Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Mission Oaks Manor,
(CCN: 67-5409),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-09-384

Decision No. CR2102

Date: April 1, 2010

DECISION

This case presents questions involving the proper use of restraints in a long-term care facility.

Petitioner, Mission Oaks Manor (Petitioner or facility), is a long-term care facility located in San Antonio, Texas, that participates in the Medicare program. The facility restrained mentally ill and sometimes volatile residents in geriatric chairs (geri-chairs)[1] using pelvic restraints. On multiple occasions, residents deliberately flipped or otherwise fell to the floor while so restrained, resulting in multiple injuries and one fatality. The Centers for Medicare & Medicaid Services (CMS) has determined that the facility was not in substantial compliance with Medicare requirements governing restraints and resident neglect, and that its deficiencies posed immediate jeopardy to resident health and safety. CMS has imposed two per-instance civil money penalties (CMPs) of $5,000 each.

The parties have filed cross-motions for summary judgment.

For the reasons set forth below, I find that the facility was not in substantial compliance with Medicare program requirements, and that the penalties imposed -- $5,000 per instance for two of the deficiencies cited (total: $10,000) -- are not unreasonably high. I therefore grant CMS's motion for summary judgment and deny Petitioner's.

[1] A geri-chair is a reclining chair that sits on casters. CMS Ex. 23; CMS Ex. 28 at 7.

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 those 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. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. 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.

Here, following a complaint investigation survey, completed January 27, 2009, CMS determined that the facility was not in substantial compliance with Medicare participation requirements, and that deficiencies cited under 42 C.F.R. § 483.13(a) (Tag 221 – physical restraints) and 42 C.F.R. § 483.13(c) (Tags F225 and F226 – staff treatment of residents) posed immediate jeopardy to resident health and safety. CMS Exs. 1, 2. Based on these findings, CMS has imposed two per instance civil money penalties: $5,000 for the deficiencies cited under § 483.13(a), and $5,000 for the deficiencies cited under 42 C.F.R. § 483.13(c). CMS Exs. 1, 3.

Although other deficiencies were cited, CMS rescinded all other penalties when it determined that the facility achieved substantial compliance.

Petitioner timely requested a hearing.

The parties have filed cross-motions for summary judgment and memoranda in support of their positions (CMS MSJ Br.; P. MSJ Br.) as well as response briefs (CMS Response; P. Response). CMS has submitted 29 exhibits (CMS Exs. 1-29). Petitioner has submitted 15 exhibits (P. Exs. 1-15).

II. Issues

I consider whether summary judgment is appropriate.

On the merits, the issues before me are: 1) whether, at the time of the survey, the facility was in substantial compliance with 42 C.F.R. §§ 483.13(a) and (c); and 2) if the facility was not in substantial compliance, were the remedies imposed -- $5,000 per instance for each of the two deficiencies cited – reasonable.

Because no penalties were imposed for the other deficiencies cited, Petitioner is not entitled to review of them. 42 C.F.R. §§ 498.3(b)(13); 498.3(d)(10)(ii); *Schowalter Villa*, DAB No. 1688 (1999).

Nor have I the authority to review the immediate jeopardy determination. An ALJ 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); 42 C.F.R. § 498.3(d)(10); *see Evergreen Commons*, DAB No. 2175 (2008); *Aase Haugen Homes*, DAB No. 2013 (2006). Here, the penalty imposed is a per instance CMP, for which the regulations provide only one range ($1,000 to $10,000), so the level of noncompliance does not affect the range of the CMP. 42 C.F.R. § 488.438(a)(2). Nor does CMS's scope and severity finding affect approval of the facility's nurse aide training program. The facility was not enrolled in a nurse aide training program at the time of the survey. Moreover, the state could not approve the facility's nurse aide training program even if it had one, because the facility has been assessed a CMP of $5,000 or more. Act § 1819(f)(2)(B); 42 C.F.R. § 483.151(b)(2)(iv).

Finally, I have no authority to review Petitioner's constitutional claims.

III. Discussion

Summary Judgment. Summary judgment is appropriate if a case presents no genuine issue of material fact, and the moving party is entitled to judgment as a matter of law. *Illinois Knights Templar Home*, DAB No. 2274 at 3-4 (2009), and cases cited therein.

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. Dep't of Health & Human Services*, 388 F.3d 168, 173 (6th Cir. 2004) (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (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). *See also Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004).

> 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 . . . .

Illinois Knights Templar, DAB No. 2274 at 4; *Livingston Care Center*, DAB No. 1871 at 5 (2003).

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. *Brightview Care Center*, DAB No. 2132 at 2, 9 (2007); *Livingston Care Center*, 388 F.3d at 172; *Guardian Health Care Center*, DAB No. 1943 at 8 (2004). *But see Brightview*, DAB No. 2132 at 10 (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. *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.").

Here, I have accepted, for summary judgment purposes, every one of Petitioner's *supported* allegations, even those for which the support seems extraordinarily weak.

A. CMS is entitled to summary judgment that the facility was not in substantial compliance with 42 C.F.R. § 483.13(c), because the undisputed evidence establishes that staff repeatedly left vulnerable residents restrained in geri-chairs, knowing that they were capable of flipping themselves over when so restrained.[2]

Facilities must develop and implement written policies and procedures that prohibit resident neglect. 42 C.F.R. § 483.13(c). "Neglect" means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. 42 C.F.R. § 488.301. *See Jennifer Matthew Nursing & Rehabilitation Center*, DAB No. 2192 at 19 (2008).

Resident 13. CMS has presented evidence (the facility's own documents) establishing that, in the middle of the night, facility staff restrained Resident 13 (R13), a mentally ill and agitated resident, in a geri-chair and left him, unsupervised, in one of the facility's dining rooms even though he had a history of flipping himself over when so restrained. Petitioner has not come forward with evidence suggesting a dispute over these facts. By itself, this undisputed evidence regarding staff treatment of R13 establishes the facility's substantial noncompliance with 42 C.F.R. § 483.13(c) and justifies imposing significant penalties.

R13 was a 60-year-old man when first admitted to the facility on August 28, 2008. His diagnoses included schizoaffective disorder, dementia, hypertension, obesity, sleep apnea, gastroesophageal reflux disease, and other ailments. CMS Ex. 20 at 1, 8, 19, 20, 42. He had neither a history nor diagnosis of seizures. P. Ex. 13 at 24, 98-104. *See* P. Ex. 6 at 1 (Rapp Decl. ¶ 3).

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[2] My findings of fact/conclusions of law are set forth, in italics and bold, in the discussion captions of this decision.

At the time of his admission, R13 was able to walk independently, using a cane or walker. P. Ex. 13 at 26. Staff determined that he was at risk for falls and elopement (CMS Ex. 20 at 73-74), and his care plan listed a number of interventions to address these issues, including non-skid shoes, placing needed articles within his reach, encouraging him to use a walker for ambulation, encouraging rest periods, reminding him to change positions slowly and to use his call light, therapy screens/referrals as needed, monitoring certain medications, and providing physical therapy reviews as needed. CMS Ex. 20 at 75.[3] No restraints were ordered or in use for him. CMS Ex. 20 at 34, 36.

