Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Silverbrook Manor,
(CCN: 23-5361),

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-706

Decision No. CR2275

Date: October 27, 2010

DECISION

I enter summary judgment against Petitioner, Silverbrook Manor, and in favor of the Centers for Medicare and Medicaid Services (CMS) sustaining the following remedies:

- A civil money penalty of $4,550 for one day, October 29, 2009;
- Civil money penalties of $600 per day for each day of a period beginning on October 30, 2009 and running through December 21, 2009; and
- Denial of payment for new Medicare admissions for each day of a period beginning on December 6, 2009 and running through December 21, 2009.

I. Background

Petitioner is a skilled nursing facility in the State of Michigan. It participates in the Medicare program and its participation in Medicare is governed by sections 1819 and 1866 of the Social Security Act (Act) as well as by implementing regulations at 42 C.F.R.

Parts 483 and 488. Its hearing rights in this case are governed by regulations at 42 C.F.R. Part 498.

Petitioner filed hearing requests to challenge the remedy determinations that I describe in the opening paragraph of this decision. The case was assigned originally to another administrative law judge who consolidated the requests into one case. The case was reassigned to me after his departure from the Departmental Appeals Board.

CMS moved for summary judgment and Petitioner opposed the motion. I advised the parties that the motion and opposition had raised an issue that neither of them had fully briefed and I directed them to file supplemental briefs. The parties complied.

CMS filed a total of 56 proposed exhibits with its motion for summary judgment which it identified as CMS Ex. 1 – CMS Ex. 56. Petitioner filed a single exhibit in opposition to the motion which it identified as P. Ex. 1. I receive these exhibits into the record.

II. Issue, findings of fact and conclusions of law

A. Issue

The sole issue before me is whether CMS was, as a matter of law, authorized to continue imposing civil money penalties of $600 per day and denial of payment for new Medicare admissions against Petitioner for each day of the period beginning on November 25 2009 and continuing through December 21, 2009.

CMS based its determination to impose remedies against Petitioner on noncompliance findings that were made at a complaint survey of Petitioner's facility conducted on November 5, 2009 (November Survey). Among the findings of noncompliance are three on which CMS now bases its motion for summary judgment. These are findings that Petitioner failed to comply substantially with the requirements of: 42 C.F.R. §§ 483.25(h)(2); 483.25; and 483.20(k)(3)(i). The finding of noncompliance with 42 C.F.R. § 483.25(h)(2) included a determination that Petitioner's noncompliance with that regulation was so egregious as to constitute immediate jeopardy for Petitioner's residents. "Immediate jeopardy" is defined to mean noncompliance that causes, or is likely to cause, serious injury, harm, impairment, or death to a resident or residents. 42 C.F.R. § 488.301.

Petitioner did not deny its noncompliance with any of these regulations nor did it contest CMS's finding of immediate jeopardy level noncompliance. Furthermore, Petitioner did not challenge the reasonableness of the penalty amount determinations that I discuss at the beginning of this decision. Instead, Petitioner argues that it attained compliance with all participation requirements on November 25, 2009. It asserts that the remedies that CMS determined to impose on or after that date are unauthorized. Thus, Petitioner

contends that no civil money penalties or denial of payment for new admissions may be imposed against it beginning with November 25, 2009. Implicitly, Petitioner concedes that the remedies imposed by CMS beginning on October 29, 2009 and continuing through November 24, 2009 are authorized and reasonable.

B. Findings of fact and conclusions of law

I find that CMS was, as a matter of law, entitled to continue imposing against Petitioner civil money penalties of $600 per day and denial of payment for new Medicare admissions on each day of the November 25 – December 21, 2009 period.

Petitioner's argument against continuation of remedies for the November 25 – December 21 period is that CMS's determination of the duration of its noncompliance is incorrect. It asserts that it attained compliance with participation requirements as of November 24, 2009 and that, consequently, CMS was not authorized to impose any remedies against it after that date. In opposing CMS's motion for summary judgment, it asserts that at the least, there are disputed issues of fact concerning the date when it finally attained compliance and that it is entitled to a hearing on the merits in order to be allowed to show that it attained compliance on November 24, 2009.

