Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Pearsall Nursing and Rehabilitation Center – North
(CCN: 45-5797),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-1333

Decision No. CR4197

Date: September 10, 2015

DECISION

Following an investigation survey that ended on February 27, 2014, the Texas Department of Aging and Disability Services (state agency) found that Petitioner, Pearsall Nursing and Rehabilitation Center – North, was not in substantial compliance with requirements for a Medicare-participating long-term care facility. The state agency determined that Petitioner's care of a resident did not comply substantially with several requirements including the general quality of care requirement in 42 C.F.R. § 483.25, cited under Tag F-309. The state agency also determined that Petitioner's noncompliance posed immediate jeopardy to resident health and safety. The Centers for Medicare & Medicaid Services (CMS) accepted the state agency's findings and, with regard to Petitioner's noncompliance with 42 C.F.R. § 483.25, imposed an $8,750 per-instance civil money penalty (CMP) against Petitioner. CMS did not impose an enforcement remedy with regard to the other deficiencies that the state agency cited. Petitioner appealed, and CMS now moves for summary judgment.

For the reasons set forth below, I find that the undisputed material facts establish that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25 during the cited period and that the enforcement remedy imposed is reasonable. I therefore affirm the noncompliance determination as well as the $8,750 per-instance CMP.

I. Background and Procedural History

Petitioner is a long-term care facility in Pearsall, Texas, that participates in the Medicare and Medicaid programs. The state agency conducted a complaint investigation survey of Petitioner's facility, which concluded on February 27, 2014. The state agency found that a resident of Petitioner's facility, referred to in survey documents and throughout this proceeding as "Resident 1," suffered an acute intertrochanteric facture of the proximal left femur[1] that Petitioner's staff discovered in a pelvic X-ray on January 11, 2014. CMS Exhibit (Ex.) 3 at 53-70. According to the state agency, Resident 1's physician subsequently ordered that she be referred to an orthopedic specialist "the sooner, the better . . . ." CMS Ex. 3 at 55. The state agency found that Petitioner's staff did not carry out the physician's order to refer Resident 1 to an orthopedic surgeon for nearly four weeks. Following Resident 1's complaints of hip pain during a dialysis treatment on February 7, 2014, the dialysis nursing staff consulted with an orthopedic surgeon's office, which ordered another pelvic X-ray. CMS Ex. 3 at 56. That second X-ray showed Resident 1's fracture had not changed. On February 10, 2014, 30 days after the initial X-ray revealed Resident 1's femur fracture and three days after her second X-ray again showed the fracture, and after Resident 1 again complained of hip pain during her dialysis treatment, the orthopedic surgeon with whom the dialysis nursing staff consulted, ordered that she be transferred for "direct admit" to the hospital. CMS Ex. 3 at 56.

Based on these findings, the state agency found that Petitioner was not in substantial compliance with the Medicare participation requirement set forth in 42 C.F.R. § 483.25 (Tag F-309), which requires a facility to provide the care and services necessary to attain or maintain a resident's well-being in accordance with that resident's comprehensive plan of care.[2]

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[1] An "intertrochanteric fracture" is a type of hip fracture. The intertrochanteric line is where the body or shaft of the femur ends and the neck of the femur begins. The femur neck leads to the femur head, which, in turn, is the "ball" portion of the ball-and-socket hip joint. An intertrochanteric fracture is a partial or full break of the femur along the intertrochanteric line, which can separate the femur body from the femur neck and head. *See* Gray's Anatomy, *Articulations of the Lower Extremity: Coxal Articulation or Hip-Joint*, Fig. 339 (20th ed.), available at http://www.bartleby.com/107/92.html.

[2] The state agency also determined that Petitioner was not in substantial compliance with four other Medicare participation requirements. However, CMS did not impose an enforcement remedy against Petitioner as a result of those four deficiencies, and they are not at issue in this appeal. *See* 42 C.F.R. §§ 488.408(g)(1), 498.3(b)(13).

By letter dated April 8, 2014, CMS notified Petitioner that it was imposing two per-instance CMPs, one for $4,250 based on the deficiency cited under Tag F-309, and another one for $4,250 based on a separate deficiency. However, in a subsequent letter dated April 24, 2014, CMS modified the per-instance CMP for the deficiency cited under Tag F-309 from $4,250 to $8,750, and it rescinded the CMP for the other deficiency.

