Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Autumn Healthcare of Cambridge,
(CCN: 36-6128),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-714

Decision No. CR4904

Date: August 3, 2017

DECISION

Autumn Healthcare of Cambridge (Petitioner or facility) challenges the Centers for Medicare & Medicaid Services' (CMS) determination that it was not in substantial compliance with Medicare participation requirements under 42 C.F.R. §§ 483.25 and 483.25(c) and the imposition of two civil money penalties (CMPs) totaling $6,400. CMS moves for summary judgment, which Petitioner opposes. For the reasons set forth below, I grant CMS's motion, affirm CMS's determination, and conclude that the amount of each CMP is reasonable.

I. Background

The Social Security Act (Act) sets forth requirements for the participation of a skilled nursing facility (SNF) in the Medicare program and authorizes the Secretary of Health and Human Services (the Secretary) to promulgate regulations implementing those statutory provisions. 42 U.S.C. § 1395i-3. The Secretary's regulations are found at 42 C.F.R. Parts 483 and 488. To participate in the Medicare program, an SNF must maintain substantial compliance with program participation requirements. To be in substantial compliance, an SNF's deficiencies may "pose no greater risk to resident

health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." *Id*.

The Secretary contracts with state agencies to conduct periodic surveys to determine whether SNFs are in substantial compliance. 42 U.S.C. § 1395aa(a); 42 C.F.R. § 488.10. State agencies must survey each SNF annually, with no more than 15 months elapsing between surveys, and must survey more often, if necessary, to ensure that an SNF corrected previously identified deficiencies. 42 U.S.C. § 1395i-3(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308. State agencies must also investigate all complaints. 42 U.S.C. § 1395i-3(g)(4).

The Act also authorizes the Secretary to impose enforcement remedies against SNFs that are not in substantial compliance with Medicare program participation requirements. 42 U.S.C. § 1395i-3(h)(2); 42C.F.R. § 488.406. Among other enforcement remedies, CMS may impose a per-instance CMP for each instance of the SNF's noncompliance. 42 C.F.R. § 488.430(a). The authorized range for a per-instance CMP is $1,000 to $10,000.[1] 42 C.F.R. § 488.438(a)(2). If CMS imposes a CMP based on a noncompliance determination, then the facility may request a hearing before an administrative law judge (ALJ) to challenge the noncompliance finding and enforcement remedy. 42 U.S.C. §§ 1320a-7a(c)(2), 1395i(h)(2)(B)(ii)); 42 C.F.R. §§ 488.408(g), 488.434(a)(2)(viii), 498.3(b)(13). However, the facility may not appeal CMS's choice of remedies. 42 C.F.R. § 488.408(g)(2).

CMS has the burden to come forward with evidence sufficient to make a *prima facie* showing of a basis for it to impose an enforcement remedy. If CMS makes this prima facie showing, Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements as well as any affirmative defenses. *Evergreene Nursing Care Ctr.*, DAB No. 2069 at 7 (2007); *Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x 181 (6th Cir. 2005).

Petitioner is an SNF located in Cambridge, Ohio, that participates in the Medicare program. The Ohio Department of Public Health (state agency) completed an annual

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[1] CMS recently increased the CMP amounts to account for inflation in compliance with the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, 104 Pub. L. No. 114-74, 129 Stat. 584, 599. The new adjusted amounts apply to CMPs assessed after August 1, 2016, for deficiencies occurring on or after November 2, 2015. *See* 81 Fed. Reg. 61538-01 (Sept. 6, 2016). As the deficiencies alleged in this case occurred prior to November 2, 2015, the increased CMP amounts do not apply in this case.

survey at the facility on September 28, 2013, and a complaint survey on October 31, 2013. CMS Exs. 3, 16.

