Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Bedford Care Center - Monroe Hall, LLC
(CCN: 25-5297),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-09-397

Decision No. CR2229

Date: August 30, 2010

DECISION

I find that Bedford Care Center – Monroe Hall (Petitioner) was not in substantial compliance with 42 C.F.R. § 483.25(h) by failing to provide a severely cognitively-impaired resident (Resident 1) with adequate supervision to prevent her elopement from the facility. I also sustain as reasonable the Centers for Medicare and Medicaid Services (CMS) imposition of civil money penalties (CMP) of $3,550 per day from January 20 through January 28, 2009 and $100 per day for January 29, 2009 for one day of non-compliance.

I. Background

Petitioner participates in the Medicare and Medicaid programs pursuant to sections 1819, 1919 and 1866 of the Social Security Act (Act) and by its 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.

On January 29, 2009, the Mississippi State Department of Health (the state survey agency) conducted a complaint survey and found Petitioner was not in substantial compliance with Tag F323 – accidents and supervision under the quality of care regulation at 42 C.F.R. § 483.25(h). CMS Ex. 3. The state survey agency determined that Petitioner failed to ensure adequate supervision for Resident 1 to prevent her from leaving the facility on January 20, 2009 at 9:22 p.m. without supervision even though the Resident had a history of wandering and was wearing a wander-alert watch. The staff was not aware of the whereabouts of Resident 1 until 11 p.m. when she was found in a nearby trailer park. CMS Ex. 1. Based on the survey finding, CMS notified Petitioner that this incident constituted immediate jeopardy to residents' health and safety and demonstrated substandard quality of care. CMS imposed a CMP in the amount of $3,550 per day for the period of January 20 through January 28, 2009 and $100 for one day of substantial noncompliance on January 29, 2009. CMS Ex. 2.

I conducted a hearing November 16-17, 2009; the parties received a transcript (Tr.) of the proceeding. CMS offered and I admitted CMS Exhibits (CMS Exs.) 1–36. Tr. at 12. Petitioner offered and I admitted Petitioner Exhibits (P. Exs.) 1–17 . Tr. at 12-13. The parties submitted posthearing briefs and reply briefs.

II. Applicable Law

The regulatory requirements for long-term care facilities that participate in the Medicare and Medicaid programs are set forth at 42 C.F.R. Part 483. Facility compliance with the participation requirements is determined through a survey and certification process. Sections 1819 and 1919 of the Social Security Act; 42 C.F.R. Parts 483, 488, and 498. This process is performed on behalf of the Secretary and CMS by state survey agencies. Under Part 488, CMS may impose a CMP against a facility that is not complying substantially with participation requirements. 42 C.F.R. §§ 488.406, 488.408, 488.430. The penalty may start accruing as early as the date that the facility was first out of compliance and runs until the date substantial compliance is achieved or the provider agreement is terminated.

"Deficiency" is defined as a facility's "failure to meet a participation requirement specified in the Act" or in 42 C.F.R. Part 483. 42 C.F.R. § 488.301. The term "substantial compliance" means "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." *Id*. "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." Id. And, "immediate jeopardy" means "a situation in which the provider's noncompliance . . . has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." *Id.*

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The

upper range of CMP, of from $3050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). The lower range of CMP, from $50 per day to $3000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). There is only a single range of $1000 to $10,000 for a per instance CMP that applies whether or not immediate jeopardy is present. 42 C.F.R. §§ 488.408(d)(1)(iv), 488.438(a)(2).

The Act and regulations make a hearing before an ALJ available to a long-term care facility against which CMS has determined to impose a CMP. Act § 1128A(c)(2); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a de novo proceeding. *Anesthesiologists Affiliated, et. al*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Cal Turner Extended Care Pavilion*, DAB No. 2030 (2006); *The Residence at Salem Woods*, DAB No. 2052 (2006). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also*, 42 C.F.R. §§ 488.330(e), 498.3. However, the choice of remedies by CMS or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge would affect the amount of the CMP that could be collected by CMS or impact upon the facility's nurse aide training program. 42 C.F.R. §§ 498.3(b)(14), (d)(10)(i). CMS's determination as to the level of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's findings of immediate jeopardy. *Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination.[1] *See, e.g.*, *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Review of a CMP by an ALJ is governed by 42 C.F.R. § 488.438(e).

