policy after the incident to assure that there were no additional elopements. Petitioner's elopement policy explicitly states that its staff will continually monitor exit doors visually in the event that door alarms are turned off. CMS Ex. 73 at 2. But, Petitioner did not do that. Rather, it directed its maintenance supervisor to re-arm the disabled door. P. Ex. 15 at 2. Petitioner did not take additional steps to protect its residents.

I find that telling the maintenance supervisor to re-arm the disabled door was at best a half measure. Petitioner did not know *why* the door had become disabled. Re-arming the door without comprehending why the door was disabled to begin with meant that the potential existed for the system to fail again. Petitioner simply had no way of knowing whether additional failures were possible. Someone or something had caused the door to fail. But, Petitioner had no idea what caused the door to fail.

Furthermore, if a contractor disabled the door, then Petitioner had a duty to make sure that the contractor was educated so that the problem did not recur. Petitioner has offered no evidence to show that it talked with or instructed its contractor about the importance of keeping the alarm system up and running.

Resident # 1 eloped Petitioner's facility again on June 16, 2013, just three days after her first elopement. At about 8:40 a.m. on that date a resident of a nearby assisted living facility called Petitioner to advise it that someone had fallen out of a wheelchair and was lying in the road near the entrance to Petitioner's facility. CMS Ex. 19 at 1. The resident's wheelchair lay about 40 feet from the resident. The resident sustained abrasions to her elbow, palm, and right outer calf. *Id.* Although the resident remained equipped with a Watch Mate bracelet, the alarm on Petitioner's exit door had failed once again to sound when the resident eloped the facility.

Petitioner speculates that, on this occasion, the resident was able to exit the premises by following a family member or visitor out of the premises. Petitioner's pre-hearing brief at 19. The exit doors at Petitioner's facility are equipped with key pads. Keying in the correct code number disables the alarm and allows a visitor to exit the premises without triggering the alarm. According to Petitioner, someone must have keyed in the disabling code number, thereby allowing Resident # 1 to leave the premises. But, this is speculation on Petitioner's part. Petitioner does not actually know – nor has it presented evidence to establish – how Resident # 1 was able to get out of its facility on June 16.

The resident was sent to a local hospital to have her injuries treated and returned to Petitioner's facility on the afternoon of June 16. Petitioner has an elopement protocol that applies to residents who either elope or attempt to elope and that protocol requires that such residents be monitored once every 15 minutes for 12 hours after their attempts and once every 30 minutes for an additional 24 hours. P. Ex. 37 at 39. Petitioner invoked its elopement protocol for Resident # 1. However, there is nothing to show that it followed the protocol. There is no record that shows that the resident was actually monitored according to the protocol's requirements. *See Id.*

Nor did Petitioner implement additional interventions to protect Resident # 1 from possible future elopement attempts. As I have discussed, it failed to investigate the actual cause of the June 16 elopement, even as it failed to investigate the actual cause of the

June 13 elopement. Nor did Petitioner change its protocols for protecting Resident # 1. The June 16 elopement by Resident # 1 should have lain to rest any doubts as to her proclivities to exit the facility. It also should have caused Petitioner's staff to realize that whatever it was doing to protect the resident was inadequate. The Watch Mate alarm bracelet was clearly insufficient to protect the resident given that she'd made two elopements – one of which caused her to sustain injuries – within three days. Yet, staff did nothing to tighten its long-term surveillance of the resident or to implement additional measures that might have protected her.

Resident # 1 was not the only resident who eloped from Petitioner's facility. On August 5, 2013, Resident # 6 – an 87-year old demented individual – eloped the premises. Addressing this elopement, Petitioner's own incident report makes the following statement:

> [R]esident was seen outside the facility by a family member of a resident on her hall. After checking the doors it was noted that one of the doors was showing that it was activated but when resident exited out that door no alarm sounded.

CMS Ex. 63 at 1. Petitioner contends that, as with the case of the June 13 elopement by Resident # 1, a contractor who disabled the door enabled this elopement. Petitioner's pre-hearing brief at 16. Petitioner once again failed to thoroughly investigate the incident and pin down the precise cause of the alarm being disabled. However, assuming that a contractor disabled the alarm, there is no evidence to show that Petitioner or its staff attempted to educate the contractor on the need for maintaining alarm integrity. In fact, there is nothing to show that Petitioner met with the contractor or its staff to discuss the issue of alarm integrity. *See* CMS Ex. 63 at 2.

