Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Life Care Center of Gwinnett, (CCN: 11-5347),	)	Date: September 24, 2008
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-08-110
	)	Decision No. CR1846
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose remedies against Petitioner, Life Care Center of Gwinnett, a skilled nursing facility doing business in Lawrenceville, Georgia, consisting of civil money penalties of:

- $5,000 for each day of a period that began on August 25 and which continued through September 4, 2007; and

- $500 for each day of a period that began on September 5 and which continued through September 18, 2007.

I. Background

Petitioner participates in the Medicare program. Its participation in Medicare 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. Its right to a hearing in this case is governed by regulations at 42 C.F.R. Part 498.

A Medicare compliance survey was conducted of Petitioner's facility on September 5, 2007 (September survey). The surveyors found that Petitioner failed to comply with Medicare participation requirements. Principally, they found that Petitioner was noncompliant with the requirements of 42 C.F.R. § 483.13(c), which mandate that a skilled nursing facility develop and implement policies and procedures that protect residents from mistreatment, neglect, and abuse. The surveyors concluded that Petitioner's noncompliance was so egregious as to comprise immediate jeopardy for the residents. The term "immediate jeopardy" is defined at 42 C.F.R. § 488.301 as noncompliance that has caused or is likely to cause serious injury, harm, impairment, or death to a resident.

CMS accepted the surveyors' findings and determined to impose the remedies that I describe in this decision's opening paragraph. Petitioner requested a hearing and the case was assigned to me for a hearing and a decision. The parties completed pre-hearing exchanges of proposed exhibits and briefs. I scheduled an in-person hearing. However, in advance of the hearing the parties agreed that it could be held by telephone. I conducted a telephone hearing on August 1, 2008.

At the hearing, I received into evidence from CMS exhibits that are identified as CMS Exhibit (Ex.) 1-CMS Ex. 12. I received into evidence from Petitioner exhibits that are identified as P. Ex. 1- P. Ex. 31. Each party filed a post-hearing brief.

II. Issues, findings of fact and conclusions of law

A. Issues

The issues in this case are whether:

1. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.13(c);[1]

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

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[1] The report of the September survey cites an additional non-immediate jeopardy level deficiency finding, Petitioner's alleged failure to comply with the requirements of 42 C.F.R. § 483.75(l)(1), which governs a facility's maintenance of clinical records. The allegation is based on Petitioner's alleged failure to document accurately events that are the basis for the immediate jeopardy level deficiency allegation. It is unnecessary that I address this additional deficiency in order to decide this case and, so, I do not.

3. CMS's remedy determinations are reasonable.

B. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below as a separate heading.

1. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.13(c).

The evidence in this case overwhelmingly supports my conclusion that Petitioner neglected the needs of a resident who is identified as Resident # 1 in the September survey report. The resident was an elderly individual who had been diagnosed with several serious medical conditions including: hemiplegia/hemiparesis as the consequence of a stroke; dysphagia; Parkinson's disease; and Alzheimer's disease. CMS Ex. 3, at 1. The resident's mental functioning was severely limited. *Id.* The resident had a history of suffering transient ischemic attacks (so-called "mini-strokes"). P. Ex. 11, at 9, 10. She required extensive assistance from Petitioner's staff for locomotion, dressing, and bed mobility, and she was totally dependent on Petitioner's staff for eating, toilet use, personal hygiene, and bathing. *Id.* The resident's medications included Coumadin, an anticoagulent. I take notice that Coumadin may greatly increase the risk of bleeding from a traumatic injury in any individual but especially one who is as frail and debilitated and at risk for falls as was Resident # 1. *See* P. Ex. 31, at 3. Petitioner's staff assessed the resident as being at risk for bleeding and bruising as a consquence of her receiving Coumadin. CMS Ex. 3, at 25.

CMS's allegations of noncompliance center around events that occurred on the morning of August 25, 2007. Between 7:30 and 8:00 a.m. on that date a nursing assistant took Resident # 1 to the bathroom. There is a dispute about what happened while the resident was in the bathroom, but this much is certain: either the resident fell to the floor or suffered an altered state of consciousness and was lowered to the floor by the nursing assistant. CMS Ex. 10, at 9, 13. Neither this nursing assistant nor a second nursing assistant whom she asked to help raise the resident from the bathroom floor and put her back into her wheelchair told anyone else about the event. CMS Ex. 10, at 13; *see id.* at 5.[2]

[2] The nursing assistant who was with Resident # 1 when the incident occurred gave at least one false statement about her involvement. On August 29, the assistant related her version of the events, omitting any reference to the incident in the bathroom, and stating only that she had taken the resident to the bathroom where the resident had