Based on the survey findings, CMS determined that the facility was not in substantial compliance with the following program requirements:

- 42 C.F.R. § 483.25(c) (Tag F314) (quality of care: pressure sores) at a scope and severity level G;
- 42 C.F.R. § 483.25 (Tag F309) (quality of care: provide the necessary care and services for highest well-being) at a scope and severity level G.[2]

CMS Ex. 1 at 22. Petitioner timely requested a hearing before an ALJ and I issued an Acknowledgement and Pre-Hearing Order (Order). In response to my Order, CMS submitted a prehearing brief (CMS Br.) and 27 exhibits (CMS Exs. 1-27). CMS provided written direct testimony for four witnesses (CMS Exs. 24-27). In its brief, CMS moved for summary judgment. Petitioner submitted an opposition to summary judgment (P. Opp.) along with five exhibits. Petitioner subsequently submitted a prehearing brief (P. Br.) and eleven exhibits,[3] five of which Petitioner had submitted with its opposition to summary judgment. Petitioner also requested to cross-examine CMS's witnesses. Because neither party objected to the proposed exhibits,[4] I admit them into the record.

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[2] Scope and severity levels are used by CMS and state agencies when selecting remedies. The scope and severity level is designated by letters A through L, selected by CMS or the state survey agency from the scope and severity matrix published in the State Operations Manual, chap. 7, § 7400.5 (Sep. 10, 2010). A scope and severity level of A, B, or C indicates a deficiency that presents no actual harm but has the potential for minimal harm, which is an insufficient basis for imposing an enforcement remedy. Facilities with deficiencies of a level no greater than C remain in substantial compliance. 42 C.F.R. § 488.301. A scope and severity level of D, E, or F indicates a deficiency that presents no actual harm but has the potential for more than minimal harm that does not amount to immediate jeopardy. A scope and severity level of G, H, or I indicates a deficiency that involves actual harm that does not amount to immediate jeopardy. Scope and severity levels J, K, and L are deficiencies that constitute immediate jeopardy to resident health or safety. The matrix, which is based on 42 C.F.R. § 488.408, specifies which remedies are required and optional at each level based upon the frequency of the deficiency.

[3] I mark the declaration of Amy Springer, R.N. as P. Ex. 11 because Petitioner failed to mark it with an exhibit number.

[4] Petitioner asserts that CMS based its noncompliance finding regarding Resident 41 on hearsay statements from Resident 41's daughter. However, the rules of evidence do not apply and generally I must admit relevant evidence. 42 C.F.R. §§ 498.60(b)(1), 498.61.

II. Issues

As a threshold matter, I consider whether summary judgment is appropriate.

On the merits, the issues are:

1. Whether Petitioner was in substantial compliance with Medicare participation requirements at 42 C.F.R. § 483.25 and 483.25(c).

2. If Petitioner was not in substantial compliance with Medicare participation requirements, whether CMS's imposition of two $3,200 per instance CMPs is reasonable.

III. Findings of Fact, Conclusions of Law, and Analysis

I set forth my findings of fact and conclusions of law in bold and italics font. Because, as explained below, summary judgment is appropriate in this case, I rely in this decision only on the undisputed facts in this case.

1. Summary judgment is appropriate.

Summary judgment is appropriate if there is "no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law." *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459 at 5 (2012) (citations omitted). In order to prevail on a motion for summary judgment, the moving party must show that there is no genuine dispute of material fact requiring an evidentiary hearing and that it is entitled to judgment as a matter of law. *Id.* If the moving party meets this initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial . . . .'" *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986). "To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact — a fact that, if proven, would affect the outcome of the case under governing law." *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 3 (2010).

In evaluating a motion for summary judgment, an ALJ does not address credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291 at 5 (2009). Rather, in examining the evidence to determine the appropriateness of summary judgment, an ALJ must draw all reasonable inferences in the light most favorable to the non-moving party. *See Brightview Care Ctr.*, DAB No. 2132 at 10 (2007) (upholding summary judgment where inferences and views of non-moving party are not reasonable). "[A]t the summary judgment stage the judge's function is not . . . to weigh the evidence and determine the truth of the matter but to determine whether

there is a genuine issue for trial." *Anderson v. Liberty Lobby, Inc*., 477 U.S. 242, 255 (1986). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cedar Lake Nursing Home*, DAB No. 2344 at 7 (2010).

Petitioner has opposed summary judgment and specified the facts that is considers material and disputed. As discussed below, for some of the allegedly disputed facts, Petitioner's own exhibits refute Petitioner's position. Further, even resolving the remaining disputes of fact in Petitioner's favor would not result in a favorable outcome for Petitioner. Petitioner has therefore failed to raise a genuine dispute of material fact a avoid summary judgment.