Petitioner filed its request for hearing on June 18, 2014. CMS filed a motion for summary judgment with a supporting brief (CMS Br.) as well as 10 proposed exhibits (CMS Exs. 1-10). Petitioner filed its opposition to summary judgment and supporting brief (P. Br.) as well as two proposed exhibits (P. Exs. 1-2). Neither party filed any objections to the admission of the proposed exhibits, although Petitioner disputed some of the legal conclusions that CMS's witnesses included in their written direct testimony, which I discuss below. In the absence of any objections, I admit CMS Exs. 1-10 and P. Exs. 1-2 into the record for consideration.

II. Issues

This case presents the following issues:

1. Whether summary judgment is appropriate;

2. Whether Petitioner was in substantial compliance with the Medicare participation requirement in 42 C.F.R. § 483.25 during the period cited; and

3. If Petitioner was not in substantial compliance, whether the penalty imposed is reasonable.

The immediate jeopardy determination is not reviewable in this case. An administrative law judge may review CMS's scope and severity findings (which include a finding of immediate jeopardy) only if a successful challenge would affect the range of the CMP or if CMS has made a finding of substandard quality of care that results in the loss of approval of a facility's nurse aide training program. 42 C.F.R. §§ 498.3(b)(14), 498.3(d)(10); *Cedar Lake Nursing Home*, DAB No. 2344, at 9-10 (2010); *Aase Haugen Homes*, DAB No. 2013, at 17-19 (2006). For a per-instance penalty, the regulations provide only one range of possible penalty ($1,000 to $10,000), so the scope and severity of any noncompliance does not affect the range of the possible CMP. *See* 42 C.F.R. § 488.438(a)(2).

There is no evidence before me that the facility operated a nurse aide training program. Even if it did, CMS's scope and severity finding would not affect approval of such a program. By statute and regulation, if, as here, CMS properly imposes a penalty of $5,000 or more, the state agency cannot approve the nurse aide training program, so the facility would lose approval of it without regard to the immediate jeopardy finding.

42 U.S.C. § 1395i-3(f)(2)(B); 42 C.F.R. § 483.151(b)(2)(iv); *see also White Sulphur Springs Ctr.*, DAB No. 2520, at 17 (2013) ("[T]he imposition of a CMP of $5,000 or more automatically results in the loss of [a facility's nurse aide training program]; thus, the fact that there was a finding of substandard quality of care in this case would not provide a basis for appealing the immediate jeopardy determination.")

Accordingly, because the immediate jeopardy finding here does not affect the range of the CMP or result in the facility losing any approval of its nurse aide training program, the immediate jeopardy determination is not reviewable.

III. Statutory and Regulatory Framework

The Social Security Act (Act) establishes the minimum standards of resident care that a long-term care facility must meet to participate in the Medicare and Medicaid programs and authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations implementing those statutory requirements. 42 U.S.C. §§ 1395i-3, 1396r. Specific Medicare participation requirements for long-term care facilities are in 42 C.F.R. Part 483. A long-term care facility must remain in substantial compliance with program requirements to participate in Medicare. 42 C.F.R. § 483.1(b). "Substantial compliance" means "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for minimal harm. *Id.* § 488.301. "Noncompliance" means "any deficiency that causes a facility not to be in substantial compliance." *Id.*

The Act authorizes the Secretary to impose enforcement remedies against a long-term care facility for failure to comply substantially with the federal participation requirements. The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility not in substantial compliance with participation requirements. State agencies survey facilities on behalf of CMS to determine whether the facilities comply with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335. Standard surveys must occur at least every 15 months, and complaints of abuse or neglect of residents in a long-term care facility may trigger a survey sooner than a standard survey. *See* 42 U.S.C. § 1395i-3(g)(1)(C), (g)(2)(A)(iii). The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406. These remedies include: termination of a facility's participation in the Medicare program, closure of the facility, temporary management, denial of certain Medicare payments, transfer of residents, state monitoring, directed plans of correction, and various CMPs. *Id.* § 488.408.

CMS may impose a per-day CMP for the number of days a facility is not in substantial compliance or a per-instance CMP for each instance of the facility's noncompliance. *Id.* § 488.430(a). A per-instance CMP, which CMS imposed in this case, may range from $1,000 to $10,000. *Id.* § 488.438(a)(2). When establishing the amount of a per-instance

CMP, CMS must consider, among other things, the seriousness of the deficiencies which includes whether the deficiencies posed no actual harm with the potential for more than minimal harm that is not immediate jeopardy, actual harm that is not immediate jeopardy, or immediate jeopardy to resident health and safety. *Id.* §§ 488.438(f), 488.404(b). "Immediate jeopardy" exists when "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.* § 488.301.