Facility response to R13's deteriorating behaviors. As reflected in nurses' notes, however, by November 2008, R13 was engaging in self-injurious behaviors, and, on a few occasions, he attacked the staff who attempted to intervene. In response, staff began regularly to obtain, by telephone, physician orders authorizing them to restrain him in a geri-chair, using a pelvic restraint. P. Ex. 13 at 6; P. Ex. 6 at 1 (Rapp Decl. ¶3).

Specifically:

- A nurse's note dated **November 5, 2008**, says that at about 9:10 p.m. a nurse aide observed R13 attempting to hit his face against a door frame. When she intervened, he "punched her in the face." He then went into the hallway and "got onto the floor [and] placed self on floor." He yelled for the nurses to help him, claiming to have fallen. They put him in a geri-chair with a pelvic restraint, citing "lack of safety awareness." They left him at the nurses' station "for closer observation." P. Ex. 13 at 6.

  A telephone order dated November 5, 2008, says "placed" resident in geri-chair with a pelvic restraint for 24 hours, due to "lack of safety awareness"; release every two hours. CMS Ex. 20 at 54.

- A nurse's note written at 3:00 a.m. on the morning of **November 12, 2008,** describes R13 as awake and "very anxious, wanting medications for his anxiety."

[3] Both CMS and Petitioner have described this care plan as "dated January 9, 2009." CMS MSJ Br. at 6; P. MSJ Br. at 20. In fact, the document was initiated on September 10, 2008, with a goal date of December 10, 2008. The January 9 date was added later, presumably following a January 2009 review. The original plan addressed R13's "potential for falls & related injuries" related to cognitive deficits/impaired safety awareness, psychotropic medication use, unsteady gait, and visual deficits. Over time, additional behaviors and interventions were added, and those additions are dated. *See* 42 C.F.R. § 483.20(k). The staff revisited the plan in November 2008 and January 2009. The entry "throws self to floor" sits between two dates: "11-24-08 . . . throws self to floor . . . 1-5-09." Presumably, this means that the behavior was first noted in the care plan on November 24, and, as of January 5, the behavior continued. It appears that no interventions were added to address that behavior on either date, except to "intervene PRN."

He was given Ativan. P. Ex. 13 at 7. At 2:30 in the afternoon, a nurse's note indicates that R13 was in the office of the Director of Nursing (DON). He announced that he was going to do "bad things" and then lay on the floor and knocked over a ceramic column with a vase on it. Staff put him in a geri-chair, according to the note, due to "lack of safety awareness." They again placed him at the nurses' station "for closer observation." P. Ex. 13 at 7.

A telephone order dated November 12, 2008, from Dr. Valdez (Olivia Valdez, M.D.) authorizes placing the resident in a geri-chair with "pelvic" for 24 hours, due to "lack of safety awareness," and to release for ten minutes every two hours. CMS Ex. 20 at 53.

- A note written at 4:00 a.m. on **November 13, 2008,** says that R13 "continued to be in [geri-chair] for behavior" but was released at 1:00 a.m. and assisted to bed. P. Ex. 13 at 7.

  A report of a physical examination on Geriatrics Associates of America letterhead is dated November 13, 2008, and refers to an un-witnessed fall. The report does not mention behavior problems or restraints. P. Ex. 13 at 75.

- In a psychiatric follow-up, dated **November 14, 2008**, Dr. Valdez describes R13 as very anxious, worried, fearful, pacing, restless, and agitated. Dr. Valdez writes that R13's paranoia and delusions continue and mentions "depressed, needy." She describes his affect as "flat, tense, suspicious." Her plan is to increase his medications. She says nothing about physical restraints, or lack of safety awareness. P. Ex. 13 at 31.

- At 1:00 in the afternoon of **November 18, 2008,** according to the nurse's note, R13 was "noted sitting on the floor of his room," claiming that he had fallen and hit his head. No injuries were noted. P. Ex. 13 at 7. An incident report prepared the following day says that he subsequently recanted, reporting that he purposely sat down, but, because he had a headache, he told the staff that he fell and hurt his head. P. Ex. 13 at 45-48.

- A nurse's note, dated **November 24, 2008**, at 5:00 p.m., indicates that R13 ambulates using a walker. His current behavior includes throwing himself on the floor, but he is "easily redirected verbally." He also has constant crying episodes. CMS Ex. 20 at 61.

  On the same day, a note was added to his August 28, 2008, MDS (minimum data set): "resident constantly throws self to ground." CMS Ex. 20 at 26.

  According to a separate form, dated the same day, no injuries were noted. The form asks whether fall/restraint risk assessments have been performed or are needed, but the section is left blank. P. Ex. 13 at 49.

Another report from Geriatrics Associates of America, dated November 24, 2008, indicates that nursing requested an evaluation following a fall. It mentions lethargy and suggests that, if falls persist, the resident be referred for further evaluation. Again, the report includes no mention of restraints. P. Ex. 13 at 76.

Entries to R13's care plan, dated November 24, 2008, add to the problem list "throws self to the floor." Although difficult to read, an additional intervention says "intervene and redirect if resident throws self on floor," assess for bruises and other injuries as needed. CMS Ex. 20 at 75, 76.

- An incident report, prepared **November 25, 2008,** says only that future episodes of throwing himself to the floor could cause injuries and that the resident was encouraged to ask for assistance as needed. The incident report says nothing about restraints. P. Ex. 13 at 50-53.

  Nevertheless, that same day, November 25, 2008, a telephone order calls for geri-chair with pelvic restraint for 24 hours, release for ten minutes every two hours for resident safety. CMS Ex. 20 at 52.

- A telephone order, dated **November 28, 2008**, again calls for geri-chair for 24 hours, release for ten minutes every two hours for resident safety. CMS Ex. 20 at 52.

- At 8:00 a.m. on **November 29, 2008**, a nurse's note describes R13 as "sitting on wheelchair [and] throwing himself onto the floor" without visible injuries. After a call to his physician's office, he is restrained in a geri-chair with a pelvic restraint. CMS Ex. 20 at 62.

  In a separate report, no recommendation for "fall/restraint assessments" is checked. CMS Ex. 20 at 72.

  A telephone order from Dr. Rapp (Keith Rapp, M.D., C.M.D.), dated November 29, 2008, at 8:00 a.m., calls for geri-chair with pelvic restraint for 24 hours, release every two hours for 10 minutes for resident safety. CMS Ex. 20 at 51.

- A nurse's note, dated **December 4, 2008**, at 9:30 p.m., says that R13 attacked a nurse aide, "blindsiding her [and] throwing himself on top of her [and] refusing to get up [and] holding her down." Staff administered a shot of Ativan and, according to the note, put R13 in the geri-chair due to "lack of safety awareness." CMS Ex. 20 at 62. He apparently went to sleep in the chair and, at 2:00 a.m., staff put him to bed. CMS Ex. 20 at 62.

An incident report, dated December 4, 2008, says that R13 had a bruise on the right side of his forehead. When asked what happened, he said that he must have fallen, but then when asked if he had fallen, he said "I don't know." P. Ex. 13 at 54.