The general rule governing duration of noncompliance is set forth at 42 C.F.R. § 488.454(a)(1). The regulation states that, where noncompliance is determined, a remedy will remain in effect until:

> The facility has achieved substantial compliance, as determined by CMS or the State based on a revisit or after an examination of credible written evidence that it can verify without an on-site visit. . . .

Id.; *see* 42 C.F.R. § 488.440(h)(1) (governing duration of civil money penalties); 42 C.F.R. § 488.417(d) (governing duration of denials of payment for new admissions).

The regulations make no explicit distinction between the circumstance in which compliance may be verified solely based on documentary evidence and that which requires an on-site visit in order to ascertain whether compliance has been attained. That guidance is provided in the preamble to the Part 488 regulations:

> There are other cases in which documentation cannot confirm the correction of noncompliance, and in these cases an on-site revisit is necessary. For example, one of the requirements for Infection Control is that personnel must handle, store, process and transport linens so as to prevent the spread of infection as specified in § 483.65. If a deficiency is cited for a violation of this requirement and a civil monetary penalty is imposed, submitting written documentation would not confirm the

> correction of the violation. An on-site revisit to observe personnel behavior is necessary in this case to confirm that the facility is, in fact, back in substantial compliance with this regulatory provision.

59 Fed. Reg. 56116, 56207 (Nov. 10, 1994).

The distinction identified by the preamble is clear. Deficiencies that involve the actual provision of care by facility staff may not be certified as having been corrected without observation of personnel providing care. That is because the hands on provision of care is an integral element of compliance. Thus, in the example cited – the handling, storing, processing and transport of linens in a way intended to avoid the spread of pathogens – it is not enough to attain compliance for a facility to provide documents which describe corrective action measures. Rather, the surveyors must personally observe the staff performing the necessary functions because staff performance in compliance with applicable standards of care cannot be demonstrated solely with documentary evidence.

This is not to say that a facility may never establish compliance based on documentary evidence of its efforts to correct a deficiency. There are some types of deficiencies for which documentary evidence will suffice as proof of rectification. For example, a facility may be found noncompliant with a Life Safety Code requirement because a particular piece of equipment, such as a boiler or a water heater, is broken. In that circumstance documents proving that repairs had been made to the equipment, that it had been tested, and that it was now functional, would be sufficient evidence to prove that the facility had attained compliance.

But, a wholly different situation presents where the deficiency involves a failure by staff to provide care that is consistent with regulatory requirements. In that circumstance it is *human performance* and not equipment that is the critical element of compliance. The regulation, as interpreted by its preamble, requires observation of staff performance to certify compliance in that circumstance.

Petitioner argues, correctly, that there is a series of decisions by the Departmental Appeals Board which hold that a facility may attempt to prove that it corrected its deficiencies at a date that is earlier than that which CMS certified compliance to have been attained. But this general principal does not suggest that a facility may successfully demonstrate compliance based on documentary evidence in those situations where observation by surveyors is the only acceptable means by which compliance may be established. Documentary evidence may be sufficient to prove compliance in the instance where a failure of human performance is not a basis for the deficiency finding. But, documentary evidence is on its face inadequate in the case where a failure of human performance is the basis for the deficiency finding. None of the decisions relied on by Petitioner is inconsistent with this distinction.

The three deficiencies that are at issue here all share the common feature that they involve human performance and, for that reason, compliance may not be demonstrated solely with documentary evidence. In the case of each of these deficiencies it was necessary to observe the staff in order to assure that the staff was doing that which was required of them. I find that, as a matter of law, documents showing that the staff had been retrained and that systems had been put in place that are intended to monitor and check on staff performance are inadequate to establish compliance. Thus, and as a matter of law, the earliest date when any of these deficiencies could have been certified to have been corrected was the date of the revisit survey – December 22, 2009 in this case – at which the surveyors were assured that the staff were correctly discharging their responsibilities.

