The Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the case of:	)	
	)	
Plum City Care Center,	)	Date: March 19, 2009
(CCN: 52-5440),	)	
	)	
Petitioner,	)	Docket No. C-07-747
	)	Decision No. CR1926
- v. -	)	
	)	
The Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose a per-instance civil money penalty of $10,000 against Petitioner, Plum City Care Center.[1]

I. Background

Petitioner is a skilled nursing facility doing business in the State of Minnesota. It participates in the Medicare program. Its participation in Medicare is governed by sections 1819 and 1866 of the Social Security Act and by implementing regulations at 42 C.F.R. Parts 483 and 488. Its right to a hearing in this case is governed by regulations at 42 C.F.R. Part 498.

Petitioner was surveyed for compliance with Medicare participation requirements on July 30, 2007 (July survey). The surveyors found that Petitioner was noncompliant in that it allegedly failed to provide adequate supervision and assistance devices to one of its residents in contravention of the requirements of 42 C.F.R. § 483.25(h)(2).[2] CMS

[1] As a consequence of my decision Petitioner also loses the authority to conduct a nurse aide competency and training program for a period of two years. 42 C.F.R. § 483.151(b)(2)-(3).

[2] There was an additional noncompliance finding made at the July survey, but that is not at issue in this case and, so, I do not address it in my decision.

concurred with the surveyors' findings and determined to remedy them with a per-instance civil money penalty of $10,000. Petitioner requested a hearing and the case was assigned to me for a hearing and a decision.

I held a hearing in Minneapolis, Minnesota on December 11, 2008. At the hearing I received into evidence exhibits from CMS that I identified as CMS Ex. 1 – CMS Ex. 15 and exhibits from Petitioner that I identified as P. Ex. 1 – P. Ex. 38, including 31A. The parties each filed pre-hearing and post-hearing briefs.

II. Issues, findings of fact and conclusions of law

A. Issues

The issues in this case are whether:

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

2. A per-instance civil money penalty of $10,000 is reasonable.

B. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below as a separate heading.

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

The regulation that is at issue requires a facility to ensure that each of its residents receives adequate supervision and assistance devices to prevent the resident from sustaining accidents. The regulation obligates a facility to undertake all reasonable measures to protect its residents from sustaining accidents. In practice a facility must: (1) assess each of its residents in order to assure that all known or knowable accident risks are identified; (2) plan each resident's care so as to develop all reasonable measures to prevent the resident from sustaining an accident; and (3) implement each element of the care plan thoroughly and effectively.

The evidence in this case supports my decision that Petitioner failed to discharge these obligations in providing care to a resident who is identified as Resident # 7 in the report of the July survey. Petitioner failed to: anticipate the risks of accidental injuries to this resident resulting from removal of a seat belt and chair alarm from her wheelchair; plan interventions that would have provided reasonable protection to the resident; and supervise her adequately.

Resident # 7 was first admitted to Petitioner's facility in January 2006. The resident, an elderly individual, had numerous physical and mental problems that put her at a very high risk for falling. She was diagnosed to be suffering from, among other things: dementia manifested by confusion, severely impaired decision-making, disorganized speech and altered perception along with short-term and long-term memory problems; abnormal convex curvature of her spine (kyphosis); osteoporosis; moderately impaired vision with glaucoma; and blindness in her left eye. CMS Ex. 7, at 1, 5, 8, 48, 55, 70, 73, 98; CMS Ex. 12, at 10-12, 33; Tr. 11, 120.

The resident had suffered several falls prior to her admission and was identified by Petitioner and its staff as being at risk for falling. CMS Ex. 12, at 22; P. Ex. 30, at 2-3; P. Ex. 33, at 2-3. During the early part of her stay at Petitioner's facility the resident sustained falls while attempting to ambulate or to transfer herself from her bed or her chair. CMS Ex. 7, at 5-11.

