Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Bartley Healthcare Nursing and Rehabilitation
Docket No. A-13-44
Decision No. 2539
October 18, 2013

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Bartley Healthcare Nursing and Rehabilitation (Bartley) appeals a decision by an Administrative Law Judge (ALJ) granting summary judgment to the Centers for Medicare & Medicaid Services (CMS). *Bartley Healthcare Nursing and Rehab.,* DAB CR2684 (2013) (ALJ Decision). CMS had found that Bartley was not in substantial compliance with two requirements for Medicare participation and had imposed a per-instance civil money penalty (CMP) of $6,200. Before the ALJ, CMS cited a third requirement as a basis for the CMP. The ALJ found that summary judgment in CMS's favor was appropriate based on the "undisputed evidence," which the ALJ concluded shows that Bartley was not in substantial compliance with the requirements at 42 C.F.R. §§ 483.12(a)(7) and 483.20(l)(3) and that the amount of the CMP is reasonable.

For the reasons stated below, we conclude that summary judgment in CMS's favor is appropriate, but base our conclusions on grounds that are more narrow than those on which the ALJ relied.

Background

Bartley is a long-term care facility, located in Jackson, New Jersey, that participates in the Medicare program. As such, it is subject to surveys by the New Jersey State Department of Health and Senior Services (state survey agency) to ensure that it remains in substantial compliance with Medicare participation requirements at 42 C.F.R. Part 483. Social Security Act §§ 1819 and 1866; 42 C.F.R. Part 488, subpart E. "Substantial compliance" means "a level of compliance 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. "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." *Id*. "Immediate jeopardy" means "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." *Id.*

The state survey agency completed a survey of Bartley on February 11, 2011. The surveyors reported their findings on a statement of deficiencies (SOD). The state survey agency found that Bartley was not in substantial compliance with two participation requirements – section 483.12(a)(7) (orientation for discharge) and section 483.25 (general quality of care). Both noncompliance findings relate to a resident referred to as Resident 3 (R3), specifically, to Bartley's discharge of R3 from the facility to his home. The SOD cited the noncompliance at the immediate jeopardy level.

Based on the survey findings, CMS imposed a per-instance CMP of $6,200. Bartley requested a hearing and the case was assigned to the ALJ. Pursuant to the ALJ's pre-hearing order, the parties exchanged pre-hearing briefs and exhibits, with CMS making its submission first. CMS's brief alleged that the facts found in the SOD provided a basis for finding noncompliance with 42 C.F.R. § 483.20(l)(3) (post discharge plan of care), as well as the two requirements cited in the SOD. CMS moved for summary disposition with respect to whether Bartley was in substantial compliance with the newly cited requirement, as well as the two requirements cited in the SOD. CMS also submitted CMS Exhibits 1-52, including written direct testimony of six witnesses, in the form of declarations.

Bartley responded, opposing the motion for summary disposition and submitting Petitioner's (P.) Exhibits 1-13, including written direct testimony of five witnesses.

The ALJ Decision

In his decision, the ALJ identified a number of background facts that he said were undisputed. The ALJ then made the following findings of fact and conclusions of law (referring to Bartley as Petitioner):

a. Summary judgment is appropriate.
b. Petitioner was not in substantial compliance with 42 C.F.R § 483.12(a) (7) because the undisputed evidence shows Petitioner released Resident 3 to his home without proper preparation and orientation to ensure a safe and orderly discharge.
    1. Petitioner did not confirm, before releasing Resident 3, that nursing and aide services were awaiting Resident 3 at his house.
    2. Petitioner discharged Resident 3 to family members who were either unable or unwilling to provide care to Resident 3.
    3. Petitioner did not provide any medications to Resident 3 upon his discharge.
    4. Petitioner did not provide any physical home assessment prior to his discharge.

c. Petitioner was not in substantial compliance with 42 C.F.R § 483.20(l)(3) because Petitioner did not develop a post-discharge plan of care with Resident 3's family that assisted the resident to adjust to his new home environment.
d. The $6,200 [per-instance] CMP that CMS imposed is reasonable.

On appeal, Bartley argues, among other things, that the ALJ Decision failed to apply proper summary judgment standards, treated certain facts as undisputed even though Bartley did dispute them, failed to consider the testimony proffered by Bartley, and treated allegations by R3's daughter as though they were undisputed facts. Request for Review (RR) at 5-11. Bartley also challenged the ALJ's analysis of the regulations as requiring a facility to make visits to a resident's home in advance of discharge home, to train an "uncooperative family" on medication administration when outside services have been arranged for this purpose, and to act as an "insurer" of outside care agencies reporting to a home to provide services. *Id*. at 11-12. Bartley requested and was granted an opportunity for oral argument before the Board on the issue of whether summary judgment is appropriate.

Standards for summary judgment

The Board reviews disputed conclusions of law for error. *Departmental Appeals Board Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs*, http://www.hhs.gov/dab/guidelines/prov.html; *Golden Age Nursing & Rehab. Ctr*., DAB No. 2026, at 7 (2006). Whether summary judgment is appropriate is a legal issue that the Board addresses de novo. *Lebanon Nursing & Rehabilitation Ctr*., DAB No. 1918 (2004).

Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986). Although the Federal Rules of Civil Procedure (FRCP) do not apply in this administrative proceeding, we are guided by those rules and by judicial decisions on summary judgment in determining whether summary judgment is proper. *Thelma Walley*, DAB No. 1367 (1992).

Under FRCP Rule 56 and the applicable case law, the party moving for summary judgment bears the initial burden of demonstrating that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. *Celotex*, 477 U.S. at 323; *St. Catherine's Care Ctr*., DAB No. 1964, at 26-27 (2005). If a moving party carries its initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial.'" *Matsushita Elec. Industrial Co. v. Zenith Radio*, 475 U.S. 574, 587 (1986) (quoting FRCP 56(e)). To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact -- a fact that, if proven, would affect the outcome of the case under governing law.

Id. at 586, n.11; *Celotex*, 477 U.S. at 322. In order to demonstrate a genuine issue, the opposing party must do more than show that there is "some metaphysical doubt as to the material facts . . . . Where the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party, there is no 'genuine issue for trial.'" *Matsushita*, 475 U.S. at 587. In making this determination, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. *See, e.g., U.S. v. Diebold, Inc.*, 369 U.S. 654, 655 (1962).

Under the applicable substantive law, CMS has the initial burden of coming forward with evidence related to disputed findings that is sufficient (together with any undisputed findings) to establish a prima facie case, i.e., that CMS had a legally sufficient basis for concluding that the provider was not in substantial compliance with Medicare participation requirements. However, the provider bears the ultimate burden of persuasion to prove by a preponderance of the evidence that it was in substantial compliance with those requirements. *Batavia Nursing & Convalescent Ctr.*, DAB No 1904 (2004); *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson,* 129 F. App'x 181 (6th Cir. 2005).

On summary judgment, the reviewer does not "make credibility determinations, weigh the evidence, or decide which inferences to draw from the facts," as would be proper when sitting as a fact-finder after a hearing, but instead should "construe the record in the light most favorable to the nonmovant and avoid [] the temptation to decide which party's version of the facts is more likely true." *Payne v. Pauley*, 337 F.3d 767, 770 (7th Cir., 2003); *see also Anderson v. Liberty Lobby, Inc*., 477 U.S. 242, 249 (1986); *Madison Health Care, Inc.*, DAB No. 1927, at 6 (2004).