If CMS imposes an enforcement remedy against a long-term care facility based on a noncompliance determination, the facility may request a hearing before an administrative law judge to challenge the noncompliance finding and enforcement remedies. 42 U.S.C. §§ 1320a-7a(c)(2), 1395cc(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13).

IV. Findings of Fact and Conclusions of Law

1. *Summary judgment is appropriate.*

Summary judgment is appropriate if there is "no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law." *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459, at 5 (2012) (citations omitted). The moving party must show that there is no genuine dispute of material fact requiring an evidentiary hearing and that it is entitled to judgment as a matter of law. *Id.* If the moving party meets its initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial . . . .'" *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986). "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." *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010). A 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.'" *Mission Hosp.*, DAB No. 2459, at 5 (quoting *Matsushita*, 475 U.S. at 586).

In examining the evidence to determine the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *See Brightview Care Ctr.*, DAB No. 2132, at 2, 9 (2007); *but see Cedar Lake*, DAB No. 2344, at 7 (2010); *Brightview*, DAB No. 2132, at 10 (noting entry of summary judgment upheld where inferences and views of non-moving party are not reasonable). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cedar Lake*, DAB No. 2344, at *7*.

There is no genuine dispute of any material fact in this case. The documentary evidence provides the material facts here and consists of, among other things, Petitioner's facility records, partial medical records for Resident 1, Petitioner's investigation documents, and survey documents. Petitioner points to medication administration records, facility job descriptions, and certain facility policies that CMS offered as evidence, which allegedly show that Petitioner "reasonably assessed the necessary care and services" for Resident 1. P. Br. at 6. But the facts Petitioner cites in reaching its legal conclusion are not in dispute, and whether Petitioner "reasonably assessed the necessary care and services" for Resident 1 is ultimately a legal question I am able to decide based on undisputed facts.

Petitioner references statements from facility employees who reported during the facility's investigation that Resident 1 did not complain of hip pain during their contact with her, which, according to Petitioner, contradicts CMS's witnesses' claims that Resident 1 complained of pain while her hip fracture remained untreated. P. Br. at 7-8. For purposes of summary judgment, I infer that Resident 1 did not complain of hip pain to those facility employees. CMS does not, however, dispute or challenge the employees' statements about Resident 1 not complaining of pain to those specific staff members. The evidence is not contradictory, either. The surveyor's finding that Resident 1 complained of hip pain is supported by documented instances of those complaints that Petitioner does not address in its opposition to summary judgment. *See, e.g.*, CMS Ex. 7 at 93 (Physician Patient Notes for Resident 1, noting that Resident 1 was complaining of pain to left groin/hip area and was "losing mobility/function/unable to bear [weight]"). Moreover, the surveyor did not allege that Resident 1 continuously complained of pain to all of Petitioner's staff members, so Petitioner's citing instances where Resident 1 did not complain of pain does not necessarily contradict the surveyor's findings based on other undisputed facts.

Petitioner also argues that summary judgment is not appropriate because the testimonial evidence that CMS submitted (CMS Exs. 9-10) raises factual disputes about the conduct of Petitioner's staff. P. Br. at 3. To the extent CMS's witness testimony offers a legal opinion about Petitioner's noncompliance, I disregard those conclusions. Moreover, it is difficult to see how the testimonial evidence of the surveyor (CMS Ex. 9) raises a factual dispute when the surveyor primarily relied on the documents that are now in the record and which Petitioner does not dispute. While the statement of deficiencies contains interview summaries that the surveyor obtained during the survey, those interviews simply confirm what is already in the documentary evidence and do not add or detract from the material facts necessary to decide this case. Accordingly, summary judgment cannot be defeated simply because the surveyor included interview summaries that provide evidence that neither confirms nor supplements the material facts of the case or because the CMS witnesses' offered legal conclusions that I must disregard as part of my *de novo* review.

Overall, in its attempt to raise a genuine dispute of material fact, all Petitioner has actually done is cite to more facts that remain undisputed. I find there are no issues of material fact to decide, and I do not need to weigh any of the evidence. My decision in this case is based on the undisputed documentary evidence and the reasonable inferences I have drawn in favor of Petitioner. Accordingly, I conclude this case turns on a matter of law where summary judgment is appropriate.

