Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Heartland Health Care Center – Kendall,
(CCN: 10-5641),

Petitioner

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-62

Decision No. CR4704

Date: September 15, 2016

DECISION

Petitioner, Heartland Healthcare Center – Kendall (Petitioner or "the facility"), is a skilled nursing facility that participates in the Medicare program. Based on a complaint investigation survey that was completed on July 22, 2015, the Centers for Medicare & Medicaid Services (CMS) determined that Petitioner was not in substantial compliance with Medicare participation requirements. CMS imposed against Petitioner a civil money penalty (CMP) of $250 per day, effective June 17, 2015, through August 21, 2015, for a total CMP of $16,500.

Petitioner contests two deficiencies cited at the scope and severity level "G," which indicates an isolated instance of noncompliance that involves actual harm that does not amount to immediate jeopardy to resident health or safety.

For the reasons set forth below, I sustain CMS's citation of two deficiencies relating to the care of Resident # 3 that involved the facility's failure to revise her care plan in a timely manner with appropriate interventions and the facility's failure to provide the necessary care and services to maintain her physical well-being following her two falls in

the facility in June 2015. However, with respect to a cited deficiency involving Resident # 2, who was struck by a vehicle on a facility roadway while being pushed in a wheelchair by a family member, I conclude that Petitioner did not fail to take reasonable measures as cited in the deficiency because the resident's accident was not foreseeable.

I find the penalty imposed, a $16,500 CMP, is reasonable.

I. Background

The Social Security Act (Act) sets requirements for skilled nursing facility (SNF) participation in the Medicare program. The Act authorizes the Secretary of the United States Department of Health & Human Services (Secretary) to promulgate regulations implementing those statutory provisions. Act § 1819 (42 U.S.C. § 1395i-3). The Secretary's regulations are found at 42 C.F.R. part 483.

A facility must maintain substantial compliance with program requirements in order to participate in the program. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301. When a deficiency is found, CMS has the burden of coming forward with evidence and making a prima facie showing of a basis for imposition of an enforcement remedy. The facility bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.,* DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson,*129 F. App'x 181 (6th Cir. 2005); *Emerald Oaks,* DAB No. 1800 (2001); *Cross Creek Health Care Ctr.,* DAB No. 1665 (1998).

The Secretary contracts with state agencies to conduct periodic surveys to determine whether SNFs are in substantial compliance with the participation requirements. Act § 1864(a) (42 U.S.C. § 1395aa(a)); 42 C.F.R. §§ 488.10, 488.20. The Act and its implementing regulations require that facilities be surveyed on average every twelve months, and more often if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A) (42 U.S.C. § 1395i-3(g)(2)(A)); 42 C.F.R. §§ 488.20(a), 488.308. A survey agency is required to review all complaint allegations and conduct a standard or abbreviated standard survey to investigate complaints of violations of requirements if the stage agency concludes that a deficiency in one or more requirements may have occurred or only a survey can determine whether a deficiency or deficiencies exist. 42 C.F.R. § 488.308(e).

If a facility is not in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies listed in 42 C.F.R.

§ 488.406, including a CMP. As relevant here, CMS may impose a per-day remedy for the number of days that a facility is not in substantial compliance with one or more program requirements. 42 C.F.R. § 488.430(a).

Petitioner is an SNF that operates in Kendall, Florida. A surveyor from the Agency for Health Care Administration for the State of Florida (state agency), K. Valdes, R.N., completed a complaint survey of Petitioner on July 22, 2015. CMS Exhibit (CMS Ex.) 1. In an August 26, 2015 letter, CMS notified Petitioner of three deficiencies at the "G" scope and severity level and imposed a per-day CMP. CMS Ex. 3. In a subsequent letter in October 2015, CMS notified Petitioner that based on its review after receiving the state agency's informal dispute resolution decision, it had upheld two of the three deficiencies and reduced the remedy imposed to a $250 per-day CMP. CMS Ex. 4. Specifically, CMS determined that the facility was not in substantial compliance with the participation requirements relating to revision of care plans (Tag F280, 42 C.F.R. §§ 483.10(d)(3), 483.20(k)(2)) and maintaining a facility free of accident hazards (Tag F323, 42 C.F.R. § 483.25(h)).[1] CMS determined that the noncompliance for both deficiencies constituted a potential for more than minimal harm with actual harm to resident health and safety from June 17 through August 21, 2015. CMS imposed a CMP in the amount of $250 per day effective June 17 through August 21, 2015. CMS Exs. 4, 5.

On October 26, 2015, Petitioner requested a hearing. On November 6, 2015, Administrative Law Judge (ALJ) Joseph Grow issued an acknowledgment and pre-hearing order (Order) establishing a briefing schedule. In accordance with the schedule, CMS and Petitioner filed pre-hearing exchanges, including pre-hearing briefs (CMS Br. and P. Br., respectively), exhibit and witness lists, proposed exhibits, and written direct testimony.[2]

CMS submitted CMS Exs. 1 to 36, and Petitioner submitted Petitioner Exhibits (P. Exs.) 1 to 34. CMS submitted written objections to 13 of Petitioner's proposed exhibits, and Petitioner submitted arguments in response. In opposition, Petitioner states, in pertinent part, that CMS "is raising technical, even frivolous, objections to unremarkable evidence."