Analysis

Below, we set out, first with respect to section 483.20(l)(3) and then with respect to section 483.12(a)(7), what the regulation requires, what are the facts on which CMS moved for summary judgment that we consider to be material to our decision, which of those facts Bartley disputed, and whether the evidence is sufficient to raise a genuine dispute regarding those facts.

We conclude that Bartley raised no genuine dispute material to our conclusions that Bartley failed to meet those requirements and that this failure had the potential for more than minimal harm and therefore constituted noncompliance. We also conclude that the disputed facts are not material in determining whether a per-instance CMP of $6,200 is a reasonable amount for that noncompliance. In view of these conclusions, we further conclude that the issue of whether Bartley was in substantial compliance with section 483.25 is not material to our decision.

1. The undisputed facts establish that Bartley failed to meet the requirements of 42 C.F.R. § 483.20(l)(3) -- Discharge plan of care.

What section 483.20(l)(3) requires

Section 483.20(l)(3) requires that, when a facility "anticipates discharge," a resident must have a discharge summary that includes a "post discharge plan of care that is developed with the participation of the resident and his or her family which will assist the resident to adjust to his new living environment."

The term "plan of care" is not defined for this purpose. We note, however, that the post discharge plan of care provision appears in the regulatory section requiring a facility to do a comprehensive assessment of each resident's functional capacity pursuant to section 483.20(b) and to develop a comprehensive care plan that is designed to meet the resident's needs identified in the assessment and that complies with section 483.20(k). The goal of the "post discharge plan of care" is different from the goal of a comprehensive care plan for services the facility is to furnish to a resident. *See* 483.20(k)(1)(i) . The post discharge plan of care is, however, part of a "discharge summary" that must include "a final summary of the resident's status . . ., at the time of discharge" that includes the items listed section 483.20(b), the section on comprehensive assessments. In other words, the post discharge plan of care is to be based on an assessment of the resident's care needs at the time of discharge. Thus, the interpretative guidelines for section 483.20(l) in Appendix PP of CMS's State Operations Manual (SOM) state that a "post-discharge plan of care" is part of a planning process that includes "assessing continuing care needs and developing a plan designed to ensure the individual's needs will be met after discharge from the facility into the community."

What CMS alleged as a basis for summary judgment

In support of its motion for summary disposition, CMS argued generally that the plain language of section 483.20(l)(3) states that purpose of the post discharge plan, developed with the resident and family, is to "assist the resident to adjust to his or her new living environment." CMS Prehearing Br. at 23. Thus, CMS argued, in the case of R3, "personal care instructions, dietary care, and any other applicable instructions or orders should have been listed clearly on the discharge plan." *Id.*

CMS asserted that it was undisputed that the "discharge plan that was sent home with Resident #3 was almost completely blank." CMS Prehearing Br. at 23; CMS Exs. 20, 39.[1] CMS's argument clearly refers to the cover form included in the documents sent home with R3; CMS goes on to describe what was and was not on the form, and refers separately to the six pages of printed physician orders and handwritten prescriptions attached to the form. CMS Prehearing Br. at 23-24. According to CMS, although the first page of the form noted that the facility's Social Worker had made a referral to "VNS through VNACJ" to provide nursing services, the only phone number given was that of the Social Worker, and no mention was made of Care Focus, the company through which home health services were arranged. *Id.* CMS also asserted that "[n]o personal care instructions, precautions and limitations, or dietary and eating instructions were listed" on the form and "the columns where the facility was supposed to list the resident's current medications and administration times were also completely blank." *Id.*

Bartley's response and the framework for our analysis

In response to CMS's motion, Bartley argued that "[the state survey agency] and CMS do not require any specific discharge form for use by nursing facilities when a resident is discharged home" and that the "format of the discharge form is left to the discretion of each facility." P. Prehearing Br. at 23. According to Bartley, the discharge form was accompanied by a printout from the resident's Electronic Medical Record (EMR) that was "clear, legible and easy to understand," which was "an acceptable method by which to provide a copy of a discharge summary . . . to a resident or their family upon discharge." *Id.*

Bartley pointed out that information CMS alleged was missing is in fact included in the printout from R3's EMR attached to the form, and that some of that information is also on the attached, handwritten prescriptions. *Id.* According to Bartley, the "EMR printout addressed all of his care needs, including medications, diet restrictions, functional needs and limitations, aspiration precautions and required interventions." *Id.* at 7. During oral argument before the Board, Bartley argued that it had also sent home with R3 a copy of his signed statement in which he attested that he understood the discharge plan and which identified Care Focus as the home health provider to which R3 had been referred. Transcript of oral argument (Tr.) at 38, 49, referring to P. Ex. 11.[2]

[1] These two exhibits are identical, except that Exhibit 20 has a page added on top with the names of two state officials. (R3's daughter attested that she had a friend fax to those officials "the papers that my father had come home with from Bartley." CMS Ex. 51 ¶ 26.) Although Bartley now says that it did not receive a copy of Exhibit 39 (Tr. at 16), Bartley cited that exhibit in its prehearing brief at page 8.

[2] Bartley did not clearly allege this below, but CMS did not clearly allege below that the only documents Bartley sent home with R3 were those in CMS's Exhibit 39.

For purposes of summary judgment, we assume that the post discharge plan of care in this case consisted of all of the documents CMS concedes were sent home with R3, as well as R3's signed statement. Thus, we need not decide here whether any particular format is required for a discharge plan of care or whether R3's signed statement was in fact sent home with him as part of that plan.

Bartley conceded, however, that the "purpose and intent" of section 483.20(l) is "to ensure appropriate discharge planning as well as **communication of the necessary information to whoever serves as the continuing care provider**." *Id*. at 22 (emphasis added). Moreover, Bartley's assertion that an EMR is an acceptable method for meeting the requirement is premised on the EMR indeed being clear, legible, and easy to understand.

With respect to who would provide continuing care to R3, Bartley argued that its Social Worker had assisted R3 in arranging for home health services through Care Focus and visiting nursing services from the Visiting Nurse Association of Central Jersey (VNACJ). P. Prehearing Br. at 6. Yet, Bartley conceded (and its evidence shows) that, although its staff had recommended that R3 receive care from those outside agencies for 24 hours a day, 7 days a week, R3 decided to accept their services only from 10 a.m. to 7 p.m., a nine-hour period. *Id*.; P. Ex. 13, at 30. Indeed, Bartley relied on this modification to the plan to show that R3 and his family participated in developing that plan. As modified, therefore, the plan was that R3 would be home for 15 hours each day, with no outside agency caregiver present. Bartley's own evidence shows that it expected that at least some of R3's care would be given by his wife during that period. *See*, *e.g.*, P. Ex. 2 ¶ 5 (Acting Director of Nursing's testimony that she was aware that R3's wife "was going to be partially responsible for his care including the administration of his medications").

