Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Liberty Health & Rehab of Indianola, LLC,
(CCN: 25-5185),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-870

Decision No. CR2409

Date: August 5, 2011

DECISION

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to impose civil money penalties of $5,000 per day against Petitioner, Liberty Health & Rehab of Indianola, for each day of a period that began on April 18, 2010 and that continued through May 4, 2010. [1]

I. Background

Petitioner is a skilled nursing facility in the State of Mississippi. It participates in the Medicare program, and its participation is subject to the requirements of sections 1819 and 1866 of the Social Security Act (Act), as well as implementing regulations at 42 C.F.R. Parts 483 and 488.

[1] CMS initially determined to impose the $5,000 per day penalty beginning April 21, 2010. It amended its remedy determination in its pre-hearing exchange to assert the April 18 beginning date. CMS Br. at 2. I find that Petitioner received ample notice of CMS's amended determination.

CMS determined to impose the remedies that I cite in the opening paragraph of this decision, based on its finding that Petitioner failed to comply with three Medicare participation requirements. These are the requirements that are set forth at 42 C.F.R. §§ 483.13(c), 483.25(h), and 483.75. CMS's noncompliance and remedy determinations are premised on the outcome of a compliance survey of Petitioner's facility that was completed on May 5, 2010 (May Survey). The surveyors found, and CMS agreed, that Petitioner's noncompliance was so egregious as to comprise immediate jeopardy for residents of Petitioner's facility. The term "immediate jeopardy" is defined at 42 C.F.R. § 488.301 to mean noncompliance that causes, or is likely to cause, serious injury, impairment, harm, or death to a facility resident or residents.

Petitioner requested a hearing, and the case was assigned to me for a hearing and a decision. The parties completed pre-hearing exchanges of briefs (CMS Br. and P. Br.) and proposed exhibits, including the written direct testimony of their proposed witnesses. They then agreed to waive an in-person hearing and to submit the case for my decision based on their pre-hearing exchanges. I allowed the parties an additional round of briefs (CMS Final Br. and P. Final Br.).

CMS filed 22 proposed exhibits (Ex), which it identified as CMS Ex. 1 – CMS Ex. 22. Petitioner filed 15 proposed exhibits, which it identified as P. Ex. 1 – P. Ex. 15. I receive all of these exhibits into evidence.

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 Medicare participation requirements;

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

3. CMS's remedy determination is reasonable.

B. Findings of Fact and Conclusions of Law

I make the following findings of fact and conclusions of law (Findings).

1. Petitioner failed to comply substantially with Medicare participation requirements.

This case addresses the level of supervision that Petitioner's staff gave to residents who the staff had identified as prone to eloping the facility premises. The staff knew that several of the residents – especially the resident who is identified as Resident # 1 – were elopement risks. The staff chose to supply each of these residents with a device known as a Wanderguard. A Wanderguard is a bracelet that is designed to provide a secure perimeter for the resident who wears the device. If a resident wearing a functioning Wanderguard approaches an exit door, the door locks, thereby preventing the resident's elopement. The device also causes an alarm to sound if the resident approaches an opened facility door, thereby alerting the staff to the possibility of a resident elopement. CMS Ex. 8 at 32.

A Wanderguard does not relieve a facility staff from their obligation to supervise elopement-prone residents. Rather, the device – in the best of circumstances – serves as a method for augmenting supervision, helping to secure a facility's doors or giving the staff an audible warning of a resident's attempt to elope the premises. The staff has the duty to assure that all of a facility's residents' Wanderguards are maintained properly and function correctly. And, should a resident's Wanderguard not function correctly, the staff is responsible for promptly replacing or repairing the device or, alternatively, for implementing enhanced supervision to assure that the resident does not elope.

The evidence unequivocally establishes that several of Petitioner's residents' Wanderguards failed to function beginning around April 18, 2010. What Petitioner did – or did not do – to protect these residents in the ensuing days is at the center of this case.

CMS alleges that Petitioner failed to comply with three specific regulatory requirements. 42 C.F.R. § 483.13(c) requires a facility to develop and implement policies and procedures that, among other things, protect a resident against neglect. 42 C.F.R. § 483.25(h) requires a facility to provide residents with adequate assistance devices and supervision to prevent accidents and to render its premises free from accident hazards. 42 C.F.R. § 483.75 requires that a facility be administered in a way that enables its resources to be utilized effectively and efficiently.

