Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Lakewood Senior Living of Pratt (CCN: 18-5166),	)	Date: October 30, 2007
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-06-265
	)	Decision No. CR1682
Centers for Medicare & Medicaid Services,	)	
	)	
Respondent.	)	
	)	

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose a civil money penalty (CMP) against Lakewood Senior Living of Pratt (Petitioner or facility) for failure to comply substantially with federal requirements governing participation of long-term care facilities in Medicare and State Medicaid programs. CMS imposed a per instance CMP of $ 7,000 on December 6, 2005, based on a finding of immediate jeopardy.

I. Background

This case is before me pursuant to a request for hearing filed by Petitioner dated February 16, 2006. Petitioner is a long-term care provider located in Pratt, Kansas.

By letter dated December 19, 2005, CMS informed Petitioner that, based on findings of an abbreviated survey conducted by the Kansas Department on Aging (State agency) on December 8, 2005, it was imposing selected remedies due to Petitioner's failure to be in

substantial compliance with the applicable federal requirements for long-term care facilities. The remedies were based on an immediate jeopardy deficiency under Tag F-324. The letter informed Petitioner that CMS was imposing the following remedies:

- A per instance CMP in the amount of $ 7,000 on December 6, 2005, based on an immediate jeopardy violation.

- Denial of Payment for New Admissions (DPNA), effective March 8, 2005,[1] if the facility failed to achieve substantial compliance at the time of a revisit.

- Termination of the provider agreement, effective June 8, 2006.[2]

I held a hearing on April 10, 2007, in Wichita, Kansas. At the hearing, CMS offered five exhibits, identified as CMS Exs. 1-5. I received CMS Exs. 1-5 into evidence without objection. Petitioner offered 15 exhibits, identified as P. Exs. 1-15. I received these exhibits into evidence without objection.

Subsequent to the hearing, the parties submitted post-hearing briefs (CMS Br. and P. Br.).

Based on the testimony offered at the hearing, the documentary evidence, the arguments of the parties, and the applicable law and regulations, I find that Petitioner was not in substantial compliance, at the immediate jeopardy level, on the date determined by the State agency and CMS. I further find that CMS was authorized to impose a per instance CMP in the sum of $ 7,000 for the immediate jeopardy violation.

II. Applicable Law and Regulations

Petitioner is considered a long-term care facility under the Social Security Act (Act) and regulations promulgated by the Secretary of Health and Human Services (Secretary). The statutory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Act, and at 42 C.F.R. Parts 483 and 488.

Sections 1819 and 1919 of the Act invest in the Secretary authority to impose CMPs and DPNAs against a long-term care facility for failure to comply substantially with participation requirements.

[1] The DPNA was no longer in effect as of December 8, 2005. CMS Ex. 2, at 5.

[2] Petitioner came into substantial compliance prior to the effective date of the termination of the provider agreement, and therefore, the termination was not effectuated.

Pursuant to the Act, the Secretary has delegated to CMS and the States the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. The regulations at 42 C.F.R. Part 483 provide that facilities which participate in Medicare may be surveyed on behalf of CMS by State survey agencies in order to ascertain whether the facilities are complying substantially with participation requirements. 42 C.F.R. §§ 488.10-488.28. The regulations contain special survey conditions for long-term care facilities. 42 C.F.R. §§ 488.300-488.335. Under 42 C.F.R. Part 488, a State or CMS may impose a CMP against a long-term care facility where a State survey agency ascertains that the facility is not complying substantially with participation requirements. 42 C.F.R. §§ 488.406, 488.408, 488.430. The CMP may start accruing as early as the date the facility was first out of compliance through to either the date substantial compliance is achieved or the facility's provider agreement is terminated. 42 C.F.R. § 488.408.

CMS may impose a CMP for either the number of days a facility is not in substantial compliance with one or more participation requirements or for each instance that a facility is not in substantial compliance, regardless of whether or not the deficiencies constitute immediate jeopardy. 42 C.F.R. § 488.430(a). Thus, CMS may impose a per instance CMP ranging from $ 1,000 to $ 10,000 for an instance of noncompliance regardless of whether the deficiency is at the immediate jeopardy level. 42 C.F.R. § 488.438(a)(2).

The regulations define the term "substantial compliance" to mean:

> [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.

42 C.F.R. § 488.301.

"Immediate jeopardy" is defined to mean:

> [A] situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

42 C.F.R. § 488.301.

In a CMP case, CMS must make a *prima facie* case that the facility has failed to comply substantially with participation requirements. To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd, Hillman Rehabilitation Center v. U.S. Dep't of Health and Human Services*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999).