Bartley also did not dispute CMS's assertion that, if a facility expects care to be given by a resident's family, then the post discharge plan of care (or "discharge instructions," as Bartley referred to the documents sent home with R3) must be understandable to a layperson. To address this issue, Bartley instead proffered expert opinions, specifically, a declaration and report by a licensed registered nurse who is a consultant to the long-term care industry and a declaration and report by a physician who specializes in geriatric medicine and is a Medical Director. Those experts offered their opinions on the documents sent home with R3. *See* P. Ex. 4 ¶ 25 ("communication of necessary information to the continuing care provider was entirely adequate), ¶ 40 ("discharge documents which [R3] left the facility with were explained in clear and simple terms and addressed all of [R3's] needs"); ¶ 41 ("instructions dealt with each and every one of his restrictions, medications, and recommendations for his post discharge care"); ¶ 42 (R3 was provided with "explicit discharge instructions"); P. Ex. 5 ¶ 24 ("discharge instructions were extremely clear and could be understood by any visiting nurse, caregiver or layperson"), ¶ 26 ("they included not only [R3's] prescriptions upon

discharge, but also direction on how to consume liquids, aspiration precautions, the use of leg stockings and glove to his left hand"). Bartley argues that the ALJ erred by granting summary judgment without considering this testimony. RR at 9.

The testimony by Bartley's experts has some relevance in evaluating what was the necessary information that had to be communicated to R3's caregivers in light of R3's status at the time of discharge, whether home health aides and nurses would understand the entries on the EMR printout attached to the discharge form, and what the consequences to R3's health might be from a lack of a compliant plan of care. In evaluating whether the documents in fact contain the necessary information and whether they do so in a manner understandable to a layperson, however, no rational trier of fact would be persuaded by expert testimony if it is contradicted by the documents on their face. In other words, the documents speak for themselves. Opinion testimony about those documents is not sufficient to raise a genuine dispute of fact precluding summary judgment if that testimony is wholly at odds with what is shown unambiguously on the face of the documents.

Bartley also relied on its experts' opinions on the ultimate legal issue. *See* P. Ex. 4 ¶ 49 ("It is my expert opinion with a reasonable degree of nursing certainty that Bartley complied with" the regulations at issue); P. Ex. 5 ¶ 34 ("Bartley was not deficient with reference to 42 C.F.R. 483.20(l)"); ¶ 36 ("It is my opinion to a reasonable degree of medical certainty the Bartley was in compliance with" the federal requirements). Summary judgment is not inappropriate merely because the parties proffer differing opinions on the ultimate legal issue, however. *Kingsville Nursing & Rehab. Ctr.*, DAB No. 2234, at 9-10 (2009).

Similarly, no genuine dispute of fact material to our conclusion here is created by the nurse expert's statement that "discharge planning" for R3 "began in March 2010 and was completed in October 2010 per the standards of practice for residents admitted to short-term stay sub-acute care as a result of a stroke." P. Ex. 4 ¶ 39. Aside from the fact that the nurse expert does not identify the source or content of the standards to which she refers, she does not assert, nor could we reasonably infer from her statement, that such standards of practice address what information a post discharge plan of care must contain for a particular patient with an identified set of needs (not all resulting from his stroke), who has declined to accept services from outside agencies except for nine hours a day.

Thus, we next turn to our examination of the documents at issue and explain why we conclude as a matter of law that those documents did not meet the requirements of section 483.20(l)(3) for a post discharge plan of care.

The general absence of necessary information regarding the planned caregivers and who would do what

As noted above, Bartley effectively conceded that the purpose of the post discharge plan of care is to communicate necessary information to the continuing care providers and, therefore, it must be understandable to any layperson who is expected to be a caregiver.

While some of the entries on the EMR printout (called a "Physician Order Activity Detail Report") attached to the discharge form would be understandable to a layperson, others would not. Some entries contain terms or abbreviations that are healthcare related terms or abbreviations that would not be clear to the typical, untrained layperson. CMS Ex. 20, at 4-7. For example, the term "without coverage" is used in the order for monitoring R3's blood sugar and the abbreviation "prn" is used in the order for a catheter for R3. CMS Ex. 20, at 4, 6. Use of such terms or abbreviations might not matter if the plan of care had made clear that these particular instructions were directed solely to the visiting nurse and/or home health aides. But, on their face, the documents lack any information about which continuing caregiver or caregivers were expected to provide what services to meet R3's care needs. Moreover, many of the entries on the EMR printout list schedules for care that clearly track the nursing facility's shift schedule (that is, "7:00 am-3:00 pm; 3:00 pm-11:00 pm, 11:00 pm-7:00 am"), rather than reflecting the plan for R3 to have his care given by outside agencies from 10 a.m. to 7 p.m. and otherwise by his wife or possibly other family members, at least until R3 adjusted that schedule. With respect to Calmoseptine ointment, the order says to "apply to buttocks every shift," but does not state who should apply the ointment during the two shifts when the home health aides would be present for part, but not all of the shift. *Id.* at 4. Bartley should have known that the printout was likely to be confusing to R3's continuing caregivers, given some of the terms and abbreviations used and the plan for different caregivers at different times of the day.

We note that, as Bartley pointed out, R3 signed the first page of the discharge form above a line stating: "I have received a copy of and understand these Instructions." CMS Ex. 20, at 9. Bartley also relied on its experts' opinions that R3 was alert and oriented and capable of understanding instructions. P. Ex. 4 ¶¶ 20, 37; P. Ex. 5 ¶ 11. We therefore accept for purposes of summary judgment that R3 understood the instructions. But the issues here are, first, whether the documents contained the necessary information about how R3's care needs would be met and, second, whether any instructions that were in the document would be understandable to R3's continuing caregivers. R3's understanding of any instructions actually contained in the documents is wholly irrelevant on the first issue. With respect to the second issue, we assume that, if R3 understood the instructions contained in the EMR printout (such as those dealing with the aspiration precautions he needed to take), that might lessen to some degree the amount of detail needed in the

information to be given to the caregivers or mitigate the risk of harm to him from the failure to communicate to the caregivers. But his understanding could not render the instructions automatically understandable to a layperson who had not been as involved in his care as he had been.

As noted above, in response to CMS's assertion that the only information about referral to outside caregivers was "VNS through VNACJ," Bartley now says it also sent home R3's signed statement that mentioned Care Focus, the home health agency. Neither document, however, gives a phone number or other identifying or contact information for either of these agencies.

Bartley did proffer evidence that R3 met with Care Focus on the day before the discharge and that the Social Worker discussed discharge plans with R3, his wife, and his daughter. P. Ex. 13, at 30. The Social Worker's notes about these discussions do not indicate whether she or anyone else gave the family any contact information for Care Focus, and her notes indicate that she did not actually make the referral to VNACJ until after her discussions with the family. *Id*. Even if we assume for purposes of summary judgment that R3 and his family were provided sufficient information about Care Focus and VNACJ prior to discharge, that would not obviate the need to include the information in writing as part of the plan of care to assist R3 in adjusting to his new environment.

Bartley also pointed to evidence that its staff called R3's family with the contact information for Care Focus and VNACJ within a few hours after he arrived home. P. Ex. 1 ¶ 19; P. Ex. 3 ¶¶ 10-12. That action might have mitigated the risk to R3 from the fact that no caregiver was at his house when he arrived, but does not go to the adequacy of the written plan of care sent home with him.