A separate form describes the incident and says again that no fall or restraint assessment is needed. CMS Ex. 20 at 71.

According to the final disposition report, dated December 8, 2008, "no orders were received," but the psychiatrist recommended Veterans' Administration (VA) hospitalization if his self-injurious behavior continued. P. Ex. 13 at 55, 57.

Notwithstanding the report's assertion of no new orders, a December 4, 2008, telephone order from Dr. Rapp authorizes a geri-chair with pelvic restraint for 24 hours, release every ten minutes for resident safety. CMS Ex. 20 at 51. Also confusing, in light of the final disposition report, a note indicates that R13 was apparently transported to the VA hospital at noon on December 4. P. Ex. 13 at 9. *See also* CMS Ex. 20 at 50 (physician telephone order to send to VA for evaluation and treatment).

That R13 subsequently went to the VA hospital is certain, although the record is not altogether clear as to when he went. Some of the notes suggest he was transferred on December 4, 2008, but nurses' notes for December 5 place him at the facility, anxious and tearful, asking to go to the hospital. His physician approved transfer to the VA hospital. CMS Ex. 20 at 63.

While at the VA, staff noted that R13 tried to throw himself out of bed, tried to get out of bed by himself, and had an unsteady gait. According to records dated December 14 and 16, 2008, the VA's intervention was to "maintain close observation for safety," which apparently had "prevented [him] from falling." The plan was to continue close observation. He was also given an extra low bed. P. Ex. 13 at 113, 115-16.

- R13 was re-admitted to the facility on **December 17, 2008**. A nurse's note describes new and old bruising, characterizes R13 as confused and wandering, with "several redirection attempts needed to complete assessment." CMS Ex. 20 at 55.

  A December 17, 2008, telephone order, attributed to Dr. Rapp, says "place in [geri-chair with] pelvic [for 24 hours due to] lack of safety awareness. CMS Ex. 20 at 49.

  A physical therapy screening form refers to R13 as "status post fall December 17, 2008," and contains the following note from a physical therapy assistant: "Resident ambulated out of his room [and] into middle of hallway [and] let himself fall backwards. Resident put in geri-chair [with] pelvic restraint due to

lack of safety awareness." CMS Ex. 20 at 98-99. The form says nothing about whether he could benefit from therapy.

An incident report says that he ambulated out of his room to the middle of the hallway and let himself fall backward. He voiced no complaints of pain or discomfort, although he suffered a hematoma. P. Ex. 13 at 58. The report lists physician orders to monitor for pain and perform neurological checks; it says nothing about any order for restraints. P. Ex. 13 at 59.

A separate report describes the incident and again says, remarkably, that "no fall/restraint assessment needed." CMS Ex. 20 at 70.

- At 2:00 a.m. on **December 18, 2008**, a nursing note describes the resident as "up in geri-chair" due to throwing himself to the floor. CMS Ex. 20 at 55.

  A physician telephone order dated December 18 calls for "skull series." CMS Ex. 20 at 49.

- An incident report, dated **December 22, 2008**, says that at 8:15 p.m., R13 was walking down the hall toward the nurses' station, when he "threw" himself forward. He broke his fall with his palms and knees, but hit the left front of his forehead, sustaining two hematomas. Redness was also noted on his palms and knees, but he voiced no pain or discomfort. He was sent to the VA hospital for a computerized tomography (CT) scan and skull x-rays. P. Ex. 13 at 60, 61; CMS Ex. 20 at 47.

  Another document describes the incident and indicates that a fall assessment (but not a restraint assessment) is needed. CMS Ex. 20 at 69.

  The final disposition report says that the resident continues to require staff reevaluation related to self-injurious behavior and mentions that the family is supportive, with increased visits and telephone calls. It also says that the care plan team has been notified, and physicians have or will review medications. P. Ex. 13 at 63. Again, the report says nothing about physical restraints.

- R13 was released from the VA on **December 29, 2008**, and returned to the facility. Kevin McNamara, M.D., his physician at the VA, noted his agitation and aggressiveness, but called for medication, close observation, and "restraints only if absolutely necessary." P. Ex. 13 at 93.

  A readmission report says no behavior problems reported and indicates that he was using a wheelchair at the time of readmission. P. Ex. 13 at 64. When he stood up from the wheelchair, a nurse's note indicates that he was redirected to sit on the bed, and he complied. But he apparently attempted again to throw himself on the floor, so was placed in restraints in a geri-chair "for lack of safety awareness."

CMS Ex. 20 at 57. A form titled "nursing comprehensive admission data" dated December 29 indicates, under a section titled "ADL" (activities of daily living) that the resident uses a wheelchair and a geri-chair, but does not explain why. It says nothing about behaviors or restraints. P. Ex. 13 at 1-4.

A report from Geriatric Associates of America dated December 29, 2008, finally mentions his behavior and says "safety, geri-chair [with] pelvic restraint." P. Ex. 13 at 77.

On December 29, 2008, use of a geri-chair with pelvic restraint is added to R13's care plan as an intervention to address falls and related injuries as well as dementia. CMS Ex. 20 at 75-76. His readmission orders also call for a geri-chair with pelvic restraint, listing the reason as "lack of safety awareness." The order instructs staff to "release and reposition" every two hours for ten minutes. CMS Ex. 20 at 42. Nevertheless, on December 29 (time is not indicated), staff also obtained a telephone order authorizing geri-chair with pelvic restraints due to lack of safety awareness. CMS Ex. 20 at 46.

- At 2:00 p.m. on **December 31, 2008**, he is up in his geri-chair with a pelvic restraint, according to the nursing note. No justification for the restraint is offered. In fact, the note says "no [signs or symptoms] of distress." CMS Ex. 20 at 57.

- A nursing note dated **January 1, 2009**, at 8:00 p.m. describes R13 as up in a geri-chair with pelvic restraint. When released after two hours, he attempts to throw himself to the floor. CMS Ex. 20 at 58.

- At 2:00 a.m. on **January 2, 2009**, according to the nurse's note, he is again in the geri-chair, because of attempts to throw himself to the floor. He asked to go to bed, and staff put him in bed, but he attempted to throw himself to the floor. So, at 2:15 a.m., staff restrained him in the geri-chair. CMS Ex. 20 at 58.

  At 5:00 a.m., staff noticed increased bruising on R13's forehead. When asked about it, he said that he "slipped." Subsequent entries for the day describe him as restrained in a geri-chair, and say that, when released, he tried to throw himself to the floor. CMS Ex. 20 at 58.

- At 3:00 a.m. on **January 3, 2009**, according to the nurse's note, R13 is up in a geri-chair. CMS Ex. 20 at 59.

- On **January 4**, **2009,** he is in the geri-chair due to trying to throw himself to the floor. CMS Ex. 20 at 59.

- A nurse's note and an incident report dated **January 5, 2009**, indicate that R13 was throwing himself to the floor, but provides no additional information. P. Ex. 13 at 66; CMS Ex. 20 at 59. On the incident report, "fall risk assessment" is

checked (although not initialed), which appears to mean that one is necessary. CMS Ex. 20 at 68.[4]

Skull x-rays were negative. According to the report, the resident "is now wearing a soft helmet" and staff and family continue to assist as needed. P. Ex. 13 at 66-67. The report says nothing about restraints.