2. ***CMS is entitled to summary judgment because it came forward with evidence establishing that facility staff did not adequately assess or treat residents' pressure sores, and Petitioner tendered no evidence disputing the facts underlying CMS's conclusions. The undisputed evidence, therefore, establishes that the facility was not in substantial compliance with 42 C.F.R. § 483.25(c).***

Under the statute and the "quality of care" regulation, each resident must receive, and the facility must provide, the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. 42 U.S.C. § 1395i-3(b)(1)-(2); 42 C.F.R. § 483.25. To this end, the facility must (among other requirements) ensure that a resident who enters the facility without pressure sores does not develop them unless his/her clinical condition shows that they were unavoidable, based on the resident's comprehensive assessment. 42 C.F.R. § 483.25(c)(1). If the resident has pressure sores, the facility must ensure that he/she receives the treatment and services necessary to promote healing, prevent infection, and prevent new sores from developing. 42 C.F.R. § 483.25(c)(2).

In assessing the facility's compliance with this requirement, the relevant question is: did the facility "take all necessary precautions" to promote healing, prevent infection, and prevent new sores from developing. If it did so, and the resident develops sores anyway, there is no deficiency. But if the evidence establishes that the facility fell short of taking all necessary precautions, it has violated the regulation. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 13-14 (2010), *aff'd*, *Senior Rehab. & Skilled Nursing Ctr. v. Health & Human Servs.*, 405 F. App'x 820 (5th Cir. 2010); *Koester Pavilion*, DAB No. 1750 at 32 (2000).

<u>Resident 10</u>

Resident 10, an 89-year old female at the time of the survey, had been identified upon admission to the facility as being at high risk for pressure sores due to her limited sensory

perception and mobility. CMS Br. at 2; P. Opp. at 4; CMS Ex. 8 at 19. On the evening of August 26, 2013, staff identified a "stage 1" pressure ulcer on Resident 10's left buttock, measuring 5 cm long by 1.5 cm wide, with no recordable depth. CMS Br. at 2; P. Opp. at 4; CMS Ex. 8 at 20, 23; P. Ex. 2 at 7. The wound was described as an "open area." CMS Br. at 2; P. Opp. at 4; CMS Ex. 8 at 20. Petitioner's staff cleaned the area with saline and left open to air. CMS Br. at 2; P. Opp. at 4; CMS Ex. 8 at 20. They also faxed Resident 10's physician and awaited a response. CMS Br. at 2; P. Opp. at 4; CMS Ex. 8 at 20. Petitioner commenced a Wound/Skin Care Management Documentation Form. P. Opp. at 4; CMS Ex. 8 at 23.

On August 27, 2013, Resident 10's left buttock wound was reassessed as an unstageable pressure sore. CMS Ex. 8 at 23. The nurse ordered dimethicone cream, a barrier cream, to the area. CMS Br. at 2; P. Opp. at 3; CMS Ex. 8 at 20. Petitioner sent another update to the doctor. P. Opp. at 5; CMS. Ex. 8 at 20. Petitioner updated the Wound/Skin Care Management Documentation Form. CMS Ex. 8 at 23.

On August 28, 2013, Petitioner staff applied barrier cream to Resident 10 and repositioned her. P. Opp. at 5; CMS Ex. 8 at 20. Petitioner did not update the Wound/Skin Care Management Documentation Form. CMS Ex. 8 at 23.

On August 29, 2013, Resident 10's physician evaluated her wound and provided new treatment orders for the care of Resident 10's wound. The orders required application of calcium alginate to the wound bed and covering the area with adhesive foam dressing to provide a bacterial barrier. The dressing was to be changed daily. CMS Br. at 3; P. Opp. at 5; CMS. Ex. 8 at 20; CMS Ex. 8 at 2; P. Ex. 2 at 13. On August 30, 2013, the doctor ordered additional interventions to include a low air loss mattress, and turning and reposition the resident while in bed. CMS Ex. 8 at 2.