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[1] The revised statement of deficiencies, Form CMS-2567, erroneously lists the applicable regulations for Tag F280 as 42 C.F.R. § 483.20(d)(3) and 42 C.F.R. § 483.10(k)(2). CMS Ex. 2 at 6. The applicable regulations are 42 C.F.R. § 483.10(d)(3) and 42 C.F.R. § 483.20(k)(2). CMS Ex. 2 at 6 (revised). Petitioner has not argued that it is prejudiced by this error.

[2] The case was reassigned to me on April 1, 2016.

Judge Grow instructed in his Order that "Petitioner is directed NOT to file as proposed exhibits any documents that CMS has already filed among its proposed exhibits." He likely did so with the intent of reducing the administrative burden associated with reviewing duplicate exhibits. A number of CMS's objections are imprecise, and at times incorrect, and the effect of these objections has undoubtedly yielded a result contrary to the intent of Judge Grow's Order that presumably sought administrative efficiency.

CMS contends that P. Exs. 17 and 28 (at pages 2-6) are duplicative of CMS Exs. 21 and 19 (at pages 20, 24-26, and 29), respectively. I agree that these documents are, on their face, duplicative, and I will not admit P. Exs. 17 and 28 (at pages 2-6). Furthermore, CMS contends that P. Ex. 2 should not be admitted into evidence because it is not reliable. It is unnecessary to address the reliability of this evidence. Rather, I observe that Petitioner did not cite to P. Ex. 2 in its brief, and therefore, I will not admit P. Ex. 2 because it has not been submitted as evidence or authority in support of Petitioner's arguments, and the document will not be needed for the purpose of cross-examination of any witness.

I overrule the remainder of CMS's objections. CMS mistakenly argues that P. Ex. 4 is duplicative of CMS Ex. 20; much of the content of P. Ex. 4 is documentation related to "Creating and Maintaining Care Plans," whereas CMS Ex. 20 consists of the facility's *Falls Practice Guide.* I therefore admit P. Ex. 4. While CMS argues that P. Exs. 5 and 6 are duplicative of CMS Exs. 24 and 25, respectively, I observe that the documents submitted by Petitioner are more recent versions of CMS's submissions, reference more numerous sources, and contain substantive differences in content. Specifically, the article submitted by CMS as CMS Ex. 24 was last updated on December 8, 2010, and contains 16 references, whereas the version submitted by Petitioner was updated on September 20, 2013, and contains 19 references. Likewise, the document CMS submitted as CMS Ex. 25 contains 18 references and was last updated on January 19, 2009, while Petitioner's version of the same article is dated February 29, 2012, and contains 27 references. Petitioner's submission of updated articles is not duplicative of CMS's submissions, and I will therefore admit P. Exs. 5 and 6.

CMS Ex. 18 is a 124-page document that contains Resident # 3's treatment records. CMS objects to Petitioner's submission of six exhibits, totaling approximately 39 pages, that it claims are duplicative of documents included in CMS Ex. 18. CMS alleges that page 1 of P. Ex. 19 is a duplicate of page 1 of CMS Ex. 18. While I agree that the content is largely duplicative, the record in question is simply an admission report and the documents bear different printing dates. CMS argues that P. Ex. 21, pages 10-11, is a duplicate of CMS Ex. 18, pages 35-36. However, I observe that the signature, while appearing to be that of the same individual, is clearly unique on both documents, and in light of the other objections raised by CMS, I find it unnecessary to undertake a line-by-line comparative analysis of the two documents in order to ascertain whether the difference in the two documents is limited to only the apparent difference in the

signatures. CMS vaguely objects to P. Exs. 22 and 23, contending that these submissions are duplicative of pages 37-41 of CMS Ex. 18. I point out that P. Ex. 22 is three pages long, and P. Ex. 23 is 18 pages long; CMS fails to point out the specific and corresponding pages in Petitioner's exhibits that it alleges are duplicative of pages 37-41 of CMS Ex. 18. CMS further asserts that P. Ex. 24 is duplicative of CMS Ex. 18, pages 5-18, yet I readily determined that one page of P. Ex. 24 (page 9) is not included in pages 5-18 of CMS Ex. 18 and the documents contained in each exhibit are not exact duplicates. And finally, while CMS states that P. Ex. 25 is duplicative of CMS Ex. 18 at page 4, I observe that P. Ex. 25 is six pages in length; CMS failed to explain which specific page it finds is duplicative of page 4 of CMS Ex. 18. CMS's objections to the preceding exhibits are therefore overruled.

Based on the discussion above, I admit CMS Exs. 1-36 and P. Exs. 1, 3-16, 18-27, 28 (page 1), and 29-34 into the record.

Judge Grow's Order explained that a hearing to cross-examine witnesses would be necessary "only if a party files admissible, written direct testimony, and the opposing party asks to cross-examine." Order § 10 (emphasis omitted). Neither party has requested the opportunity to cross-examine any witnesses at a live hearing. This matter is therefore ready for a decision on the merits. Order § 13.

II. Issues

The following issues will be addressed in this decision:

1) Whether Petitioner was in substantial compliance with 42 C.F.R. §§ 483.20(k)(2) and 483.25(h).[3]

2) Whether CMS's imposition of a CMP is reasonable from June 17 through August 21, 2015.

III. Findings of Fact and Conclusions of Law[4]

A. Factual Background

Resident # 2

[3] I need not address whether Petitioner was in substantial compliance with 42 C.F.R. § 483.10(d)(3) in assessing whether the deficiency cited as Tag F280 should be sustained.