A second report "prepared in anticipation of litigation," says that at 3:30 a.m., he threw himself to the floor, hitting the top and side of his head. P. Ex. 13 at 68.

- On **January 9, 2009**, a social worker's psycho/social assessment notes that the resident has been throwing himself out of bed, and injuring himself. She notes that his family is supportive, and that social work will follow as needed. The note does not mention restraints. P. Ex. 13 at 80.

  An MDS completed January 9, 2009, identifies socially inappropriate/disruptive behavioral symptoms exhibited within the previous week that were "not easily altered." It says that he requires a one-person physical assist for most activities of daily living. CMS Ex. 20 at 18. The form indicates that a trunk restraint and chair to prevent rising are used *daily*. CMS Ex. 20 at 21. It refers to nursing notes to document behavioral symptoms and use of restraints. CMS Ex. 20 at 24.

R13's success in flipping over himself and the geri-chair while restrained. Undisputed evidence establishes that by mid-January, R13 was capable of flipping himself over – chair and all -- while restrained in his geri-chair:

- On **January 10, 2009**, at 10:00 a.m., a nurse's note describes R13 as "yelling" and "throwing himself backwards into his geri-chair repeatedly." When verbal redirection proved ineffective, he was given a shot of Ativan. CMS Ex. 20 at 64.

- On **January 13, 2009**, staff found R13 "on [the] hallway" at 2:00 a.m. He said that he was not sleeping. A nurse aide restrained him in a geri-chair "to prevent any possible injuries." CMS Ex. 20 at 64. But, at 2:15, he began a new and very dangerous behavior. According to the nurse's note, he attempted to flip the geri-chair by grabbing the hall side rails. Staff gave him an injection of Ativan. CMS Ex. 20 at 64. At 2:30 a.m., he again attempted to flip the geri-chair. Staff describe him as "sitting in" the geri-chair, then leaning forward and pushing back, "attempting to flip [the] chair backward." Staff reminded him that he could injure himself. CMS Ex. 20 at 64. At 2:45 a.m., he "*succeeded in his attempts*" (emphasis added). According to the note, his chair fell backward, with him still

[4] The form is curious because it allows staff to check that "no" restraint assessment is necessary, but it does not provide a place to check that a restraint assessment is necessary.

> restrained in it. Fortunately, he suffered no injuries. He was given an injection of Haldol "for extreme agitation." CMS Ex. 20 at 64-65.

R13 thus demonstrated that he was capable of flipping himself over while restrained in a geri-chair. This was a serious warning to facility staff that restraining him in a geri-chair placed him in danger. At a minimum, they should have considered alternatives. Yet, no one even filled out an incident report. No one investigated.[5] No one assessed this significant change in the resident's behavior. No interdisciplinary team or anyone else amended his care plan to address the behavior. I see no evidence that they even told R13's attending physician. Indeed, in his declaration, Dr. Rapp indicates that he ordered R13 restrained in a geri-chair "in direct response to the resident's ability to tip the wheelchair." P. Ex. 6 at 1 (Rapp Decl. ¶ 3). He does not claim that it was appropriate to restrain R13 in a geri-chair after R13 showed that he could also flip over that type of chair.[6]

And staff continued to restrain R13 in a geri-chair:

- At 4:00 a.m. on **January 15, 2009**, R13 was again trying to jump out of bed and was striking out at staff. They placed him in a geri-chair with pelvic restraints. CMS Ex. 20 at 65.

- At 2:00 a.m. on the morning of **January 16, 2009**, he was trying to get out of bed, so they "placed [him] in [a] geri-chair for lacking of safety awareness." CMS Ex. 20 at 65.

- At what appears to be 5:00 a.m. on **January 18, 2009**, he was in his geri-chair wearing protective head gear. He again "leaned forward, then quickly pushed

[5] Petitioner asserts generally that staff "performed a complete investigation and completed incident reports following each incident," but then cites only to reports of the incidents occurring November 18 and 24, December 4, 17, and 22, and January 5 and 21. Petitioner offers no reports for this incident or the one occurring on January 18 (discussed below). P. MSJ Br. at 22. Moreover, as this discussion shows, none of the cited reports evidence a "complete investigation." *See Century Care of Crystal Coast*, DAB No. 2076 at 21 (2007), *aff'd*, No. 07-1491, 2008 WL 2385505 (4th Cir. 2008) (by not investigating, the facility loses an opportunity to analyze and correct its problems).

[6] I recognize that I must draw every reasonable inference in the light most favorable to Petitioner. From Dr. Rapp's conspicuous silence on the issue, I could infer that staff did not inform him that R13 was able to flip himself over while restrained in a geri-chair. Or, I could infer that staff told him, and he nevertheless continued to renew the restraint order whenever staff requested, without regard to the dangers posed. Inasmuch as Dr. Rapp is the facility's medical director, neither inference seems more favorable to Petitioner. P. Ex. 6; CMS Ex. 7 at 9. In any event, the physician's willingness to issue the order does not absolve the facility of its duty to provide R13 with the services necessary to protect him from harm.

back[,] flipping the G-chair back." He fell on top of the chair's padding. He was placed on one-on-one supervision for the remainder of the shift. CMS Ex. 20 at 65. Notes indicate that, at 2:00 in the afternoon of January 18, he was in the geri-chair wearing protective headgear. CMS Ex. 20 at 65.

Thus, for a second time, R13 showed himself capable of flipping over while restrained in his geri-chair. While providing him with one-on-one supervision for the remainder of the shift was probably a good idea, staff did not address the underlying problem, which was that R13 could no longer be considered safe while restrained in a geri-chair. Again, I see no evidence of an incident report, investigation, interdisciplinary team meeting, or care plan changes.

- A note dated **January 20, 2009**, at 8:00 a.m., says that he "continues to throw self on ground in an attempt to hurt self." In the office of the Director of Nursing, he threw himself onto his knees, and old scabs started bleeding. CMS Ex. 20 at 66.

- A nurse's note dated **January 21, 2009**, 10:30 p.m., says that R13 was trying to jump out of bed, so staff placed him in a geri-chair with pelvic restraints, and then put him in the "B" dining room. At 11:00 p.m., a nurse at the nurses' station "heard a loud thump." She found R13 on the floor, lying on his back still restrained in the geri-chair, wearing a helmet. Staff noted seizure activity; his pupils were dilated and non-reactive to light. Staff called Emergency Medical Services (EMS), and he was taken to the emergency room. P. Ex. 13 at 14; CMS Ex. 20 at 67.

  A physician's telephone order indicates that, at 10:30 p.m., staff "may place in geri-chair for 24 [hours] [due to] lack of safety awareness." CMS Ex. 20 at 45. At 11 p.m., another telephone order says "notify EMS." CMS Ex. 20 at 45.