CMS contends that with respect to Resident 10, Petitioner did not properly notify her doctor of the wound to her left buttock and as a result Petitioner did not ensure that Resident 10 received necessary treatment and services to promote healing. CMS Br. at 13. Specifically, CMS argues that while Petitioner faxed Resident 10's physician about the sores, Petitioner did not make contact by telephone, resulting in a three-day delay in care. CMS Br. at 13. Petitioner argues that it met professional standards of care because it complied with the physician's orders related to Resident 10. P. Opp. at 11. However, Petitioner does not dispute that Resident 10's physician was only sent faxes on August 26 and August 27, but no effort was made to contact the physician by telephone, when no response to the faxes was promptly received. There is no indication that the physician received the faxes or was aware of the new wound.[5] There is also no indication that

[5] Petitioner indicated on the "Wound/Skin Care Management Documentation Form" for August 26 and August 27, 2013, under the Other column, "Dr. aware," presumably based on the fact that Petitioner faxed him updates on Resident 10's condition. The fact that the

Petitioner made any contact with the physician on August 28. The physician did not assess the wound and provide treatment orders until three days after the wound was discovered. There is nothing in the treatment records to indicate that the family also was notified of the new wound.[6] Petitioner does not dispute these facts.

Petitioner contends that the disputed facts regarding Resident 10 are: Resident 10 was diagnosed with a pressure ulcer that was unavoidable; Petitioner complied with its procedures for wounds; and Resident 10 received proper treatment when diagnosed. P. Opp. at 2. However, accepting those as all true, Petitioner still failed to ensure that Resident 10's physician actually knew of the new wound and consulted with Petitioner regarding that wound. This delayed Resident 10 from receiving proper treatment for her wound. Therefore, Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(c)(2) because it failed to ensure that Resident 10 received necessary treatment and services to promote healing and prevent infection from her pressure sore.

Resident 25

At the time of the survey, Resident 25 was a 93-year-old female diagnosed with dementia, chronic pain, osteoporosis, osteoarthritis, and right hip replacement. CMS Br. at 3; P. Opp. at 5; P. Ex. 3 at 5. Resident 25 had a history of developing pressure sores and was identified as having a mild risk for developing pressure sores. CMS Br. at 3; P. Opp. at 5-6; P. Ex. 3 at 5; CMS Ex. 9 at 25-26. Resident 25's care plan included interventions to prevent pressure sores, such as a lamb's wool cushion and the use of barrier creams to be applied to affected areas every shift and as needed; these interventions were in place as early as October 2012 and June 2013. P. Ex. 3 at 16-17, 31, 76. On August 10, 2013, facility staff noted an "abrasion" to Resident 25's left buttock, characterized in the Nurse's Notes as an "open area to buttocks" 3 cm long by 2 cm wide with a depth of greater than 1 cm. P. Ex. 3 at 61, 69. Petitioner's "Skin/Wound" Protocol requires that skin sweeps are performed weekly and measurements are completed at that time. P. Ex. 1 at 1. The Wound/Skin Care Management Documentation form for the wound to Resident 25's buttocks first noted on

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faxes were sent does not mean that the physician was actually aware of her condition or had received them.

[6] Petitioner stated on page 3 of its brief that Resident 10's care plan was updated on August 26, 2013 "to notify her family of the open area, to monitor the area and report as required," citing P. Ex. 2 at 7. However, page 7 of that exhibit contains no such information; page 7 is an October 25, 2013, skin integrity evaluation by Resident 10's physician with respect to the August 26, 2013 wound to her left buttock. The only reference in the records that the family was notified is on the "Wound/Skin Care Management Documentation Form" which states that on September 12, 2013, "family and Dr. aware." P. Ex. 2 at 6.

August 10, 2013, is missing measurements and/or assessments for that wound for the weeks after August 25, 2013, and before September 16, 2013. P. Ex. 3 at 69. Under Petitioner's policy, Petitioner's wound should have been measured on or around September 1, 2013, as well as September 8, 2013. No records of any assessments or measurements exist for that period. After the assessment on August 25, 2013, the next assessment noted and performed was on September 16, 2013. Thus, for 22 days there is no evidence of a measurement or assessment of the wound discovered on August 10, 2013.