[4] My findings of fact and conclusions of law are in italics and bold font.

Resident # 2 was admitted to the facility on July 13, 2015. P. Ex. 14. On July 17, 2015, Resident # 2's son, T.R., visited her at the facility at approximately 6:30 pm and told a nurse that he planned to take Resident # 2 downstairs for "fresh air." P. Ex. 16 at 6. A certified nursing assistant and T.R. transferred Resident # 2 to a wheelchair, and Resident # 2 "was happy and agreed to go downstairs." P. Ex. 16 at 6. T.R. proceeded to push his mother in a wheelchair outside of the facility, and he stated that he had taken his mother around the building five times. P. Ex. 16 at 6; *see* P. Ex. 16 at 14 (stating that T.R. "advised he had gotten around the building about 5 times and never expected [the accident] to happen."). At 8:31 pm, a kitchen employee, A.M., "clocked out" and departed the facility by his vehicle. P. Ex. 16 at 6. At approximately 8:35 pm, Resident # 2 "was traveling on a wheel chair [eastbound] on a private roadway (9400 SW 137 AVE)" when A.M., while driving his vehicle, struck Resident # 2. CMS Ex. 21 at 3, 5. A State of Florida Traffic Crash Long Form report (police report) documents that A.M. operated a motor vehicle in a careless or negligent manner, but the available evidence does not show that a citation was issued to any person involved in the accident. CMS Ex. 21 at 3. The police report documents that Resident # 2 had been "Walking/Cycling Along Roadway Against Traffic (in or adjacent to travel lane)" at the time of the accident. CMS Ex. 21 at 4. The police report indicates that at the time of the accident, the light condition was "[d]ark [l]ighted." CMS Ex. 21 at 1. A.M. reported, through an interpreter, that he was traveling at 5 miles per hour at the time of the accident. P. Ex. 16 at 9. A.M. further stated that T.R. and Resident # 2 "were dressed in black," each had a dark complexion, and that he "didn't see anyone." P. Ex. 16 at 9. The police report documents that the vehicle had an estimated $1,000 of "[m]inor damage," [5] and the estimated speed at the time of the collision was 15 miles per hour with a posted speed of 10 miles per hour.[6] CMS Ex. 21 at 2.

Emergency Medical Services personnel responded to the accident and transported Resident # 2 to a hospital. CMS Ex. 21 at 5. The following day, on July 18, 2015, T.R. reported to the facility's Administrator that Resident # 2 was "doing very well," but that she had back pain and a bump on her head. P. Ex. 16 at 14. On July 19, 2015, T.R. reported to the Administrator that he expected that she would return to the facility in another day or two, but that she was awaiting a repeat CT scan. P. Ex. 16 at 14.

CMS submitted color "street view" photographs of various locations on the grounds of the facility. CMS Ex. 23. Handwritten and typed notations on the photographs indicate that, at one particular location, a 5 miles per hour speed limit sign is visible from one

[5] A.M. alleged that T.R. deliberately broke a window on his vehicle following the accident. P. Ex. 16 at 9. It is unclear if the damage estimate in the police report encompasses the damage that is allegedly unrelated to the collision with Resident # 2.

[6] The posted speed limit documented in the police report is inconsistent with the photograph of the speed limit signage submitted by CMS. *See* CMS Ex. 23 at 16.

direction. CMS Ex. 23 at 15, 16. Several images show a patio in the front of the building (CMS Ex. 23 at 27, 28, 30), and numerous photographs show there are sidewalks on the grounds. CMS Ex. 23 at 2, 5, 24-39. Photographs (which contain annotations) show that a roadway without a sidewalk is adjacent to a number of parking spaces in the approximate area of the accident. CMS Ex. 23 at 7-21.

Resident # 3

Resident # 3, an 85-year-old woman, was admitted to the facility on June 3, 2015. CMS Ex. 18 at 1, 15. Progress notes document that her admitting diagnoses included head injury, dementia, hypertension, and a "history of falls," and state that she "is mobility impaired, cognitively impaired, and bowel/bladder incontinent." CMS Ex. 18 at 15. Immediately prior to Resident # 3's transfer and admission to the facility, she had received inpatient treatment at Kendall Regional Medical Center, with an admission date of May 31, 2015. P. Ex. 20 at 1. At the time of her admission to Kendall Regional Medical Center, she "was found wandering in the streets in her neighborhood by police" and "[s]he apparently had a mechanical fall with some facial injury at some point, but does not remember the event at all." P. Ex. 20 at 1. A CT scan of the resident's brain was abnormal with possible intracerebral hemorrhage. P. Ex. 20 at 2.