Petitioner's temporary solution to the alarm's malfunctioning was to tape over the door until its maintenance supervisor could reactivate the alarm on the following day. P. Ex. 16 at 1. This is contrary to what Petitioner's protocol called for, which was continual monitoring of the door by staff until it could be repaired. CMS Ex. 73 at 2.

Petitioner asserts that it took all reasonable measures to protect Residents #s 1 and 6, but the evidence belies this assertion. Petitioner argues that there is no proof that its alarm system malfunctioned periodically. But, whether the alarm system "malfunctioned" periodically or at all is not at issue here. What is at issue is Petitioner's failure to address the obvious inability of the alarm system to protect residents from eloping. Whether that was due to malfunctions in the system or human error is unknown. But, *something* caused the system to be defeated on more than one occasion and Petitioner never really addressed that issue systematically. The ad hoc measures that Petitioner took in reaction to each elopement were not a systematic attempt to fix the system and, in fact, they were ineffective.

Petitioner also makes a series of assertions about the care that it provided to Residents #s 1 and 6 and about how it provided security for these residents and others. I find some of these assertions to be unsupported. Others may be correct, but they do not help, and in some instances, hurt Petitioner's case.

Petitioner contends that it appropriately responded to residents' elopement attempts by placing its eloping residents on an elopement watch in order to monitor them. Petitioner's post hearing brief at 13. But, "placing" residents on elopement watch was not enough. Petitioner's elopement watch protocol required documented monitoring of those residents on watch at specified intervals. Petitioner failed to do that in the case of Resident # 1 on June 16, 2013 after her elopement on that date. P. Ex. 37 at 39. This resident may have been on elopement watch, but she was not being observed according to Petitioner's own mandatory protocol.

Petitioner asserts that, in the cases of Resident # 1's elopement on June 13, 2013 and Resident # 6's elopement on August 5, 2013, each resident was "located immediately and without incident . . . ." Petitioner's post hearing brief at 13. The record does not support this contention. As I have discussed, Petitioner has no record of, nor did its staff ascertain, how long Resident # 1 was outside of the premises on June 13.

Next, Petitioner contends that the elopements of June 13 and August 5 were the consequence of a contractor's disarming Petitioner's exit door. Petitioner's post hearing brief at 13. I have explained above why this assertion is speculative. But, even if Petitioner is correct, the fact that a contractor may have disarmed the door does not relieve Petitioner of the responsibility to protect its residents nor does it excuse Petitioner for the June 13 and August 5 elopements. Petitioner had a duty to make sure that its contractors did not disarm exit doors. And, if it knew after June 13, 2013 that a contractor had disarmed a door, then it had an absolute duty to make sure that the same thing did not happen the next time a contractor entered its premises. There is nothing at all in the record to show that Petitioner discussed with its contractors the problems resulting from exit doors being disarmed. Nor is there anything to show that Petitioner alerted the contractor who worked on August 5 to the harm that would likely occur if exit doors were disarmed. Furthermore, there is nothing to show that Petitioner ever briefed its staff to be on the alert for possibly disarmed exit doors when contractors were working on the premises.

Petitioner then asserts that it followed its policies for eloping residents by "continually" monitoring its exit door on August 5, 2013 after Resident # 6 eloped the premises. Petitioner's post hearing brief at 14. But, according to Petitioner, "continually" meant "periodically" and not "continuously." It does not deny that it failed to keep the door under constant scrutiny, but asserts that its policy never required it to do so.

This argument by Petitioner appears intended to divert focus from the real issue, that being Petitioner's failure to ensure that the disarmed exit door was secure on August 5, 2013. The fact is that on August 5 the alarm on the exit door was non-functional. That meant that any resident could leave the premises without triggering an alarm. Petitioner opted not to repair the door until the following day, August 6, 2013. That decision imposed on Petitioner the very heavy responsibility to ensure that residents did not simply walk out of the facility through the un-alarmed door. Petitioner's solution was to place tape over the door and, according to Petitioner, to monitor the door periodically.

But, Petitioner has offered no evidence to show how securely the door was taped and whether a resident could not have walked out simply by removing the tape. Nor has it provided proof as to how often the door was observed by its staff. It has left the term "periodic monitoring" undefined and provided nothing to show what schedule was used for monitoring. And, most important, it provided nothing to show why a resident couldn't have simply walked out the door whenever the door was not being monitored.