Petitioner attempted several interventions to protect Resident # 7 against falling. In February 2006 the staff, noting the resident's tendency to fall forward from her wheelchair, equipped the wheelchair with a lap buddy – essentially a pad – which was intended to keep the resident stable while she was in the chair. CMS Ex. 12, at 23-24. In October, 2006, the staff discontinued the lap buddy and replaced it with a self-releasing seat belt and a chair alarm. CMS Ex. 7, at 75. The intent of the staff was to keep the resident securely in her chair but also to provide the staff with a warning signal in the event that the resident attempted to get out of her chair unassisted. In February 2007 the staff augmented the protections that they gave to Resident # 7 by equipping her with a low wheelchair. CMS Ex. 12, at 12; Tr. 93-94, 167, 185.

The staff continued to classify the resident as being at a high risk for sustaining falls. However, the seatbelt and chair alarm successfully protected Resident # 7 against attempts at self-transfers and unassisted ambulation from her wheelchair. CMS Ex. 12, at 17; P. Ex. 1, at 2.

On July 13, 2007 Petitioner's staff, motivated by the resident's apparent inability to release the seatbelt, decided on a trial basis to discontinue using it. CMS Ex. 7, at 23. At about the same time the staff discontinued the resident's chair alarm. In discussing the staff's decision to remove the seatbelt and alarm Petitioner's director of nursing commented that:

> I-team reviewed use of self-release seatbelt in her [wheelchair]. Noted that she has not made attempts to transfer self from [wheelchair] per day/PM staff when asked. [Wheelchair] positioning has been appropriate. Has [history] of leaning forward in [wheelchair] to touch the floor, but this has not been observed. I-team agreed to do a trial reduction without seatbelt.

CMS Ex. 7, at 23.

It is evident that the staff did not consider the possibility that removing the seatbelt and chair alarm might put the resident at a serious risk for accidents. That is made obvious from the director of nursing's failure to discuss what could happen to the resident if, contrary to the staff's assumptions, the resident attempted to transfer herself from her wheelchair after the seatbelt was removed. Nor did the staff consider the possibility that the reason that the resident had not attempted self-transfers was that she had been wearing a seatbelt. There was no discussion of the possible consequences of removing the resident's chair alarm.

Petitioner's staff had ample reason – given the resident's history of falls – to exercise extreme caution when removing the resident's seatbelt and chair alarm. Furthermore, events occurring in the immediate wake of that decision should have been treated by Petitioner's staff as urgent evidence that the level of risk to Resident # 7 had increased substantially as a consequence of removing these two assistance devices. Although, in deciding to remove the seatbelt and alarm, Petitioner's staff had assumed that the resident was not leaning forward in her wheelchair to touch the floor, the resident engaged in such behavior repeatedly immediately following the removal of these devices. She was observed to do so by Petitioner's staff on the evening of July 13, 2007, on the afternoon of July 15, and again on the afternoon of July 16. CMS Ex. 6, at 12-14; CMS Ex. 7, at 23-26.

With the seatbelt and alarm removed Resident # 7 also began attempting to self-transfer from her wheelchair. On July 13, the day that the devices were removed, staff on three occasions observed the resident attempting to stand, either by pulling on the back of a chair, or by using a handrail in Petitioner's hallway. CMS Ex. 7, at 94. On July 14 a nurse observed the resident making several attempts to stand up from her wheelchair before and during supper. CMS Ex. 7, at 24. A nursing assistant also observed the resident attempting to rise from her wheelchair on July 14. P. Ex. 25, at 1.

However, none of these observations – which directly contradicted the director of nursing's assumption that the resident's seatbelt and alarm could be removed safely – triggered any change in the way in which Petitioner's staff dealt with Resident # 7. At the time that the devices were removed, Petitioner's staff was instructed only to monitor Resident # 7, without being given explicit instructions as to how monitoring was to be accomplished. CMS Ex. 7, at 23, 64.

No plan was written that instructed the staff to monitor Resident #7 continuously or systematically.[3] There were no explicit and detailed instructions given to individual members of Petitioner's staff as to how to monitor the resident. No changes were made to the directive to monitor the resident in the days immediately following the removal of the devices despite the resident's attempts at self-transfer and her repeated episodes of leaning forward from her wheelchair.