The Act and regulations make a hearing available before an Administrative Law Judge (ALJ) to a long-term care facility against whom CMS has determined to impose a CMP. Act, § 1128A(c)(2), 42 C.F.R. §§ 488.408(g), 498.3(b)(12), (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).

III. Issues

The issues in this case are:

- Whether the facility was complying substantially with federal participation requirements;
- Whether the finding of immediate jeopardy was clearly erroneous; and,
- Whether the amount of the penalty imposed by CMS is reasonable, if noncompliance is established.

IV. Findings and Discussion

The findings of fact and conclusions of law noted below in italics are followed by a discussion of each finding.

A. Petitioner was not in substantial compliance with federal participation requirements.

The facility failed to provide five residents who were at risk for elopement, one of whom successfully eloped on December 6, 2005 (Resident (R)1), with adequate supervision and assistance devices to prevent accidents. 42 C.F.R. § 483.25(h)(2) (Tag F-324).

The applicable regulation at 42 C.F.R. § 483.25(h)(2), entitled "Quality of Care," provides that the facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.

A summary of the surveyor findings as reflected in the Statement of Deficiencies (SOD) reveals that:

> Based on observation, interview, and record review, it was determined that the facility failed to provide adequate supervision to prevent accidents for 5 of 5 residents. Resident number 1 (R1) exited the facility on December 6, 2005, without staff knowledge. Observations and interview made on December 8, 2005, with the Director of Nurses (DON), revealed that all exit doors did alarm when activated, however, not all of the doors had a loud sound. Specifically, the northeast[3] door had a very soft sound. Staff busy in resident rooms could not hear the alarm. When interviewed on December 8, 2005, the administrator reported that she checked the door alarms after the elopement and found them too quiet. R1, who was a cognitively impaired resident, left the facility dressed only in street clothes, without a coat. The temperature outside was very cold, reaching eleven degrees below zero Fahrenheit, with wind chill. R1 remained outside close to an hour, until the Pratt police found her in an alley two blocks away from the facility. She had fallen and suffered abrasions to the face and left knee, and her eyeglasses had broken. An ambulance took R1 to the emergency department at Pratt Regional Hospital.

CMS Ex. 2, at 1-4.

Petitioner's contentions may be summarized as follows:

CMS has made no allegation that anything was wrong with R1's care plan nor that the facility failed to follow its care plan. There is no allegation that anything was wrong with its elopement policy and procedure or in the way that the facility implemented the policy and procedure. There is no allegation that Pratt failed to respond appropriately to the elopement incident. In other words, Petitioner did everything it could to prevent the elopement, and the elopement occurred in spite of these measures, and not because of any deficient practice. CMS's contention that there are a number of practical steps that Petitioner could have taken to prevent the elopement is not the test for whether a deficiency under Tag F-324 has been appropriately cited. The fact that something could have been done differently does not support the conclusion that there was anything wrong with the measures implemented by the facility. The facility regularly tested its door alarms for functioning, but could not have predicted that staff members would not hear the door alarm when it sounded on December 6, 2005. P. Br. at 1, 2.

[3] The northeast door is also referred to as the "east" door at other times in this decision.

During her testimony, surveyor Marsha Wilkening acknowledged that neither R1's care plan, nor the facility's elopement policy and procedure, was in question. Nor was there any question as to whether the care plan and elopement policy and procedure were followed. The surveyor also acknowledged that there was no question as to whether the facility conducted regular testing of the Wanderguard bracelets or whether the facility staff performed 15-minute checks on R1. Transcript (Tr.) at 20. Thus, those items of care as applied to R1, though important, are not at issue here.

The issue that merits attention and consideration is whether Petitioner provided its elopement-prone residents with adequate supervision and assistance devices to prevent accidents. Care plans, policies and procedures, or alarm systems do not, without more, prevent elopements. What can deter elopement is the manner in which staff apply those measures. Thus, the issue here is a narrow one. Did the facility do everything in its power to prevent the elopement? *Koester Pavilion*, DAB No. 1750, at 24 (2000).

R1 is a 90-year-old female that, on admission to the facility, was assessed as being at risk for elopement. The care plan called for fitting her with a Wanderguard, visual observation every 15 minutes, and knowledge of her whereabouts at all times. She had significant mental as well as physical deficits. P. Ex. 8, at 1; CMS Ex. 4, at 5. At 4:00 p.m., on December 6, 2005, prior to her eventual elopement, R1 had disabled the front door alarm in an effort to exit the facility. P. Ex. 5, at 8.