The weight of the evidence establishes that Petitioner did not comply substantially with all three of these regulations. Although Petitioner had developed policies to protect its residents against the risks of elopement, it failed to implement those policies in the cases of the four residents whose Wanderguards failed to function

beginning on April 18, 2010. Furthermore, it failed to protect those residents from obvious risks and hazards by not providing them with adequate supervision or other protection to account for the failure of the residents' Wanderguards. These failures ultimately point to a failure by Petitioner's management to coordinate effectively a response to an obvious problem, one that was known to Petitioner's staff, but which was not acted on in an organized fashion.

Specifically, Petitioner failed in the following ways to address the needs of its elopement prone residents:

- Petitioner's staff depended on Wanderguards to augment their surveillance of these residents, all of whom were elopement prone individuals. However, the staff did not effectively implement increased surveillance of the residents, when their Wanderguards ceased functioning.

- The staff did not implement a coordinated response to the failure of residents' Wanderguards. At least one member of the staff was not informed of the problem. The staff did not devise nor did it implement a plan to assure that facility doors were guarded during the period when the Wanderguards were not working.

- The staff did not implement measures that they had developed previously to monitor elopement prone residents. The staff was supposed to monitor Resident # 1 at 15 minute intervals in the event that her Wanderguard failed. However, on April 21, 2010, in the hours leading up to the resident's elopement of the premises, the staff monitored the resident only at 30 minute intervals.

Resident # 1 was identified by Petitioner's staff as a wanderer and also voiced a desire to go home. Resident # 1 wandered nearly constantly and was oblivious to risks to her personal safety. CMS Ex. 4 at 17-19. The resident had a history of eloping Petitioner's premises. On April 4, 2010, the resident was found outside of the facility in Petitioner's parking lot. CMS Ex. 4 at 46.

The resident was not only prone to eloping but was beset with a number of conditions that placed her at great risk for injury, or worse, if she eloped. Resident # 1 suffered from, among things, dementia and episodes of syncope (sudden loss of consciousness). CMS Ex. 4 at 1, 15, 63; CMS Ex. 22. She suffered from visual and hearing impairments. She was wheelchair bound, and she had fallen in the past. CMS Ex. 4 at 9. On April 12, 2010, the resident experienced an apparent episode of syncope in which she stopped breathing. CMS Ex. 4 at 46. The resident was hospitalized on that date and was readmitted to Petitioner's facility on April 16, 2010.

Petitioner's staff understood the dangers that Resident # 1 would encounter, if she eloped. The resident's care plan directed that the resident wear a Wanderguard. But, it also suggested that this was a resident who needed virtually constant observation. CMS Ex. 4 at 25. Thus, facility staff understood that, with Resident # 1, a Wanderguard was no substitute for close observation of the resident to prevent her from eloping.

On or about April 19, 2010, Resident # 1's Wanderguard ceased working.[2] CMS Ex. 8 at 3; CMS Ex. 21 at ¶13. The resident remained unprotected by a Wanderguard on the 20th and 21st of April. Additionally, on or about April 18, 2010, the Wanderguards for three other residents, identified as Residents #s 2 and 3, and Resident J.P., also ceased working. CMS Ex. 8 at 13, 15; CMS Ex. 13 at 1; CMS Ex. 21 at ¶22. Petitioner's staff was aware that the residents' Wanderguards were not functioning but was unable immediately to find replacements for them. CMS Ex. 8 at 20; CMS Ex. 21 at ¶23; *see* P. Ex. 14.

Petitioner's staff – in obvious recognition of Resident # 1's propensity to wander and elope – had directed in early April that the resident be monitored at 15 minute intervals when she was not wearing her Wanderguard. CMS Ex. 4 at 34. The staff did not intensify the monitoring of Resident # 1 after her Wanderguard ceased functioning. *See* CMS Ex. 4 at 25. There is no record of the staff planning enhanced supervision of the resident, nor is there any evidence that the staff assessed Resident # 1 on or after April 19 for what additional security measures might be needed as a consequence of the resident not having a functioning Wanderguard. *See id.* Nor is there evidence showing that the staff assessed the other residents whose Wanderguards had ceased functioning or that they implemented enhanced security measures to address those residents' needs. Petitioner's staff did not place observers by the doors to Petitioner's facility to assure that residents without functioning Wanderguards did not pass through them undetected. CMS Ex. 8 at 20-21.

