Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of: Ocean Springs Nursing Center, (CCN: 25-5142) Petitioner, - v. - Centers for Medicare & Medicaid Services.	Date: April 28, 2008 Docket No. C-07-534 Decision No. CR1778

DECISION

I sustain the Centers for Medicare & Medicaid Services (CMS's) determination to impose a per-instance civil money penalty of $7,500 against Petitioner, Ocean Springs Nursing Center.

I. Background

Petitioner is a skilled nursing facility doing business in the State of Mississippi. It participates in the Medicare program. Its participation in Medicare is governed by sections 1866 and 1818 of the Social Security Act (Act) and by implementing regulations at 42 C.F.R. Parts 483 and 488. Additionally, its right to a hearing in this case is subject to regulations at 42 C.F.R. Part 498.

Petitioner was surveyed for compliance with Medicare participation requirements on April 20, 2007 (April survey). The surveyors found that Petitioner had failed to comply substantially with a Medicare participation requirement stated at 42 C.F.R. § 483.25(m)(2). The regulation at issue mandates that a facility ensure that its residents are free from any significant medication errors.

CMS concurred with the surveyors' findings and determined to impose a $7,500 per-instance civil money penalty as a remedy. Petitioner requested a hearing and the case was assigned to me for a hearing and a decision. The parties completed pre-hearing exchanges in compliance with a pre-hearing order that I issued. Based on the parties' exchanges I scheduled an in-person hearing.

Petitioner then moved for summary disposition. CMS opposed the motion and cross-moved for summary disposition. Petitioner opposed CMS's cross motion. In opposing CMS's motion Petitioner averred that it was willing to forego an in-person hearing and to rest its case based on its written submissions provided that CMS did not offer additional evidence to support its case. CMS has made no request that I convene an in-person hearing. Therefore, I find this case to be ready for decision without the need for an in-person hearing.

Each party offered proposed exhibits as part of its pre-hearing exchange or in connection with the motions for summary judgment. CMS offered 17 proposed exhibits with its pre-hearing exchange which it designated as CMS Ex. 1 - CMS Ex. 17. Petitioner offered 11 proposed exhibits with its pre-hearing exchange which it designated as P. Ex. 1 - P. Ex. 11. It offered an additional exhibit, P. Ex. 12, in response to CMS's cross motion. CMS then filed a motion objecting to P. Ex. 12 and offered as a supplemental exhibit, CMS Ex. 18, which consists of photographs of two of Petitioner's residents whose care is at issue in this case. I overrule CMS's objections to P. Ex. 12. While I do not find that Petitioner made any misrepresentations in offering the exhibit, I conclude that the statements in the exhibit are not particularly germane to my decision and I do not rely on it. As to CMS Ex. 18, I am not receiving that exhibit because it is unnecessary, but also out of privacy considerations. Therefore, I receive into evidence CMS Ex. 1 - CMS Ex. 17, and P. Ex. 1 - P. Ex.12.

II. Issues, findings of fact and conclusions of law

A. Issues

The issues in this case are:

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

2. Assuming noncompliance, whether a per-instance civil money penalty of $7,500 is a reasonable remedy.

It is unnecessary that I address a third potential issue, that being whether the case is ripe for summary disposition, inasmuch as the parties have expressed their willingness to have the case decided based on their written submissions.

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

On March 20, 2007, a nurse working at Petitioner's facility gave medications to a resident (identified as Resident #1 in the report of the April survey) whom she misidentified as another resident. CMS Ex. 1, at 2. The medications that the nurse incorrectly administered to the resident included several drugs that would cause reduced blood pressure. Subsequently, Resident #1 experienced profound hypotension that required her to be hospitalized and treated in that hospital's intensive care section with intravenous anti-hypotensive medications. *Id.*, at 1, 5-6; CMS Ex. 5, at 17-19.

The prima facie evidence offered by CMS establishes the medication administration error to be an obvious episode of negligence by a member of Petitioner's nursing staff. The nurse who committed the error did not regularly administer medications but, on the day in question, substituted for another nurse who was absent from work. CMS Ex. 5, at 4. The nurse who mis-administered the medications acknowledged that she had confused Resident #1 with another resident. She failed to take even basic measures – such as checking the resident's records for identifying information – to verify the resident's identity before administering medications to her.

On its face the negligence that occurred in this case is noncompliance with the requirements of 42 C.F.R. § 483.25(m)(2). The regulation imposes a burden on a facility to take all reasonable measures to ensure that residents are not victims of medication errors. In this case the actions of the nurse who mis-administered medications to Resident #1 clearly were not reasonable. The evidence offered by CMS establishes that the nurse was not closely familiar with the residents to whom she was administering medications and did not take effective measures to be certain that she was administering medications to the right resident.