We conclude as a matter of law that, to constitute a "post discharge plan of care" under section 483.20(l), the documents sent home with a resident must, when the expectation is that there will be more than one caregiver, communicate who those caregivers are and who is expected to give what needed care and must use language that will be understood by any caregiver expected to give that care. The documents sent home with R3 did not, on their face, meet this regulatory standard.

> *The absence of necessary information regarding the Hoyer lift (and the presence of information that might confuse R3's caregivers)*

With respect to the Hoyer lift that was used to transfer R3 between his bed and his wheelchair, CMS's motion relied on testimony by state officials for the following assertion:

> The facility was also responsible for insuring that any special equipment that the resident needed was at the house when the resident arrived and that the resident and/or his family was instructed on how to use the equipment.

CMS Prehearing Br. at 30, citing CMS Ex. 47 ¶ 57; CMS Ex.50 ¶ 41. CMS also asserted the following:

- "Resident #3's care plan also identified the resident as being at risk of falls, with interventions including to 'supervise resident and assist with transfers as needed' and 'Hoyer lift for transfers via 2 person assist.'"
- "[T]he resident had a physician order for Hoyer Lift for Transfers."
- "[T]he facility failed to ensure that Resident #3's family was instructed in the use of the Hoyer lift, and failed to provide home aide services trained to perform such transfers."
- "Resident #3 was a heavy man, over 200 pounds[.]"
- Resident 3 "was basically immobile due to his hemiparesis."
- "If the resident was not properly strapped into the lift, if the chains connecting the slings to the lift were not properly placed, if the base of the lift was not properly positioned, or if the lift was not properly operated, there is a likelihood the resident would have fallen and suffered a serious injury."
- "Although a Hoyer lift was ordered by the facility, it arrived at the house just before Resident #3 arrived."
- "The resident's daughter confirmed that no one in the family had been instructed on how to operate the Hoyer lift."
- "A Hoyer lift was delivered to the resident's house shortly before his arrival, but Bartley failed to provide instructions or training to the family on how to use it."

CMS Prehearing Br. at 30-38.[3]

Bartley proffered no evidence creating any genuine dispute about the facts asserted by CMS regarding the steps that need to be taken to safely use a Hoyer lift for a transfer or about the need for instructions or training in order for someone to properly use the lift. Nor did Bartley take the position that there were no dangers inherent in improper use of the lift. Bartley did proffer some evidence about R3's health status at the time of discharge and about his training with respect to the lift that might, read in the light most favorable to Bartley, indicate that he was not quite so vulnerable as CMS portrayed him. *See, e.g.,* P. Ex. 9, at 2 (stroke "caused weakness on his left side" and "after completing

[3] Many of these statements appear in sections of CMS's prehearing brief that discuss requirements other than 483.20(1)(3). Bartley had notice, however, that CMS considered them to be undisputed facts warranting summary disposition.

his rehabilitation program he progressed . . . ."); P. Ex. 12, at 7 ("Able to wiggle toes and fingers [left upper and lower extremities]"); P. Ex. 8, at 2 (referring to transfer training, balance exercises, and on how to push off with his arms when standing up) . But this evidence does not create a genuine dispute about the risks to R3's safety if the lift were used improperly, given the undisputed facts about his weight and left-sided weakness.

Bartley argued, however, that the plan was for caregivers from Care Focus to transfer R3, not the family, and its experts' opinions were premised on this being the plan. *See, e.g.*, P. Ex. 9, at 5 (R3's "transfers were to be handled using a hoyer lift by trained personnel from Maxim"). This plan is not, however, reflected in the documents sent home with R3. The only reference to the Hoyer lift is an October 12, 2010 entry on the EMR printout, with the following information in the column for "Physician Orders":

> Hoyer Lift for Transfers
> Schedule. Every Day at 7:00 am-3:00 pm, 3:00 pm – 11:00 pm, 11: 00 pm-7:00 am
> Entered by: Service. Readmission Orders.

CMS Ex. 20, at 7.[4] Absent from this entry is any instruction on how to use the lift or who was expected to use the lift. Moreover, if the plan was that only caregivers arranged through Care Focus would transfer the resident (and therefore Bartley did not need to instruct or train R3's family in how to use the lift), then the schedule given in the entry is at the very least inaccurate. At worst, it could lead the outside caregivers to think they did not need to use the lift to put R3 to bed before leaving at 7 p.m. or lead family members to think it was acceptable for them to use the lift during times no trained caregiver was present. Yet, the entry contains no warning that only outside caregivers or other persons instructed or trained in how to use the Hoyer lift should attempt to transfer R3 using the lift.

As noted above, Bartley proffered evidence that the discharge instructions were reviewed with R3 prior to his discharge and that R3 was able to understand and signed that he did understand those instructions. We conclude that this evidence does not create a genuine dispute about the adequacy of the plan of care for the Hoyer lift. Even accepting that the "discharge instructions" were reviewed with R3 and that he understood them, it is not

[4] Other columns on the printout contain irrelevant information about who requested and approved the order and what its status was as of October 12, 2010, the date all of the orders were entered.

reasonable to infer that R3 understood as a result of these reviews how the Hoyer lift should or should not be used, given that the discharge documents on their face contain no such instructions.[5]

We note, moreover, that Bartley proffered no testimony from any of the individuals who allegedly reviewed the discharge instructions with R3, and the documentary record noting the discussions with R3 state little about the content of those discussions. For example, the nurse progress note stating that "Nursing" reviewed discharge instructions with R3 gives no detail about what was reviewed with him, much less any statement from which one could reasonably infer that the nurse discussed precautions for use of a Hoyer lift. CMS Ex. 27, at 1. The physician notes on which Bartley relied for its assertion that the physician reviewed the "discharge plan" with R3 on October 20 refer only obliquely to his transfer needs, stating only that R3 told the physician that "his wife is at home and planning to get home services to help him get out of bed." P. Ex. 12, at 7; *see also* P. Ex. 5. No other mention is made about transfers or the lift. *Id*. Thus, it is not reasonable to infer from his notes that the physician reviewed with R3 any instructions about the Hoyer lift, even viewing those notes in the light most favorable to Bartley.

Bartley proffered evidence it said showed that it did provide care training to R3 and his family, including information about assistive devices used in his care. Bartley relied on entries about care planning conferences, entries in R3's plan of care, and Bartley's nurse expert's analysis of R3's record. The notes from the care planning conferences show attendance by R3 and his family at only two such conferences, one in March 2010 and one in April 2010. As pertinent here, the notes of the meeting on March 30 of the interdisciplinary care plan (IDCP) team state:

> ICDP team met with [R3] and his family to discuss his progress and discharge plans. . . . Per therapy, [R3] requires max x2 for transfers . . . Therapy states [R3] needs a lot of assistance due to his L sided weakness from CVA [cerebral vascular accident]. His swelling has improved and he is able to shrug his shoulders. Therapy states [R3] continues to make slow progress with no concerns at this time.