The evidence establishes that, in violation of her plan of care, Resident # 1 was not monitored consistently at 15 minute intervals. Facility records establish that the resident was monitored at 30 minute, and not 15 minute, intervals from 7:00 a.m. until 3:00 p.m. on April 21, 2010. CMS Ex. 4 at 68-69. Staff commenced monitoring this resident at 15 minute intervals at 4:00 p.m. on April 21, only after the resident eloped the facility earlier that afternoon. CMS Ex. 4 at 70-75.

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[2] It may have ceased working as early as April 17. Petitioner's staff did not make entries for the 3 p.m. to 11 p.m. shifts on those dates confirming whether the Wander guard was working at those times. CMS Ex. 4 at 39.

The evidence also establishes a lack of coordination among Petitioner's staff concerning the monitoring of Resident # 1. The charge nurse for the 3 p.m. to 11 p.m. shift on April 21, 2010 denied being aware that Resident # 1 did not have a functioning Wanderguard on that date. CMS Ex. 8 at 7. Had the nurse known of the resident's situation, she might have kept the resident in her presence during her shift. *Id.*

Petitioner's staff observed Resident # 1 in a hallway close to the facility's nurse's station at 3:30 p.m. on April 21. CMS Ex. 7 at 2. At 3:55 p.m. on that same date, a visitor to the facility advised a staff member that Resident # 1 was seen in her wheelchair propelling herself along the edge of a highway that fronts Petitioner's facility. Petitioner's staff retrieved the resident. CMS Ex. 4 at 51.[3]

The failures of Petitioner's staff to increase surveillance of its elopement prone residents after their Wanderguards failed (and, in the case of Resident # 1, to monitor her at 15-minute intervals) is a failure to provide these residents with the protection and security that they needed. The fact that these residents all wore Wanderguards meant that the staff had concluded that something was needed to protect them beyond the monitoring and supervision that the staff had planned for the residents. When the Wanderguards failed, it meant that an element of the protection that the staff had put into place was no longer present. The staff should have recognized that and should have implemented compensatory measures to substitute for the inoperative Wanderguards. They failed to do so.

Petitioner argues in its defense that it placed Resident # 1 on 15 minute monitoring when her Wanderguard failed. P. Final Br. at 4. This measure, according to Petitioner, was a "more stringent intervention than . . . [its] policy required." *Id.* But, in fact, the staff did not monitor the resident at 15 minute intervals prior to her elopement. On the afternoon that she eloped, the resident was being monitored at 30 minute intervals, as is established by Petitioner's records. CMS Ex. 4 at 68-69. The staff learned at 3:55 p.m. on April 21 that the resident had eloped, 25 minutes after she was last observed by Petitioner's staff.

Furthermore, even monitoring at 15 minute intervals was an inadequate measure given that the doors to Petitioner's facility were unmonitored.[4] It does not take

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[3] Had the staff been observing the resident at 15 minute intervals, as her care plan directed them to do, they would have made an observation of the resident at 3:45 p.m., or discovered her elopement if she eloped between 3:30 and 3:45.

[4] According to the Administrator, there were six exit doors, but the Logbook Report, which documents the door monitors for the Wanderguard system, indicated there were eight exit doors. CMS Ex. 8; P. Ex. 11.

much imagination to foresee what can occur during a period of 15 minutes of not monitoring a constantly wandering resident like Resident # 1.