2. *Petitioner was not in substantial compliance with 42 C.F.R. § 483.25 because the undisputed evidence establishes that staff did not take reasonable steps to provide Resident 1 timely treatment and care after an X-ray showed that she had an acute intertrochanteric fracture in her left femur.*

Resident 1 was a 47-year-old female, admitted to Petitioner's facility on May 17, 2013, with diagnoses of Alzheimer's-type dementia, insulin-dependent diabetes mellitus (also referred to as Type I diabetes), end-stage renal disease, hypertension, and hypokalemia (low potassium levels), among other ailments. CMS Ex. 7 at 12-16. She was wheelchair bound and required staff assistance for nearly all of her activities of daily living. CMS Ex. 7 at 48-49. Resident 1's care plan noted that she was "at risk for misunderstanding" and "usually understands/comprehends most of conversation but may miss part or intent of message." CMS Ex. 7 at 52. Her care plan also documented that Resident 1 was "at risk for unrelieved pain," and stated that she should receive acetaminophen (acetyl para-aminophenol or "APAP") as needed for pain and fever. CMS Ex. 7 at 63. One of the approaches listed for staff to address Resident 1's pain included "monitor for [complaints of] pain or increased [signs and symptoms] of pain: increased tearfulness, agitation, facial grimacing/moaning." CMS Ex. 7 at 63.

Resident 1 complained of hip pain in early January 2014, prompting her physician to order an X-ray. *See* CMS Ex. 7 at 20, 30. A pelvic X-ray taken on January 11, 2014, revealed that Resident 1 was suffering from an acute intertrochanteric fracture of her left proximal femur. CMS Ex. 7 at 20; CMS Ex. 8 at 3. That evening, staff documented in the facility's "24 Hour Report" that Resident 1 needed an appointment to address her fractured femur. CMS Ex. 7 at 85. The next day, staff documented that Resident 1 "needs appt [with orthopedic surgeon] the sooner the better." CMS Ex. 7 at 86.

The following day, the same notation appeared for Resident 1, with an added note to the side: "NEEDS PRIOR." CMS Ex. 7 at 87 (capitalization in original). As Petitioner argues, and later staff notations confirm, the "NEEDS PRIOR" notation refers to prior insurance authorization for Resident 1 to see the orthopedic surgeon. *See* P. Br. at 7; CMS Ex. 7 at 88. On January 14, 2014, staff noted that Resident 1 "Needs prior auth[orization] to be seen by [orthopedic surgeon] . . . ." CMS Ex. 7 at 88. The same or very similar notation appears in the 24 Hour Report for the following eight days, through January 22, 2014. CMS Ex. 7 at 89-92, 100-03. Petitioner does not allege, nor is there

any documentation in the record that staff took any steps from January 11 to January 22, 2014, to follow up about the status of the prior authorization or consult with Resident 1's physician about different treatment options to address her fracture.

On January 21, 2014, Resident 1's nephrologist evaluated her at a dialysis center. He noted that her potassium levels improved and addressed Resident 1's hip pain and femur fracture. The nephrologist ordered a referral to an orthopedic surgeon. CMS Ex. 7 at 93. A dialysis nursing staff member noted that Resident 1 complained of "pain to [left] groin/hip." CMS Ex. 7 at 93. She also noted that Resident 1 complained of "losing mobility/function/unable to bear [weight]." CMS Ex. 7 at 93. On January 22, 2014, staff apparently consulted with Resident 1's physician about the status of Resident 1's prior authorization to see the orthopedic surgeon. There is a notation in the record on that date saying that Resident 1's physician was "aware" that prior authorization was needed. CMS Ex. 7 at 103. The following day, on January 23, 2014, Petitioner's staff noted that Resident 1's physician was expected "to send referral to see [orthopedic surgeon]." CMS Ex. 7 at 104. That referral did not come, because on January 24 and January 25, 2014, the same notation appeared, saying that Petitioner's staff was expecting the physician to send a referral for Resident 1 to see the orthopedic surgeon. CMS Ex. 7 at 105-06.

On January 28, 2014, Resident 1's nephrologist again evaluated her in the dialysis center and noted that she was "pending" a follow-up with an orthopedic surgeon for her femur fracture. The dialysis nurse called an orthopedic surgeon's office, which responded that an appointment could not be scheduled for Resident 1 because "office does not accept [Resident 1's] insurance."[3] CMS Ex. 7 at 93.