Petitioner acknowledges that an error was committed by one of its staff. But, it contends that holding it responsible for the error of its nurse would amount to a finding of strict liability that is contrary to the intent of the Act and implementing regulations. It asserts that the "receipt of a single dose of the wrong medication by a resident cannot be the basis for finding a violation." Petitioner's motion for summary disposition at 3. Petitioner also argues that even if the nurse erroneously administered medications to the wrong resident she did so in compliance with accepted nursing practices and standards. It contends that the nurse may have "made an unfortunate mistake, but it was not because she failed to follow any required policy or nursing practice." *Id.*

I find neither of these arguments to be persuasive. First, a facility is not immunized from a finding of noncompliance on the ground that the noncompliance is confined to error – even isolated error – by a single employee. In fact, what comprises compliance or noncompliance by a facility is the work product of its employees. Ultimately, it is a facility's employees that provide the care that is subject to regulatory requirements. When an employee errs that error must be evaluated as if it were committed by the facility itself. Moreover, the error that is at issue here is hardly inconsequential. It was employee negligence that jeopardized the life of one of Petitioner's residents. The fact that the negligence constituted a single event does nothing to diminish its significance.

Finding Petitioner noncompliant given the facts of this case hardly is a finding of "strict liability." There was obvious negligence here in the failure of the nurse to administer medications properly to a resident. And, as I have discussed, the negligence of the nurse appropriately is imputed to the facility.

Second, I am not persuaded that the nurse in question – and, by extension, Petitioner – acted consistent with accepted nursing practices and standards in administering medications to Resident #1. The gravamen of Petitioner's argument is that, prior to administering medications to the resident, the nurse addressed her by name and the resident responded positively to that (admittedly incorrect) greeting by saying "good morning." Petitioner's motion for summary disposition at 2. This, according to Petitioner, was consistent with applicable nursing practices and standards to provide reasonable assurance to the nurse that she was giving medications to the correct resident. Petitioner argues that accepted nursing practices and standards require that a nurse do nothing more than greet a resident who is not cognitively impaired before administering medications to that individual. Under Petitioner's analysis the fact that the nurse was misled by the asserted response of Resident #1 to the nurse's greeting may have been unfortunate but establishes nothing to show that the nurse failed to discharge her duty appropriately.

But, the facts of this case show clearly why simply greeting the resident was an inadequate way of identifying her. Administering medications to residents including Resident #1 was not part of the nurse's normal duties. She was a substitute, being asked to do something that was not part of her normal routine. Her error was a direct consequence of her relative lack of familiarity with the resident. The fact that the nurse was being asked to do something that was not part of her normal daily work routine imposed on her the duty to exercise great caution in identifying residents and administering medications to them. What might have sufficed in the case of a nurse who was intimately familiar with a resident and with the medications that she took clearly was inadequate under the circumstances pertaining to the substitute nurse's administration of medications.

Moreover, the fact that the nurse was a substitute imposed a duty on her supervisors and Petitioner's management to exercise extra caution to assure that the nurse provided medications correctly to residents. The nurse – given that she was a substitute and not the nurse who regularly administered medications to the residents – should have been counseled to make absolutely certain of each resident's identity before administering medications to the resident.

And, in fact, that easily could have been done here. Petitioner had in place systems that – had they been utilized by the nurse – ought to have eliminated the possibility that medications would be administered erroneously.

Residents in Petitioner's facility wore identifying armbands and their files contained photographs that could have been used to identify them. P. Ex. 4; P. Ex. 8; P. Ex. 10. Petitioner imposed no obligation on its staff to check a resident's armband or photograph prior to administering medications to him or her except in the circumstances where a resident is cognitively impaired and unable to respond appropriately to a greeting by staff and where the staff has some doubt about the resident's identify. *Id.* But, in this case, given the nurse's relative unfamiliarity with the routine of administering medications to the residents, it would have been a simple matter to counsel her in advance of her performing her duties to make certain by, if necessary, checking each resident's identifying information, that she was providing medications appropriately to the correct resident. She certainly would have identified Resident #1 and avoided the mis-administration of medications to the resident had she looked at the resident's armband or checked her treatment record.

2. A per-instance civil money penalty of $7500 is reasonable.

A per-instance civil money penalty may range from $1,000 to $10,000. 42 C.F.R. § 488.438(a)(2). Criteria for deciding where a per-instance penalty should fall within that range are established 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 criteria include: the seriousness of a facility's noncompliance; its noncompliance history; its culpability for noncompliance; and its financial condition. *Id.*

In this case the evidence shows that the deficiency was extremely serious. The consequence of the nurse's negligence was that Resident #1 suffered adverse medical consequences that she had to be hospitalized for a time in intensive care. The noncompliance caused serious injury to the resident and even jeopardized her life. Moreover, and as I have discussed above, the error that caused harm to the resident may have been a single event but it emanated from critical misjudgments by Petitioner's management and the nurse who committed that error. There was a palpable failure on the part of Petitioner to recognize that putting a nurse into a situation where she would be

asked to perform acts that were not part of her daily routine could pose extreme risk to residents if appropriate safeguards – even safeguards that exceeded the facility's ordinary routine – were not employed.

I find that a $7500 penalty is reasonable given the injury caused by the error and by the misjudgment that the error revealed. I note that Petitioner has offered no evidence that its financial condition precludes it from paying a penalty of this amount.

/s/

Steven T. Kessel
Administrative Law Judge