Petitioner contends that it protected Residents #s 2 and 3 and Resident J.P. adequately. It asserts that it implemented its Elopement Risk Reduction Plan for these residents when their Wanderguards ceased working, and this intervention prevented the residents from eloping. The Elopement Risk Reduction Plan requires Petitioner's staff to, among other things, complete a visual check of elopement prone residents at 30 minute intervals and to sign off on the resident's ADL (activities of daily living) Flow Sheet (or Observation Monitoring Form) at the end of each shift. P. Ex. 1. As alleged proof that this policy was carried out, Petitioner submitted flow sheets for two of the three residents. P. Ex. 12; P. Ex. 13. However, these sheets only record observations for two dates, April 21 and 22, 2010. Petitioner supplied no evidence showing that the residents were monitored on April 18, or on the dates between April 18 and April 21. *Id.* Moreover, these observations, even for the dates in question, do not cover a complete 24-hour cycle, but only portions of that cycle.

Petitioner's arguments concerning the three residents other than Resident # 1 reduce to a sort of "no harm, no foul" argument. Petitioner notes that none of these residents eloped. It reasons that they must have been protected adequately because they did not elope. That conclusion simply does not follow from the facts that show that Petitioner failed to implement heightened surveillance of these residents after their Wanderguards failed. That none of these residents eloped is merely fortuitous.

Petitioner argues that its Wanderguard system is:

> not the only intervention implemented or capable of being implemented by . . . [Petitioner] to protect its residents. It is just one of the redundancies of protection . . . [Petitioner] relied on as a whole. Without extra bracelets between April 18 and April 22, . . . [Petitioner] effectively implemented alternative measures.

P. Final Br. at 10. However, Petitioner has not offered persuasive evidence that it, in fact, did implement effective alternative measures to protect its residents. As I have discussed, evidence of monitoring of Residents #s 2 and 3 and Resident J.P. is incomplete and does not prove consistent monitoring of these residents. Petitioner alleges that it monitored Resident # 1 at 15 minute intervals, but, in fact, the evidence shows that the resident was monitored only once every 30 minutes up until her elopement on April 21. None of the four residents were assessed for any special protective measures that might be needed. Not all of Petitioner's

professional staff was informed of the circumstances involving the non-functioning Wanderguards. And, Petitioner did not monitor its doors.

Petitioner argues that, with respect to Resident # 1, it had in place policies and procedures, "which specifically addressed or encompassed elopement and resident assessment and care . . . ." P. Final Br. at 12. While these policies may have been necessary, the fact that Petitioner developed and promulgated them does not mean that it protected the residents adequately. What is missing from Petitioner's proof is evidence that it effectively implemented its policies. As I have discussed, the weight of the evidence shows that the policies were not implemented in the case of the four residents whose care is at issue, at least not to the extent that they assured the enhanced monitoring and supervision that these residents needed when their Wanderguards failed.

Petitioner argues that, in fact, Resident # 1's Wanderguard worked until 7 a.m. on the morning of April 21, 2010. P. Final Br. at 13. CMS's evidence that the resident's Wanderguard failed as early as the 19th of April is in large measure based on the fact that the nursing staff that checked the functioning of the Wanderguard circled their initials on the resident's Medication Administration Record (MAR) in the column reserved for certifying Wanderguard performance. Vickie Lewis, R.N., a surveyor who participated in the May survey, testified that in nursing parlance circled initials on a MAR means that the resident did not receive the medication or device that had been prescribed to him or her. Her conclusion is that the circled initials on Resident # 1's MAR meant that her Wanderguard did not function on the dates and times at issue. CMS Ex. 21 at ¶13.

Petitioner argues that Ms. Lewis' testimony, and CMS's contention, is: "nothing more than supposition by CMS, with nothing to support the inference." P. Final Br. at 13. I disagree. Ms. Lewis is qualified to testify about common nursing practice. Furthermore, Petitioner has not offered testimony that directly contradicts Ms. Lewis' conclusions. No employee of Petitioner, including any of the individuals who initialed the MAR, has come forward and asserted that her circled initials mean anything other than that which Ms. Lewis infers that they mean.

Moreover, Petitioner is not relieved of liability, even if Resident # 1's Wanderguard functioned until April 21, 2010, as Petitioner contends. As I have found, Petitioner's staff was supposed to observe the resident at 15 minute intervals in the event of a Wanderguard failure. However, Petitioner's staff only observed Resident # 1 at 30 minute intervals on April 21, after the point in time that Petitioner alleges that the resident's Wanderguard failed, and right up until the time that she eloped.