Two days following her admission, on June 5, 2015, Resident # 3 sustained a fall on her right hip. CMS Ex. 18 at 2. An incident report documents that Resident # 3's care plan was "initiated/revised" and that a "wedge cushion [was] provided." CMS Ex. 18 at 43. The incident report documents that Resident # 3 had difficulty maintaining a standing position, impaired balance during transitions, and a gait problem. CMS Ex. 18 at 42; P. Ex. 25 at 2. The narrative portion of the investigation report documented that Resident # 3 "is a disoriented patient who was on her [wheelchair] quiet and comfortable and stand up all of the sudden and fel[l] to floor." CMS Ex. 18 at 4; P. Ex. 25 at 1. The report further stated that "[s]he was unable to be reach[ed] by personnel around her" and that "no injury result[ed] from [the] incident." CMS Ex. 18 at 4; P. Ex. 25 at 1. The incident report does not document the reason why Resident # 3 stood up from her wheelchair prior to her fall. CMS Ex. 18 at 4; P. Ex. 25 at 1. Resident # 3's care plan that was implemented on June 4, 2015, reported that she was "[a]t risk for further falls due to unsteady gait, history of falls, possible side effects of medication," and interventions included a low bed and "provide assist to transfer and ambulate as needed." CMS Ex. 18 at 37. Following Resident # 3's fall on June 5, 2015, an intervention was added for a "wedge cushion," although the care plan does not indicate how the wedge cushion should be used.[7] CMS Ex. 18 at 37.

[7] While the investigation report documents that a wedge cushion should be used to prevent further falls from the wheelchair (CMS Ex. 18 at 4; P. Ex. 25 at 1), such detail regarding the wedge cushion is not included in the care plan.

Following Resident # 3's fall on June 5, 2015, which was the second fall in the period of one week (with the first fall resulting in the aforementioned admission to Kendall Regional Medical Center with a diagnosed head injury), facility staff clinically evaluated Resident # 3 for purposes of the Minimum Data Set (MDS) on June 10, 2015. CMS Ex. 18 at 46-90. The assessment determined that Resident # 3 required "extensive assistance" with such activities as bed mobility, transfers, walking and locomotion, eating, toilet use, and personal hygiene, and that a one-person physical assist would be necessary for those tasks. CMS Ex. 18 at 60. Regarding balance during transitions and walking, Resident # 3 was assessed as being "[n]ot steady, only able to stabilize with staff assistance" when moving from a seated to a standing position and walking, and that she normally used a walker and a wheelchair. CMS Ex. 18 at 61 (emphasis in original). Resident # 3 reported that she is not capable of increased independence in at least some ADLs, and direct care staff agreed with the resident's self-assessment. CMS Ex. 18 at 61. The active diagnoses listed on the June 10, 2015 MDS include: hypertension; aphasia; Non-Alzheimer's dementia; head injury, not otherwise specified; dysphagia, oral phase; difficulty in walking; muscle weakness; and history of fall. CMS Ex. 18 at 63-64. Registered nurse J. Maud, who is identified as an "RN assessment coordinator," verified completion of the MDS on June 16, 2015. CMS Ex. 18 at 87.

Progress notes from June 17, 2015, document that Resident # 3 was "in activities" at 7:45 pm when she was observed to be standing with an unsteady gait and "los[t] balance and fell to floor on right side of body." CMS Ex. 18 at 11. An incident report indicated that "[patient] [was] observed standing, los[t] balance and fell to right side of body" in the dining room. CMS Ex. 18 at 3. An Adverse Incident Report submitted to the state agency states that "[p]atient got up quickly from her wheelchair and started to walk. Nurse advised patient not to get up but before nurse could get to patient, the patient fell to the floor on her right side." P. Ex. 27 at 2. Treatment records and the investigation report do not indicate the reason why Resident # 3 stood up from her wheelchair or continued to stand up before the nurse could assist her. CMS Ex. 18 at 3, 11. The facility's investigative report sent to the state agency documented that the "[p]atient had been given dinner, toileted and then placed comfortably in her wheelchair with wedge cushion intervention in place. Every attempt was put in place to minimize the risk of fall for patient. Care plan updated with psychiatric evaluation to improve anxious behaviors." P. Ex. 27 at 2. A CT scan of Resident # 3's abdomen and pelvis obtained on June 17, 2015, indicated that she sustained a "[h]ighly comminuted fracture involving the proximal left femur including the femoral neck." P. Ex. 28 at 3. X-ray imaging of the hip revealed an "oblique intertrochanteric fracture of the proximal right femur with distraction of the lesser trochanter fragment." P. Ex. 28 at 6. Progress notes document that Resident # 3 returned to the facility on June 20, 2015, following surgery to repair her hip fracture. CMS Ex. 18 at 11. Upon Resident # 3's return to the facility on June 20, 2015, the only intervention added to Resident # 3's care plan with respect to prevention of falls was a "[p]sychiatric evaluation." P. Ex. 30 at 19; *see* P. Ex. 27 at 2 ("care plan updated with psychiatric evaluation to improve anxious behaviors"); CMS Ex. 18 at 33-

34 (June 23, 2015 psychiatric evaluation reporting, in relevant part, that Resident # 3 will continue taking Seroquel as prescribed). No other interventions with respect to fall prevention were added prior to August 2015. P. Ex. 30 at 18-19.

B. Petitioner was not in substantial compliance with 42 C.F.R. §§ 483.20(k)(2) and 483.25(h) when it failed to add any meaningful interventions to Resident # 3's care plan to minimize the risk for further falls after she experienced her third fall in the span of less than three weeks.

The Medicare participation requirement set forth at 42 C.F.R. § 483.20(k)(1) provides:

> *Comprehensive care plans.* (1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following---
>
> (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under § 483.25.

Additionally, a care plan must be:

> (i) Developed within 7 days after completion of the comprehensive assessment;
> (ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and
> (iii) Periodically reviewed and revised by a team of qualified persons after each assessment.