Members of Petitioner's staff testified that they were told to monitor the resident "closely", or to "be on the lookout" for untoward events, or to be "especially watchful" or to "pay special attention" to the resident. P. Ex. 14, at 1; P. Ex. 17, at 1; P. Ex. 23, at 1; P. Ex. 27, at 1. But, these instructions were no substitute for a plan to keep the resident under close surveillance. What was critically lacking from Petitioner's approach to caring for the resident was any plan designed to assure that the resident was being directly supervised at all times when she was in her wheelchair. The need for such supervision was made manifest by the resident's clear proclivities for leaning forward or attempting to rise out of her wheelchair unaided.

As a consequence of the obvious failure to react to the resident's propensity to engage in extremely hazardous conduct she was left unprotected for a time on July 16, 2007 and she was alone and unsupervised when she fell. Resident # 7 fell at about 4:00 p.m. on the 16th. It cannot be said definitively how the fall occurred because no member of Petitioner's staff was attending to the resident when she fell. However, it is clear that the resident either fell after rising from her chair or fell directly from it, possibly after leaning forward. CMS Ex. 7, at 24.[4]

The fall occurred during a social event in the facility's dining room. Tr. 53-55. The resident had been present at the event but left it without being directly supervised.[5] The

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[3] In fact, Petitioner's staff also was directed to monitor the resident *prior to* July 13, the date when the resident's seatbelt and alarm were removed. CMS Ex. 7, at 75-76; 79. The care plans and other documents generated by Petitioner's staff for Resident # 7 do not suggest that the monitoring that was ordered beginning with July 13 represented an increased level of surveillance from that which had been ordered previously. *See* CMS Ex. 7, at 23, 64, 76.

[4] Petitioner contends that the fall could not have been caused by an attempt by Resident # 7 to transfer herself from her wheelchair because the resident "lacked the strength to simply stand up by herself and there was no railing or piece of furniture in the vicinity of the fall which . . . [the resident] might have utilized for that purpose." Petitioner's post-hearing brief at 6. However, the resident had been observed attempting to rise out of her chair and even an unsuccessful attempt to stand could have precipitated a fall. At bottom the argument about whether attempting to stand caused the resident to fall is irrelevant. The manner by which the resident may have fallen does not excuse Petitioner's failure to provide her with adequate monitoring and protection.

[5] At one point during the social event, twenty or more minutes before she sustained her fall, the resident became agitated. CMS Ex. 25, at 2; Tr. 80-83.

staff member who responded to the fall was about 25 feet away when the incident occurred and had her back turned to the resident at the moment of the fall. CMS Ex. 7, at 24, 94; P. Ex. 16, at 2; P. Ex. 34, at 3.[6] The fall was, in fact, brought to the staff's attention only by the loud noise caused by the incident. *Id.*

As a consequence of her fall Resident # 7 sustained, among other injuries, a broken neck and a fractured bone in her right hand. CMS Ex. 7, at 24, 97-98. Her cervical fracture was diagnosed as being unstable. Further displacement of the fracture could have caused the resident to suffer from paralysis and/or could have caused her death. *Id.* at 111. However, and as a consequence of the resident's age and medical condition, it was determined that Resident # 7 was not a candidate for surgical repair of her broken neck. *Id.* Her physician decided to treat the resident conservatively by fitting her with a cervical collar. The resident's physician recognized that use of a collar in lieu of surgery would inevitably lead to non-healing of the fracture, meaning that the resident would always be at risk for further exacerbation of her injury, including paralysis and death. *Id.* at 98.[7]

I have considered Petitioner's arguments which it makes to support its assertion that it complied with regulatory requirements. I find them to be without merit.

Petitioner asserts that its duty pursuant to 42 C.F.R. § 483.25(h)(2) is only to protect its residents against accidents that are foreseeable. It asserts that the risk which led to Resident # 7's accident was not foreseeable and, therefore, according to Petitioner, it is not liable for contravening the regulation's requirements.