P. Ex. 8, at 3. No mention is made of the Hoyer lift. Even assuming the discussion of his need for assistance with transfers included a mention of the lift used to transfer him, the context is a discussion of his progress and continuing needs, not of providing information to the family on how to meet those needs. The notes from the April 30 conference state as pertinent here:

[5] We note that Bartley's nurse expert attested that the EMR printout "addressed the care needs, including …functional needs and limitations . . . and required interventions" and that it included "very clearly worded and specific instructions" with respect to R3's medications, but she did not claim that the EMR printout contained very clearly worded and specific instructions with respect to the interventions such as the Hoyer lift. P. Ex. 4, ¶¶ 24-25. Similarly, the physician expert refers specifically to directions regarding other needs and interventions, but is silent on the Hoyer lift. P. Ex. 5 ¶ 26.

> IDCP team met with [R3] his wife and [daughter] to discuss his progress and discharge planning. . . . Per therapy, [R3] is standing in the standing frame for 6 minutes with max x 2. . . . He is also sitting on the edge of the mat in therapy to work on leg stretching and trunk/stomach muscles for support. [R3] is able to push weight on his hands . . . He is exhibiting slight movement in his fingers. . . . [R3] is showing slight progress in therapy and is very motivated in therapy sessions. Therapy to start working on sliding board transfers if able . . . .

Id. Again, no mention is made of the Hoyer lift, much less of providing any training or instructions to R3's family about the lift. While the Social Worker's notes from a June 2010 IDCP meeting (that were modified in July 2011) do refer to the Hoyer lift, there is no indication in those notes or elsewhere in the record that R3 or his family attended that meeting. P. Ex. 8, at 4; P. Ex. 13, at 11. Nor did Bartley present testimony from anyone who attended those meetings about what was said or who else attended the meetings.

Bartley also relied on the education interventions adopted as part of R3's comprehensive care plan. As potentially relevant here, a care plan developed on March 13, 2010 to address R3's problem of decreased mobility as a result of his CVA (stroke) included the following interventions, with a goal that R3 would be able to perform bed mobility and transfers with less assistance:

- "Educate on use of assistive devices"
- "Explain and demonstrate each step of procedure"
- "Provide oversight, verbal cues, and assistance as needed."
- "Transfer training and balance exercises."

P. Ex. 8, at 2.

To address his fall risk, another care plan entry developed on the same date included the following interventions to educate R3:

- "Educate and remind resident when standing up from chair to push off with arms. If in w/c educate resident of the need to lock the brakes."
- "Encourage resident to rest to prevent falls related to fatigue."

Id.[6]

[6] We have omitted other listed interventions not even conceivably related to education about transfers.

These interventions appear geared to educating and training R3 so he would need less assistance with the transfers and be less likely to fall. Such education and training arguably would mitigate the risk of R3 falling during a transfer, but does not necessarily mean that R3 was educated on the steps a caregiver operating the Hoyer lift would need to take to transfer R3 properly using the lift or on the dangers if an untrained person tried to use the lift to transfer him.

Even accepting for purposes of summary judgment that R3 was trained in the steps and or procedures a **caregiver** had to use to properly transfer him in the lift and accepting that R3 was capable of understanding instructions and communicating to others (as the experts attest), we still conclude that summary judgment is appropriate with respect to whether the discharge instructions contained all necessary information regarding the Hoyer lift. Bartley presented no evidence that R3 was capable of demonstrating to a family member matters such as how to properly strap him into the lift, how to properly place the chains connecting the slings to the lift, or how to properly position the base of the lift. In the absence of any evidence from which we could reasonably infer that any family member was trained or could be instructed by R3 on how to use the lift to transfer him safely, we conclude as a matter of law that Bartley at the very least was required to include in R3's post discharge plan of care the precaution that no untrained caregiver should attempt to transfer him using the lift.

In sum, we conclude that, on their face, the discharge instructions sent home with R3 did not provide information regarding his care using the Hoyer lift that Bartley should have known it needed to communicate to his caregivers.

The inaccurate information about R3's insulin

In its motion, CMS also asserted that the following was undisputed:

- The "list of physician orders was not organized in any way that a layperson could easily understand what kind of medications the resident was supposed to be taking or how they were to be administered . . . ."
- R3 was "diabetic and had physician orders to administer Lantus by subcutaneous injection in the evenings, as well as to monitor blood sugar via fingerstick once daily."
- R3 was "unable to perform a fingerstick or give himself insulin" and this was because Resident #3 had "hemiparesis (i.e., one sided weakness of his left side)."

CMS Prehearing Br. at 24-25. CMS also pointed out that Bartley sent R3 home with a script for VNA to do diabetic training. By doing so, CMS asserted, Bartley was "implicitly acknowledging that no diabetic training had been done by the facility." *Id*. at 25.

In response, Bartley argued that R3's needs had been discussed with his family as early as the care planning conference in March 2010 and that his diabetic condition was longstanding. P. Prehearing Br. at 3-4; P. Ex. 4 ¶ 6; P. Ex. 8, at 13. Bartley also relied on its nurse expert's description of R3's EMR printout as including "very carefully worded and specific instructions for administration of each medication, including the exact dose, the reason for use and the exact time the medications should be taken, as well as how to take them." P. Prehearing Br. at 6-8; P. Ex. 8, at 8.

Contrary to what Bartley implied, however, R3's EMR printout did not contain all of that type of information with respect to R3's insulin. The EMR printout entry is dated October 12, 2010 and states the following in the column for "Physician Orders":

> Lantus 100 unit/mL Sub-Q
> SIG 14 units of Lantus inject by subcutaneous route at bedtime
> Dx: 250-Diabetes Mellitus
> Schedule Every Day at 9:00 pm

CMS Ex. 20, at 5.

The dose of "14 units" on the printout is not the same as the dose on the attached handwritten prescription, which is dated October 20, 2010 and says: "Inject 12U via subcutaneous Route at bedtime daily." *Id.* at 8. The physician notes from October 20 state: "Pt on lantus 14u qhs, will be decreased and Pt will be d/c home on Lantus 12U." P. Ex. 12, at 7. Apparently, R3's EMR was not amended to reflect this decrease in dosage, so the EMR printout did not in fact reflect the plan of care for R3's diabetes after discharge, as ordered by the physician.

Moreover, while the handwritten prescription refers to "Lantus pen," the EMR entry does not. Neither entry contains any instruction about how to administer the Lantus except to inject "via subcutaneous route," an instruction not every layperson would understand. Yet, as discussed above, Bartley did not deny that discharge instructions must be understandable to a layperson providing care, and the plan was for R3 to receive the injection at bedtime, meaning 9:00 p.m., when no outside caregiver would be present in R3's home.

Bartley's reliance on evidence from earlier care planning conferences, as well as on the fact that R3's diabetes was longstanding, is misplaced. Arguably, one could infer from the notes of the March or April meetings that the wife and daughter who attended those meetings would understand from the discussion of his diabetic needs what "subcutaneous" meant. But Bartley points to no evidence from which we could reasonably infer that any instruction or training was given on how to administer insulin via subcutaneous route using a Lantus pen, which the physician ordered only the day before discharge. Moreover, the care planning meetings attended by family members

were more than five months before R3 was discharged. We question whether Bartley could reasonably rely on any instructions or training provided at those sessions about how to administer insulin subcutaneously in determining what information the family needed as part of a post discharge plan of care. Indeed, Bartley proffered no evidence that it did in fact rely on those meetings in deciding what information to include in the "discharge instructions."