42 C.F.R. § 483.20(k)(2). While the regulation requires that a care plan be implemented within 7 days of completion of the comprehensive assessment, the facility stated that it implements an interim care plan upon admission, and it explained that such a plan "is edited and amended on an ongoing basis as the physician gives additional orders and we learn more about the resident and her condition, needs, and preferences." P. Ex. 33 at 2.

The facility's guidance to employees regarding fall prevention is set forth in its *Falls Practice Guide.* CMS Ex. 20. In its brief, Petitioner acknowledges that when its interdisciplinary care planning team reviews a care plan and considers interventions, it uses the *Falls Practice Guide*. P. Br. at 15-16. With respect to the initial plan of care,

the *Falls Practice Guide* suggests a number of strategies, which include the following strategies that were not listed on Resident # 3's care plan in furtherance of the goal of minimizing the risk for injury from falls (these were not listed at any time from her admission through her return to the facility following hip repair surgery): use of appropriate footwear; use of hip protector products, as clinically indicated; review of ordered medications for potential fall risk side effects; provision of assistive devices, as clinically indicated (may include a walker); and referral to physical and occupational therapy. CMS Ex. 20 at 6. In addressing comprehensive care plans, the *Falls Practice Guide* suggests potential ongoing interventions that may include:

- exercise and activity programs
- patient education regarding safe transfers, ambulation and assistive device use
- structured programs for those patients who wander
- restraint reduction, if applicable
- rehabilitation programs
- toileting programs
- environmental modification
- medication regimen review
- vision interventions/treatment
- orthostatic hypotension evaluation and management
- restorative nursing programs

CMS Ex. 20 at 8. Pertaining to ongoing management strategies, the *Falls Practice Guide* instructs:

> The center may designate members from the interdisciplinary team to participate in post-fall patient evaluation activities. The interdisciplinary team members may include a physical therapist, occupational therapist, licensed nurse, nurse practitioner or nursing assistant. It is recommended that a member of the interdisciplinary team conduct a bedside evaluation after a fall occurs or per a center identified schedule with findings documented in the clinical record. The bedside evaluation may include, but is not limited to the following:
>
> - review of the circumstances surrounding a patient's fall
> - evaluation of the patient's room and other areas to identify environmental risk factors
> - interview of the patient or others witnessing the fall, if possible

- identification of any changes in patient's risk factors, condition, and functional status
- review of the patient's current plan of care
- revision of the care plan to address the patient's current risk factors and needs

CMS Ex. 20 at 9. The *Falls Practice Guide* further directs that the "*care plan is revised as clinically indicated to meet the patient's current needs*" following a fall. CMS Ex. 20 at 12 (emphasis added).

Resident # 3 had three falls in the span of less than three weeks, with two of those falls resulting in significant injury, specifically, a head injury with possible intracerebral hemorrhage immediately prior to her admission to the facility and a highly comminuted fractured hip resulting from her second fall at the facility. Petitioner identified Resident # 3 as being at risk of fall upon her admission to the facility on June 3, 2015. P. Ex. 32 at 4 (Director of Nursing, A. Cadenhead, R.N., testified that initial assessments noted that Resident # 3 was "confused, demented, had suffered a head injury, and was at risk for falls due to muscle weakness, unsteady gait, a history of falls, incontinence, use of psychoactive medications, and other underlying conditions.").

The facility's *Falls Practice Guide* clearly addresses the role of the interdisciplinary care team in care planning: An interdisciplinary team "designs the patient's care plan to focus on all of the patient's issues including those associated with fall prevention and fall risk management." CMS Ex. 20 at 8. Furthermore, as stated by the facility's *Falls Practice Guide*: "Regardless of the interventions that are put in place, a key factor to success is the timely review of the interventions as the patient's condition and needs change." CMS Ex. 20 at 8. And importantly, the *Falls Practice Guide* directs that following a fall, "[t]he interdisciplinary care plan team reviews the patient's most current *Falls CAA* [Care Area Assessment] or fall evaluation . . . to determine if the patient's present condition or status has changed and therefore requires the completion of a new fall evaluation." CMS Ex. 20 at 12; *see, e.g.,* 42 C.F.R. § 483.20(k)(2)(iii) (noting periodic review of care plan by interdisciplinary team).

The Director of Nursing, in her testimony, stated that "I agree that the interdisciplinary team must *reevaluate* a resident's care plan after any fall (and any other significant event), but it does not necessarily follow that the care planning team must *change* the care plan after every fall. P. Ex. 32 at 7 (emphasis in original). However, the Director of Nursing, in explaining in her testimony that Resident # 3's falls care plan was timely reviewed after the June 5 fall and interventions were added, discussed that a *lone* individual, Y. Morales, R.N., reviewed the care plan and added the intervention of a wedge cushion. P. Ex. 32 at 8; *see* CMS Ex. 18 at 43 (falls report signed by Y. Morales, R.N., noting care plan initiated/revised with "wedge cushion provided" on June 5, 2015); CMS Ex. 18 at 37 (addition of care plan intervention of "wedge cushion" by Y. Morales,

R.N. on June 5, 2015); CMS Ex. 18 at 4 (investigation report signed by Y. Morales, R.N., noting "care plan initiated, patient place on wedge cushion to avoid further falls from [wheelchair]").

