Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Maple Manor Rehab Center,	)	Date: June 1, 2009
(CCN: 23-5613),	)	
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-08-703
	)	Decision No. CR1958
Centers for Medicare & Medicaid	)	
Services.	)	
	)	

DECISION

Petitioner, Maple Manor Rehab Center (Petitioner or facility), is a long-tern care facility located in Wayne, Michigan, that is certified to participate in the Medicare program as a provider of services. Following a survey completed June 24, 2008, the Centers for Medicare and Medicaid Services (CMS) determined that the facility was not in substantial compliance with program participation requirements and imposed a $1500 per instance civil money penalty (CMP). Petitioner challenges that determination and CMS now moves for summary judgment.

For the reasons discussed below, I find that summary judgment is appropriate. Based on the undisputed evidence, I conclude that the facility was not in substantial compliance with the Medicare requirement that services provided under a comprehensive care plan meet professional standards of quality, 42 C.F.R. § 483.20(k)(3)(i).

I. Background

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program, and authorizes the Secretary of Health and Human Services to promulgate regulations implementing the statutory provisions. Act § 1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program

requirements. Substantial compliance means that 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.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance with program participation requirements. Act § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months, and more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308.

In this case, surveyors from the Michigan Department of Community Health (State Agency) completed a complaint investigation survey on June 24, 2008. Based on the survey findings, CMS determined that the facility was not in substantial compliance with federal requirements for nursing homes participating in the Medicare program. Specifically, they found that the facility did not provide services that met professional standards of quality as required by 42 C.F.R. § 483.20(k)(3)(i). CMS Ex. 4. CMS imposes a per instance CMP of $1500 for the deficiencies cited under 42 C.F.R. § 483.20(k)(3)(i). CMS Ex. 2, at 1.

Petitioner timely requested a hearing. CMS has moved for summary judgment, which Petitioner opposes. With its motion and brief, CMS has submitted 14 exhibits (CMS Exs. 1-14). With its response (P. Br.), Petitioner submitted 12 exhibits, which are identified as P. Exs. 1-12, with P. Ex. 1 deliberately omitted. Thereafter, Petitioner asked leave to supplement its pre-hearing exchange with three additional documents, identified as P. Exs. 13-15. CMS has voiced no objections to the supplemental submissions.

II. Issues

I consider whether summary judgment is appropriate.

On the merits, the issue is whether the facility was in substantial compliance with 42 C.F.R. § 483.20(k)(3)(i). Except to argue that it was in substantial compliance, Petitioner has not challenged the reasonableness of the CMP, so that issue is not before me.[1]

Petitioner has argued that CMS's determination as to scope and severity is unreasonable. I have no authority to review scope and severity findings unless a successful challenge would affect the range of the CMP, or CMS has made a finding of substandard quality of care that results in the loss of approval of the facility's nurse aide training program. Here, the penalty imposed is per instance, so a successful challenge would not affect the

[1] As CMS points out, the $1500 CMP is just $500 above the minimum amount for per instance penalties. 42 C.F.R.§ 488.438(a)(2).

range of the penalty; the nurse aide training prohibition was rescinded when the facility brought itself back into substantial compliance. CMS Ex. 3, at 2. I therefore have no authority to review scope and severity.

III. Discussion

CMS is entitled to summary judgment because the undisputed facts establish that facility staff did not provide services that met professional standards of quality as required by 42 C.F.R. § 483.20(k)(3)(i).[2]

Summary judgment is appropriate if a case presents no genuine issue of material fact. "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 . . . ." *Livingston Care Center*, DAB No. 1871, at 5 (2003). The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law, or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to [that party's] case, and on which [that party] will bear the burden of proof at trial." *Livingston Care Center v. U.S. Dep't of Health & Human Services*, 388 F.3d 168, 173 (6th Cir. 2004) (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986)). To avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986); s*ee also Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004). In examining the evidence for purposes of determining the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *Livingston Care Center*, 388 F.3d at 172; *Guardian Health Care Center*, DAB No. 1943, at 8 (2004). 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. *Cf. Guardian Health Care Center*, DAB No. 1943, at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.").