III. Issues, findings of fact and conclusions of law

A. Issues

The issues in this case are whether Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h) that the resident environment remain as free of accident hazards as is possible and that each resident receives adequate supervision and

[1] Such a challenge is only applicable where CMS has imposed a per day CMP within the upper range; there is no such challenge available if a per instance CMP is imposed.

assistance devices to prevent accidents; and whether CMS's determination that Petitioner's noncompliance with the requirements of 42 C.F.R. § 483.25(h) constituted immediate jeopardy was clearly erroneous.

Petitioner has not argued that the CMPs imposed are unreasonable.

B. Findings of fact and conclusions of law

I make the following findings of fact and conclusions of law (Findings), set forth below as separate headings in bold and italics, to support my decision in this case.[2]

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

This case involves a single deficiency. Specifically, CMS maintains that Petitioner violated section 483.25(h) by failing to provide a cognitively-impaired resident, Resident 1 with adequate supervision to prevent her elopement.

Resident 1, a 66 year-old female, was diagnosed as having schizophrenic disorder of paranoid type, other persistent mental disorders, dementia, depression, and neurotic behaviors. CMS Br. at 2; CMS Ex. 8, at 5; CMS Ex. 10, at 8. Resident 1 had both short term and long term memory problems. CMS Ex. 9, at 2. Her cognitive skills for daily decision making were moderately impaired and had deteriorated prior to the time of the Minimum Data Set Assessment on November 21, 2008. *Id.* Resident 1 had periods of altered perception or awareness of her surroundings, episodes of disorganized speech, and mental function variations over the course of the day. *Id.* She also had auditory hallucinations (she appeared to be "hearing things"), delusions (she believed people were trying to shoot her) and confusion. CMS Ex. 8, at 18, 24, 26, 44.

Resident 1 was fully ambulatory, but was at risk for falls. CMS Ex. 8, at 6; CMS Ex. 10, at 3-4. She wandered around the facility aimlessly, and often wandered into other residents' rooms. *Id.*; CMS Ex. 9, at 3; CMS Ex. 11, at 2-4, 8, 11. She also had made one or more attempts to elope the facility and she was considered an elopement risk. CMS Ex. 8, at 6. Her physician ordered a wander-alert watch for her and her care plan

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[2] I have reviewed the entire record, including all the exhibits and testimony. As I am not bound by the rules of evidence applicable to court procedure (*See* 42 C.F.R. § 498.61), I may admit evidence and determine later, upon a review of the record as a whole, what weight, if any, I should accord that evidence or testimony. To the extent that any contention, evidence, or testimony is not explicitly addressed or mentioned, it is not because I have not considered the contentions. Rather, it is because I find that the contentions were not supported by the weight of the evidence or by credible evidence or testimony.

addressed her wandering behavior and required that she be monitored for her location every two hours with visual checks. CMS Ex. 8, at 8; CMS Ex. 10, at 18.

On January 20, 2009, at approximately 9:20 p.m., Resident 1 was standing at the nurses' station, refusing to take her medications. CMS. Ex. 11, at 9. At 9:50 p.m., LPN Holmes went to Resident 1's room to attempt to give her the medications, but Resident 1 was not in her room. LPN Holmes then checked all the places Resident 1 usually would go to in the facility. Resident 1 was not found. LPN Holmes alerted all the staff and everyone searched the inside of the facility three times. *Id.* When she still was not found, the staff went outside to search for Resident 1 around the buildings and parking lots. *Id.* She was not found; the police then were called to aid in the search. *Id.*, at 9-10.