Similarly, there is no evidence that an interdisciplinary care team reviewed and revised Resident # 3's care plan following her fall that resulted in a hip fracture on June 17, 2015. Following Resident # 3's second fall at the facility on June 17, 2015, N. Wolfe, R.N., added "[p]sychiatric evaluation" to Resident # 3's care plan (P. Ex. 30 at 19), yet there is no evidence, such as witness testimony, physician orders, therapist assessments, progress notes, or documentation, of any meetings with Resident # 3 and/or her family members, of any action by an interdisciplinary team, or that the order for a psychiatric evaluation was the product of an interdisciplinary review following Resident # 3's significant injury. Even though this resident experienced her third fall in less than three weeks and sustained a very significant injury, no additional interventions were added to prevent the risk of injury from falls other than a psychiatric consultation, which determined that "[p]atient will continue taking the Seroquel as prescribed, to the patient for symptoms of akathisia and dystonia."[8] CMS Ex. 18 at 33-36. Furthermore, there is simply no contemporaneous evidence that Resident # 3's repeated falls were *due to* a psychiatric impairment or medications prescribed therefor.[9] *See* CMS Ex. 18 at 34 (June 23, 2015 psychiatric

[8] With respect to this psychiatric evaluation, the Director of Nursing testified that "[the psychiatrist] was continuing to evaluate [Resident # 3's] use of psychoactive medications . . . to determine whether they could be contributing to possible agitation and balance issues." P. Ex. 32 at 9. The Director of Nursing further testified that the psychiatrist did order some adjustments to Resident # 3's meds, including a trial course of Xanax. P. Ex. 32 at 9. However, the reports of both psychiatric evaluations in June 2015 do not reference any prescriptions for Xanax. CMS Ex. 18 at 33-36.

[9] Although the June 6, 2015 psychiatric evaluation report states Resident # 3 was reported to have agitation, and the June 17, 2015 fall report references "agitation" and "anxiety disorder" as relevant "[d]isease and [c]onditions," there is no indication in progress notes or investigative reports that "agitation" or other mental symptomatology was the cause of her falls. CMS Ex. 18 at 35, 44. In fact, the June 17, 2015 fall report documents a number of other relevant physical performance limitations, diseases and conditions, and laboratory tests, including difficulty maintaining standing position, impaired balance during transition, gait problems, medication usage, incontinence, Alzheimer's disease, and dehydration. CMS Ex. 18 at 44-45. Further, I note that it appears that, prior to Resident # 3's admission to the facility in June 2015, she was living at home. It is simply quite possible that Resident # 3 was not accustomed to being seated in a wheelchair and did not understand that she should seek assistance prior to standing from her wheelchair and attempting to walk. Additionally, the MDS indicates that she "normally used" *both* a wheelchair and a walker, indicating that she may have been accustomed to standing and ambulating with a walker prior to her admission to the

evaluation stating that Resident # 3 will continue taking the lowest dose of psychotropic medication). In fact, the investigative and incident reports and witness statements simply report that both falls were the result of Resident # 3 attempting to stand up from her wheelchair and walk, and they do not provide a reason *why* Petitioner is believed to have stood up from her wheelchair. I consider the lack of meaningful interventions, or any record of interdisciplinary review of Resident # 3's care plan preceding the addition of the care plan intervention for a psychiatric evaluation, to be significant in light of the facility's policies set forth in its *Falls Practice Guide* and Medicare requirements. In fact, the *Falls Practice Guide* states that risk factor management interventions include the following: therapies for balance, gait, strength training, pain, cognition, low vision, chair/bed positioning, spasticity management, incontinence management; exercise and activity programs; patient education regarding safe transfers, ambulation and assistive device use; and structured programs for those patients who wander. CMS Ex. 20 at 8-9. Likewise, other interventions, including additional supervision, could have been considered by an interdisciplinary care team immediately following either fall at the facility. While the facility's Director of Nursing testified that "I believe we did all we could do to keep this Resident from falling" (P. Ex. 32 at 10), I disagree that the facility took the requisite measures to update Resident # 3's care plan to prevent foreseeable risks of harm from accidents. Although Petitioner's witness, M. Jean, R.N., who is the MDS Coordinator, testified that "[e]very day, the clinical team has a meeting . . . to discuss falls, accidents, and other incidents and clinical issues that may require reassessment of care plans [and] [the] meeting is attended by the Director of Nursing, Assistant Director of Nursing, Unit Managers, and most department heads" (P. Ex. 33 at 2-3), there is no evidence that such a meeting occurred to address Resident # 3's care plan interventions in the immediate aftermath of either of her falls. In fact, Resident # 3's care plan was revised only minutes following her fall on June 5, 2015. Likewise, there is no indication that Resident # 3, her family, or her doctors were consulted prior to the addition of either intervention that was added to her care plan following her falls. While the facility believes that it did everything possible to prevent Resident # 3's falls, it did not do so, and the result was that Resident #3 sustained a significant fracture on June 17, 2015, and remained at risk for further falls until the facility achieved substantial compliance on August 21, 2015.