The facility had a wandering and elopement policy that provided for ongoing monitoring of door alarms to ensure that they were operational 24 hours a day. It was specifically established that staff was to check each door alarm every shift and make an entry on the "Door Alarm Maintenance Checklist."[4] P. Ex. 6, at 2. The "Door Alarm Checklist" for the month of December 2005 reveals that entries were made in the morning (7:00 a.m.), afternoon (3:00 p.m.), and at bedtime (11:00 p.m.) on the 6th. Tr. at 44, 57. Those entries appear at P. Ex. 12, at 12 in the form of initials in the appropriate box designed to convey the message that each alarmed door in the facility was tested for proper operation.

Notwithstanding the above precautions, R1 was able to exit the facility sometime after 6:00 p.m. on the 6th of December 2005. She was found in an alley by the police and taken to the hospital for evaluation and treatment of abrasions to her face and left knee. Facility staff was alerted to the elopement by another resident who stated having seen R1 leave the facility through the east door. P. Ex. 5, at 1.

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[4] The facility had a three-shift work schedule.

On December 7, 2005, the facility administrator submitted a complaint investigation report to the Kansas Department on Aging wherein the State was notified of the corrective actions taken by the facility in the aftermath of R1's elopement. Concerning the door alarms, the report stated that the facility did the following:

- On December 7, 2005, checked all doors to see if they were working, and found that the alarm to the east door was not loud.

- Contacted maintenance and Tri-State Alarm Co. for a full evaluation of the alarm system.

- Assigned door monitors. (The posting of staff at the exit door when a problem is noted with the alarm is an intervention required by the Wandering and Elopement policy. P. Ex. 6, at 2.)

- On December 8, 2005, maintenance increased the alarm sound after receiving instructions from Tri-State Alarm Co. over the phone.

P. Ex. 5, at 2, 3.

It should be noted that after checking all of the doors, the facility staff determined that only the east door had a low volume. That is precisely the door through which R1 eloped. Thus, nothing out of the ordinary was evident when the *other* doors were checked. Moreover, when the alarm company technicians conducted an inspection after the elopement incident, the alarm system was found to be in good working order. The only adjustment required was an increase in the volume. Tr. at 55. If all of the *other* door alarms were set at a normal volume, as it was inferred in the complaint investigation report prepared by the administrator, when staff performed the alarm check at the beginning of each shift, the persons performing the test should have noted the absence of desired decibels on the east door alarm. P. Ex. 5 at 2. The administrator explained that it took two people to conduct the test to determine if the alarms were functioning properly. One staff member would go and open an alarmed door while another member would be positioned at the nurses' station to verify proper operation. The alarm sounded throughout the facility and a red light would go on at the nurses' station. Tr. at 51. As part of the complaint investigation report submitted by the administrator, a statement by staff member Anita Cunningham asserts that around the time of the elopement call lights were going off and had the effect of drowning out the door alarm sound. However, the call light buzzer sounded only at the nurses' station where an amber light was located, to provide a visible warning that a call light had gone off. Tr. at 52. Additionally, the amber lights were also located outside each resident's room. Tr. at 51.

A close look at the facility "Door Alarm Checklist" leads me to infer that the staff either did not check the alarmed doors for proper operation or performed a perfunctory test without paying attention to the results. I base this inference on the fact that the afternoon alarm check (3:00 p.m.) and the "bed time" check (11:00 p.m.) of the east door on December 6, 2005, did not reveal any abnormality in the operation of the alarm at that exit. This is evident from the absence of any mention by the nurse in the comments section of that form regarding the low volume of the alarm in the east door. P. Ex 12 at 12. However, at some point between those two testing events of the alarm system, which to the nursing staff revealed no abnormality, an elopement occurred because the east door alarm had a low volume (sometime after 6:00 p.m. on December 6, 2005). In fact, the "Door Alarm Checklist" form contains no mention of any alarm door abnormality for December 7, 2005 in spite of the fact that when the system was checked that day, it was revealed that the volume was low and the volume adjustment was not made until the following day. Moreover, Petitioner has admitted that there was no malfunction in its alarm system, and that the only problem with the east door exit was that the volume was set too low. That same situation had to be present since the time when that alarm was set to a low volume. Petitioner has not shown why any of the alarm tests that took place prior to December 7, 2005, failed to alert staff to the low decibels in the east door alarm. There is no basis for the administrator's testimony to the effect that she noticed the east door alarm to be lighter in volume on December 7 compared to previous occasions. Tr. at 56. She was not the person who made the system checks, nor did she explain why the alarm would respond differently on December 7 than on December 6, if as determined by the technician, there was nothing wrong with it, except that the volume was set too low. That situation was addressed on December 8, 2005, by merely raising the volume on the alarm.