Petitioner asserts that the disputed facts regarding Resident 25 are: Resident 25 was never diagnosed with a pressure ulcer; Resident 25 received appropriate care for a pressure ulcer; Petitioner complied with its skin care policy and made weekly sweeps of Resident 25. P. Opp. at 2-3. Even accepting that Petitioner never diagnosed Resident 25 with a pressure ulcer, Petitioner has failed to come forward with evidence that it properly complied with its skin care policy and made the weekly skin sweeps and measurements. Petitioner's own exhibit, the Wound/Skin Care Management Documentation Form shows a gap in assessments and measurement of the identified skin condition from August 25 to September 16. P. Ex. 3 at 69. Further, Petitioner's "Skin/Wound" Protocol, again one of Petitioner's exhibits, requires that skin sweeps are performed weekly and measurements are completed at that time. P. Ex. 1 at 1. This policy is for all wounds to the skin. Petitioner has a separate policy for ulcer monitoring. P. Ex. 1 at 2. Therefore, even though Petitioner did not diagnose Resident 25's wound as an ulcer, it still did not comply with its policy. Petitioner's own documentation makes clear that it is very important to follow that policy because abrasions are "prone to develop into pressure ulcers." CMS Ex. 9 at 3.

The failure to assess and measure this wound weekly as required means that there was no accurate information as to whether the wound was healing or getting worse. This failure constitutes substantial noncompliance with 42 C.F.R. § 483.25(c)(1) because Petitioner did not take proper action to ensure Resident 25 would avoid the development of pressure sores.

Resident 38

At the time of the survey, Resident 38 was a 54-year old woman diagnosed with Down Syndrome, chronic fatigue, hypothyroidism, seizures and failure to thrive. CMS Br. at 4; P. Opp. at 6; CMS Ex. 3 at 12; P. Ex. 4 at 3. She required extensive assistance with her activities of daily living. CMS Ex. 10 at 9. She also had a history of skin integrity issues and was considered at risk for pressure sores due to her impaired mobility, incontinence, and need for assistance with activities of daily living. CMS Ex. 10 at 52-55. Because she was at risk for pressure sores, her care plan dated October 18, 2012, included interventions such as skin assessments, recording changes in skin status, reporting any changes to her physician, and applying protective barrier cream as ordered. *Id.* An

assessment performed in July 2013 indicated her cognition decreased to very limited from her previous assessment in April as slightly limited and her mobility decreased to completely immobile from a previous assessment of slightly limited. CMS Ex. 10 at 84. Her pressure sore risk increased from mild in April 2013 to high in July 2013. *Id.* At the time of her assessment in July 2013 no new interventions were added to her care plan with respect to her increased pressure sore risk.

Resident 38 developed two pressure sores on her left buttocks. The first was discovered on her lower left buttock on June 23, 2013, measuring 0.2 cm long by 0.2 cm wide and was initially assessed as an abrasion. CMS Br. at 4; P. Opp. at 6; CMS Ex. 10 at 1; P. Ex. at 63. Petitioner used a Wound/Skin Care Management Documentation Form after noting the abrasion. P. Opp. at 6; P. Ex. 4 at 63. There was an order for barrier cream to be applied topically "bid [twice a day] and prn [as needed]" until healed. CMS Ex. 10 at 1. Petitioner's staff made Resident 38's physician "aware" of the abrasion. P. Opp. at 6; P. Ex. 4 at 63.

On July 2, 2013, the physician ordered Petitioner to cleanse left buttocks "with NS and apply Allevyn to area once @day until healed." P. Ex. 4 at 114. On July 3, 2013, the physician ordered a cushion for her wheelchair. P. Ex. 4 at 113. Staff periodically assessed Resident 38's skin. P. Ex. 4 at 63-64.

On August 15, 2013, the wound measured .2 cm long by .2 cm wide and no depth. P. Ex. 4 at 62. By August 22, 2013, however, the lower left buttock wound had grown in size to 1 cm long by 1 cm wide, with a depth of less than .1 cm. P. Ex. 4 at 62. The physician was not notified of the change in the wound even though the facility's pressure sore monitoring policy required that a physician be notified immediately when pressure ulcers appear to negatively progress. CMS Ex. 11 at 2. It was not until August 29, 2013, after performing the skin assessment that Petitioner noted that the wound to the left lower buttocks was worsening and notified the physician. P. Opp. at 6-7; P. Ex. 29 at 4. By this time the wound measured 2.1 cm long and 1.2 cm wide with a depth of less than .1 cm with yellow exudate, 100% slough in the wound and considered an unstageable pressure sore. P. Ex. 4 at 62. On August 29, 2013, Resident 38's physician ordered Dimethicone 1.0% cream applied to her left buttock twice a day and as needed especially after incontinence "until healed." P. Ex.4 at 94. It was not until August 30, 2013, that Resident 38's physician examined her and diagnosed her as having an unstageable pressure ulcer. P. Opp. at 7; P. Ex. 4 at 7. Resident 38's pressure sore on her left lower buttock was not fully healed until September 23, 2013. P. Opp. at 6; P. Ex. 4 at 61.