  A very puzzling incident report says nothing about the restraint, but reports that "Charge Nurse Della Pinder stated 'resident had a [seizure]'" but was uninjured "due to the protection of the tall padded back of [the geri-chair] and helmet." P. Ex. 13 at 72. Nevertheless, the report also says that staff called EMS, and sent the purportedly uninjured resident to the hospital. P. Ex. 13 at 72. The report mentions R13's history of throwing himself on to the floor, notes that he continues to wear a helmet, and "receives staff redirection" as needed, and "is afforded the use of a geri-chair for protection." With respect to the particular incident, it says that on January 21 at 10:30 p.m., R13 attempted to throw himself from his bed, but staff were "able to intervene." It mentions, without further explanation, that the restraint committee would meet prior to R13's readmission. P. Ex. 13 at 73.

  And apparently some misinformation made its way to the VA hospital. Trauma staff there understood that R13 had been sitting in his chair and fell to the ground. He was found unresponsive and had one episode of seizure-like activity. The trauma note indicates "difficult to assess whether this was a witnessed fall or not."

> CMS Ex. 20 at 10. A CT scan revealed a subdural hematoma, and he was admitted to the intensive care unit. CMS Ex. 20 at 10. The neurosurgeon described the injury as "traumatic." CMS Ex. 20 at 12. He was subsequently removed from his ventilator and died on January 25, 2009. CMS Ex. 20 at 13.

Petitioner concedes that R13 "was placed in a geri-chair with a pelvic restraint for safety," and "[a]fter hearing a noise," a licensed vocational nurse (LVN) "assessed [him] to be 'on his back with [geri-chair] and restraint and helmet on' and non-responsive." P. MSJ Br. at 20-21. Although silent on some of the additional details, Petitioner has not come forward with evidence to challenge CMS's assertions that: 1) staff put the restrained resident "in the B dining room"; or 2) no staff person witnessed the incident. Petitioner also concedes that staff immediately called EMS, and transferred R13 to the hospital, where he was diagnosed with a subdural hematoma and died on January 25, 2009. P. MSJ Br. at 21.

On the other hand, Petitioner makes the following assertions, which have little or no support in the record:

- Citing the nurse's note (CMS Ex. 20 at 67) Petitioner asserts that R13's "head never hit the floor." P MSJ Br. at 22. The note says that R13 was found "on the floor, on his back [with the] geri-chair [and] restraint on [and] helmet on." CMS Ex. 20 at 67.

- Without any citation to the record, Petitioner asserts that "[t]he resident was in direct line of observation of the LVN at the nurses' station," and that his "geri-chair likely tipped backwards as the resident experienced a seizure and the resident was admitted to the hospital. The circumstances of the event were observed and recorded." P. MSJ Br. at 25.

- Citing generally to Dr. Rapp's declaration, Petitioner suggests that the "geri-chair may have tipped backwards as a result of the resident's seizure." P. MSJ Br. at 22.

With respect to whether R13's head hit the floor, although the nurse's note is far from definitive, for summary judgment purposes, I accept Petitioner's inference that R13's head did not actually hit the floor. Nevertheless, the undisputed evidence demonstrates that:

> 1) R13 had no history of a seizure disorder;
> 2) until this incident, he had not displayed any seizure-like activity;
> 3) immediately after the incident, the nurse observed seizure-like symptoms; and
> 4) R13 was subsequently diagnosed with a subdural hematoma.

Accordingly, the only reasonable inference is that the geri-chair and soft helmet did not provide sufficient protection and that he injured his head.

Petitioner's claims that R13 was in "direct line of observation" of the nurse and that the circumstances "were observed" are not supported by any evidence in this record. No staff member has come forward claiming to be a witness. Neither the nurse's note nor the incident report identifies any witness to the event. The nurse's note says that staff put R13 in the dining room and responded, because the nurse *heard* (but did not see) the incident. Moreover, in defending the facility's failure to investigate and to notify the Texas State Agency of this incident, Petitioner inconsistently argues that, under state rules, "an unwitnessed fall is not a reportable event," which seems to concede that no one witnessed R13's accident. P. MSJ Br. at 24.[7]

Finally, the suggestion that a seizure, rather than R13's well-documented behaviors, caused the geri-chair to flip is neither supported by any of the evidence nor a reasonable inference. Dr. Rapp's declaration does not mention the January 21 incident and says nothing about seizures. P. Ex. 6 (Rapp Decl.). No evidence in the record suggests that R13 had ever had a seizure before he suffered that head injury on January 21.

But even if I accepted all of Petitioner's unsupported assertions and unreasonable inferences, I would find them not material. My finding of substantial noncompliance does not turn on whether R13 hit his head on the floor, nor on whether he had a seizure before or after his head injury. From at least January 13 on, staff were on notice that R13 could and would flip over his geri-chair. The facility was not in substantial compliance, because, knowing that R13 engaged in such dangerous and self-injurious behavior, they continued to restrain him without taking appropriate precautions to ensure his safety. On the night of January 21, they so restrained him, and left him in a dining room. This was neglect and posed the potential for more than minimal harm.

R13 was not the only resident who was regularly restrained in a geri-chair, even after he proved himself capable of overturning it.

Resident 3. The facts regarding Resident 3 (R3) are undisputed. He was admitted to the facility on December 20, 2007, with diagnoses of Alzheimer's disease, dementia with delusions, and hypothyroidism. At the time of the survey, he was 68-years old. CMS Ex. 11 at 1.

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[7] Petitioner allows for an exception to its "unwitnessed fall" rule: if the fall results in death, it must be reported and investigated. But Petitioner also points out that when the surveyors arrived at the facility, R13 was not yet dead. P. MSJ Br. at 24. I do not accept Petitioner's interpretation of state law, and, in any event, federal regulations required reporting and investigation of the incident. 42 C.F.R. § 483.13(c)(2) and (3); *see Century Care of Crystal Coast*, DAB No. 2076 (2007), *aff'd*, No. 07-1491, 2008 WL 2385505 (4th Cir. 2008) (Professional standards of quality require that incidents be reported and investigated.) Certainly, any time a fall is followed by significant symptoms of serious injury and hospitalization, it must be reported and investigated.

A physical restraint assessment form, dated **January 8, 2008**, suggests restraining R3 in order to maintain posture and decrease falls. CMS Ex. 11 at 5. The same day, his attending physician, Dr. Lira, ordered a geri-chair with tray when out of bed due to "lack of safety awareness." CMS Ex. 11 at 16. In a psychiatric consult, dated January 8, 2008, Dr. Valdez indicates that she reviewed the chart and talked to staff. She writes that, according to staff, R3 is "restless, easily angered [and] agitated." He sleeps poorly, is confused, anxious, worried, paranoid, and delusional. Dr. Valdez recommended medication changes, but her report does not mention physical restraints. P. Ex. 3 at 22-23.

A nurse's note indicates that, on **January 18, 2008**, R3 attacked one of the nurse aides. Staff responded with medication, and, when he refused to stay in bed, they transferred him to a geri-chair. P. Ex. 3 at 3. According to the notes, at 4:00 a.m., he was found trying to get into bed with his roommate. Staff put him in a geri-chair with a tray restraint, citing "lack of safety awareness." P. Ex. 3 at 3.