Bartley's reliance on its experts' testimony and reports as creating a genuine dispute of material fact on this issue is also misplaced. This evidence does not create a genuine dispute in response to CMS's assertion and evidence that R3 was incapable of self-administering the Lantus and that there was not sufficient time to train him to do so in any event. The expert physician report pointed out that R3 had progressed to the point where he could eat independently and stated that R3 "was capable of taking his own medications." P. Ex. 9, at 2; P. Ex. 5. Bartley clarified during oral argument, however, that it was not asserting that R3 had been adequately trained so that he could safely self-administer his Lantus, but only that continued training through the visiting nurse was part of his care plan. Tr. at 30.

Bartley's nurse expert did attest that "[i]f the family had followed the instructions to fill the medications, they would have received further instructions and materials specific to the use of each drug from the pharmacist." P. Ex. 4 ¶ 26; P. Ex. 8, at 8. Bartley's expert physician stated that "Lantus insulin injection was prescribed in a pen form and the visiting nurse services were to arrive at his home the following morning to start teaching the patient and his family how to administer insulin." P. Ex. 9, at 5. The physician attested that this "method of insulin administration via a pen can even be done by a visually impaired person!" *Id*. For purposes of summary judgment, we infer from this testimony that the plan of care sent home with R3 did not need to include detailed instructions on using a Lantus pen because he and his family would receive such instructions through other means and because using a Lantus pen is relatively easy. If this was the plan, however, the document should have at least communicated this plan to the family, given that the facility knew that no outside caregiver would be present to administer the Lantus on the night of discharge and had no expectation that the visiting nurse would provide training before the following morning at the earliest.

In sum, we conclude that the post discharge plan of care for R3's diabetes did not, as a matter of law, meet federal requirements because it contained inconsistent information regarding the dose of Lantus required, used terminology that would not normally be understood by a layperson expected to administer the Lantus, and did not either contain instructions on how to use a Lantus pen or inform the family caregivers they could obtain such instructions from the pharmacist when filling the prescription.

For the reasons stated above, we conclude that summary judgment is appropriate with respect to the issue of whether Bartley met the requirements of section 483.20(l).

2. The undisputed facts establish that Bartley failed to meet the requirements of 42 C.F.R. § 483.12(a)(7) – Orientation for discharge.

What section 483.12(a)(7) requires

Section 483.12(a)(7) provides:

> *Orientation for transfer or discharge*. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

This provision tracks the wording of section 1919(c)(2)(C) of the Social Security Act.

The legislative history says that the facility "would also have to sufficiently prepare the resident for the transfer or discharge." H.R. Rep. No. 391 (II), 100th Cong. 1st Sess. (1987).[7]

SOM guidelines for section 483.12(a)(7) state among other things:

> "Sufficient preparation" means the facility informs the resident where he or she is going and takes steps under its control to assure safe transportation.

The SOM describes the goal as to minimize "unnecessary and avoidable anxiety or depression . . . ." CMS's prehearing brief also cited to an ALJ decision stating that section 483.12(a)(7) and some related regulations impose "on a facility's management and staff the obligation to do the utmost to protect its residents and their family members from the trauma associated with transfer" or discharge. CMS Prehearing Br. at 28, citing *Oakwood Nursing Ctr., Inc.*, DAB CR2001 (2009).

In response, Bartley did not deny that the purpose of this requirement is to protect residents from transfer trauma, but argued essentially that its responsibility ended when R3 left the facility since it had made appropriate referrals for continuing care and R3 understood the plan. In support of this argument, Bartley cited to the definition of "discharge" in the SOM as "moving the resident to a non-institutional setting when the

[7] Section 1919(c)(2) of the Social Security Act and section 483.12 in general address the transfer and discharge rights of a resident of a skilled nursing facility. The SOM notes that the regulation applies to transfers and discharges that are initiated by the facility, not the resident. SOM, App. PP, Guidelines for § 483.12(a)(7). In general, the regulation provides that a facility must permit each resident to remain in the facility, and not transfer or discharge the resident unless one of five specified reasons exists, and then must document certain of the reasons, and give the required notice. Bartley did not deny that these requirements apply to the discharge at issue here.

releasing facility ceases to be responsible for the resident's care." SOM, App. PP, Guidelines for § 483.12. Bartley argued that a state official had found the discharge to be "safe" two days in advance. P. Prehearing Br. at 18. According to Bartley, CMS was relying on events that did not occur until after the discharge and that were beyond Bartley's control, namely, the "family failed to cooperate" and the "outside vendor of home health aide services failed to report." *Id.* at 18, 24. According to Bartley, "how orderly a discharge will be can only be controlled by a facility until the resident leaves the building." Tr. at 52.

While section 483.12(a)(7) refers to a "safe and orderly discharge from the facility," we disagree with Bartley to the extent it suggests that, in evaluating whether this requirement was met, we should examine only whether the resident left the building in a safe and orderly manner. Such a reading would be inconsistent with the SOM guidance and the purpose of the provision. The SOM provisions cited above refer to discharge as "moving the resident to a non-institutional setting" and define "sufficient preparation" as meaning the facility must, among other things, take "steps under its control to assure safe transportation." Bartley did not claim it lacked notice of the SOM interpretations of the wording of this provision and, in fact, relied on the SOM definition of the term "discharge." Moreover, to prevent trauma that might be associated with transferring or discharging a resident home, a facility necessarily must take into account factors that would affect whether the arrival home would be safe and orderly.

Certainly, a facility may not be faulted for matters beyond its control, but, as we discuss below, the undisputed facts show that Bartley did not take steps within its control to ensure a safe and orderly discharge of R3.

What facts CMS alleged as a basis for summary judgment

CMS's motion alleged, among other things, that the following facts were undisputed:

- "In Resident #3's case, the facility had supposedly arranged for nursing services through VNA, and aide services during the day through Care Focus."
- "However, no aide or nurse from an outside agency was available on October 21, 2010, the day of Resident #3's discharge."
- Bartley's Social Worker acknowledged that she "only contacted VNA and Care Focus about home nursing and aide services on Tuesday October 19, two days before Resident #3's discharge."
- The surveyor's interviews with two representatives from Care Focus confirmed that Care Focus had not agreed to provide home aide services to Resident #3."
- A Care Focus representative "stated that he specifically told [the Social Worker] that his agency could not provide the type of care that Resident #3 needed, i.e. transfer via Hoyer lift, though he indicated he would try contacting another agency."

- "Bartley gave assurances to the State that home nursing and aide services had been arranged for Resident #3 . . . ."
- Interviews by the surveyor confirmed that "staff received one day notice of the discharge home, and thus there was 'no time' to do any discharge teaching."
- A facility nurse confirmed with the surveyor that "there needs to be at least 3-4 days notice to do discharge teaching."

CMS Prehearing Br. at 28-31. "In light of the fact that it knew there was 'no time' for training the resident's family in the resident's care," CMS argued, "Bartley was required under the regulation to ensure that nurse and aide services were available to Resident #3 upon his return home." *Id*. at 30-31. CMS also argued that the undisputed facts it asserted with respect to the requirement at 483.20(l) also would provide a basis for finding noncompliance with section 483.12(a)(7).