On February 7, 2014, Resident 1 presented to the dialysis center complaining of hip pain. CMS Ex. 7 at 10. A dialysis center nursing note stated that an appointment had been scheduled — apparently by the dialysis center staff — for Resident 1 to see an orthopedic surgeon. The orthopedic surgeon that the nursing note refers to is one who was not previously referred to in the medical documentation and apparently had not been consulted before. The orthopedic surgeon's office requested the report from Resident 1's January 11, 2014 pelvic X-ray, which the dialysis center's staff faxed to the surgeon's office. CMS Ex. 7 at 94. The surgeon's office then requested a more recent X-ray and ordered a "STAT" X-ray for Resident 1. CMS Ex. 7 at 94. The dialysis center nursing staff then "[c]alled [Petitioner]- spoke with nurse[.] Made aware of app[ointment] and

[3] It is not clear whether the dialysis center nurse contacted the same orthopedic surgeon's office that Petitioner's staff contacted. The dialysis nursing notes refer to a different physician's name than the orthopedic surgeon listed in the 24 Hour Report. *Compare* CMS Ex. 7 at 93 *with* CMS Ex. 7 at 86. The record does not indicate whether the two surgeons were part of the same practice or had separate practices. Ultimately, an entirely different orthopedic surgeon treated Resident 1 and, after seeing her X-rays, ordered that she be directly admitted to the hospital for treatment. *See* CMS Ex. 7 at 94.

need for STAT Xrays." CMS Ex. 7 at 94. The dialysis center staff notation confirms that the dialysis staff — and not Petitioner's staff — was responsible for setting up an appointment with an orthopedic surgeon and ensuring she receive a second X-ray. The X-ray taken on February 7, 2014, again showed a left femoral neck intertrochanteric fracture. CMS Ex. 7 at 21. However, as noted in a later incident report, after Petitioner's staff received the February 7 X-ray results, "[n]o follow up was done." CMS Ex. 7 at 10.

On February 10, 2014, Petitioner's charge nurse "followed up" and faxed the X-ray report from February 7, 2014 to the orthopedic surgeon's office. In response, the surgeon immediately ordered that Resident 1 be directly admitted to the hospital for treatment. CMS Ex. 7 at 10, 94.

The state agency and CMS determined that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25 with regard to how its staff handled Resident 1's femur fracture. CMS Ex. 3 at 53-70. The lead-in language of 42 C.F.R. § 483.25 states:

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

The Board has explained that this regulation "imposes on facilities an affirmative duty designed to achieve favorable outcomes to the highest practicable degree." *Windsor Health Care Ctr.*, DAB No. 1902, at 16-17 (2003), *aff'd*, 127 F. App'x. 843 (6th Cir. 2005). "The facility must take 'reasonable steps' and 'practicable measures to achieve that regulatory end.'" *Golden Living Ctr. - Foley*, DAB No. 2510, at 23 (2013) (quoting *Clermont Nursing & Convalescent Ctr.*, DAB No. 1923, at 21 (2004)). The regulation implicitly imposes on a facility the duty to provide care and services that, "at a minimum, meet accepted professional standards of quality 'since the regulations elsewhere require that the services provided or arranged by the facility must meet such standards.'" *Id.* (quoting *Spring Meadows Health Care Ctr.*, DAB No. 1966, at 17 (2005)). The Board has also determined that the regulation requires facilities to furnish the care and services set forth in the resident's care plan, to implement physicians' orders, to monitor and document the resident's conditions, and to follow its own policies. *See Life Care Ctr. of Bardstown*, DAB No. 2479, at 22 (2012), *aff'd*, No. 12-4420 (6th Cir. 2013).