Petitioner's noncompliance with the requirements of 42 C.F.R. § 483.25(h)(2) relates to the failure of Petitioner's staff to provide appropriate supervision and assistance to residents who were prone to eloping the facility. Petitioner relied on a system of alarms connected to doorways to assure that residents who were prone to eloping did not exit the facility unnoticed. However, there was more than one instance of elopement in which the alarms did not function as intended. That reflected an overall failure on the part of Petitioner and its staff to assure that the alarms were in working order.

The findings of noncompliance relate in large measure to the care that Petitioner gave to a resident who is identified as R-100. This was a resident who had been identified by Petitioner's staff as having numerous physical and mental impairments including delusional behavior. She wandered constantly and was a very high risk for eloping Petitioner's facility. In August 2009, the resident had 24 episodes of exit-seeking behavior. Prior to September 6, 2009, the resident had eloped the facility three times. CMS Ex. 29 at 12. On September 5, 2009, the resident was observed exiting the facility through a door with a non-functioning alarm. CMS Ex. 28 at 3. On September 6, 2009, the resident eloped the facility again, and was found walking down a neighbor's driveway. *Id.*; CMS Ex. 30 at 20. As with a previous elopement the resident exited through a doorway that was equipped with an alarm. However, the alarm did not function.

Petitioner's failure to assure that door alarms worked was a persistent problem. On October 27, 2009, more than six weeks after the September 6 incident involving R-100, a surveyor observed that the facility's front door alarm was not functioning properly. CMS Ex. 1 at 23.

The human element in this deficiency is the necessity that staff must check alarms regularly and routinely to make sure that they operate as intended. Alarms are not like a hot water heater that can be set and then ignored so long as it functions properly. They

must constantly be checked and calibrated. Failure by staff to perform this function on a regular basis – as happened at Petitioner's facility – is an invitation for malfunction and that, in turn, provides a gateway to elopement.

Consequently, a facility may not provide sufficient assurance that it has corrected the noncompliance by providing documentation that its staff have been trained in monitoring and adjusting alarms. Rather, the staff must be observed performing these functions in order to assure that they have been trained properly and that their training translates into effective performance.

Petitioner's noncompliance with the requirements of 42 C.F.R. § 483.25 is a failure by its staff to provide residents with the necessary care and services to attain or maintain the highest practicable level of physical, mental, and psychosocial well being in accordance with residents' plans of care. The deficiency lies in the failure of the staff to provide a resident, identified as R-104, with wound care treatments that are consistent with and in compliance with a physician's orders. This resident suffered from stasis ulcers on his lower extremities. CMS Ex. 44. There were specific orders from a physician issued to provide wound care to the resident. However, on several occasions the staff failed to comply with those orders. CMS Ex. 45; CMS Ex. 46; CMS Ex. 50; CMS Ex. 51; CMS Ex. 52; CMS Ex. 53. CMS documented a period of at least 48 hours beginning on August 22, 2009 and continuing through August 24, 2009, during which the staff failed to provide R-104 with prescribed care.

The compliance failure here clearly was human error. It consisted of a dereliction of duty by Petitioner's staff in that they failed to do what a physician had ordered them to do. As with the previously discussed deficiency, documentation showing that the staff had been retrained, or that protocols were in place for monitoring staff performance, is not sufficient to assure that the relevant staff members actually did what was required of them. Only observation could provide reasonable assurance that they had learned their duties and were performing them correctly.

The third deficiency that I address is a quality of care deficiency involving failure by Petitioner to comply with the requirements of 42 C.F.R. § 483.20(k)(3)(i), a regulation that requires care to satisfy professionally recognized standards of quality. CMS's findings of noncompliance with this requirement again relate to the care that Petitioner gave to R-104 and, specifically, are based on Petitioner's staff's failure to follow a physician's orders for wound care. As with the two other deficiencies that I discuss, the errors that are involved are human errors directly implicating the staff's performance. And also as with the two other deficiencies, this is a deficiency that cannot be certified to

have been corrected based solely on documentary evidence showing that the staff had been retrained. As a matter of law observation of staff performance was necessary to certify compliance.

/s/
Steven T. Kessel
Administrative Law Judge