A physician's order, dated **February 21, 2008**, calls for pelvic restraint in a geri-chair when out of bed due to "lack of safety awareness [related to] dementia." Release every two hours. P. Ex. 3 at 4. On March 11, 2008, Dr. Lira apparently amended the order and called for a pelvic restraint while in a wheelchair when out of bed. P. Ex. 3 at 5.

Physician progress notes, dated **February 20, March 7**, and **March 12, 2008,** indicate that Dr. Valdez reviewed the chart and discussed with staff the resident's paranoia, delusions, anxiety, and agitation. She increased the resident's medications, but, again, her report does not include physical restraints as part of the "plan." P. Ex. 3 at 6-9.

An **April 8, 2008,** progress note indicates that Dr. Valdez again discussed R3's chart with facility staff who reported that R3 was "very agitated, anxious, [and] restless in his geri-chair -- *to the point that he knocks himself [and] the geri-chair over to the floor*"[8] (emphasis added). The physician's subsequent plan includes medication changes and lab work, but does not mention physical restraints. P. Ex. 3 at 10-11.

On **April 9, 2008**, another physician renewed R3's order for a geri-chair with pelvic restraint when out of bed, citing restlessness, dementia, and lack of safety awareness. CMS Ex. 11 at 17.

Between **April** and **November 2008**, additional physician progress notes mention R3's symptoms and medication changes, but none of them talk about physical restraints or the resident's ability to overturn his geri-chair. P. Ex. 3 at 12-16.

[8] I note that, except for this note, the record contains no evidence that, prior to November 12, 2008, facility staff investigated or reported any instances of R3 overturning his geri-chair while restrained.

The record also includes versions of a care plan indicating that use of a geri-chair with table top and use of a geri-chair with pelvic restraint were added to the plan, but the entries are dated in such a jumbled way that I am not able to determine when that occurred. CMS Ex. 11 at 8-10. In any event, notwithstanding Dr. Valdez's April 8 note that R3 "knocks himself and the geri-chair over to the floor," the care plan does not describe or address that dangerous behavior.

A cryptic note says that on **November 12, 2008**, while in his geri-chair, R3 was "noted to have fallen backward." He suffered no injuries. CMS Ex. 11 at 19. The report offers no additional information. Sections on the form regarding referrals and assessments are left blank. An incident report only repeats the same information (or lack of information). P. Ex. 3 at 18. No further investigation was conducted, and no interdisciplinary team met to consider this development. No changes were made to the resident's care plan. Physician notes, dated November 19, 2008, do not mention the incident or R3's physical restraints. P. Ex. 3 at 17.

Thereafter, facility staff continued to restrain R3 in a geri-chair, using the pelvic restraint. A second report, dated **November 24, 2008**, indicates that R3 was again "noted" to be lying on the back of the chair, "chair being flipped backwards." CMS Ex. 11 at 18. Again, the sections of the form relating to referrals and assessments are left blank, and the facility took no additional action to address the problem. An incident report includes the same information. P. Ex. 3 at 20-21.

On **January 24, 2009**, one of the surveyors observed R3 in the hallway restrained in a geri-chair by means of a pelvic restraint. He was repeatedly raising his legs, pushing off the wall, causing the chair's front legs to lift. CMS Ex. 8 at 7.

Petitioner does not dispute any of this, but argues that the regular physician assessments and multiple changes in the resident's care plan were sufficient to satisfy the regulations. Petitioner also points to R3's behaviors and suggests that restraining him in a geri-chair was safer than allowing him to walk, because "[h]e would often run, staggering down the hall, oblivious to other residents and to other hazards," as well as safer than restraining him in a wheelchair, which "he would have flipped." P. MSJ Br. at 9-10.

Even accepting (for summary judgment purposes) that facility staff chose an intervention that was safer than others might have been, when that intervention proved dangerous, they were obligated to consider alternatives. But, even though R3's care plan notes that he "flips over" the geri-chair, facility staff did not even consider ways to address that dangerous behavior until the time of the survey. CMS Ex. 11 at 9 (a note, dated January 25, 2009, says discontinue the restraint; a note, dated January 26, 2009, calls for 1:1 supervision).

Staff put R3 in harm's way whenever they restrained him in a geri-chair -- knowing that he was able to overturn it – without taking precautions to ensure his safety. They were thus not providing him the services "necessary to avoid physical harm" and were guilty

of neglect. I find this ongoing practice particularly disturbing here since staff were doing it on January 24, just days after R13 had suffered his subdural hematoma while restrained in the same fashion.

Resident 4. Again, the facts surrounding Resident 4 (R4) are not in dispute. He was re-admitted to the facility on August 25, 2008. CMS Ex. 12 at 1.[9] He was 57-years-old, suffering from Parkinson's disease and dementia. CMS Ex. 12 at 5. He also had a long history of schizophrenia and depression. P. Ex. 4 at 25. At 5:00 a.m. on August 26, Dr. Lira ordered R4 placed in a geri-chair with a pelvic restraint when out of bed due to "lack of safety awareness related to Parkinson[']s." He was to be checked every hour and released every two hours for ten minutes. CMS Ex. 12 at 1. CMS alleges that no restraint assessment accompanied the order, and Petitioner has neither produced an assessment nor claimed to have performed one.

Physician notes, dated August 28, September 10, and September 12, 2008, describe R4 as "totally demented," paranoid, anxious, delusional, agitated, restless, and aggressive. Dr. Valdez includes a plan in her notes, which describes medication changes, but, again, does not mention physical restraints. P. Ex. 4 at 15-16.

At 5:25 p.m. on **September 20, 2008**, according to the nurses' notes, staff "heard a noise" and found R4 on the floor on his left side, still restrained in the geri-chair. No injuries were noted. CMS Ex. 12 at 2. Staff paged Dr. Lira, who did not return the call. They called Dr. Valdez, who did not answer and did not have voice mail, so they were unable to leave a message. At 11:15 a.m. the following day, staff apparently reached Dr. Valdez, who prescribed Ativan. The nurse's note does not include any discussion of physical restraints. CMS Ex. 12 at 2.

According to another note, at 12:15 p.m. on **September 21, 2008**, an agitated R4 "flipped [his] geri-chair over and fell" but sustained no visible injuries. Staff again called Dr. Lira, who returned the call a couple of hours later but gave no new orders. CMS Ex. 12 at 2.

Physician notes, dated **September 22** and **23** and **October 29, 2008,** mention the resident's anxious and aggressive behaviors and provide for more medication changes, but they say nothing about the physical restraint employed, much less the risk of injury it posed. P. Ex. 4 at 17-18.

A report, dated **November 5, 2008**, on Geriatrics Associates of America letterhead notes that R4 is at high risk of falls and injury. He is "in geri-chair, very restless – restrained [secondary to] risk of injury." P. Ex. 4 at 23. The note does not mention a pelvic

[9] The record is murky as to R4's earlier admission and discharge. He was apparently admitted on July 4, 2008, discharged on August 22, and readmitted on August 25. P. Ex. 4 at 1.

restraint and, again, says nothing about the resident's ability to flip over the geri-chair and the risks of injury posed by the restraint itself.