It is undisputed that for 30 days Petitioner's staff did not arrange for or provide any care or services to address Resident 1's acute intertrochanteric fracture. Petitioner's staff was certainly aware of Resident 1's fracture. *See* CMS Ex. 7 at 85-92, 100-04 (documenting Resident 1's diagnosis as a femur fracture). But Petitioner's nursing staff appeared to stop all active attempts at arranging the appropriate services for Resident 1 once they determined that preauthorization was needed to refer the resident to a specific orthopedic surgeon. Rather than search for a different surgeon or consult with Resident 1's

physician about her treatment options, Petitioner comes forward with no evidence to suggest its staff took meaningful and reasonable steps to ensure Resident 1 received the care and services necessary to treat her femur fracture. Instead, they waited. There are no documented assessments of Resident 1's hip or her pain levels during this time, nor does there appear to be any attempt to secure even temporary care for her fracture. Even more distressing, after Resident 1's physician learned of the delay in referring her to an orthopedic surgeon, he did not follow through in providing a referral as nursing staff indicated he would. Indeed, it ultimately was Resident 1's nephrologist and the dialysis center nursing staff, not Petitioner, who located an orthopedic surgeon willing to treat Resident 1 and scheduled an appointment for Resident 1 to see that surgeon. The dialysis center's efforts prompted a second X-ray of Resident 1's hip and eventual admission to the hospital for treatment. Even after Petitioner received the results of the second X-ray and Petitioner's staff was aware that the dialysis center had arranged for an orthopedic surgeon to see Resident 1, Petitioner's staff took no follow up actions. CMS Ex. 7 at 10. Only three days later did a charge nurse fax the X-ray results to the orthopedic surgeon who immediately ordered that Resident 1 to go to the hospital. *See* CMS Ex. 7 at 10, 94.

Petitioner's lack of any reasonable efforts to secure or attempt to provide appropriate services for Resident 1's femur fracture represents a shocking disregard of Resident 1's health and overall well-being. It is equally shocking and remarkable that Petitioner's staff undertook no assessments of Resident 1's pain, mobility, or ability to bear weight despite being fully aware that she was suffering from a fractured hip. Her care plan required staff to assess Resident 1 for pain (CMS Ex. 7 at 63), yet there is no indication in the medical records that Petitioner's staff ever did so between January 11 and February 10, 2014. *See* CMS Ex. 7 at 17 (providing a blank pain management flow sheet for Resident 1 during January 2014).[4] Waiting for preauthorization to occur, which appears to be all that Petitioner's staff did with Resident 1 in this case, is never a "reasonable step" to provide the necessary care and services to maintain resident well-being. Resident 1's highest practicable well-being could not possibly have been met while she had a diagnosed, yet untreated fracture for 30 days. Petitioner's passive approach and failure to obtain the necessary care and services to treat Resident 1's acute femur fracture is a clear violation of the regulatory requirement.

[4] It is possible that the absence of any notations in Resident 1's pain management flow sheet means that she did not complain of pain to Resident 1's staff. *See* CMS Ex. 7 at 17 (showing column labeled "Origin of Pain," implying that the resident must complain of pain before the flow chart would be used). However, I am not required to make unreasonable inferences in favor of Petitioner, and there is no other documentation that staff assessed Resident 1 for pain, considering she was suffering from an acute femur fracture at the time, and no negative reports that she denied such pain. Instead, there are times during January 2014 when Resident 1 complained of pain. CMS Ex. 7 at 93.

Petitioner claims that Resident 1 did not complain of any pain during the month she had a fractured hip. P. Br. at 7-8. Petitioner cites three statements that staff members provided during the internal investigation, all of which state that Resident 1 did not complain of pain while those staff members interacted with her. CMS Ex. 8 at 16-18. For purposes of summary judgment, I will accept these facts as true, but I do not find them material. It is undisputed that Petitioner's staff knew that Resident 1 had a fractured hip, and her complaints of pain (or lack thereof) should have made no difference in whether Petitioner sought to obtain further treatment for her fracture. Even if she were not in pain (or could not verbalize her pain), staff could not ignore or unreasonably delay treatment for a known acute fracture and still maintain the resident's highest overall well-being. Simply because Resident 1 did not state to those staff members that she was in pain does not mean that she was not actually in pain or that staff carried out its responsibility to assess Resident 1 for pain. *See* CMS Ex. 7 at 63. None of the three staff members' statements say that they assessed Resident 1's hip for pain. It is further undisputed that the individuals who actually assessed Resident 1 for hip pain found that she was in pain. *See* CMS Ex. 7 at 93.

Petitioner claims without any evidentiary support, that its staff "took reasonable measures to assess Resident 1 by conducting assessments, care planning and monitoring to determine whether Resident 1 was comfortable and to ensure care plan goals were being achieved." P. Br. at 8. The undisputed evidence before me does not support this argument at all. There are no documented assessments of Resident 1's hip or pain levels by Petitioner's nursing staff, there were no changes to Resident 1's care plan between the time her hip fracture was first shown on an X-ray and the time she was finally admitted to the hospital, and there are no documented occasions where staff determined Resident 1's comfort level.