Petitioner contends that it adequately supervised those residents whose Wanderguards failed. P. Final Br. at 18. It asserts, relying on the testimony of one of its staff (Tenise Worship), that Petitioner's staff implemented immediately observations of these residents at 15 minute intervals, when the Wanderguard failures were discovered. P. Ex. 15 at 2. This assertion is simply not supported by Petitioner's own documentation. As I have discussed, Resident # 1 was monitored at 30 minute intervals – and not at 15 minute intervals as Petitioner contends – until her elopement from the facility on April 21, 2010. As for the other three residents, the facility documentation that Petitioner relies on shows only monitoring at 30 minute intervals, and this documentation is incomplete. *See* P. Ex. 12; P. Ex. 13.

Petitioner also contends that Residents #s 2 and 3 and Resident J.P. were not deemed to be "true elopement risks." P. Final Br. at 19. But, in fact, Petitioner's staff had determined that these residents were sufficiently at risk for elopement so as to necessitate wearing Wanderguards.

As respects Resident # 1, Petitioner argues that CMS is seeking to enforce a strict liability standard against it, premising its allegations of noncompliance only on the fact that the resident eloped on April 21, 2010. P. Final Br. at 19-20. I do not find this argument to be persuasive. Petitioner's noncompliance is not premised on the fact that the resident eloped but on its failure to protect the resident against the possibility of elopement.

Petitioner argues that one may not infer that its facility was improperly managed solely from the other two deficiencies that I have found to have existed (noncompliance with 42 C.F.R. §§ 483.13(c) and 483.25(h)). I agree with Petitioner's general premise that a facility's noncompliance with a particular regulation does not mean, necessarily, that there were management deficiencies at the facility. But, here, there is evidence of poor coordination of staff. As I have discussed, not all critical personnel were aware that Resident # 1's Wanderguard was not functioning on April 21, 2010. Furthermore, the evidence shows that enhanced observation was not implemented for the four residents whose Wanderguards failed. The across-the-board failure to implement enhanced observation is evidence from which I infer a lack of coordination of efforts and poor communication from management to Petitioner's staff.

2. CMS's determination of immediate jeopardy was not clearly erroneous.

Petitioner argues that, if it was noncompliant with participation requirements, its noncompliance was not so egregious as to pose immediate jeopardy for its residents. I disagree. At a minimum, the failure to provide adequately for the

needs of Resident # 1 was a clear instance of immediate jeopardy level noncompliance.

As I have discussed, Resident # 1 was a frail, demented, and severely handicapped individual. The resident was confused, wandered without apparent purpose, and had both hearing and visual impairments. In the weeks prior to April 21, 2010, the resident had experienced an apparent episode of syncope that caused her to stop breathing and that necessitated her hospitalization. Resident # 1 was at risk for severe injury or death at any time that she was not under the direct supervision of Petitioner's staff.

The resident's April 21, 2010 elopement ended at the edge of a busy four lane highway that is adjacent to Petitioner's facility.[5] Exposed as she was, there was likelihood that the resident would suffer serious injury or death. Furthermore, the failure to protect Resident # 1 and other Wanderguard-wearing residents established a systemic problem at Petitioner's facility consisting of a failure to implement policies and procedures intended to protect these residents from harm. The risks that Resident # 1 was exposed to show what might have happened to any of these residents had they eloped.

Petitioner argues that, if immediate jeopardy existed, Petitioner corrected it immediately upon discovering that Resident # 1 had eloped. Petitioner contends that the evidence shows that it "had in place an adequate collective of policies and procedures which were sufficient to prevent neglect and that residents were being monitored (including 1-on-1 supervision for . . . [Resident # 1]) in accordance with these policies and procedures." P. Final Br. at 26.

I do not find this argument to be persuasive. As I have discussed, the policies and procedures that Petitioner had in place prior to the Wanderguard failures at its facility, and prior to Resident # 1's elopement, were inadequate to protect residents, not because the policies were on their face, inadequate, but because the policies were not effectively implemented. Thus, the possibility that the facility had in place an "adequate collective of policies and procedures" does not prove that it rectified its noncompliance with the discovery of Resident # 1's elopement and implementation of subsequent measures that were designed uniquely to provide special protection to that resident.