In view of the foregoing, I find that Petitioner did not do everything that it could have done to prevent R1's elopement. Thus, I conclude that CMS has established a *prima facie* case that Petitioner was not in substantial compliance by failing to ensure that each resident receives adequate supervision and assistance devices to prevent accidents. Petitioner has not overcome that showing by a preponderance of the evidence.

B. CMS's finding of immediate jeopardy was not clearly erroneous.

Immediate jeopardy exists where a "provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. For a finding of immediate

jeopardy, it is not necessary to show that the noncompliance caused serious injury, harm, impairment, or death; it is sufficient to show that the noncompliance was likely to cause serious injury, harm, impairment, or death. *Fairfax Nursing Home, Inc.*, DAB No. 1794, at 14 (2001).

In this case, there is strong *prima facie* evidence of immediate jeopardy level deficiencies inasmuch as vulnerable residents were placed at risk of likely suffering serious injury, harm, impairment, or death. The credible evidence of record establishes that R1 suffered injuries and actual harm. She was found in an alley where she fell and suffered abrasions to her face and left knee after leaving the confines of the facility, unsupervised and undetected. She was exposed to severe cold weather for approximately one hour without proper winter clothing, and suffered mild hypothermia. CMS Ex. 4, at 7.

Petitioner should have foreseen that the failure to properly inspect the door alarms could result in the elopement of wandering residents. It is unquestionable that once a resident is out of sight of facility staff, and is outside without supervision, the resident could be exposed to serious harm or even death. I have already found that CMS has established a *prima facie* case that Petitioner did not provide adequate supervision and assistance devices to prevent accidents. Furthermore, Petitioner's failure to adequately protect elopement-prone residents created a window for R1, as well as others similarly situated, to successfully exit the facility without detection or supervision. Petitioner argues that facility staff regularly tested its alarm doors for functioning, but could not predict that facility staff members would not hear the door alarm when it sounded on December 6, 2005. However, the only reason the staff did not hear the alarm was because the volume had been set too low, and they failed to take corrective action when they checked the system on a daily basis. Of course, that is assuming that the staff did in fact check the alarms for proper functioning and did not complete the "Door Alarm Checklist" without actually testing the system. Had the facility been more diligent, the low volume on the east door alarm could have been noticed before R1 exited the building without detection. Petitioner knew that R1 was an elopement risk and had previously attempted to elope. The staff was aware or should have been aware that if given a window of opportunity, she would elope.

I must uphold CMS's determination as to immediate jeopardy unless it is clearly erroneous. 42 C.F.R. § 498.60(c)(2). Petitioner has not met its burden of showing that CMS's determination of immediate jeopardy is clearly erroneous.

C. The amount of the CMP is reasonable.

I have already discussed the basis for a finding of noncompliance. Indeed, there is not only a *prima facie* case of noncompliance here, but the preponderance of the evidence is that Petitioner was not complying substantially with the regulatory requirements under 42 C.F.R § 483.25(h)(2). Furthermore, Petitioner has not met its burden of showing that CMS's determination of immediate jeopardy is "clearly erroneous."

CMS imposed a $ 7,000 per instance CMP. CMS may impose a CMP for either the number of days a facility is not in substantial compliance with one or more participation requirements or for each *instance* that a facility is not in substantial compliance, regardless of whether or not the deficiencies constitute immediate jeopardy. 42 C.F.R. § 488.430(a). Thus, CMS may impose a per instance CMP ranging from $ 1,000 to $ 10,000 for an instance of noncompliance even if the deficiency is at the less than immediate jeopardy level. 42 C.F.R. § 488.438(a)(2). In this case, where Petitioner failed to ensure that R1 received adequate supervision and assistance devices to prevent accidents, and such failure resulted in her leaving the facility unsupervised, during which time she suffered injury and actual harm, a CMP of $ 7,000 is not unreasonable. Moreover, Petitioner has not disputed the reasonableness of the CMP.

V. Conclusion

I conclude that CMS correctly determined that Petitioner was not complying with federal requirements governing participation of long-term care facilities in Medicare and State Medicaid programs at the immediate jeopardy level, and that the imposition of a per instance immediate jeopardy CMP of $ 7,000 is appropriate.

/s/ José A. Anglada
Administrative Law Judge