Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Nathaniel Witherell,
(CCN: 07-5117),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-414

Decision No. CR4673

Date: August 5, 2016

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose a per-instance civil money penalty against Petitioner, Nathaniel Witherell, a skilled nursing facility, in the amount of $1800.

I. Background

Petitioner requested a hearing to contest CMS's findings of noncompliance and remedy determination. CMS filed a pre-hearing exchange that included a brief plus six proposed exhibits that are identified as CMS Ex. 1-CMS Ex. 6. Petitioner filed a brief in opposition to CMS's brief plus eight proposed exhibits that are identified as P. Ex. A - P. Ex. H. I receive the parties' exhibits into the record.

CMS included a motion for summary judgment with its pre-hearing exchange. Petitioner opposed that motion, asserting that there are disputed issues of material fact. I find it unnecessary to decide whether there are material facts in dispute because neither CMS nor Petitioner established a basis for me to conduct an in-person hearing. Therefore, I decide this case based on the parties' exhibits and make such credibility findings as are appropriate.

Petitioner provided affidavit testimony for three witnesses. P. Ex. A - P. Ex. C. CMS did not request to cross-examine any of these witnesses and, therefore, it is not necessary to convene an in-person hearing for that purpose. CMS provided sworn testimony for one witness, Richard Howe, RN. CMS Ex. 5. Petitioner requested an in-person hearing so that it could cross-examine Mr. Howe. Petitioner asserted that there were apparent discrepancies between facts cited in a statement of deficiencies for a survey of Petitioner's facility and facts that Mr. Howe attested to in his declaration. Petitioner indicated that it desired to cross-examine Mr. Howe as to these alleged discrepancies.

I have examined Mr. Howe's declaration and I find nothing in it that I rely on for this decision. I do not cite it nor do I rely on it in any respect. For that reason, I find cross-examination of Mr. Howe to be unnecessary. His testimony falls into two categories. First, he summarizes the contents of documents that he obtained while surveying Petitioner's facility. Second, he draws inferences from those documents and concludes that Petitioner failed to comply substantially with regulatory requirements. As to the documents cited by Mr. Howe, I do not rely on his testimony at all. The documents, to the extent that they are in evidence, speak for themselves. Mr. Howe adds nothing to the evidence by reciting their contents in a declaration. Second, in asserting that Petitioner failed to comply with regulatory requirements, Mr. Howe reaches conclusions of law that he is unqualified to make. Consequently, those conclusions are irrelevant.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues are: whether Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h); and, assuming that there was noncompliance, whether the remedy imposed is reasonable.

B. Findings of Fact and Conclusions of Law

Summarized, 42 C.F.R. § 483.25(h) requires a skilled nursing facility to ensure that its premises are as free from accident hazards as is possible and also to ensure that each of its residents receives adequate supervision and assistance devices to prevent accidents. The regulation does not impose a strict liability standard on a skilled nursing facility but it requires the facility to take all reasonable measures in order to protect its residents against foreseeable hazards. In order to do so, a facility must carefully monitor and assess its residents in order to ascertain what risks the residents might encounter. It must develop care plans that address whatever risks the facility ascertains. It must implement those plans. And, it must continually evaluate whether the plans, as implemented, are providing the residents with adequate protection against foreseeable risks.

CMS alleges that Petitioner failed to comply with these requirements in providing care to a resident, identified as R92. It contends that Petitioner failed to provide this resident with care that Petitioner's staff determined as necessary to protect the resident against injuring herself. It contends further that Petitioner failed to adjust the resident's plan of care when it became apparent to Petitioner's staff that the assistance it developed for R92 failed to protect her adequately.

More specifically, CMS asserts that Petitioner's staff found it necessary that R92 wear an assistance device known as a "Geri sleeve." This is a protective device designed to protect an individual's extremities against skin tears and bruising. CMS contends that Petitioner's staff failed to ensure that the resident wore Geri sleeves at all times, notwithstanding the staff's conclusion that she needed to wear them. It suggests that the resident sustained skin tears on her arm – one so severe that it required emergency treatment at a hospital – due to the staff's failure to ensure that the resident wore Geri sleeves.