After the incident, at about 9:00 a.m., the nursing assistant who had been with the resident when the incident occurred wheeled the resident into the facility's activity room and placed her in front of the television set. *Id.* at 20. This nursing assistant later saw Resident # 1 at the entrance of the activity room, crying, with her left palm pressed against the left side of her face. She brought the resident to a licensed professional nurse. *Id.* at 15. However, she did not report the incident in the bathroom. At about 10:30 a.m., the licensed professional nurse sought the assistance of a registered nurse. *Id.* at 19. The registered nurse observed a walnut-sized bruise on the left side of the resident's forehead. *Id.* At this time the resident appeared to be neurologically unaffected. Neither the licensed professional nurse, nor the registered nurse was aware of the incident that had occurred in the bathroom and, evidently, they assessed Resident # 1 as having suffered a minor injury. As a precaution, the registered nurse notified the resident's physician and family and, at about noon on the 25th, the resident was transported to a local hospital. CMS Ex. 7, at 7.[3]

The resident's condition deteriorated. At the hospital, Resident # 1 was diagnosed to be suffering from a subarachnoid hemorrhage, a closed injury to her head. CMS Ex. 3, at 7, 9. Her condition continued to deteriorate and she was transferred to hospice care. Subsequently, the resident died.

The evidence that I have discussed provides strong prima facie support for a finding that Petitioner neglected the needs of Resident # 1. The incident that occurred in the bathroom on August 25, 2007 was a potentially life-threatening event for the resident. This resident had a history of stroke and transient ischemic attacks. Any alteration in the resident's state of consciousness – whether or not the resident actually fell – demanded immediate notification of the facility's professional staff, notification of the resident's family, and consultation with the resident's treating physician. And, if the resident in fact fell in addition to suffering a change in her state of consciousness, that raised the additional red flag of the possibility of bruising and bleeding related to the resident's intake of Coumadin. Petitioner's professional staff was aware of the risks that Resident # 1 faced inasmuch as they had assessed her to be at risk for bruising and bleeding as a consequence of her use of Coumadin. Furthermore, the professional staff was aware of the resident's history of, and propensity for, stroke.

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been combative but had a bowel movement. CMS Ex. 10, at 17. She also averred that she didn't know what had happened to Resident # 1. *Id.*

[3] There is no allegation that Petitioner's nursing staff neglected Resident # 1's needs after the resident had been brought to their attention on the morning of August 25.

It is, apparent, however, that the nursing assistant who was with Resident # 1 in the bathroom on August 25, 2007, and the second nursing assistant, as well, did not recognize the ominous implications of the resident's altered state of consciousness on that date. While these employees had been trained in the need to report falls, there is no evidence that either of them had been counseled prior to the incident that *this resident* presented unusually high risk factors.

The failure of the two nursing assistants who provided primary and secondary assistance to Resident # 1 to report the incident of August 25 put the resident at grave risk for serious injury. Their failure to report immediately the incident was obvious neglect of the resident's needs. So also was the failure of the nursing assistant who was present at the time of the incident on the 25th to honestly describe what had happened when she finally brought the resident to the attention of the licensed professional nurse. I have no doubt that, had this nursing assistant been more forthcoming, Petitioner's professional staff would have responded to the situation with a much greater degree of urgency.

Petitioner doesn't dispute what happened on August 25 so much as it attempts to argue that those events should not be a basis for a finding of noncompliance. I find Petitioner's arguments to be unpersuasive.

As a threshold matter, I note that the issue here is not whether whatever happened in the bathroom on August 25, 2007 caused the resident's injuries. Rather, it is whether the events that occurred in the bathroom imposed obligations on Petitioner's staff that the staff failed to discharge. Given the resident's history, all of the staff – professional and non-professional alike – should have reacted instantly and urgently to the incident on August 25, 2007. That is so irrespective of the event's ultimate consequences.

Petitioner's essential argument is that it should not be held accountable for the misfeasance and malfeasance of its staff because this conduct was not condoned by Petitioner's policies governing resident care or by Petitioner's management and because Petitioner had diligently trained its staff to implement its patient care policies. Petitioner asserts that, to find Petitioner responsible for its employees' actions in the context of this case, would essentially be a finding of per se liability, contrary to the intent of the Act and the regulations. According to Petitioner, the acts and omissions of the two nursing assistants on August 25, 2007 were beyond Petitioner's ability to control and, therefore, it should be held blameless for them.

