Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
South Salem Rehabilitation, LLC d/b/a Avamere Rehabilitation of Salem,	)	
	)	Date: September 01, 2009
Petitioner,	)	
	)	Docket No. C-09-176
- v. -	)	Decision No. CR1998
	)	
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION GRANTING SUMMARY DISPOSITION TO CENTERS FOR MEDICARE & MEDICAID SERVICES

I grant the motion for summary judgment by the Centers for Medicare & Medicaid Services (CMS). I deny the motion for summary judgment by Petitioner, South Salem Rehabilitation, L.L.C. In granting CMS's motion I sustain imposition of remedies against Petitioner consisting of two per-instance civil money penalties each in the amount of $3,500.

I. Background

Petitioner is a skilled nursing facility in the State of Oregon. It participates in Medicare and its participation in that program 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.

CMS determined to impose against Petitioner the remedies that I discuss in the opening paragraph of this decision.[1] CMS based its remedy determination on noncompliance

[1] In September 2008 CMS threatened to impose an additional remedy against Petitioner, (…continued)

findings that were made at a survey of Petitioner's facility completed on August 7, 2008 (August survey). Petitioner requested a hearing and the case was assigned to me for a hearing and a decision. The parties completed pre-hearing exchanges. Then, Petitioner moved for summary disposition and CMS cross-moved for summary disposition.

CMS filed 24 proposed exhibits with its pre-hearing exchange which it designated as CMS Ex. 1 – CMS Ex. 24. Petitioner filed no proposed exhibits. I receive CMS Ex. 1 – CMS Ex. 24 into the record of this case and I cite to some of them in this decision for purposes of illustration. However, I base my decision to impose summary disposition in favor of CMS on the undisputed facts and I make no evidentiary findings based on the exhibits.

II. Issues, findings of fact and conclusions of law

A. Issues

CMS imposed the two per-instance penalties to remedy specific deficiencies that were identified at the August survey consisting of failures of Petitioner to comply with the requirements of: 42 C.F.R. §§ 483.20(d) and 483.20(k)(1); and 42 C.F.R. §§ 483.25(h)(1) and (2).[2] The issues that I decide are whether:

1. The undisputed material facts establish that Petitioner failed to comply substantially with these regulatory requirements; and

2. CMS's penalty 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.

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[1](continued…)

a denial of payment for new Medicare admissions effective November 7, 2008, if Petitioner did not attain compliance by that date. Petitioner attained compliance prior to November 7 and the remedy was not imposed.

[2] There was a third finding of noncompliance made at the August survey consisting of a failure by Petitioner's management to comply with the requirements of 42 C.F.R. § 483.75. CMS does not assert that it imposed remedies based on this noncompliance finding, and, therefore, it is unnecessary that I make any findings about it.

1. The undisputed material facts establish that Petitioner failed to comply substantially with the requirements of 42 C.F.R. §§ 483.20(d) and 483.20(k)(1); and 42 C.F.R. §§ 483.25(h)(1) and (2).

a. Petitioner failed to comply substantially with the requirements of 42 C.F.R. §§ 483.20(d) and 483.20(k)(1).

The regulations that are at issue here require in pertinent part that a skilled nursing facility use the results of comprehensive assessments of each resident's condition to develop, review, and revise that resident's plan of care. They require additionally that each resident's comprehensive plan of care include measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

CMS asserts that Petitioner failed to comply with these requirements in providing care to two of its residents who are identified as Resident # 13 and Resident # 14 in the report of the August survey. With respect to Resident # 13, the undisputed facts are that the resident had problems with his balance and a history of falls. Additionally, Petitioner's staff assessed the resident to be an elopement risk. However, the facts offered by CMS show that Petitioner failed to update Resident # 13's plan of care to address the resident's falls and elopement risks. CMS Ex. 1, at 17; CMS Ex. 24, at 3 ¶ 16. Nor did the care plan contain interventions that addressed the possibility that the resident might attempt to elope Petitioner's facility despite the fact that Petitioner's staff had identified the resident as being an elopement risk. CMS Ex. 1, at 17; CMS Ex. 24, at 6 ¶ 31.

CMS contends that Resident # 14 had problems that were similar to those manifested by Resident # 13. The resident had experienced a series of falls. CMS Ex. 1, at 18. On July 20, 2008, the resident fell and was found lying on the floor of Petitioner's facility. CMS Ex. 24, at 12 ¶ 61. The resident was also a known eloper. The staff knew that he had a history of wandering. CMS Ex. 14, at 4; CMS Ex. 24, at 12 ¶ 62. Petitioner's staff recorded the resident's name in a document known as a "Code Green Book" which identified those residents who were at risk for eloping the premises. In February 2008 the resident eloped the facility and was found near the entrance to a cemetery across the street from the premises.