CMS argues additionally that R92 sustained multiple skin tears over a period of months. Notwithstanding, according to CMS, Petitioner failed to modify the resident's plan of care to establish new interventions intended to protect her. According to CMS, Petitioner failed in two respects to consider modifying the resident's plan of care. First, Petitioner allegedly failed to consider whether additional or new assistance should be provided to the resident in order to protect her against accidental injuries. Second, Petitioner allegedly failed to take into account fully the resident's dementia-related behavior and failed to develop a plan to deal with that behavior.

There is little dispute as to the facts of this case. The resident in question is a woman of advanced age whose principal impairments include relatively advanced dementia. R92 is often combative, especially when receiving care from Petitioner's staff and she manifests her combativeness by striking out at caregivers. CMS Ex. 1 at 19-20, 45-46. Petitioner's staff assessed the resident as being delusional, as exhibiting threatening and aggressive verbal behavior one to three times daily, and rejecting care. *Id.* at 2-15.

R92's problems are complicated by the fact that she has skin integrity issues. The fragile condition of her skin makes her susceptible to injury, including skin tears. In fact, the resident has sustained multiple skin tears, often as a consequence of her combative behavior. On September 1, 2015, the resident sustained a skin tear to her left forearm when she became combative while receiving care. CMS Ex. 1 at 46. She sustained another tear on September 11, 2015, when she bumped her lower right leg. *Id.* at 47. On September 17, 2015, R92 became agitated and aggressive when a nursing assistant attempted to provide incontinence care. As a consequence she sustained another skin tear to her left forearm, which bled profusely. *Id.* at 34, 51-52. This injury necessitated transporting the resident to an emergency room where she received sutures.

Petitioner developed and implemented a care plan in October 2014 that addressed R92's various problems. CMS Ex. 1 at 19-33. The staff amended the plan from time to time and memorialized these amendments with handwritten annotations. *Id.* The plan included interventions that were intended to address R92's skin issues. These included: conducting systematic weekly inspections of the resident's skin to assess her for skin tears and bruising; dressing the resident in long sleeved shirts and pants in order to protect her extremities; handling the resident with care while giving her direct care; keeping the resident's skin lubricated; and having the resident wear a Geri sleeve on her left forearm. *Id.* at 20. The care plan noted that the resident was noncompliant with the lattermost intervention, suggesting that she would remove the Geri sleeve. I note that prior to September 17, 2015, none of the handwritten amendments consisted of modifications of or additions to the original interventions designed to address the resident's skin integrity problems.

Petitioner's staff implemented additional interventions on September 18, 2015, after the resident had sustained a skin tear that required sutures. On that date, the staff determined that the resident should wear Geri sleeves on both arms at all times except when she was receiving hygiene. CMS Ex. 1 at 56. Additionally, the staff determined that two caregivers would be present when the resident received care. *Id.*

CMS contends that the resident was not wearing a Geri sleeve or sleeves on September 1 and 17, 2015, in contravention of the express requirements of her plan of care, when she sustained skin tears. CMS argues that I should infer this from the fact that notes pertaining to these incidents are silent as to whether the resident was wearing a Geri sleeve on those occasions. Petitioner does not deny that the resident was not wearing a Geri sleeve when she sustained her September 1 and 17 injuries. It asserts, however, that these incidents occurred at night and that Petitioner never intended that the resident wear a Geri sleeve at night. Consequently, according to Petitioner, R92 was receiving care that was entirely consistent with her plan of care.

I find Petitioner's argument to be unpersuasive. Petitioner's staff plainly concluded that wearing a Geri sleeve was a necessary protection for R92. It identified this intervention as an appropriate way of protecting the resident from skin tears and bruising. Although Petitioner's staff now avers that they never intended that the resident wear a Geri sleeve at night, the care plan is silent as to whether the sleeve would be removed in the evening. CMS Ex. 1 at 20. I do not accept Petitioner's assertion that the sleeve was to be removed in the evening in the absence of anything in the resident's care plan suggesting that was part of the care intended for the resident. *See* P. Ex. A; P. Ex. B. Furthermore, Petitioner has offered no corroborative documentation, such as nursing notes, suggesting that the staff was instructed to remove the sleeve in the evening.