Some of the staff drove over to a nearby trailer park, about two blocks south of the facility. They found Resident 1 at around 11 p.m. She was on the ground, sitting up against one of the trailers. She had on a top, but her pants and her brief were off. No one else was around her. When the staffers started to walk over to Resident 1, a pit bull jumped up and came after them. However, they quickly noticed to their relief that the pit bull was tied up on a chain and couldn't reach them. The dog, though, was only about three feet away from Resident 1 when it reached the end of its chain. CMS Ex. 12, at 13-14; CMS Ex. 20, at 3. An ambulance was called and Resident 1 was transported to the hospital. CMS Ex. 20. The outside temperature was 30 degrees Fahrenheit at the time Resident 1 was found. CMS Ex. 33; CMS Ex. 12, at 14.

Petitioner relied on the Elopement Computer Tracking System (ECTS or system) to track and monitor those residents assessed to be at risk for elopement. This system monitors the physical location of each resident wearing a wander-alert watch, provided the resident is within the system's monitoring range, and displays the resident's location on a computer monitor located at the front reception desk.[3] CMS Ex. 12, at 2-3; Tr. 31, 178. The system will lock down all the exit doors when a resident wearing a wander-alert watch comes close to the doors, except for the dining room exit or smoking area exit doors where the residents are allowed to go out. CMS Ex. 15, at 3. If a resident wearing a wander-alert watch does leave through any of these doors, an alert sounds on a pager unit, discussed in more detail below. *Id.* If this occurs, Petitioner's policy states that the nurse should advise the CNA to join the resident outside to monitor the resident's activity. *Id.* Should any of the residents wearing the wander-alert watch leave the monitoring range, the system sounds an alert through a pager that an elopement is in progress and identifies the door through which the resident has passed. CMS Ex. 15, at 3; P. Ex. 6.

[3] The reception desk is located away from the residents' rooms and away from where all the nursing care, daily care, and meals are provided. CMS Ex. 36; Tr. 222.

The facility maintains two pagers for the ECTS. Petitioner's policy requires that while one pager is in use, the other pager should be charging at the nurses' station. Tr. 76, 176-77, 183, 240-41; P. Exs. 6 and 7. A designated nurse for each shift is to have the pager on his or her person at all times while working. *Id.* According to Petitioner's policy, the pagers are literally to be "handed off" to the next designated nurse at each shift change. P. Exs. 2 and 7; Tr. 234; CMS Ex. 35, at 7. And, at each shift change, the designated ongoing nurse is responsible for making sure the pagers are functioning correctly. P. Exs. 6 and 7; CMS Ex. 35, at 7. If the pager is not functioning correctly or if the system becomes inoperable, the designated nurse is responsible for notifying her or his supervisor, the Director of Nursing, and for stationing personnel at the appropriate doors if the system is not functioning. *Id.* Also, the facility policy notes that if the pagers are not working or not charged completely, the computer monitor at the front desk will allow the staff to locate the residents. P. Ex. 6.

On the day of the elopement, Andrea McGill was the designated nurse in charge of keeping the pager on the day shift. CMS Ex. 12, at 9; CMS Ex. 35, at 12; P. Ex. 2. At the end of her shift, Ms. McGill left the pager on the nurse's desk instead of handing it to Sarah Holmes, the ongoing designated nurse, in person. P. Ex. 2. Ms. Holmes left both pagers at the nurse's station desk to be charged because, she claimed, both pagers had blank screens and she thought this meant that both pagers needed to be charged. CMS Ex. 12, at 5; CMS Ex. 24, at 6. Ms. Holmes notified no one about the alleged problem with the pagers. CMS Ex. 24, at 6. Consequently, she was not wearing the pager as she proceeded with her duties. Resident 1 exited the building at 9:23 p.m., while both pagers were left at the nurse's station.

There is no dispute that on the night of the incident, the ECTS was operational and functioning. There is no dispute that the pagers also were working that night — the Director of Nursing, upon returning to the facility after the search for Resident 1, checked the pagers and confirmed that the pager "was charged, on and working." P. Ex. 16; Tr. at 251.