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[5] A surveyor observed the site at which Resident # 1 was found and counted a traffic flow of 144 vehicles, including a dozen 18-wheel trucks, during a five minute period at the same time of day as the time of the resident's elopement. CMS Ex. 8 at 19; CMS Ex. 21 at ¶19.

To prove abatement of immediate jeopardy prior to the date that CMS determined that abatement occurred, May 4, 2010, Petitioner must prove that it effectively implemented *all* of the corrective actions that it pledged to undertake. Petitioner has not done so. Petitioner conducted in-service training of its staff after April 21, 2010 and conducted an elopement drill. But, the evidence offered concerning the in-service training does not establish that all of Petitioner's professional staff received training before May 4. *See* P. Ex. 6; CMS Ex. 17 at 1-3.

What is lacking from Petitioner's evidence – including its evidence relating to in-service training and documentation of various drills and notifications to staff about elopement issues – is proof that Petitioner actually implemented a plan, prior to May 4, 2010, that assured that each of its elopement prone residents would receive the enhanced supervision that he or she required in the event of a Wanderguard failure. I am not satisfied from the evidence presented by Petitioner that the staff would, for example, coordinate observations of residents, or that they would guard doorways at the facility.

3. Civil money penalties of $5,000 per day are reasonable.

Civil money penalties for immediate jeopardy level noncompliance must fall within a range of from $3,050 to $10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). Regulatory factors establishing the criteria for deciding where within this range an immediate jeopardy level penalty amount should fall 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)). These factors include: the seriousness of the noncompliance; a facility's culpability for its noncompliance; the facility's noncompliance history; and the facility's financial condition.

The $5,000 per day civil money penalty that CMS determined to impose falls below the mid-point of the immediate jeopardy level penalty range. CMS contends that there are three bases of support for this penalty amount: the seriousness of Petitioner's noncompliance; its culpability; and its noncompliance history. CMS Final Br. at 33.

The evidence amply supports penalties of $5,000 per day. The noncompliance in this case was quite serious. The seriousness of the noncompliance is made evident by the elopement of Resident # 1. Only good fortune prevented this resident from being seriously or even fatally injured.

Moreover, Petitioner is culpable for its noncompliance. As I have stated, there was poor coordination of Petitioner's staff and a failure by the staff to implement Petitioner's directives concerning elopement-prone residents when several residents' Wanderguards failed. Most notably, the staff failed to provide these

residents with enhanced supervision even though staff knew that these residents were at a heightened risk for elopement and consequent injury or death. Finally, CMS established that Petitioner has a history of noncompliance with the requirements of 42 C.F.R. § 483.25(h). Petitioner was previously found noncompliant with this requirement at a survey of its facility completed in 2008. CMS Ex. 19 at 1.

The remedy determination made by CMS addresses the three immediate jeopardy level deficiencies that I have discussed in this decision. All three of these deficiencies involve essentially the same facts and evidence. Any one of them is sufficiently egregious to justify penalties of $5,000 per day. Consequently, I would sustain the remedy in this case, even if the evidence had established that Petitioner had failed to comply with only one of the three regulations that are at issue in this case.

Petitioner argues that the penalty amount is unreasonable, asserting that it took reasonable measures to protect its residents from harm. The evidence in this case proves otherwise. As I have discussed, Petitioner had plans and policies that were designed to protect residents. But, those plans were not implemented to protect those residents whose Wanderguards failed. There was an obvious and glaring weakness in the system Petitioner had in place because it clearly did not give these residents the enhanced supervision and protection that they needed.

Petitioner argues also that its past noncompliance was relatively non-serious. I agree that the facility has no recent history of immediate jeopardy level noncompliance. *See* CMS Ex. 19. Notwithstanding, Petitioner has a history of relatively serious failure to comply with the requirements of 42 C.F.R. § 483.25(h). Furthermore, I would sustain a remedy of $5,000 per day, based solely on the seriousness of Petitioner's noncompliance. The dangers that were created for Resident # 1 and other elopement prone residents by Petitioner's deficiencies are, in and of themselves, sufficient to justify the penalty amount.

/s/
Steven T. Kessel
Administrative Law Judge