CMS's case involves the care provided to two of the facility's residents, identified as Resident 112 (R112) and Resident 115 (R115). For each of these residents, a physician's order directed that he or she not bear any weight on one leg. CMS alleges as undisputed fact – and presents evidence to establish – that facility staff did not provide or arrange services to ensure that those physicians' orders were followed. In CMS's view, such failures put the facility out of substantial compliance with 42 C.F.R. § 483.20(k)(3)(i),

[2] I make this one finding of fact and conclusion of law.

which mandates: 1) that the facility develop for each resident a comprehensive care plan with measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs as identified in the resident's comprehensive assessment; and 2) that the services provided or arranged by the facility pursuant to that plan meet professional standards of quality.

R112. The basic facts regarding R112 are not disputed. R112 was admitted to the facility on January 8, 2008, after undergoing surgical repair of his right hip. CMS Ex. 7, at 6; P. Ex. 8, at 1. Upon admission, his diagnoses included a closed fracture to his femur, Parkinson's disease, and dementia. P. Ex. 8, at 1, 4.[3] R112's transfer instructions indicated that he was confused at times, required assistance with ambulation, and was to be strict non-weight bearing on his right leg. P. Ex 8, at 3. Consistent with the transfer instructions, R112's physician ordered that he not bear any weight on his right leg, an order that was repeated throughout his stay at the facility. P. Ex. 8, at 7; *see also* P. Ex. 8, at 21, 25, 28; CMS Ex. 7, at 27, 86, 110, 140 ("no weight bearing . . . *please*."). He required a wheelchair as well as staff assistance with transfers and standing. CMS Ex. 7, at 37, 80.

R112 was also confused and unaware of his hip fracture. He did not understand that he should not bear weight on his right leg, and would frequently get out of his bed or wheelchair. P. Ex. 5, at 1 (Begin Decl. ¶ 8-9); P. Ex. 8, at 6, 28; CMS Ex. 7, at 27 ("nursing reports [resident] has difficulty observing [no weight bearing] to [right] leg [due to] confusion and unable to follow instructions [due to] cognitive impairment"), 86.

To address the problem, facility staff put a bed bolster in his bed and raised his side rails. Bed and chair alarms were in place. P. Ex. 14, at 140-142; P. Ex. 15, at 13. A written care guide was placed in his room to advise direct care staff of his condition. Staff were instructed to "monitor" his attempts to bear weight, to explain the importance of compliance, and to encourage him to use his call light for assistance. P. Ex. 8, at 4-5, 28, 49, 55. His room was directly across from the nurses' station. P. Ex. 14, at 173; P. Ex. 15, at 14. On January 11 his physician ordered a lap buddy, which was placed on his wheelchair. P. Ex. 15, at 16.

But everyone agrees that these measures did not prevent R112 from putting weight on his right leg, and that he successfully thwarted facility efforts to prevent him from weight-bearing. P. Ex. 14, at 144; P. Ex. 15, at 16, 37; P. Ex. 8, at 6 ("Resident is able to remove lap buddy by himself and multiple attempts to get up . . . noted . . . resident is noted not to follow instructions."); P. Ex. 8, at 12, 13, 34 ("[n]eeds constant supervision as he continually attempts unsafe, unassisted transfer/ambulation"), 36, 40, 42 ("education was

[3] Facility documents occasionally report R112's diagnosis as Alzheimer's rather than Parkinson's disease. The bulk of the evidence shows that he suffered from Parkinson's. *Compare* P. Ex. 8, at 1, *with* P. Ex. 8, at 4, 6, 49, *and* P. Ex. 14, at 26.

to no avail since [resident] is non-receptive to care and teaching due to severe confusion"); CMS Ex.7, at 30, 55, 90, 104, 167 ("resident is noted to get up and down from his wheelchair and attempts to ambulate by himself is noted [sic] multiple times during the day as well as during his waking hours; when in bed – he also is noted to get up from bed and attempts to get out of his room; he does not use the call light when instructed to do so . . ."); P. Ex. 13, at 122; P. Ex. 14, at 141 (his bed and chair alarms went off "constantly"), 170; P. Ex. 5, at 1-2 (Begin Decl. ¶¶ 10, 14); P. Ex. 14, at 136 ("Repeatedly took off safety devices, would disrobe to where the devices attached to his clothing would not be effective. He damaged and took apart part of a wheelchair" in an apparently successful effort to disarm his chair alarm.).