Petitioner contends that it provided adequate supervision and assistance devices to prevent Resident 1 from eloping from the facility. Petitioner further contends that it took all reasonable steps to protect Resident 1 and that her elopement was not because of a failure on the part of the Petitioner but because one employee, LPN Holmes, who had been trained and knew the Petitioner's policies, failed in her duty to follow those policies and procedures in place. Petitioner therefore argues that the conduct of LPN Holmes was an isolated event and not evidence of deficiencies in Petitioner's practices. Petitioner contends that if I sustain the deficiency cited against Petitioner because LPN Holmes failed to have the pager on her person, I would be elevating the standard from reasonable and adequate measures to a strict liability standard. P. Br. at 24-25.

I disagree with that argument; I am not persuaded by Petitioner's arguments and assertions that it adequately protected Resident 1. On the contrary, I find CMS's arguments to be persuasive and supported by the weight of the evidence.

The applicable regulation has been the subject of much litigation.[4] It requires a facility to take all reasonable measures to protect its residents from accident hazards that are known or that are foreseeable. Here, Petitioner chose to implement the ECTS as its method to protect those residents who were at risk for elopement; however, the preponderance of the evidence shows that the ECTS, as implemented and used by Petitioner, did not constitute an adequate level of supervision for residents at risk for elopement such as Resident 1. Moreover, the preponderance of the evidence also shows that the failure to supervise Resident 1 adequately to prevent her elopement was not an isolated event to be blamed on the failure of a single employee to follow the facility's policy. Rather, I agree with CMS that the elopement of Resident 1 resulted from a multitude of failures on the part of Petitioner's staff, not simply and solely the failure of LPN Holmes, to follow established policies and procedures for implementation of the ECTS. First, the designated nurse going off-duty did not "hand off" the pager directly to LPN Holmes; she merely put it on the nurse's station desk — a failure to follow ECTS policy. Tr. 234; CMS Ex. 35, at 12. Next, LPN Holmes did not carry the pager on her person on the night of the incident, claiming that she believed that the pagers were not operating properly — a failure to follow the policy. Then, LPN Holmes did not call her supervisor immediately to report that the pagers were not working — a failure to follow the policy. CMS Ex. 1, at 9 ("LPN #1 stated that he/she had not notified anyone regarding the blank pager screen. . ."), 10. Based on her belief that the pagers were not working, LPN Holmes did not look at the computer monitor to verify the operation of the system and the whereabouts of the residents wearing the wander-alert watches, nor did any of the other staff in the facility that evening who were supposedly trained in the use of the ECTS system — a failure to follow ECTS policy. She also did not station staff at the exit doors

[4] *See Koester Pavilion*, DAB No. 1750, at 24 (2000) (the regulation does not impose strict liability of unforeseeable mishaps, but requires a facility "to do everything in its power to prevent accidents"); *Windsor Health Care Center*, DAB No. 1902, at 5 (2003) (a facility may "choose the methods it uses to prevent accidents, but the chosen methods must constitute an 'adequate' level of supervision under all the circumstances"); *Briarwood Nursing Center*, DAB No. 2115, at 11 (2007) (the relevant inquiry is "whether the facility took all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents"); and *Burton Health Care Center*, DAB No. 2051, at 14 (2006) (in determining whether the supervision a facility provides was adequate, the Board looks "first to whether the facility provided supervision in accordance with the resident's . . . plan of care" and a facility's failure to "provide the type of supervision that it had determined was required to meet the resident's needs" supports the finding of a deficiency under section 483.25(h)(2)).

to prevent an elopement in the event that the system was not operational — a failure of the ECTS policy. Prior to the night in question, LPN Holmes routinely failed to wear the pager on her person, placing the pager on the medication cart instead, thus making it impossible for her to hear the pager if she was away from the medication cart.

Petitioner tries to diminish its responsibility here by claiming that any deficiency is due solely to LPN Holmes' failure to follow the policies and procedures established by Petitioner on how to implement the ECTS. However, Petitioner has an ongoing responsibility to make sure its staff not only is trained in its policies and procedures on implementation of the ECTS but also to supervise its staff in the performance of their duties after they are trained to determine if the staff actually follow the policies and procedures established. This is all the more important in the circumstances as in this case, where Petitioner chose to use and rely solely on a particular system to prevent elopement from its facility. Thus, under the federal participation requirement, it is Petitioner's responsibility to make sure that its staff is familiar with ECTS and know how it should be used. This requires that Petitioner properly supervise its staff to determine if whatever system they choose to use is properly implemented.