Staff continued to restrain R4 in a geri-chair. On **January 7, 2009**, at 10:00 a.m., they found him on the floor, his geri-chair tipped on the right side. An incident report describes no injuries and offers no additional information. CMS Ex. 12 at 7. According to surveyor notes, however, R4 injured his shoulders, and Petitioner has not disputed that fact. CMS Ex. 8 at 20; CMS MSJ Br. at 9.

Finally, at 6:00 p.m. on **January 24, 2009**, one of the surveyors observed R4 restrained in a geri-chair; he was fidgeting and "would fling his legs over the . . . arm rests." CMS Ex. 8 at 6.

Again, Petitioner disputes none of this but points out R4's significant behaviors as justification for keeping him restrained. P. MSJ Br. at 10-12. But the undisputed evidence establishes that R4 could not safely be restrained in a geri-chair. Yet, knowing that he was capable of overturning the geri-chair, staff made no plans and took no precautions to keep him safe.

Resident 5. The parties also agree about the facts surrounding Resident 5 (R5). He was admitted to the facility on November 14, 2007. CMS Ex. 8 at 15. A restraint assessment, dated January 9, 2008, says that he has a history of falls, is unable to comprehend safety instructions, and needs a restraint to "[increase] socialization." CMS Ex. 13 at 1. His care plan was amended to add "pelvic restraint while in [geri-chair]. Release and reposition [every two hours and as needed]." CMS Ex. 13 at 3. On April 10, 2008, R5 was "found sitting on floor [with geri-chair] tipped on one side." The pelvic restraint was still attached to the resident and to the chair, although it had been loosened. CMS Ex. 13 at 4. Again, the facility was on notice that R5 was able to tip himself over while restrained, yet staff took no precautions to keep him safe. They did not even review his assessment until November 25, 2008, more than seven months after he demonstrated that he could tip himself over while restrained in a geri-chair. CMS Ex. 13 at 1.

Thus, the undisputed evidence establishes that, from at least as early as April 2008 until the time of the survey, staff regularly restrained these residents in geri-chairs. Staff knew, or should have known, that it was a dangerous practice, because these individuals were capable of tipping or flipping themselves over while so restrained. And yet, the facility did not timely assess the safety of its practice nor initiate interventions to ensure resident safety. When incidents occurred, staff failed to investigate adequately. The facility therefore failed to implement policies and procedures that prohibit resident neglect, and was not in substantial compliance with 42 C.F.R. § 483.13(c).[10]

[10] Because I find that the deficiencies involving the residents discussed above more than justify the minimal penalties imposed, I do not discuss every resident CMS identifies as at risk under 42 C.F.R. § 483.13(c), nor all of the incidents cited. *See Grace Healthcare of Benton*, DAB No. 2189 at 5 (2008).

B. CMS is entitled to summary judgment that the facility was not in substantial compliance with 42 C.F.R. § 483.13(a), because the undisputed facts establish that the facility imposed physical restraints that were not required to treat the resident's medical symptoms.

> The use of restraints is associated with numerous negative outcomes, such as emotional desolation, agitation, fractures, chafing, burns, nerve damage, circulatory impairment, decubitus ulcers, strangulation, and death.

Cross Creek Health Care Center, DAB No. 1665 at 6 (1998), *citing* 57 Fed. Reg. 27, 397, 27, 398 (June 19, 1992). Driven by such concerns, Congress explicitly required that skilled nursing facilities protect and promote the rights of each resident "to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms." Restraints may only be imposed "to ensure the physical safety of the resident or other residents," and, except in an emergency, only upon the written order of a physician that "specifies the duration and circumstances under which the restraints are to be used." Act § 1819(c)(1)(A)(ii).

By regulation, CMS has implemented the statutory provision:

> The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

42 C.F.R. § 483.13(a). As the Departmental Appeals Board has noted, this regulation imposes on the facility an independent obligation to ensure that its use of restraints, even with a doctor's order, meets the regulatory criteria. The facility must "continue to assess the impact of the use of a restraint and to consult with the doctor if [it] finds that use of the restraint no longer meets the criteria of the regulation." *Cross Creek*, DAB No. 1665 at 11. The mere existence of the doctor's order does not presumptively establish that the facility is complying with the requirements of the statute or regulation. *Cross Creek*, DAB No. 1665 at 12, n.9.

The parties do not disagree as to what policies and procedures a long-term facility must have in place in order to comply with the regulation. Petitioner has come forward with what it identifies as the facility policy on restraint (P. Ex. 14), and its provisions echo those sections of the State Operations Manual, relied on by CMS.[11] *See* CMS Ex. 29; *see also* CMS Ex. 21 at 1-5. For summary judgment purposes, I accept as true that

[11] In the State Operations Manual, CMS provides guidance to state survey agencies on procedures and regulatory criteria relating to the Medicare certification of long term care facilities and other providers.

Petitioner's proffered document encompasses the facility's written policies and procedures governing its use of restraints.

The policy recognizes that "[i]n practice, restraints have many negative side effects and risks that, in some cases, far outweigh any possible benefit that can be derived from their use." P. Ex. 14 at 5.

In this case, Petitioner justifies the facility's extensive use of restraints by pointing to the "unique" character of its population, the majority of whom "suffer from major depression, psychotic disorders. . . and/or dementia with major behavioral features," and many of whom are "also mentally impaired." P. MSJ Br. at 4. In fact, as Petitioner's policy explains, the facility has a heightened obligation to employ restraints judiciously when caring for the cognitively impaired.

> Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by restraints. *It is vital* that restraints used on this population be carefully considered and monitored. In some cases, the risk of using the device may be greater than the risk of not using the device.

P. Ex. 14 at 3 (emphasis added). Thus, prior to employing any restraint,

> the facility *must* assess the resident to properly identify the resident's needs and the medical symptom that the restraint is being employed to address.

P. Ex. 14 at 5 (emphasis added). *See Lakeridge Villa Health Care Center*, DAB No. 1988 (2005) ([A] facility must properly document that its staff assessed the resident for restraint use prior to calling the resident's physician requesting an order, and that the specific medical symptom cannot be addressed by another less restrictive intervention.).

The undisputed evidence establishes multiple instances in which the facility routinely restrained its residents, without first performing the necessary resident assessment. In addition to R13 and R4, discussed above,

- R7's diagnoses included convulsion, Alzheimer's disease, anxiety, and schizophrenia. P. Ex. 7 at 1. The facility obtained physicians' orders to restrain him as early as May 2008 (P. Ex. 7 at 28), and use of a pelvic restraint with the geri-chair was apparently added to his care plan on June 14, 2008. CMS Ex. 14 at 3. By August 2008, facility staff were regularly restraining him in a geri-chair. Yet, the facility did not assess R7 for restrains until December 3, 2008. CMS Ex. 14 at 1.

- R9 was readmitted to the facility on October 15, 2008, and the parties agree that he was restrained in a geri-chair, using a pelvic restraint, as early at October 2008. CMS MSJ Br. at 12; P. MSJ Br. at 16; P. Ex. 9 at 5, 6, 12, 14; CMS Ex. 16 at 8. Yet the pelvic restraint with geri-chair intervention was not added to his care plan

until December 23, 2008, and his restraint assessment form is dated January 2009. CMS Ex. 16 at 1, 3-6.