Petitioner identified Resident 38's second pressure sore, located on her left upper buttock, on July 2, 2013. That sore measured 1 cm long by .5 cm wide. P. Ex. 4 at 66. Petitioner assessed this wound as an abrasion. P. Opp. at 7. Weekly assessments through August 8, 2013, indicated wound improvement. P. Ex. 4 at 65-66; CMS Ex. 7 at 46. But starting on August 15, 2013, the wound again increased in size. P. Ex. 4 at 5. Petitioner did not

notify the physician of the wound's deterioration until at least August 29 when Petitioner assessed the wound as an unstageable pressure ulcer measuring .3 cm long by .3 cm wide by .2 cm deep with 100% granulation and yellow exudate. P. Opp. at 7; P. Ex 4 at 65.

Petitioner asserts that it made Resident 38's physician aware of the left upper buttock pressure sore on August 29, 2013. P. Opp. at 7; P. Ex. 4 at 65. Petitioner appears to assert that on August 30, 2013, a physician assessed Resident 38. P. Opp. at 7. However, the records only show an examination for the wounds on lower left buttock and right buttock, but not the left upper buttock. P. Ex. 4 at 6-7. However, for purposes of summary judgment, I will infer that the physician who examined Resident 38's left lower buttock and right buttock also examined her left upper buttock on August 30, 2013. As with the left lower buttock pressure sore, the physician ordered various actions taken and the left upper buttock pressure sore was resolved on September 12, 2013. P. Ex. 4 at 64.

Petitioner asserts that the following are disputed facts: Resident 38 was diagnosed with two pressure sores that were unavoidable; Petitioner complied with all wound policies; and Resident 38 received proper treatment once the pressure sores were diagnosed. P. Opp. at 2. Even accepting these as true, Petitioner failed to take appropriate action to obtain physician assistance to avoid the sores from worsening. The skin monitoring form used by Petitioner warned that "abrasions" are "prone to develop into pressure ulcers." CMS Ex. 10 at 50. Despite this, Petitioner waited until both abrasions became pressure sores before obtaining significant physician involvement in the matter. After such involvement, Resident 38's sores healed in relatively short periods of time.

It is significant that both of these wounds caused the resident pain, exhibited by facial grimacing when sitting in her wheelchair directly on the wounds, and requiring the administration of Tylenol 650 milligrams at least four times starting August 29th to relieve the pain. P. Ex. 4 at 109-110. Resident 38's condition improved and her treatment was discontinued on September 23, 2013, three months after the first abrasion was noted.

Petitioner's repeated failure to promptly notify Resident 38's physician of the deterioration of her wounds meant that she did not receive necessary treatment in a timely manner to promote healing of her wounds and to prevent infection and new sores from developing. Even accepting that pressure sores were unavoidable, Petitioner failed to take prompt action to get physician care to ensure recovery from the pressure sores. As a result, Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(c).

3. Petitioner was not in substantial compliance with 42 C.F.R. § 483.25 when it failed to provide care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of a resident.

The events relevant to this deficiency were discovered during an October 31, 2013 complaint survey. CMS Ex. 16 at 1. Resident 41 is a woman who, in October 2013, was 89 years old. P. Ex. 5 at 1. Petitioner admitted Resident 41 in June 2012, and had noted diagnoses for Resident 41 that included chronic kidney disease, urinary retention, diabetes mellitus and chronic obstructive pulmonary disease. CMS Br. at 6; P. Opp. at 8; P. Ex. 5 at 1-3. On September 28, 2013, Resident 41 was treated at an Emergency Room due to abdominal pain and her inability to urinate. CMS Br. at 7; P. Opp. at 8; P. Ex. 5 at 18-24. As a result, she was given an indwelling catheter and instructed to follow up with a urologist. CMS Br. at 7; P. Opp. at 8; P. Ex. 5 at 18. On October 7, 2013, the urologist, after seeing Resident 41, instructed that the indwelling catheter remain in place until the next morning and that the catheter could be replaced if necessary. CMS Br. at 7; P. Opp. at 8; CMS Ex. 22 at 1; P. Ex. 5 at 14-17.