But, even if staff intended to remove the resident's sleeve at night, the question remains: how was the staff going to protect R92 when they provided nighttime care to the resident? There is nothing in the plan of care that addresses that issue. If the plan intended that a necessary protection be removed at night, it failed completely to provide alternate measures of protecting the resident from skin tears.

There is also nothing in the resident's care plan prior to September 18, 2015, to show that Petitioner's staff evaluated R92 and developed new interventions to protect the resident. Essentially, the care plan developed in October 2014 contained the sole interventions addressing the resident's propensity for developing skin tears notwithstanding the fact that the plan obviously was not working to protect the resident.

It should have been obvious to Petitioner's staff that the interventions developed in October 2014 were not working adequately to protect the resident from sustaining skin tears. She sustained multiple skin tears after October 2014. CMS Ex. 1 at 45-47. But, from October 2014 until September 18, 2015, after the resident was sent to the emergency room for treatment of the tear that she sustained on September 17, there are no additional interventions noted in the plan that were designed specifically to address the resident's ongoing problems with skin tears. There is no assessment, for example, as to whether the resident's use of a Geri sleeve was effective. There is no discussion of the problems caused by the resident's apparent propensity to remove her sleeve. There is no analysis of the resident's dementia in relationship to her propensity for developing skin tears and there are no additional interventions designed to address what might have been the resident's worsening dementia.

Petitioner argues that, in fact, its staff conducted ongoing evaluations of R92's condition. It contends that the staff did not amend the resident's care plan with new interventions because they determined that none were needed. To this end, Petitioner offers the testimony of Jayne Kennelly, R.N., a member of Petitioner's staff who provided care to the resident. She avers that:

> As a group . . . [the staff] considered the September 1, 2015 skin tear and made a determination that the extensive interventions already in place continued to be the most reasonable and appropriate to protect R92.

P. Ex. C at 2. I find this declaration to be unpersuasive for more than one reason. First, Petitioner has offered no records whatsoever that show that its staff actually conducted this alleged assessment. But, beyond that, I am baffled as to *why* the staff would believe that no additional interventions were necessary after September 1. By that date, the resident had demonstrated that she: was noncompliant due to her dementia; was often combative; and had sustained multiple skin tears as a result of her noncompliance and combativeness. Notwithstanding, the staff continued to rely on a set of interventions that was not working and provided no explanation of why they would do so. Furthermore,

there is not a shred of documentary evidence showing that the staff even considered additional interventions much less that they made an assessment that such interventions would be unnecessary.

Petitioner also offers the testimony of Francis X. Walsh, M.D., Petitioner's medical director, to support its argument that the skin tears that R92 sustained were unavoidable. P. Ex. B at 2-3. It may be that the skin tears that the resident sustained were unavoidable. Had Petitioner implemented all reasonable measures to address the resident's propensity for developing skin tears I would not hold it liable for the tears that the resident sustained if she sustained tears despite the implementation of those measures. But, the fact is that Petitioner did not investigate whether additional measures might have better protected the resident. The deficiency in this case does not hinge on whether the resident sustained avoidable tears. Rather, it emanates from Petitioner's passiveness in the face of a continuing problem that its staff neither investigated nor instituted additional interventions for almost a year.

I find that a civil money penalty of $1800 is reasonable. CMS is authorized to impose per instance penalties of from $1000 to $10,000 for each instance of noncompliance by a skilled nursing facility. 42 C.F.R. § 488.438(a)(2). Here, it determined to impose a penalty that is on the low end of the permissible range, comprising only 18 percent of the maximum allowable amount. The seriousness of Petitioner's noncompliance certainly supports the modest penalty that CMS imposed here. 42 C.F.R. § 488.404. The failure of Petitioner's staff to consider the efficacy of the measures that it had developed to protect R92 is, in and of itself, sufficiently serious to justify the penalty amount.

/s/
Steven T. Kessel
Administrative Law Judge