Petitioner asserts that it was under no duty to warn the contractor who worked on August 5 about the risks of disarming an exit door because the August 5 contractor was not the same contractor as the one who disarmed the door on June 13, and therefore, no generalizations could be drawn from the June 13 episode. Petitioner's post hearing brief at 15. I disagree, emphatically. The possibility that a contractor disarmed a door on June 13 should have put Petitioner on notice that there was a possibility that *any* contractor might do the same if not forewarned about the dangers of doing so. Petitioner clearly had an obligation to warn the contractor who worked on August 5 about the risks relating to disarming a door. More than that, Petitioner and its staff had the duty to make sure that the doors were functioning as intended on August 5, given their June 13 experience.

Next, Petitioner contends that Resident # 1 was care planned appropriately to go outside of Petitioner's facility under supervision. Petitioner's post hearing brief at 17. That may be so, but that is no justification for the resident's elopements.

Finally, Petitioner argues that CMS is effectively holding Petitioner to a strict liability standard, something that is not contemplated by the regulations. Petitioner's post hearing brief at 18. Petitioner argues that CMS would have it be held deficient simply because elopements occurred and without regard to the measures that Petitioner took to protect its residents.

That is simply not the case. I have discussed in detail the obvious shortcomings in Petitioner's security measures, including its failures to: monitor the work of its contractors and to communicate with them; monitor its eloping residents pursuant to its own policies; implement effective alternative measures to keep exit doors secure when alarms were disabled; and above all, to examine closely the elopement incidents to

determine their causes and to develop comprehensive measures to prevent them from happening again. These are not per se deficiencies; they are very obvious failures by Petitioner and its staff to anticipate and to address problems.

Petitioner argues that, if it was deficient, its noncompliance did not rise to the level of immediate jeopardy noncompliance. 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 a resident or residents of a facility. The evidence amply supports CMS's determination of immediate jeopardy level noncompliance. First, and most obviously, Resident # 1 sustained serious injuries – serious enough to require a trip to the emergency room – on June 16, 2013, when she eloped. The June 16 elopement occurred only three days after a previous elopement by the same resident and I have concluded that Petitioner failed to protect this resident against the second attempt. That is enough to find immediate jeopardy. But, beyond that, the likelihood existed for other serious injuries or worse as a result of elopements. Resident # 1 was not the only frail, demented, and sick individual on Petitioner's premises who was at risk for eloping. Petitioner's failure to learn from the events of June 13 and 16, 2013 meant that a very real risk of future elopements – a risk that came to fruition on August 5 – existed and that created a likelihood of residents sustaining serious injuries or worse.

The civil money penalties imposed by CMS against Petitioner, $3150 per day for each day of the period running from July 26 through August 13, 2013, and $150 per day for each day of the period running from August 14 through August 29, 2013, are minimal penalties given the level of Petitioner's noncompliance and are easily supported by the seriousness of the noncompliance. Daily penalties for immediate jeopardy level noncompliance must fall within a range of from $3050 to $10,000 per day and daily penalties for non-immediate jeopardy level noncompliance must fall within a range of from $50 to $3000 per day. 42 C.F.R. § 488.438(a)(1)(i), (ii). Here, CMS determined that Petitioner manifested immediate jeopardy level noncompliance between July 26 and August 13 and I have sustained that determination. An immediate jeopardy level penalty amount at almost the bottom of the immediate jeopardy level penalty range is plainly supported and Petitioner has offered no evidence to show why this amount is unreasonable.

As for the period after August 13, Petitioner contends that no penalty, even what constitutes a minimal non-immediate jeopardy level penalty of $150 per day, should be imposed. Petitioner asserts that it completely corrected its deficiencies, including the immediate jeopardy level deficiency that I address in this decision, by no later than August 14, 2013. According to Petitioner, it "provided sufficient evidence that it was in substantial compliance with . . . [the requirements of 42 C.F.R. § 483.25(h)(1) and (2)]

during the survey of August 14, 2013." Petitioner's post-hearing brief at 25. But, Petitioner, aside from contending that its alarm system was functional as of that date, has provided no evidence that it attained substantial compliance with the regulation by August 14.

Ensuring that the alarm system functioned correctly was certainly an element of compliance but not all that Petitioner had to do in order to attain compliance. One of its residents, Resident # 1, had eloped the premises on June 16, 2013 even though Petitioner contends that its alarm system was in perfect operating order on that date. So, Petitioner could not rely just on its alarm system in order to attain compliance with the regulation. It had to assure that residents could not escape its premises despite the alarm system. It has not provided evidence to show that it attained that level of compliance by August 14, 2013.

Finally, Petitioner protests the loss of its nurse aide training program (NATCEP). That loss is a consequence of its immediate jeopardy level noncompliance and is, effectively mandatory.

/s/
Steven T. Kessel
Administrative Law Judge