The inadequate assessments were not the facility's only shortcoming with regard to its use of restraints. The facility's treatment of R13 illustrates that the facility was not in substantial compliance with 42 C.F.R. § 483.13(a) in other respects:

- I have already discussed how the facility regularly applied restraints without ever having assessed the resident's needs, symptoms, or whether his symptoms could be addressed by less restrictive means.[12] When staff prepared an incident report, they simply ignored questions about the need for a restraint assessment, or said that none was necessary. P. Ex. 13 at 45-49, 70-72.

- Staff invariably justified applying the restraints by pointing to R13's "lack of safety awareness," even though they restrained him in response to his aggressive and/or self-injurious behaviors. P. Ex. 13 at 6, 7; CMS Ex. 20 at 62.

- In responding to his behaviors, staff did not follow R13's care plan. His problematic behaviors began at least as early as November 5, 2008, and were added to his care plan on November 24. But, as of November 24, staff were instructed to "intervene and redirect" whenever R13 threw himself on the floor. CMS Ex. 20 at 75, 76. Nothing in the care plan directed them to restrain him. Yet, on November 29, December 4, December 17, December 18, and December 29, 2008, staff restrained the resident in response to his behavior. CMS Ex. 20 at 55, 57, 62, 98-99. On December 29, 2008, restraint in a geri-chair was finally added to the resident's care plan; however, the plan still says that staff should attempt to redirect first.

- I see no evidence that staff even regarded Dr. McNamara's December 29, 2008, order calling for "close observation" and "restraints only if absolutely necessary." P. Ex. 13 at 93.

- On some occasions, R13 is restrained without any documented justification, or for reasons not justified by his care plan. For example, the nurse's note for the morning of January 13, 2009, does not describe any behavior other than the resident's wandering in the hallway. He did not become agitated until after he was

[12] According to Surveyor Cyndia Kitt, RN, when staff could not produce a restraint assessment for R13, the facility's Director of Nursing (DON) explained that the responsible nurse was not aware that he needed to do them. The DON also told Surveyor Kitt that the restraint was "physician driven" and used when the resident demonstrated injurious behaviors to himself or others. If allowed to propel himself in a wheelchair, "he would be more difficult to monitor." CMS Ex. 27 at 3 (Kitt Decl.). Petitioner has not come forward with any evidence suggesting a dispute over the DON's admissions. Of course, even without the remarks, sufficient evidence justifies CMS's actions.

restrained. CMS Ex. 20 at 64. On other occasions, no reason is given for the restraint. CMS Ex. 20 at 57 (December 31, 2008); 59 (January 3, 2009); 64 (January 10, 2009); 65(January 15, 2009).

- I am deeply disturbed by the disconnect between R13's January 9, 2009, MDS, which indicates that the resident was restrained *daily*, and the rest of his record, which suggests frequent, but not daily restraints. CMS Ex. 20 at 21.

Without any citation to the record, Petitioner claims to have "reduced" restraint utilization by the time of the survey. P. MSJ Br. at 24. Inasmuch as the claim is unsupported, I need not accept it. Although Petitioner provides a sign-in sheet for a restraints meeting held December 23, 2008, that document does not support Petitioner's claim. It lists the topic discussed there as "Suggestions – steps to restraint reduction," but includes nothing else. No evidence even suggests that R13 or any other resident was discussed. P. Ex. 13 at 127. According to Petitioner, the meeting's purpose was "to implement a plan to reduce restraints in the facility," but nothing in that document, or any other document in this record, suggests that staff developed or implemented such a plan until after the survey.[13] P. MSJ Br. at 23.

Thus, the undisputed evidence establishes that facility staff repeatedly imposed restraints without any assessment. They regularly imposed restraints without considering alternatives. They failed to follow resident care plans that called for other interventions, rather than restraints. They imposed restraints for reasons other then that listed in the physician order. For all of these reasons, the facility was not in substantial compliance with 42 C.F.R. § 483.23(a).[14]

C. The penalties imposed are not unreasonably high.

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

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[13] In fact, staff were more likely to add even more restraints whenever a restrained resident suffered injury. *See, e.g.*, P. Ex. 14 at 23 (noting that after resident suffered falls while restrained in a geri-chair with a table top, staff added pelvic restraint).

[14] Again, because I find that the deficiencies involving the residents discussed above more than justify the minimal penalties imposed, I do not discuss every resident CMS identifies as at risk under 42 C.F.R. §§ 483.13(a), nor all of the incidents cited.

In reaching a decision on the reasonableness of the CMP, I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Center*, DAB No. 1848 at 21 (2002); *Community Nursing Home*, DAB No. 1807 at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800 at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638 at 8 (1999).

Petitioner incorrectly asserts that CMS has imposed the "maximum daily penalty." P. MSJ Br. at 25. In fact, CMS has imposed two per-instance penalties: $5,000 for each of the deficiencies discussed above. These penalties are in the middle of the range for per-instance penalties ($1,000 to $10,000). 42 C.F.R. § 488.408(d)(iv). On the other hand, they are extraordinarily modest considering what CMS might have imposed. *See PlumCity Care Center*, DAB No. 2272 at 18-19 (2009) (even a $10,000 per instance CMP can be "a modest penalty when compared to what CMS might have imposed").

CMS has produced evidence, which Petitioner does not challenge, that the facility has a history of noncompliance. According to Daniel J. McElroy, R.N., a nurse consultant employed by CMS, "this is the ninth noncompliance cycle and the second enforcement action" taken against the facility since October 20, 2004. CMS Ex. 28 at 6 (McElroy Decl.).

With respect to the facility's financial condition, Petitioner asserts, without explanation or underlying support, that the $10,000 penalties place "a significant financial burden on the facility." P. MSJ Br. at 25. Of course, the burden should be "significant" or it is not likely to produce corrective action. In any event, since Petitioner has not come forward with any evidence regarding its financial condition, its opportunity to raise that issue has been waived. *Community Nursing Home*, DAB No. 1807 at 15-16, 22 *et seq*.

With respect to the remaining factors, I consider the severity of the deficiencies significant enough to warrant penalties much higher than those imposed here. These deficiencies did not stem from single, isolated instances. Among other transgressions, facility staff regularly imposed restraints in the absence of assessments or care plans. They disregarded the instructions in resident care plans in order to restrain residents. Knowing that residents were capable of flipping themselves over while restrained in their geri-chairs, staff continued the practice, without even considering the dangers posed. When accidents occurred, they failed to report or investigate in any meaningful way. Based on these and the other facility practices discussed above, I find a high degree of staff "neglect, indifference, or disregard" for resident safety. The facility's culpability justifies the relatively minimal penalties imposed.

In light of the facility's significant degree of culpability, particularly with respect to R13, the two $5,000 per instance penalties seem minimal.

IV. Conclusion

Accepting as true all of Petitioner's factual assertions, I find that the facility was not in substantial compliance with the Medicare requirements governing restraints and neglect. 42 C.F.R. § 483.13(a) and (c). The penalties imposed were not unreasonably high. I therefore grant CMS's motion for summary judgment.

/s/
Carolyn Cozad Hughes
Administrative Law Judge