First, Petitioner's argument fails because I do not find that Petitioner had provided its assistants with all of the training necessary to assure that Resident # 1 was protected adequately. Petitioner's falls reporting policy is a general policy that covers falls. It does not teach nursing assistants and other non-professional members of the staff to look for the sometimes subtle signs that suggest a potentially grave change in condition in a resident like Resident # 1. Training the non-professional staff to implement Petitioner's falls policy without training the staff to recognize the unique risk factors presented by Resident # 1 simply was inadequate to protect the resident sufficiently.

As Petitioner concedes, this resident manifested several unique risk factors. These included her history of stroke and transient ischemic attack and her intake of Coumadin. These factors both singly and in combination should have put the entire staff of Petitioner's facility, and not just the professional staff, on notice, that any alteration in the resident's consciousness – whether or not such alteration produced immediate apparent injury – was a very dangerous sign that could under no circumstances be ignored.

Petitioner's falls policy provides that: "when a resident has a fall, the charge nurse will be notified immediately." P. Ex. 23, at 7. But, in this case, the only eye witness to the event, the nursing assistant who was with Resident # 1 during the incident, claimed that the resident *did not* fall. If, in fact that was true, then the nursing assistant may have concluded that her non-reporting of the incident was literally consistent with the facility policy. Obviously, however, and as I have discussed, the incident mandated immediate reporting and in fact much more whether or not the resident fell.

Thus, training the non-professional staff to report falls or injuries was, in the context of Resident # 1's problems, simply inadequate to protect the resident completely. The nursing assistant who was with the resident in the bathroom on August 25, 2007 asserted subsequently that the reason she did not immediately report the incident to the professional staff was that she didn't comprehend such an event to be even potentially serious. Had she been alerted to the extreme dangers associated with such an event in the case of Resident # 1, it is at least possible that she would have treated it with greater urgency than she did.

Second, Petitioner's argument fails because it would render the protections of the Act and regulations meaningless. Essentially, Petitioner would immunize itself from any staff errors that deviate from its policies. Taken to its logical end, Petitioner's argument would exempt a skilled nursing facility from compliance with Medicare participation requirements *except* in those situations where a failure to provide care as is required by applicable regulations can be attributed directly to a failure by the facility's management to design and implement policies for operating the facility.

However, that is not what neither the Act or the regulations contemplate. Petitioner's argument notwithstanding, the Act and regulations recognize that a facility cannot be separated under the law from the individual acts of its staff.

The Act and regulations make a facility responsible for all of its staff's actions because it is those actions which comprise the care that residents receive. *Emerald Oaks*, DAB No. 1800, at 7, n.3 (2001); *Barn Hill Care Center*, DAB No. 1848 (2002).[4] The care rendered by any skilled nursing facility to its residents depends on the performance of the facility's individual staff members. When a staff member provides care to a resident that care is an individual act. Indeed, all care provided to a facility's residents is the product of a myriad of acts by individual staff members. Staff members assess the resident's condition, they plan the resident's care, and they implement care planning decisions. Separating actions by the staff from the facility simply makes no sense given that the facility would not exist and it would not provide care to residents but for the individual actions of its staff.

Petitioner attempts to distinguish *Emerald Oaks* from the facts of this case by arguing that, in *Emerald Oaks*, the staff member who failed to respond to a resident's change in condition, thereby neglecting the resident's care, was a nurse – a medical professional – and not nursing assistants, as is the case here. I find that distinction to be meaningless. Every member of a facility's staff must be trained to recognize the signs and symptoms that denote a significant change in a resident's condition and to take the necessary measures when such a change is apparent. As I discuss above, the two nursing assistants who were involved with Resident # 1 during and after the August 25, 2007 event should have been trained to understand that a transient alteration of consciousness by this resident was a danger sign that mandated immediate and urgent notification of professional staff.

2. Petitioner did not prove that CMS's determination of an immediate jeopardy level deficiency was clearly erroneous.

Even as the overwhelming evidence supports a finding of noncompliance so also does it support a finding of immediate jeopardy level noncompliance. The undisputed facts show that Resident # 1 was at great risk for bruising and bleeding from any traumatic event. They show also that this resident's medical history placed her at great risk for stroke. The altered state of consciousness and/or fall experienced by Resident # 1 on August 25, 2007

[4] The regulations recognize that there are certain responsibilities that are unique to a facility's management and, consequently, they establish specific participation requirements that management must meet. 42 C.F.R. § 483.75.

was thus a potentially life threatening event. The probabilities were extremely high that the resident would suffer severe harm or death if that event was not immediately reported. The failure to do so put the resident in a state of jeopardy.

Petitioner has offered no evidence to show that a finding of immediate jeopardy, given its noncompliance, is clearly erroneous. Consequently, I sustain CMS's determination.