And, finally, it is well settled that a facility cannot disown the acts and omissions of its own staff, not even an isolated error by a single employee, to immunize itself from a finding of substantial noncompliance. As the Board stated in *Cal Turner Extended Care Pavilion*--

> [a facility cannot] avoid responsibility by blaming one nurse for the failure of multiple systems. . . a facility "cannot disown the consequences of the inadequacy of the care provided by the simple expedient of pointing the finger at her fault, since she was the agent of her employer empowered to make and carry out daily care decisions." *Emerald Oaks*, DAB No. 1800, at 7, n.3 (2001); *see also Cherrywood Nursing and Living Center*, DAB No. 1845 (2002) and *Ridge Terrace*, DAB No. 1834 (2002).

DAB No. 2030, at 15 (2006); *see also Life Care Center of Gwinnett*, DAB No. 2240, at 12-13 (2009).

2. CMS's determination that the facility's noncompliance posed immediate jeopardy to resident health and safety is not clearly erroneous.

Immediate jeopardy exists if a facility's noncompliance has caused, or is likely to cause, "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R.

§ 498.60(c). The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a heavy burden to show no immediate jeopardy and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1962, at 11; *Florence Park Care Center*, DAB No. 1931, at 27-28 (2004).

I find that there is no question that Petitioner's noncompliance placed Resident 1 and other elopement-risk residents in immediate jeopardy. I further find that the finding of immediate jeopardy was not clearly erroneous. Here, the failure of Petitioner to adequately supervise and provide assistance devices to prevent accidents to Resident 1 resulted in the elopement of this Resident from the facility. As a result of the elopement, the whereabouts of this Resident went unnoticed for well over an hour. While the Resident suffered abrasions to her knee caps and was exposed to extremely cold weather with out adequate clothing, it is merely fortuitous that she did not suffer more serious harm. Clearly, the likelihood of serious harm or death to Resident 1 was great due to her cognitive impairment and her lack of safety awareness; once she eloped from the facility, she was at risk for being struck by a motor vehicle, for falling, for hypothermia, or for attack by one of the several dogs tied up in the canine minefield where she was found.

3. The penalty imposed is reasonable.

CMS imposed a penalty in the amount of $3,550 per day from January 20 through January 28, 2009 and $100 per day for January 29, 2009.

In order to determine whether the CMPs are reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f), which are: (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 listed in 42 C.F.R. § 488.404 include: (1) the scope and severity of the deficiency; (2) the relationship of 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.

In reaching a decision on the reasonableness of the CMP, I must 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 deficiency found, and in light of the above 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 Center*, DAB No. 1848, at 21 (2002).

CMS has imposed a penalty of $3,550 per day, which is at the low end of the penalty range for situations of immediate jeopardy ($3,050-$10,000). CMS does not cite facility history as a factor that justifies a higher CMP and Petitioner does not argue that its financial condition affects its ability to pay the penalty. I have considered the remaining necessary factors. The facility here is culpable for the deficiency because it did not properly supervise its staff to determine whether its own policies and procedures intended to prevent elopements were being implemented as required. This measure of culpability, taken into consideration together with the finding of immediate jeopardy, is sufficient to sustain the CMP at $3,550 per day for the period of January 20 through January 28, 2009. I further conclude that the CMP of $100 for January 29, 2009 is reasonable because while Petitioner had abated the immediate jeopardy by that date, the facility had not completed the keypad locks on some of the exits until after January 29, 2009.

Therefore, I find the penalties imposed reasonable.

IV. Conclusion

For the reasons discussed above, I find that Petitioner's facility was not in substantial compliance with the Medicare requirements, and that its noncompliance posed immediate jeopardy to resident health and safety. I affirm as reasonable the penalty imposed.

/s/
Richard J. Smith
Administrative Law Judge