However, Petitioner's staff failed to update Resident # 14's care plan to provide interventions that addressed either the resident's evident risk for falling or his propensity to elope. Indeed, the staff acknowledged that it failed to update instructions in the plan which elaborated on the supervision that the staff would give the resident. CMS Ex. 24, at 12 ¶ 62; CMS Ex. 13, at 8.

Petitioner has not offered any facts or argument to challenge the facts alleged by CMS. It attempts to minimize the possibility of harm that resulted from the staff's failures to comprehensively plan the residents' care by asserting that these failures comprised merely "administrative failings" which, when viewed either individually or collectively, did not show that there was a likelihood of serious injury or harm to Petitioner's residents. Petitioner's pre-hearing brief at 9.[3]

I disagree with Petitioner's characterization. The problems manifested by Residents #s 13 and 14 were serious and they called for serious interventions by Petitioner's staff. Both of these individuals were at risk for serious injury from falling. The knowledge of that risk imposed on Petitioner's staff the burden of planning and implementing interventions that would protect the resident. Similarly, both of these residents were known elopement risks and the dangers to these residents posed by their propensity to elope should have been obvious to Petitioner's staff. If nothing else, the residents' risks of falling while unsupervised made it imperative that Petitioner's staff know the residents' locations at all times. Elopement by falls prone residents such as these two greatly increased the risk of injury or harm. Yet, the undisputed facts offered by CMS show that Petitioner failed to respond to either of these residents' needs for comprehensive planning to address their problems.

b. Petitioner failed to comply substantially with the requirements of 42 C.F.R. §§ 483.25(h)(1) and (2).

The applicable regulatory sections require that a skilled nursing facility ensure that its residents' environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. The regulation imposes several distinct duties on a skilled nursing facility. First, the facility must assess its premises and each resident individually in order to identify all known and knowable risks of accidents. Second, the facility must adopt plans to eliminate all identified risks. And, finally, the facility must implement that which it has planned.

The residents' conditions and their environment change over time and a facility must therefore adapt to all changes that are encountered. Assessment of risks and hazards, planning to deal with such risks and hazards, and implementation of plans must be updated on an ongoing basis by a facility if it is to anticipate and address effectively the risks and hazards which its residents face.

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[3] It is not entirely clear whether Petitioner means by this argument to challenge the finding of noncompliance or whether it concedes noncompliance but challenges only the finding of immediate jeopardy that CMS made in assessing scope and severity.

CMS argues that Petitioner failed to perform its duty to protect its residents. It relies on the following fact contentions:

- Several of Petitioner's residents, including Resident # 13 and Resident # 14, whose conditions I describe above, were known elopement risks. Petitioner allowed these residents unsupervised access to a patio on the exterior of Petitioner's premises. CMS Ex. 1, at 25. On July 30, 2008, the lock which secured the patio gate and which was supposed to restrict residents' access to the exterior of Petitioner's facility, was unlocked. CMS Ex. 24, at 7 ¶ 36; CMS Ex. 16, at 29; CMS Ex. 1, at 24. Residents who were not supervised, including those who were elopement risks, thus had access to the exterior of Petitioner's premises.

- During the August survey the call button on the doorway to Petitioner's patio was missing. CMS Ex. 1, at 37. This increased the possibilities that residents might egress Petitioner's facility while unsupervised or that, if they fell, response by Petitioner's staff would be delayed.

- On July 30, 2008, Resident # 13 fell while unsupervised on Petitioner's patio.

If not disputed, these facts strongly support a conclusion that Petitioner failed adequately to protect its residents against accident hazards and to provide them with necessary supervision. The patio gate, if unlocked, was an obvious hazard. Indeed, the fact that Petitioner's staff found it necessary to put a lock on the gate underscores the risks resulting from leaving the gate unlocked. The gate provided residents of Petitioner's facility with direct access to the exterior of the premises and several of these residents had been identified as elopement risks. Under the circumstances, it was absolutely imperative that Petitioner's staff keep the gate locked at all times except when the residents were under their direct supervision. The fact that the lock was unlocked was obvious negligence on the part of the staff.

Similarly, the failure to supervise closely elopement and falls prone residents while they were on the patio was an invitation to disaster. Petitioner's staff should have known that there were obvious dangers associated with leaving these residents unsupervised.

Petitioner does not deny any of the facts relied on by CMS. It attempts to minimize the significance of the unlocked patio gate by asserting that this was a "one-time failure on the part of someone to re-engage the lock after passing through the gate." Petitioner's pre-hearing brief at 11. Petitioner argues that such error could occur at any time and cannot, in and of itself, constitute a hazard to residents. *Id.*

I disagree. Whether the failure was an isolated incident or something that happened more frequently doesn't answer the question of whether leaving the patio gate unlocked posed a risk to resident safety. Whether the failure was isolated or not, it was egregious and posed a great risk of harm to residents. Leaving the gate unlocked created precisely the type of hazard a facility must anticipate and address in order to comply with the requirements of 42 C.F.R. § 483.25(h)(1).