Petitioner argues that one may not reasonably extrapolate immediate jeopardy from an isolated episode of staff neglect (although it does not concede that there was neglect here) because an isolated episode is not sufficient basis to conclude a systemic failure on the part of Petitioner to protect its residents from neglect. But a systemic failure, while it is certainly a potential ground for finding immediate jeopardy, is not the only permissible ground for such a finding. An individual – even an isolated – incident of neglect may be sufficient to establish immediate jeopardy where it creates the conditions that meet the regulatory definition of the term.

Furthermore, and as I have discussed, there was a systemic gap in Petitioner's policies that may have contributed to the failure to report the incident involving Resident # 1. Petitioner's staff was trained to report *falls*. But, there is no evidence to show that the non-professional staff, including the nursing assistants, were trained to recognize incidents that did not comprise falls but which, in the context of specific residents' conditions could denote grave underlying problems, required reporting as well.

3. CMS's remedy determinations are reasonable.

At issue here are two civil money penalty amounts which CMS determined to impose over two periods of time. As a remedy for Petitioner's immediate jeopardy noncompliance, CMS determined to impose civil money penalties of $5,000 per day for each day of a period that began on August 25 and which continued through September 4, 2007. CMS determined also that Petitioner remained out of compliance, albeit at a level of noncompliance that was less than immediate jeopardy, from September 5 through September 18, 2007 and it determined to impose civil money penalties of $500 per day throughout this period.

Petitioner has not challenged the duration of CMS's findings of noncompliance. Therefore, my evaluation of the remedies in this case starts with a finding that Petitioner was noncompliant at the immediate jeopardy level from August 25 through September 4, 2007 and remained noncompliant, albeit at a level that was less than immediate jeopardy, from September 5 through September 18, 2007.

There are regulatory criteria which govern civil money penalty amounts. Penalties ranging from $3,050 to $10,000 per day may be imposed for noncompliance that is at the immediate jeopardy level. 42 C.F.R. § 488.438(a)(1)(i). Penalties ranging from $50 to $3,000 per day may be imposed for non-immediate jeopardy level noncompliance. 42 C.F.R. § 488.438(a)(1)(ii).

Where a penalty amount may fall within a given range depends on evidence relating to several regulatory factors. These are set forth at 42 C.F.R. §§ 488.438(f)(1)-(4) and 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)). The factors include: the seriousness of a facility's noncompliance; its culpability; its compliance history; and its financial condition.

I find that the penalty amounts in this case are amply supported by evidence relating to the seriousness of the noncompliance. The failure by Petitioner's staff to report the incident involving Resident # 1 on August 25, 2007 surely jeopardized that resident's life. As I have discussed above, a fall by the resident and/or an altered state of her consciousness were red flags that should have prompted Petitioner's staff into taking immediate and urgent action on the resident's behalf. The failure by Petitioner's nursing assistants to notify Petitioner's nursing staff of the incident not only caused the resident to be ignored for at least two hours after the incident occurred but, it almost certainly caused the nursing staff to treat the resident's apparent injuries less urgently than they would have had they known about the incident. The evidence establishes that, although the resident's bruise and complaints were finally brought to the nursing staff's attention some time after 10:00 a.m. on the 25th, the resident was not finally transported to a hospital until about noon on that date. CMS Ex. 7, at 7. It is reasonable to infer that Petitioner's nursing staff would have acted more expeditiously had they known the likely cause of the resident's complaints and bruising or had they known that the resident had suffered an altered state of consciousness at about 8:00 a.m. on that date.

Petitioner argues that civil money penalties – any penalties – are pointless in this case because the poor judgment of the nursing assistants who failed to report the incident involving Resident # 1 may not be attributed reasonably to Petitioner. As I discuss above, at Finding 1, I reject Petitioner's assertion that a facility is not liable for the individual acts of noncompliance of its employees. Furthermore, the deficiency in this case was not just caused by individuals failing to follow facility policies but by policies that did not provide adequate training to non-professional staff to recognize and report potentially life-threatening events. But, beyond that, it is evident that civil money penalties in a case like this have a legitimate remedial intent. Moreover, the likelihood that remedies would be imposed here had a beneficial effect on Petitioner.

It is obvious that, whatever training or supervision Petitioner may have given to the nursing assistants who were involved, it was inadequate to prevent their mis- and malfeasance on August 25, 2007. The probability that CMS would impose remedies against Petitioner for continuing noncompliance spurred Petitioner into providing additional training and education to its staff concerning the issues of neglect, abuse, and the need for prompt and accurate reporting of incidents that put residents at risk. That training was not planned prior to the September survey. It occurred as a consequence of it and the likelihood that remedies would be imposed. CMS Ex. 2.

/s/
Steven T. Kessel
Administrative Law Judge