The record shows that the orthopedic surgeon's preauthorization requirement seemed to paralyze Petitioner's staff, resulting in no follow up or treatment, even within Petitioner's facility, for Resident 1's fracture for a significant amount of time. CMS Ex. 7 at 85-92. Petitioner does argue that its staff initially attempted to set up an appointment for Resident 1 with an orthopedic surgeon, but that surgeon "refused to see Resident 1 because he did not accept her insurance." P. Br. at 13. For purposes of summary judgment I will infer that as true, however, it is unreasonable to claim that Petitioner did not have to follow up or arrange for any further care for Resident 1's acute hip fracture simply because one surgeon refused to operate based on Resident 1's insurance.[5] Petitioner had an obligation to provide the necessary care and services to Resident 1 so that she could maintain her highest practicable well-being, which most certainly included not suffering from a known hip fracture for 30 days without treatment. Indeed, the

[5] Resident 1 had Medicaid coverage. CMS Ex. 8 at 6.

dialysis facility that treated Resident 1 did not have the same difficulty consulting with and arranging for treatment from an orthopedic surgeon. *See* CMS Ex. 7 at 93-94. By not ensuring that Resident 1 received the care and services necessary to treat her hip fracture, Petitioner did not substantially comply with 42 C.F.R. § 483.25.

3. *The $8,750 per-instance CMP is reasonable.*

Based on Petitioner's noncompliance, CMS imposed an $8,750 per-instance CMP against Petitioner. CMS Ex. 2 at 4. The factors listed in 42 C.F.R. § 488.438(f) guide whether the CMP imposed here is reasonable. Those factors include: (1) the facility's history of noncompliance; (2) the facility's financial condition; (3) factors specified in 42 C.F.R. § 488.404; and (4) the facility's degree of culpability, including neglect, indifference, or disregard for resident care, comfort or safety. Among the factors specified in section 488.404 are the scope and severity of noncompliance, the relationship of one deficiency to another deficiency resulting in noncompliance, and the facility's history of noncompliance generally as well as with reference to the cited deficiencies. 42 C.F.R. § 488.404(b)-(c). In addition, the "absence of culpability is not a mitigating circumstance in reducing the amount of the penalty." 42 C.F.R. § 488.438(f)(4).

Unless a facility shows that a particular regulatory factor does not support the CMP amount, the ALJ must sustain it. *Coquina Ctr.*, DAB No. 1860 at 32 (2002). Here, Petitioner has not alleged or offered evidence that its financial condition affects its ability to pay the CMP.

Despite prior findings of noncompliance, there has been no recent enforcement remedies imposed against Petitioner. *See* P. Ex. 2. Nevertheless, this case involves a serious instance where the facility did not meet Medicare participation standards. Once Petitioner's staff knew of Resident 1's acute femur fracture and the refusal of one orthopedic surgeon to see Resident 1 based on her insurance, Petitioner did not take any other steps to provide the necessary care and services to Resident 1, which left her with an untreated fracture for nearly one month. It is impermissible for Petitioner to shift blame to the orthopedic surgeon's office or Medicaid, or to downplay its culpability in this case. Petitioner's staff allowed Resident 1's fracture to go untreated for a month and did not ensure she received care during that time. In fact, but for the dialysis center's nursing staff — not Petitioner — making arrangements for Resident 1 to see a surgeon, it may have been even longer while the fracture went untreated.

Compared to the level of CMP that CMS could have imposed based on the nearly month-long period that Petitioner's staff failed to maintain Resident 1's overall well-being, the per-instance CMP imposed in this case is very modest. *See Plum City Care Ctr.*, DAB No. 2272 at 18-19 (2009) (observing that even a $10,000 per-instance CMP can be "a modest penalty when compared to what CMS might have imposed"). In light of all of these circumstances, I find that the $8,750 per-instance CMP imposed here is well-supported by the record before me.

V. Conclusion

For all of the reasons stated above, I conclude that the undisputed facts show Petitioner was not in substantial compliance with Medicare participation requirements and the CMP imposed is reasonable. CMS, therefore, is entitled to summary judgment affirming the noncompliance determination and enforcement remedy.

/s/
Joseph Grow
Administrative Law Judge