A January 22 report from R112's interdisciplinary team's care-planning conference reflects that his family asked that he be provided one-on-one supervision. P. Ex. 13, at 126; P. Ex. 14, at 109. The report also incorporates recommendations from the physical/occupational therapy department that R112 be supervised "24/7" to prevent weight-bearing. Surveyor Deborah Fenner testified that "24/7" means that he needed someone with him at all times. P. Ex. 13, at 120-121; P. Ex. 14, at 98-100. The facility's Director of Nursing (DON), Cecelia Nugal, agreed that "24/7" requires "that there is always somebody with the patient supervising his activities" (P. Ex. 15, at 23), but argued that the facility could accomplish the necessary level of supervision without specifically providing one-on-one supervision.[4]

> What we mean with 24/7 is supervise the patient 24 hours a day, seven days a week. It doesn't mean that there is a one-on-one in there – in there with the patient. Meaning that we are already providing 24/7 care because we have nurses and CNAs around . . . the clock.

P. Ex. 15, at 22-23. To the extent that the parties disagree on the care plan's meaning, for summary judgment purposes, I accept DON Nugal's interpretation: the facility could provide R112 the level of supervision called for in his plan without providing one-on-one

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[4] DON Nugal nevertheless agreed that a one-on-one sitter would have prevented R112 from getting out of bed. P. Ex. 15, at 47. Her opinion is consistent with Certified Nursing Assistant (CNA) Michael Begin's testimony that, when physically present with R112, he was able to prevent the resident from getting out of his bed or wheelchair. P. Ex. 14, at 172. Elsewhere, however, DON Nugal inconsistently suggested that, even with the closest monitoring, staff were incapable of preventing R112 from bearing weight on his right leg, and that the facility could only have protected him by imposing restraints, which its policies precluded. P. Ex. 10. If, in fact, the facility was not capable of keeping the resident safe, which may have been the case, given its admitted lack of experience with cognitively impaired individuals, it should not have admitted him. *See* P. Ex. 9, at 2 (Duba Decl. ¶ 8) ("Generally, we do not normally accept patients with severe cognitive impairment.").

supervision, so long as he was at all times in "sight and hearing distance" of facility staff. *See* P. Ex. 15, at 88.

The parties also agree that R112 ultimately suffered an injury related to bearing weight on his right leg. On January 29 his physician reported "collapse of the fracture secondary to early weightbearing." CMS Ex. 7, at 161. X-rays confirmed that the right hip fracture collapsed and that the surgically placed screws were "backing out." P. Ex. 8, at 22. R112's physician again ordered that R112 continue "STRICT NON WEIGHT BEARING on right leg." P. Ex. 8, at 22 (emphasis in original); CMS Ex. 7, at 178 (NON-Weight bearing on right leg) (emphasis in original); *see also* P. Ex. 8, at 23.

The parties disagree about whether R112's injury is related to his weight-bearing during an incident that occurred on January 11, 2008. First, the cause of the fracture's collapse is of marginal importance since I need not find actual harm in order to sustain the finding of substantial noncompliance. Without question, R112's physician ordered that he not be allowed to bear weight on his right leg because doing so would jeopardize his recovery. Such jeopardy creates "the potential for more than minimal harm." Whenever a deficiency poses the potential for more than minimal harm, the facility is not in substantial compliance, and CMS has the authority to impose a remedy. Act § 1819(h); 42 C.F.R. §§ 488.301, 488.402, 488.406.

With respect to the January 11 incident, CMS claims that an unidentified CNA, disregarding the family's objections, helped R112 walk to the bathroom without an assistive device, bearing weight on his right leg. CMS Ex. 6, at 28; *see* P. Ex. 14, at 16, 17. At the time of the survey, DON Nugal confirmed the family's account. CMS Ex. 4, at 5.

Now, however, Petitioner challenges that version of events, explaining that the DON only learned of the incident from nurses (whom Petitioner does not identify), whose only knowledge came from the family's complaints. P. Ex. 15, at 7-10. Petitioner maintains that, on January 11, CNA Michael Begin was walking past R112's room when he observed the resident returning from the bathroom, walking and bearing weight on his right leg. No other staff were present. CNA Begin entered the room and returned R112 to his bed. P. Ex. 5, at 2 (Begin Decl. ¶¶ 15, 16, 17); P. Ex. 14, at 138-139. The bed alarm had not sounded because the resident had removed his shirt, to which the alarm was attached. "[H]e had a habit of disrobing down to nothing." P. Ex. 14, at 169.