The premise which underlies Petitioner's argument that the resident's accident was unforeseeable is that the particular way in which the resident fell – arguably, by pitching herself forward from her wheelchair – was unprecedented at Petitioner's facility. Petitioner's post-hearing brief at 9. Moreover, according to Petitioner, the resident had never fallen from her wheelchair previously by pitching forward from the chair. Therefore, it asserts, it could not possibly have foreseen the accident that occurred on July 16th.

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[6] Petitioner contends that the fall occurred within 20 feet of its nurses' station and that a nurse was in the hallway about 10-20 feet away from the resident and within a line of sight of the resident when the fall occurred. Petitioner's post-hearing brief at 5; P. Ex. 30, at 11; P. Ex. 34, at 3. But, none of these staff members were observing the resident when the resident fell. The close proximity of one or more staff members to the resident at the time of the fall is simply irrelevant if these staff members were not directly supervising her.

[7] On two occasions the resident, in her demented state, removed her surgical collar. CMS Ex. 7, at 37; CMS Ex. 9, at 14-15.

This argument is without merit for several reasons. First, Petitioner is speculating as to how the accident occurred. No member of Petitioner's staff observed the accident.

Furthermore, and despite Petitioner's contention that there was no reason for the staff to assume that the resident might fall forward from her wheelchair, Petitioner had ample notice that precisely such an accident could occur. Indeed, one of the director of nursing's concerns when she participated in the staff's decision to discontinue the resident's seatbelt and chair alarm was that the resident had a history of leaning forward in her chair to touch the floor. CMS Ex. 7, at 23. That concern – which the director of nursing dismissed on July 13 as being no longer a problem – proved to be prescient. Between July 13 and July 16, 2007 the staff observed the resident on several occasions leaning forward from her chair. The staff also had ample notice that the resident was attempting to transfer herself out of the chair.

But, in the final analysis, how the accident occurred does not excuse Petitioner from providing adequate supervision to Resident # 7. Indeed, Petitioner would have contravened the regulation's supervision requirements had *no accident occurred* on July 16. Whether an accident occurred or not the staff was on notice that the resident was engaging in behavior that put her at great risk. And, despite that knowledge, the staff did not enhance the supervision and protection it was giving to the resident. The potential for harm resulting from that failure to supervise is in and of itself sufficient to establish a violation of the regulation's requirements.

Petitioner contends additionally that it provided adequate supervision and assistance devices for Resident # 7. In support of this contention it argues that it had supplied the resident with a backward-leaning low wheelchair without foot pedals which, Petitioner asserts, kept the resident safely seated with her feet planted on the floor. Petitioner's post-hearing brief at 11.[8]

I am willing to accept Petitioner's contention that the low wheelchair may have provided enhanced stability for Resident # 7. But, the fact that Petitioner supplied this resident with this device and that it provided her with some protection simply begs the question of whether Petitioner needed to do more to protect her. Petitioner's staff *knew* that the resident was attempting to rise from the chair after her seatbelt was removed. They *knew* that the resident was leaning forward from the chair. They *knew*, therefore, that the chair was not in and of itself sufficient to protect the resident against obvious risks.

Next, Petitioner asserts that there is neither evidence nor law supporting a theory that restraining a resident (as with a seatbelt) would be acceptable. Petitioner's post-hearing brief at 12. This argument is a red herring. CMS does not contend that Petitioner should have restrained Resident # 7. The question here is whether Petitioner should have

[8] The wheelchair had been supplied to Resident # 7 at some point in time prior to removal of the resident's seatbelt and chair alarm. It was not given to her as an enhanced protection measure in consideration of the removal of these devices.

provided Resident # 7 with enhanced supervision and protection after it removed the resident's seatbelt and chair alarm in light of the known risks to the resident. Contending that the seatbelt had become an unacceptable restraint simply begs that question.

Petitioner then asserts that a tab alarm or lap buddy would have been ineffective protective devices for Resident # 7 because the resident had easily removed these devices when they had been supplied to the resident previously. Petitioner's post-hearing brief at 13. That may be so, but the contention again begs the question of whether Petitioner was providing adequate protection to Resident # 7. Other options were available to Petitioner – such as enhanced supervision of Resident # 7 – even if a lap buddy or a tab alarm were proven to be ineffective protective devices.