How Bartley responded to these assertions and why that response is inadequate to show a genuine dispute of material fact

In response to CMS's motion, Bartley relied on progress notes by its Social Worker, asserting that there is "no indication in the record thus far that any surveyor or CMS witness reviewed the handwritten 'soft notes' of the social department of Bartley" that "detail [that] department's contacts with families and outside agencies to plan discharge" of R3. P. Prehearing Br. at 4-5, P. Exs. 13, 8. The Social Worker's notes, read in the light most favorable to Bartley, indicate that discharge home (at least as an option) and some of R3's care needs were discussed with him and his family in the first few months of R3's stay at the facility. They also indicate that, in subsequent months, after Bartley had notified R3 and his family that he would be discharged for nonpayment of what he owed Bartley, the Social Worker contacted many other facilities closer to R3's home (per the family's preference) to try to arrange transfer to such a facility. The notes further indicate that each of those facilities declined to accept him because he had not been determined eligible for Medicaid (despite efforts by the Social Worker to assist the family in providing required information to the state Medicaid office). Bartley also notes that R3 told the Social Worker on September 15 that he wanted to go home. P. Ex. 8, at 11.

With respect to arranging for nursing and home health services for R3, however, the notes either confirm CMS's factual assertions in key respects or are silent on them, and thus do not create a genuine dispute of material fact. The date on which the handwritten notes first show a call from the Social Worker to Care Focus is written over, but could be either October 19 or October 20. *Id.* at 30. Other handwritten notes clearly dated October 20 state:

> Care Focus came in to meet [with patient]. [Patient] declined recommendation of 24-7 care and set up care from 10 am to 7 pm and will adjust schedule as needed. [Social Worker] confirmed schedule [with patient] and Care Focus. Home care to begin at home **upon discharge**.

Id. (emphasis added).[8] Nothing in this October 20 note contradicts CMS's allegation, based on a statement by a Care Focus representative, that he specifically told the Social Worker that his agency could not provide the type of care that R3 needed, i.e., transfer via Hoyer lift. While the Care Focus representative also said he indicated he would try contacting another agency, the Social Worker's notes from October 21 state the following:

> [Social Worker] met with [patient] to discuss and confirm all discharge plans set up for today. [Patient] in agreement [with] all discharge plans. [Patient] to be picked up at 3pm with GEM. Delivery of equipment to be this afternoon prior to discharge. . . . . [Social Worker] placed call to [Care Focus] to confirm services. [Social Worker] spoke [with one of the Care Focus representatives] who states they are trying to locate caregiver. [He] will have [the other representative] call. [Social Worker] received call from [the other Care Focus representative] who states they're still locating caregiver. [Representative] to locate caregiver for [patient's discharge] to home [at] 3pm and to [call back] [Social Worker]. [Social Worker] placed call [at] 2:30pm to confirm plans. [Care Focus representative] told [Social Worker] that he had not located caregiver but stated that if he was unable to get caregiver from [Care Focus] he would go through another company that he feels comf[ortable] working [with]. He stated that he would have someone and confirmed [discharge] time [with Social Worker]. . . . [Patient] picked up around 3:30pm.

Id. at 31.

These notes raise a question about CMS's assertion that Care Focus had not agreed to provide services to R3 (or at least indicate that Bartley's Social Worker could reasonably think that Care Focus had agreed either to provide the services or to arrange for them through another company). The notes also unambiguously establish, however, that the Social Worker knew as of 2:30 on the date of discharge that Care Focus had not yet located a caregiver for R3, but Bartley nonetheless discharged R3 around 3:30. In other words, as of half an hour before the planned discharge time and an hour before the actual discharge, the Social Worker had been unable to confirm even that a caregiver had been

[8] A note handwritten on the side of the sheet indicates that the Social Worker "recommended 24-7 care but wife declined as she does not feel comf [with] and refuses a live-in aid (sic)." The October 21 social services progress notes about the discharge plans set up and confirmed with R3 state that R3 "decided to have services from 10am to 7pm starting day of discharge . . . ." CMS Ex. 28, at 1.

located. While the notes indicate she confirmed the time of discharge, and that the representative said he would have someone, given the short time until discharge, we cannot reasonably infer the Social Worker had any firm assurance a caregiver would start caring for R3 at home upon discharge, as planned. Bartley does not assert that the Social Worker or anyone else from Bartley took any further steps prior to discharging R3 to confirm that Care Focus had located a caregiver, much less to confirm that the services would start upon discharge. Instead, Bartley went ahead with the discharge rather than delaying the discharge to a time it could be assured that outside agency services would begin upon discharge, as planned.

Given the undisputed facts about what the Social Worker knew and the undisputed facts about R3's care needs due to his left-sided weakness and other conditions, we conclude that Bartley did not provide sufficient preparation and orientation to R3 to ensure his safe and orderly discharge from the facility.

The preparation and orientation that Bartley provided to R3 (and the plan to which he agreed in the morning) included the plan noted on October 20 by the Social Worker that home health aide services would start "upon discharge." Bartley proffered no evidence that R3 was notified, before he signed the statement saying that he agreed to the discharge plan, that the Social Worker had been unable to confirm that a caregiver would be at his home when he arrived or that, after signing, he had agreed to modify the plan. In our view, Bartley could reasonably have anticipated problems with his arrival home and the possibility that he would suffer unnecessary and avoidable anxiety or depression if no outside caregiver was present when he arrived home.

Bartley's reliance on its experts' testimony is misplaced. As discussed above, their testimony on the ultimate legal issues does not preclude summary judgment. Moreover, even assuming that the "discharge planning" for R3 met the practice standards for discharge planning for stroke victims to which the nurse expert referred, that would not create a genuine dispute material to our conclusion here, which is based on Bartley's failure to ensure that services would start upon discharge, as planned. That failure, under the circumstances here, constituted a failure to meet the federal requirement that the facility provide sufficient preparation and orientation to the resident to ensure a safe and orderly transfer.

In support of its position that its discharge plan provided for a safe and orderly discharge, Bartley also asserted that its staff reviewed the discharge plan with a state survey agency official in advance and that she "voiced no objection to the plan of discharge and, in fact, characterized it as 'safe'." P. Prehearing Br. at 18. While CMS's proffered testimony from the state officials arguably does not directly contradict Bartley's assertion, the officials do clearly state they did not "approve" the plan. CMS Exs. 47, 49. In any event,

Bartley presented no evidence that any state official was aware prior to the discharge that the Social Worker knew that Care Focus was having trouble locating a caregiver, and had only the representative's vague assurance he would "have someone," rather than confirmation that care would begin upon discharge, as planned.