While there is no evidence documenting that an interdisciplinary care *team* reviewed Resident #3's care plan following either of her falls on June 5 or June 17, the evidence

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facility. CMS Ex. 18 at 61; *see Facility Falls Guide,* CMS Ex. 20 at 4 (stating "[t]he risk for patient falls is potentially greater upon admission and within the first few days post-admission to a long-term care center compared to other similar environments"). There is no evidence that she was provided with a walker to use if she stood up from her wheelchair, even though the MDS reported that she normally used a walker. CMS Ex. 18 at 61; *see* 42 C.F.R. § 483.25(h)(2) (facility must ensure that each resident receives assistive devices to prevent accidents).

strongly suggests that such an interdisciplinary review did *not* occur. For instance, there are no physician's orders documenting that the physician was consulted regarding care plan interventions. Further, even though Resident # 3 fell at approximately 3:35 p.m. on June 5, her care plan was updated a mere 11 minutes later on that same day with a single new intervention added, a wedge cushion. CMS Ex. 18 at 42-43 (noting the time of fall of 3:35 p.m. and the time of the care plan revision as 3:46 p.m.). It appears that Nurse Wolfe was the sole individual responsible for updating Resident # 3's care plan following Resident # 3's fall on June 17, 2015, and there is no documentation supporting that anyone else was consulted. While Petitioner's MDS Coordinator, M. Jean, explained that the facility holds a daily interdisciplinary meeting called an "Eagle Room" meeting "to discuss falls, accidents, and other incidents that may require reassessment of care plans," the facility has presented no evidence or testimony indicating that such an "Eagle Room" meeting addressed Resident # 3's care plan following either of her falls in June 2015. P. Ex. 33 at 2-3. Thus, the evidence supports that a single individual, a registered nurse, updated Resident # 3's care plan on both June 5 and 17, 2015, in contravention of the facility's *Falls Practice Guide*, Medicare regulations, and the facility's own witnesses' testimony.

C. Petitioner was in substantial compliance with 42 C.F.R. § 483.25(h) at the time Resident # 2 and her son were involved as pedestrians in a motor vehicle accident in the facility's roadway.

While I have sustained CMS's determination that the facility was not in substantial compliance with 42 C.F.R. §§ 483.20(k) and 483.25(h) with respect to the care of Resident # 3, I will nonetheless briefly address the parties' arguments regarding the care of Resident # 2. Pursuant to 42 C.F.R. § 483.25(h), a resident environment must "[remain] as free of accident hazards as is possible" and the facility must ensure "[e]ach resident receives adequate supervision . . . ." CMS's discussion of the accident involving Resident # 2 in the argument portion of its brief is limited, in that it contends:

> [Petitioner] knew that residents and visitors regularly walked around the building using the sides and back of the parking lot/private road. . . . But [Petitioner] failed to take all reasonable and adequate steps to limit residents' access to the back and side areas of its parking lot/private road or to make these areas safe for pedestrians. . . . As a result, Resident 2 was struck by a vehicle in the parking lot/private road, suffered serious injuries,[10] and was hospitalized.

[10] The only apparent support for CMS's assertion that Resident # 2 sustained "serious injuries" is its reference to the survey notes. *See* CMS Ex. 8 at 4 (reporting a hematoma to the right side of the head); CMS Ex. 11 at 6 (reporting that Resident # 2 was alert and oriented following the accident and had a hematoma to the right side of the head, a small

CMS Br. at 9. In support of this argument, CMS cites to the statement of deficiencies, surveyor notes, photos of the grounds, the surveyor's testimony, and the police report. However, CMS has not demonstrated noncompliance on the part of the facility. While CMS has submitted numerous photographs to demonstrate how the facility environment is purportedly not free of accident hazards on its rear roadway, I point out that many of the photographs visibly demonstrate that there are sidewalks on the facility grounds, and other photographs show there is an outdoor patio area in the front of the facility. CMS Ex. 23 at 2, 5, 24-39. Therefore, it appears that there is an ample amount of outdoor space that is safely accessible for a family member to take a resident out for "fresh air" without the need to walk the resident in a roadway. The photographs submitted by CMS clearly show that the roadway surfaces are just what they are: *roadways*. No one from the facility's staff pushed Resident # 2 in her wheelchair in the roadway; rather, the resident's own son pushed her wheelchair in the roadway, and admitted that he had circled the campus on its roadway five times and that other vehicles had passed them except for the vehicle that struck Resident # 2. P. Ex. 16 at 6. The accident report documents that Resident # 2 was in the roadway in dark but lighted conditions. CMS Ex. 21 at 1. One nurse, M. Peddie, LPN, testified that "I believe I told the surveyor that I did not recall any similar accident during the twenty five years I have worked at the Center." P. Ex. 34 at 4. Although the surveyor testified that there are several benches near the rear roadway, she acknowledged that the area's "primarily [sic] use is as a loading dock for large deliveries of food and supplies, as well as garbage storage and removal." CMS Ex. 36 at 4. While the surveyor was critical that the sidewalk does not surround the campus and that a speed limit sign was not visible in both directions, I note that, based on the photographs, it appears that it would be difficult to drive much faster than 5 miles per hour due to the curvature and narrow width of the road at that location, along with the close proximity to the building structure and adjacent parking spaces. *See* CMS Ex. 23. Furthermore, I ultimately conclude that a major factor in the accident is that Resident # 2's son pushed the resident in her wheelchair *on* a roadway during dark conditions while both were wearing dark clothing, rather than utilizing the available sidewalks or outdoor patio. Based on the instant circumstances underlying this particular and unfortunate accident, I cannot conclude that the facility failed to take *reasonable* steps to mitigate any foreseeable risks of harm from accidents on its roadway. *See, e.g., Maine Veterans' Home - Scarborough*, DAB No. 1975 at 10 (2005).