Moreover, a tab alarm is a different device from a pressure alarm. A tab alarm is a device that connects to a resident's garment and which is activated when it pulls free. By contrast, a pressure alarm is activated by simple release of pressure. The alarm that Petitioner discontinued at about the same time that it discontinued Resident # 7's seat belt was a pressure alarm and not a tab alarm.

A pressure alarm, had it been present, might have given Petitioner's staff warning that the resident was shifting position in her wheelchair, either in an attempt to rise from the chair, or in the course of leaning forward, and that warning, in turn, might have given the staff a chance to react to the resident's movement and to protect her. Petitioner has offered no satisfactory explanation for its decision to remove the pressure alarm and, indeed, it has offered no evidence to show that removal of the alarm was a considered decision made by the staff after weighing carefully the pros and cons of keeping it.

Petitioner speculates that a pressure alarm would not have protected Resident # 7 because, if she fell as a result of being propelled forward, it would not have sounded until it was too late for the staff to react. Petitioner's post-hearing brief at 14. That is possible. But, there were other scenarios where the alarm would have given the staff warning of the resident's actions. An attempt by the resident to rise out of her wheelchair, for example, would have caused the alarm to sound.[9]

I do not mean to suggest that leaving the resident with a chair alarm after removing her seatbelt would have sufficed to protect the resident adequately. At best, an alarm – whether it is a tab or a pressure alarm – serves only to warn the staff of an impending problem. Alarms *never* substitute for adequate supervision. In this case, leaving Resident # 7 unsupervised, even for short periods of time, constituted a clear violation of

[9] Petitioner argues here, as it argues elsewhere, that the evidence shows that the resident fell by "forward propulsion." Petitioner's post-hearing brief at 15. I reiterate that how the resident fell is irrelevant to my decision. The issue is not precisely how the accident occurred, but whether Petitioner failed to protect the resident from known or foreseeable risks. These may have included falling by being propelled forward, but they also included falling as a consequence of attempting to rise out of the wheelchair unsupervised.

the regulation's requirement that the resident be provided with adequate supervision. Removing the resident's chair alarm served only to aggravate the problem caused by lack of supervision.

Petitioner argues that it should have been allowed a "trial period" during which it could have assessed whether it was providing adequate protection to Resident # 7. Petitioner's post-hearing brief at 15. It contends that, in fact, it was providing the resident with adequate supervision during the first days after the staff had removed her seatbelt given what the staff knew about the resident, and that it should not be penalized if something adverse happened during this "trial period."

Notwithstanding Petitioner's assertion the regulation allows no grace period for a facility to disregard knowledge that what it has implemented is jeopardizing a resident's safety. Petitioner's staff knew that the resident was engaging in highly risky behavior beginning almost immediately after they removed the resident's seatbelt and chair alarm. Whatever the staff assumed before they implemented the decision to remove the seatbelt and chair alarm became almost instantly obsolete. That should have caused them to change their assessment and to modify the care they were providing to the resident.

Finally, Petitioner argues that Resident # 7's fall was unavoidable because it happened so quickly that staff – several of whom were within 10 to 25 feet of the resident at the time of her fall – had no opportunity to react to it. Petitioner's post-hearing brief at 15-17. I find this argument to be unpersuasive for two reasons. First, whether or not there were staff members in the vicinity of Resident # 7 at the time of her accident, *no one was supervising her at that time*. Indeed, despite the relatively intimate presence of staff members, no one saw the resident fall precisely because no one was paying attention to her at that moment. The failure here lies not in the presence or absence of staff but in the failure of the staff to supervise Resident # 7. Second, the failure to supervise would have been proof of noncompliance whether or not the resident fell and whether or not the fall was avoidable. As I have discussed above, the deficiency in this case lies in the failure by Petitioner to protect Resident # 7 against known and foreseeable risks and not in finding whether any specific accident was preventable.