Petitioner also argues that the regulation does not impose a standard of strict liability on a facility but merely requires that a facility keep its premises as free from accidents as possible. Petitioner's pre-hearing brief at 11. Petitioner contends that CMS's determination of noncompliance effectively imposes a strict liability standard because it implies that any accidental failure by a facility to leave a door or gate locked would always constitute a deficiency. Petitioner's pre-hearing brief at 11-12.

However, I do not base my finding of noncompliance solely on the fact that Petitioner's staff left the patio gate unlocked. The failure here lies not so much in the fact that the gate was unlocked but in the failure by the staff to police the gate and to detect that the gate was unlocked.

The undisputed facts of this case are that the staff knew that the gate potentially could allow egress from the facility of elopement prone residents and that the staff knew also that such residents were allowed to congregate on a patio which abutted the gate without close supervision. That knowledge imposed on the staff the duty to assure that the gate remained locked whenever residents were given access to the patio.

Petitioner also attempts to minimize the fact that the call button was missing by asserting that any call button, including the one in question, could be subject to acts of vandalism. Petitioner's pre-hearing brief at 12. According to Petitioner, there was no deficiency associated with the missing call button because the button was repaired by Petitioner's maintenance personnel as soon as its absence was brought to Petitioner's attention. *Id.*

This argument is not persuasive because it fails to address the question of why Petitioner's staff was unaware that the call button was missing prior to the surveyors calling its absence to the staff's attention. Obviously, the call button was a necessary safety device because it was in an area that was frequented by falls prone residents. Without one-to-one supervision by facility staff, the call button served as a lifeline for residents who might find themselves at risk while alone on the patio. It was imperative, therefore, that a functioning call button be in place at all times and staff had a duty to be constantly aware of any problems that might be associated with vandalism or malfunctions. It is no excuse to say that the staff repaired the button promptly after its absence was brought to their attention.

Petitioner asserts that, in fact, it adequately supervised its residents, including those falls and elopement prone residents who had access to Petitioner's patio. To support this assertion, it lists the various interventions that the staff had implemented in order to address the elopement risks posed by three of its residents (Residents #s 6, 13, and 14). Petitioner's pre-hearing brief at 13-15.

I do not dispute that Petitioner implemented these interventions. But that begs the question. The issue here is not what other interventions Petitioner may have implemented but what it did to protect those residents who it allowed to have access to its patio. And, here, there is no dispute whatsoever that these residents were allowed *unsupervised access* to the patio, thus increasing the risk that those who were falls prone might fall without being observed and those who were elopement prone would have increased opportunities to escape the premises if other security and safety measures (i.e., the patio gate and the call button) failed. The seriousness of Petitioner's noncompliance is measured not simply by the fact that its residents were allowed to go out on the patio unsupervised but by the failure of Petitioner's staff to assure that the patio was secure despite knowing that a very serious hazard would exist if the patio gate was not securely locked and the call button was not operating.

2. A finding of immediate jeopardy is not a prerequisite to sustaining a per-instance civil money penalty of more than $3,050.

Petitioner argues that the two $3,500 per-instance civil money penalties that CMS determined to impose could not be imposed lawfully in the absence of a finding of immediate jeopardy. That argument is incorrect as a matter of law. CMS is authorized to impose per-instance penalties of up to $10,000 without regard to whether immediate jeopardy exists.

The authority for CMS to impose civil money penalties for noncompliance with nursing home regulations is stated at 42 C.F.R. § 488.438(a). The regulation describes three types of civil money penalties which include daily penalties of between $50 and $3,000 for non-immediate jeopardy level deficiencies, daily penalties of between $3,050 and $10,000 for immediate jeopardy level deficiencies, and per-instance penalties of between $1,000 and $10,000 that CMS may impose for specific instances of noncompliance. 42 C.F.R. §§ 488.438(a)(1)(i),(ii); (2).

Nothing in this regulation or in the Act links a per-instance civil money penalty amount to a finding of immediate jeopardy. There simply is no requirement in the Act or in the regulations that immediate jeopardy be present as a prerequisite for imposing a per-instance civil money penalty of $3,050 or higher.[4]

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[4] The Act does not use the term "immediate jeopardy." It states only that the Secretary

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Petitioner argues also that the presence of immediate jeopardy is a necessary prerequisite to sustaining per-instance civil money penalties of more than $3,050 because, in this case, CMS allegedly predicated its remedy determinations on the presence of immediate jeopardy. Petitioner's reply brief at 2. Petitioner asserts that CMS never would have imposed the remedies that are at issue in this case but for findings of immediate jeopardy. Therefore, according to Petitioner, the civil money penalties that are at issue here cannot be sustained absent findings of immediate jeopardy.