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abrasion to the right side of the face, a small skin tear to the right side of the knee with bleeding, and was observed by a member of the facility's staff to be wearing a neck brace while undergoing treatment in the hospital trauma unit). While *any* injury to a facility resident in such a manner is concerning and unfortunate, I disagree with CMS's characterization of the injuries as "serious," in the absence of any citation to treatment records or other medical evidence documenting the severity of the injuries.

D. Petitioner does not dispute CMS's determination as to the duration of noncompliance, and the duration of the period of noncompliance is consistent with statutory and regulatory requirements.

Substantial compliance means not only that the facility corrected the specific cited instances of substantial noncompliance but also that it implemented a plan of correction designed to assure that no additional incidents would occur in the future. Once a facility is found to be out of substantial compliance, it remains so until it affirmatively demonstrates that it has achieved substantial compliance once again. *Premier Living & Rehab Ctr.*, DAB No. 2146 at 23 (2008); *Lake City Extended Care*, DAB No. 1658 at 12-15 (1998). The burden is on the facility to prove that it is compliant with program requirements, not on CMS to prove that deficiencies continued to exist after they were discovered. *Asbury Ctr. at Johnson City*, DAB No. 1815 at 19-20 (2002). A facility's return to substantial compliance usually must be established through a resurvey. 42 C.F.R. § 488.454(a). To be found in substantial compliance earlier than the date of the resurvey, the facility must supply documentation "acceptable to CMS" showing that it "was in substantial compliance and *was capable of remaining in substantial compliance*" on an earlier date. 42 C.F.R. § 488.454(e) (emphasis added); *Hermina Traeye Mem'l Nursing Home*, DAB No. 1810 at 12 (2002) (*citing* 42 C.F.R. § 488.454(a), (e)); *Cross Creek Care Ctr.*, DAB No. 1665 (1998).

Here, Petitioner raises no arguments regarding the duration of the period of substantial noncompliance. Because Petitioner has not established that an effective plan of correction was implemented any earlier than August 21, 2015, I sustain CMS's determination as to the duration of the period of substantial noncompliance. *See* CMS Ex. 1 at 17 (plan of correction indicating date of correction of August 22, 2015).

E. The penalty imposed is reasonable.

I examine whether the amount of a CMP is reasonable by applying the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) the factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort, or safety. The absence of culpability is not a mitigating factor. The factors listed in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

The regulations specify that a CMP that is imposed against a facility on a per-day basis will fall into one of two ranges. 42 C.F.R. §§ 488.408, 488.438. The upper range of a CMP, $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate

jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), 488.438(d)(2). The lower range of CMP, $50 to $3,000 per day, is reserved for deficiencies that do not pose immediate jeopardy, but either cause actual harm to residents, or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). In assessing the reasonableness of a CMP amount, an ALJ looks at the per-day amount, rather than the total accrued CMP. *See Kenton Healthcare, LLC,* DAB No. 2186 at 28 (2008). The regulations leave the decision regarding the choice of remedy to CMS, and the amount of the remedy to CMS and the ALJ, requiring only that the regulatory factors at 42 C.F.R. §§ 488.438(f) and 488.404 be considered when determining the amount of a CMP within a particular range. 42 C.F.R. §§ 488.408, 488.408(g)(2), 498.3(d)(11); *see also* 42 C.F.R. § 488.438(e)(2) and (3); *Alexandria Place,* DAB No. 2245 at 26-27 (2009); *Kenton Healthcare, LLC,* DAB No. 2186 at 28-29.

Unless a facility contends that a particular regulatory factor does not support the CMP amount that CMS imposed, the ALJ must sustain it. *Coquina Ctr.*, DAB No. 1860 at 32 (2002). CMS decided to impose a per-day CMP in this case of $250 from June 17, 2015, through August 21, 2015, which is at the very low end of the penalty range for deficiencies that do not pose immediate jeopardy.[11] 42 C.F.R. § 488.438(a)(1)(ii). The per-day penalty for these violations was very close to the minimum permissible under CMS's regulations, and Petitioner in its brief has not pointed to any factors that show the CMP was unreasonable. The deficiencies I have affirmed justify a penalty of $250 per day, and the CMP is therefore reasonable. 42 C.F.R. § 488.438(a)(1)(ii).

Petitioner has raised no arguments in its brief regarding the amount of the CMP. CMS contended in its brief that the facility "has a considerable history of noncompliance." CMS Br. at 11, citing CMS Ex. 7 (AEM Nursing Home Enforcement History). Furthermore, the facility is culpable, as evidenced by the actual harm sustained by Resident # 3. I reiterate that the per-day CMP is at the very low end of the wide range allowed by regulation, and the $16,500 CMP is reasonable.

[11] CMS exercised discretion in determining that Petitioner's noncompliance began on June 17, 2015. The evidence arguably demonstrates that the noncompliance began earlier, at the time of Resident # 3's first fall at the facility on June 5, 2015 (and second fall in the span of a week), at which time the facility implemented a single additional intervention to Resident # 3's care plan only minutes after her fall.

IV. Conclusion

For the reasons discussed above, I find that the facility was not in substantial compliance with Medicare requirements and that the $250 per day penalty from June 17 to August 21, 2015, was reasonable.

/s/
Leslie C. Rogall
Administrative Law Judge