According to the Statement of Deficiencies that resulted from the October 31, 2013 survey related to Resident 41, as well as witness interview notes taken by surveyors, on October 14, 2013, Resident 41 complained of urinary retention to a nurse employed by Petitioner, Amy Springer, RN. CMS Ex. 16 at 2; CMS Ex. 21 at 3. Nurse Springer called Resident 41's daughter to notify her of the need to insert an indwelling urinary catheter. Although Resident 41's daughter did not object to the insertion of a catheter, she told Ms. Springer that Nate Shannon, RN, a male nurse, should not make the insertion. CMS Ex. 16 at 2; CMS Ex. 21 at 3, 4. Nurse Springer attempted to insert the catheter, but was unsuccessful. CMS Ex. 16 at 3; CMS Ex. 21 at 3. Nurse Springer then asked for Nurse Shannon's assistance because Nurse Springer believed that he was the only nurse available. CMS Ex. 16 at 3; CMS Ex. 21 at 3. Nurse Shannon attempted to insert the catheter "us[ing] nursing judgment rather tha[n] honoring the desire for him not to provide care," but ceased after the first attempt because Resident 41 told him to stop.[7] CMS Ex. 21 at 3.

Approximately a half hour later, Nurse Springer and Nurse Shannon learned there was another nurse in the building, Heather Smith, RN. P. Ex. 11 at 1; CMS Ex. 21 at 3. Nurse Smith was able to insert the catheter on the first try. *Id.*; CMS Ex. 16 at 3. All in all, this was the fourth or fifth attempt to insert the catheter. Nurse Smith indicated in her notes that the resident tolerated the procedure and had no complaints of pain or discomfort. CMS Ex. 22 at 11; P. Ex. 5 at 78. Later that evening, the daughter of Resident 41 asked questions regarding the insertion of the catheter and indicated that she

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[7] Nurse Springer's declaration contradicts Nurse Shannon's account: "Nurse Shannon was unable to insert the indwelling catheter twice but was unable to do so." P. Ex. 11 at 1.

had "never seen her [mother] this upset." CMS Ex. 22 at 11; P. Ex. 5 at 78. The Nurse's Notes state that upon entering the room, Resident 41 was yelling aloud, "I told them to stop and they wouldn't." The nurse tried to calm Resident 41 but she stated, "I would rather die or commit suicide before I live here any longer." CMS Ex. 22 at 11; P. Ex. 5 at 78. The Nurse's Notes state, "[m]any attempts to calm Resident were ineffective. States, '[t]hey set nursing back 50 years because they didn't know what they were doing." CMS Ex. 22 at 11; P. Ex. 5 at 78. Still awake at 10 p.m., Resident 41 was still upset and told the nurse, "Look at my gown. They didn't even change it and it was wet." CMS Ex. 22 at 12.

When the surveyor interviewed the resident about this incident on October 30, 2013, she became visibly upset and tearful. CMS Ex. 21 at 4. She told the surveyor that the procedure took two hours by 3 different staff members. *Id.* The resident said she told them to stop after Nurse Shannon failed to insert the catheter. *Id.* She told the surveyor she felt violated. *Id*. Resident 41 was scheduled for a cystoscopy with the urologist on October 22, 2013 to assess her continued urinary retention but the procedure was not performed because Resident 41 was still emotionally upset from the catheter insertion at the facility on October 14, 2013. P. Ex. 5 at 8; CMS Ex. 16 at 3; CMS Ex. 21 at 5; CMS Ex. 27 at 3.

Petitioner contends that the note, that "she tolerated the procedure," demonstrates that Resident 41 experienced no harm. P. Opp. at 8. Instead Petitioner argues that there was "no indication in Resident 41's medical record that she opposed the catheter insertion of the catheter by staff and there is no indication that Resident 41 refused care from any of [Petitioner's] staff." P. Opp. at 8. Petitioner states "Resident 41 has no notation in her medical record that named staff members were not to care for her." P. Opp. at 8.