Petitioner's argument is incorrect. My authority to conduct a hearing in this case is not limited to a quasi-appellate review of CMS's actions. I have de novo authority to decide both the issues of noncompliance and remedy. I make my decision as to what is appropriate as civil money penalties based on an independent review of the evidence. Therefore, I am in no sense constrained by the way in which CMS may have evaluated that evidence.

Petitioner also argues that the remedies that CMS determined to impose are in effect "category 3" remedies and not "category 2" remedies. Petitioner's reply brief at 4. Petitioner predicates this argument on 42 C.F.R. § 488.408, which, it contends, establishes the procedures for CMS's selection of remedies. Petitioner argues that to sustain the penalties that CMS determined to impose absent a finding of immediate jeopardy would contravene the regulatory framework for selecting remedies, thereby invalidating the penalty determinations.

This argument is also incorrect because, as with Petitioner's previous argument, it rests on a conception of my authority that is completely at odds with the law. Petitioner seems to believe that my authority is limited to reviewing CMS's actions for propriety. In fact, and as I have explained, my hearing and decision authority is de novo. Consequently, whether the noncompliance should be described as "category 2" or "category 3" is simply irrelevant. The issue before me is simply whether the noncompliance justifies the remedy amount based on the criteria that I explain below, at Finding 3.

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[4](continued…)

may impose a civil money penalty not to exceed $10,000 for each day of a skilled nursing facility's noncompliance with Medicare requirements. Act, section 1819(h)(2)(B)(ii). Consequently, the Secretary's determination to allow per-instance penalties of up to $10,000 without regard to whether there is immediate jeopardy is entirely consistent with the Act and within her discretion.

3. The penalty amounts are reasonable.

The regulations establish a framework for deciding whether a penalty amount is reasonable. Factors which may be considered include the seriousness of a facility's noncompliance, its compliance history, 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 undisputed material facts provide ample support for CMS's determination to impose two $3,500 per-instance penalties against Petitioner. First, the undisputed facts of this case clearly support a finding of immediate jeopardy level noncompliance even if it is not necessary that I find immediate jeopardy in this case in order to sustain CMS's penalty determinations.

The likelihood of serious injury, harm, or worse for residents created by Petitioner's noncompliance was evident in Petitioner's failures to plan the care of two of its residents (Resident # 13 and Resident # 14) despite its staff's knowledge that these residents were at risk for injuries from falls and were elopement prone. Indeed, Petitioner failed to develop additional interventions to protect Resident # 14 against elopement even after the resident eloped and was found near the entrance to a cemetery across the street from the facility.

The likelihood of serious injury, harm, or death was also evident in Petitioner's failure to protect its residents, including Resident # 13 and Resident # 14, from obvious hazards. Allowing these residents and other falls and elopement prone residents unrestricted and unsupervised access to an exterior patio was an invitation to disaster. Not assuring that the patio gate remained locked and that the patio call button was functioning properly compounded the risks to these residents.

Petitioner has adduced no facts that, assuming they are true, would establish CMS's immediate jeopardy determination to be clearly erroneous. Essentially, Petitioner's argument in opposition to a finding of immediate jeopardy boils down to asserting that there was no actual harm to any resident caused by Petitioner's noncompliance. But actual harm is not a prerequisite for a finding of immediate jeopardy. Immediate jeopardy is present whenever there is a *likelihood* of serious injury, harm, or death to a resident and Petitioner has done nothing to rebut those facts which establish that likelihood.

Furthermore, whether or not Petitioner's noncompliance was at the immediate jeopardy level, it was egregious and put Petitioner's residents at grave risk for injury or worse. Penalties in the amount determined by CMS are made reasonable by the seriousness of Petitioner's noncompliance even if immediate jeopardy is not established.

The penalties that CMS determined to impose are, in fact, minimal when measured against the noncompliance that is established by the undisputed facts of this case. Petitioner's noncompliance clearly predated the August survey. The failure by its staff to plan residents' care and to supervise residents was an ongoing problem and not something that occurred only during a few moments on the date of the survey. The undisputed facts of this case establish that CMS would have been justified in imposing very substantial daily civil money penalties for the duration of Petitioner's noncompliance. Had CMS done so, the total penalty amounts would have dwarfed what CMS actually determined to impose, and the two per-instance penalties at issue here would have been a pittance compared to what CMS might legitimately have imposed. Thus, the remedies in this case are actually extremely modest and well-supported by the undisputed material facts.

/s/
Steven T. Kessel
Administrative Law Judge