Finally, Bartley's argument that the problems that occurred upon R3's arrival home were because the discharge plans were "sabotaged" by R3's daughter is not material to our decision here. P. Prehearing Br. at 9-10. Our analysis here does not rely on the daughter's conduct or allegations. Rather, we conclude that, having prepared R3 for a discharge with services from an outside caregiver to start upon discharge and knowing that Care Focus still had not located such a caregiver shortly before the planned time of discharge, Bartley's preparation and orientation of R3 was insufficient to "ensure a safe and orderly discharge," because Bartley did not take steps within its control to minimize any anxiety or depression that might be caused to R3 under the circumstances. Such steps could have included making further calls to confirm that a caregiver was in place before discharging him, informing him and obtaining his consent to modify the plan, or delaying the discharge if necessary.

3. Bartley's failure to comply with the federal requirements had the potential for more than minimal harm.

A facility is in substantial compliance with federal requirements if "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. Thus, noncompliance (and a basis for a CMP) exists if the deficiencies have the potential for causing more than minimal harm.[9]

Bartley proffered evidence about the steps its staff took to prevent harm to R3, after it learned the day after discharge that no outside caregiver had arrived, such as sending a nurse and aide to R3's home to care for him and then readmitting him to Bartley. *See, e.g.*, P. Exs. 1, 2. Bartley also proffered testimony from its experts opining that R3 suffered no actual harm from the discharge home and contesting the opinions of CMS's experts on the potential effects from the fact he did not receive medications he should have received the evening of the discharge or early the next morning (which Bartley argued was because the family did not timely fill his prescriptions, not because of its failures). P. Exs. 4, 5.

[9] Here, CMS determined that the level of noncompliance was "immediate jeopardy." The Board has held, however, that CMS's determination of the level of noncompliance is outside the scope of ALJ and Board review if CMS imposes only a per-instance CMP, unless there is a finding of substandard quality of care. *See, e.g., Oaks of Mid-City Nursing &Rehab Ctr.*, DAB No. 2375, at 23-24 (2011). While a finding of noncompliance with section 483.25 at the immediate jeopardy level would constitute substandard quality of care, we make no such finding. Bartley did not challenge on appeal the ALJ's decision not to reach the issue of whether the facility was in substantial compliance or his conclusion that he lacked authority to review the immediate jeopardy determination. ALJ Decision at 3.

The disputes about these issues are not material to our conclusions here, however. Even accepting Bartley's allegations as true, they do not obviate the potential for more than minimal harm from the deficiencies we found above, based on the undisputed facts. In particular, we base our determination of noncompliance as to section 483.20(l) on our finding that the deficiency with respect to the post discharge plan of care for R3's transfer with the Hoyer lift had the potential for more than minimal harm. Nothing in the testimony on which Bartley relied creates a genuine dispute regarding the potential for more than minimal harm to R3 if untrained persons attempted to transfer him using the lift, to which CMS's witnesses attested.

Bartley did point to evidence that it had sent R3 home with a prescription for training by the VNA nurse and that she had arrived the day after discharge and began training but then did not continue because it was determined that R3 would return to Bartley. CMS Ex. 20, at 9; CMS Ex. 29, at 12. The relevant prescription, however, states only "VNA for diabetic teaching." CMS Ex. 20, at 9. No mention is made of any other care training. Thus, even accepting Bartley's assertion that the VNA nurse would have provided the ordered training the day after discharge (rather than just doing an evaluation, as CMS alleged), that training would not have addressed the risk from potential misuse of the Hoyer lift.

With respect to Bartley's deficiencies in meeting the requirements of section 483.12(a)(7), Bartley's experts pointed to evidence that R3 was in "no distress" when he left the facility. CMS Ex. 27, at 1. Bartley also pointed out that R3 was going home, and cited evidence that he had said that he wanted to go home, and that he was alert and oriented and capable of making his own decisions. P. Prehearing Br. at 9. For purposes of summary judgment, we assume that R3 was going home per his own choice and left the facility in no distress. Having chosen to go home, he might be less anxious about the discharge than if he were being transferred to an environment with which he was unfamiliar or to which he did not want to go. The absence of signs of distress when R3 left the facility is irrelevant, however, since Bartley proffered no evidence that he knew upon departure that the facility had not confirmed that the caregiver services would begin upon discharge as planned. The issue is whether there was a **potential** for more than minimal harm from Bartley's failure to take steps within its control to address a situation in which it had prepared the resident for discharge home with home health services to begin upon discharge but had no adequate assurance the services would begin as planned, We conclude that there was a potential for more than minimal harm to R3's mental health from the facility's discharge of him home without either confirming that care would begin upon discharge, as planned, or at least informing R3 that things might not go as planned, especially in light of the undisputed facts showing that he was discharged in the late afternoon, the family had no more than a few days' notice that he would be coming home that day, and the instructions sent home with him were deficient.

4. The amount of the CMP is reasonable

The amount of the CMP here is $6,200. Under the regulations, the range of per-instance CMPs is $1,000-$10,000 per instance of noncompliance.

The reasonableness of the amount of a CMP must be evaluated using the factors specified in section 488.438. *See* 42 C.F.R. § 488.438(e), (f); *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 19-20 (2010), *aff'd, Senior Rehab. & Skilled Nursing Ctr. v. Health & Human Servs.*, 405 F. App'x 820 (5th Cir. 2010); *Lakeridge Villa Healthcare Ctr.*, DAB No. 2396, at 14 (2011). Those factors are: (1) the severity and scope of the noncompliance, and "the relationship of the one deficiency to other deficiencies resulting in noncompliance"; (2) the SNF's degree of culpability for the noncompliance; (3) the SNF's "history of noncompliance, including repeated deficiencies"; and (4) the SNF's financial condition – that is, its ability to pay a CMP. 42 C.F.R. §§ 488.438(f), 488.404(b), (c)(1). "Culpability" includes, but is not limited to, "neglect, indifference, or disregard for resident care, comfort or safety." 42 C.F.R. § 488.438(f)(4).

We note at the outset that Bartley's request for review contains no direct challenge to the reasonableness of the amount of the CMP. We nonetheless address that issue because Bartley did identify disputed facts that arguably could affect application of the relevant factors and because we grant summary judgment on grounds more narrow than those on which the ALJ relied.

We conclude that the amount of the CMP here is reasonable, based on the regulatory factors and the undisputed facts discussed above. Those facts show that Bartley was not in substantial compliance with two interrelated requirements and was deficient with respect to the post discharge plan of care requirement in several respects. Although only one resident was involved, the undisputed facts show that, as a post discharge plan of care for R3, Bartley did little more than printing out physician orders from his EMR that had been entered on October 12. Bartley's staff allegedly reviewed the printout, but that review either was so cursory it did not disclose the flaws on the printout or the reviewers disregarded the flaws. Those flaws included the lack of necessary information about the Hoyer lift, the incorrect dosage of Lantus, use of terminology that would not be understandable to a layperson, lack of identification of who would provide what care, and schedules that were not consistent with the discharge plan, as modified. Although Bartley's Social Worker knew that Care Focus had not yet located a caregiver shortly before the scheduled time of discharge, Bartley did not take steps within its control to address this situation. At the very least, these circumstances show some indifference to R3's care and safety. As the ALJ pointed out, moreover, Bartley did not allege that either its compliance history or its financial status would provide a basis for reducing the CMP amount.

Conclusion

For the reasons stated above, we grant summary judgment to CMS and uphold the imposition of a per-instance CMP of $6,200.

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan

/s/
Judith A. Ballard
Presiding Board Member