Although Petitioner does restate information from Resident 41's records at the facility, Petitioner failed to come forward with evidence that disputes the facts related to multiple attempts to insert a catheter and that Petitioner's daughter expressly indicated that Nurse Shannon ought not to insert the catheter. It is true that Nurse Springer, in her declaration, testified, "[t]o the best of my recollection," that "the resident's daughter stated she 'preferred' a male nurse not perform the procedure" and "[t]o the best of my recollection, Resident 41's daughter did not state that a male nurse should not perform the procedure under any conditions." P. Ex. 11. However, this testimony does not create a dispute of material fact because Nurse Springer is not certain of any of it. If Nurse Springer were certain about it, I would conclude that it essentially corroborates that Resident 41's daughter conveyed a restriction on male nurses inserting the catheter.

Nurse Springer's declaration corroborates that she and Nurse Shannon each attempted to catheterize Resident 41 twice and that Resident 41 became upset and asked them to stop trying, and that there was another female nurse in Petitioner's facility after all, who was able to insert the catheter on the first attempt. P. Ex. 11.

Petitioner's four or five attempts to insert an indwelling catheter resulted in emotional distress, physical discomfort, and possible pain to Resident 41. Moreover, Petitioner's staff did not honor Resident 41's wish that the insertion be performed by someone other than a male nurse. There was at least one other female nurse in the facility and Petitioner's staff decided not to wait until that nurse was available. As a consequence, both the repeated failed attempts at the insertion of the catheter and Petitioner's failure to respect Resident 41's express wishes resulted in substantial noncompliance with the regulatory requirement at 42 C.F.R. § 483.25, i.e., that the resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

4. The penalty imposed, two $3,200 per-instance CMPs, is reasonable.

In determining whether the amount of each CMP imposed here is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f). 42 C.F.R. § 488.438(e)(3). These factors include: (1) the facility's history of compliance; (2) the facility's financial condition; (3) the factors specified at 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 at 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. Unless a facility contends that a particular regulatory factor does not support the CMP amount, the ALJ must sustain it. *Coquina Ctr.*, DAB No. 1860 at 32 (2002).

My review of the reasonableness of a CMP is de novo and based upon the evidence in the record before me. I am not bound to defer to the CMS determination of the reasonable amount of the CMP to impose, but my authority is limited by the regulations. The limitations as set forth in the regulations are: (1) I may not set the CMP at zero or reduce it to zero; (2) I may not review the exercise of discretion by CMS in selecting to impose a CMP; and (3) I may only consider the factors specified by 42 C.F.R. § 488.438(f) when determining the reasonableness of the CMP amount. I am to determine whether the amount of any CMP proposed is within reasonable bounds considering the purpose of the Act and regulations. *Emerald Oaks*, DAB No. 1800 at 10 (2001); *CarePlex of Silver Spring*, DAB No. 1683 at 14-18 (1999); *Capitol Hill Cmty. Rehab. & Specialty Care Ctr.*, DAB No. 1629 (1997).

Petitioner has a long history of deficiencies, at the scope and severity levels ranging between D and G, for each year from 2005 through 2012. CMS Ex. 1 at 32-36.

Petitioner submitted no evidence of its financial condition; however, I note that a CMP of $3,200 is in the lower range for per instance CMPs and is not likely to have a financial effect on Petitioner.

Petitioner is very culpable. As indicated above, Petitioner's repeated failure to promptly notify Resident 38's physician of the deterioration of her wounds meant that she did not receive necessary treatment in a timely manner to promote healing of her wounds, and to prevent infection and new sores from developing, resulting in substantial pain. Further, not only did Petitioner's staff fail multiple times to insert a catheter into Resident 41, but, contrary to the resident's wishes, a male nurse made such an attempt.

Petitioner offered no arguments or facts to challenge CMS's imposition of two per-instance CMPs of $3,200 each, and I do not otherwise find any reason to lower the CMP amounts. Therefore, I sustain the two per-instance CMPs, which amount to a total penalty of $6,400.

Because I sustain both per-instance CMPs totaling $6,400, I must also sustain the loss of all Nurse Aid Training and/or Competency Evaluation Programs (NATCEP) for two years. 42 C.F.R. § 483.151(b)(2)(iv), (f)(1).

IV. Conclusion

I affirm CMS's determination and conclude that the CMPs imposed on Petitioner were reasonable.

/s/

Scott Anderson
Administrative Law Judge