For purposes of summary judgment, I accept Petitioner's version of events, and, based on that version and the other undisputed facts, I find that facility did not provide services in accordance with the resident's care plan that met professional standards of quality. In reaching this conclusion, I recognize that Petitioner has presented opinions from physicians and staff that the facility's actions were adequate. *See, e.g.*, P. Ex. 9, at 3 (Duba Decl. ¶¶ 15, 16). I am not obligated to accept these conclusions. An opinion

unsupported by a rationale or reference to specific facts is insufficient to create a triable issue. *Guardian Health Care Center*, DAB No. 1943, at 13 (citing *Shaw by Strain v. Strackhouse*, 920 F. 2d 1135, 1144 (3d Cir. 1990) (expert affidavits that are conclusory and lacking in specific facts are insufficient to create a genuine factual dispute) and *United States v. Various Slot Machines on Guam*, 658 F.2d 697, 699-701 (9th Cir. 1981)).

First, as CNA Begin's testimony illustrates, the facility staff was not providing the level of supervision called for in R112's care plans. Notwithstanding the location of his room and the use of bed and chair alarms, R112 was well able to remove the alarm, get out of bed, placing weight on his vulnerable leg, walk to the bathroom and be well on his way back to bed without the staff's knowledge or intervention. The overwhelming and undisputed evidence establishes that R112 habitually engaged in such conduct, and the facility's strategy – to assume that sufficient staff would inevitably be in his general area to observe and intervene as necessary – was plainly insufficient to meet his needs.

An alternative inference could be drawn from Petitioner's version of events – that staff were available as anticipated and, in fact, observed his behavior but declined to intervene, knowingly allowing him to bear weight on his vulnerable leg. *See, e.g.*, P. Ex. 12, at 6 (Evangelista Decl.) ("multiple staff constantly monitor[ed] him closely"). In either case, the facility was not providing a level of services sufficient to meet his needs and the regulatory requirement. Petitioner has not come forward with evidence of alternative facts that would warrant a finding of substantial compliance, and, under any interpretation of the facts Petitioner presents, the facility was not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(i). *See Windsor Health Care Center*, DAB No. 1902 (2003).

I note also that the undisputed evidence establishes that CNA Begin did not report the incident. Nursing notes for January 11-12 include no mention of R112's having left his bed and walked to the bathroom, with or without the assistance of a CNA. CMS Ex. 7, at 89-92. And, even though R112's family complained about it to the nursing staff, accusing the CNA of mistreating R112, the incident was neither reported nor investigated until January 29, following the discovery of R112's fracture collapse. P. Ex. 4; P. Ex. 8, at 23; P. Ex. 14, at 52, 170. Professional standards of quality require that incidents be reported and investigated. *See, e.g.*, *Century Care of Crystal Coast*, DAB No. 2076 (2007), *aff'd, Century Care of Crystal Coast v. Leavitt*, No. 07-1491 (4th Cir., May 13, 2008).

R115 was admitted to the facility on June 12, 2008, after undergoing open reduction internal fixation surgery for a displaced fracture of the right patella. Her assessments, therapy evaluations, and physician orders all mandated strict non-weight bearing on her right leg. CMS Ex. 8, at 1, 6, 15-16, 18-20. As with R112, the facility's plan to assure compliance with this mandate included the use of a written care guide, which was

supposed to be placed in her room, advising staff of her condition. However, according to CMS, on June 24, 2008, the surveyor found no care guide in R115's room. CMS Ex. 6, at 30. DON Nugal and two CNAs searched the resident's room and the nurses' station but were unable to locate the care guide. CMS Ex. 6, at 30; CMS Ex. 4, at 6. Petitioner does not challenge CMS's assertions. The facility was thus not following its own plan for assuring that staff knew that R115 was not allowed to bear weight on her right leg, and was not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(i).

Thus, accepting as true all of Petitioner's factual assertions, the facility was not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(i). The regulations require the facility to provide services that meet professional standards of quality. While the facility implemented some interventions, they did not provide to R112 the level of supervision called for in his care plan. As a result R112 was allowed to bear weight on his right leg in contravention of his physician's orders. Nor did the facility post R115's care guide in her room. Indeed, staff were not even able to produce such a guide.

Because the undisputed facts show that the facility did not provide R112 or R115 with services that meet professional standards of quality, and therefore, the facility was not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(i), CMS is entitled to summary judgment on that issue.[5]

IV. Conclusion

For all of the reasons discussed above, I find that the facility was not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(i).

/s/
Carolyn Cozad Hughes
Administrative Law Judge

[5] Petitioner also attacks the quality of the survey. *See* P. Br. at 9-13. In this *de novo* review, I do not consider the method by which CMS reached its determination.