2. A per-instance civil money penalty of $10,000 is reasonable.

CMS is authorized to impose a per-instance civil money penalty, ranging in amount from $1000 – $10,000, as a remedy for noncompliance with Medicare participation requirements. 42 C.F.R. § 488.438(a)(2). The regulations contain criteria to be used in deciding the amount of a per-instance civil money penalty. These criteria include: the seriousness of a deficiency or deficiencies; a facility's compliance history; its culpability; and its financial condition. 42 C.F.R. §§ 488.438(f)(1)-(4); 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)).

In this case CMS determined to impose the maximum per-instance penalty of $10,000. CMS argues that the primary evidence that supports this penalty amount relates to the seriousness of Petitioner's noncompliance. [10]

I find that the seriousness of Petitioner's noncompliance is in and of itself sufficient to justify a $10,000 per instance penalty. The noncompliance in this case was extremely serious. As I have discussed, there is no persuasive evidence that Petitioner's staff made a thorough analysis of the risks that might be encountered by Resident # 7 if the staff removed her seatbelt and chair alarm. Instructions to the staff that they monitor the resident were inadequate because they contained no comprehensive directions to assure that the staff systematically and closely monitor her.

Furthermore, Petitioner knew almost from the inception of its staff's decision to remove Resident # 7's seatbelt and chair alarm that the resident was engaging in behavior that put her at grave risk for injury. That behavior should have been a red flag to Petitioner's staff that the resident was in jeopardy at any moment that she was not being observed. Yet, the staff clearly did not react to the overwhelming evidence of increased risk to Resident # 7 by enhancing the protection that they provided to her.

Petitioner contends that CMS's determination that its noncompliance with the requirements of 42 C.F.R. § 483.25(h)(2) put Resident # 7 in a state of immediate jeopardy is clearly erroneous and should not be a basis for deciding to impose a civil money penalty against Petitioner. An "immediate jeopardy" level deficiency is defined at 42 C.F.R. § 488.301 to be a deficiency that is so egregious that it causes or is likely to cause serious injury, harm, impairment or death to a resident.

Technically, it is not necessary that I make a finding of immediate jeopardy in this case because such a finding is not a prerequisite for imposing a per-instance civil money penalty of up to $10,000. However, all of the elements of immediate jeopardy are present in this case and the evidence establishing the presence of those elements is strong support for a maximum per-instance civil money penalty. The evidence establishes that Resident # 7, by virtue of her dementia and medical conditions, is an individual who is highly susceptible to serious injury or death from falling. Failure to provide the resident with the protections mandated by regulation created a high probability that she would fall and, at the least, sustain serious injuries. And, in fact, the resident sustained life-threatening injuries as a consequence of the fall she experienced while unsupervised by Petitioner's staff. Moreover, even if the fall had not occurred and the resident were uninjured, the

[10] CMS also asserts that Petitioner's compliance history supports the penalty. However, CMS has offered no analysis to explain why previous findings of noncompliance would justify the civil money penalty that it determined to impose here.

extreme level of risk – in and of itself – that Petitioner's actions created would be enough to support a finding of immediate jeopardy.[11]

Petitioner also argues that its compliance history is not so egregious as to support a $10,000 per-instance penalty. As I discuss above, I have not considered Petitioner's compliance history as a factor weighing against Petitioner. The seriousness of Petitioner's noncompliance, without regard to Petitioner's history, is by itself sufficient to justify the penalty amount. Furthermore, even if Petitioner's compliance history were benign, as is contended by Petitioner, the seriousness of its noncompliance would nevertheless justify a $10,000 penalty.

/s/
Steven T. Kessel
Administrative Law Judge

[11] The $10,000 per instance civil money penalty is equivalent to the maximum civil money penalty that I may impose for a single day of immediate jeopardy level noncompliance. 42 C.F.R. § 488.438(a)(1)(i). As CMS notes, it would have been within its discretion to impose daily penalties at the immediate jeopardy level for each day of Petitioner's noncompliance, which began on July 13, 2007 and which extended through at least the 16th of July. Consequently, a penalty of $10,000 is actually a modest penalty when compared to what CMS might have imposed.