Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

West Texas LTC Partners, Inc., d/b/a Cedar Manor
Docket No. A-15-51
Decision No. 2652
September 1, 2015

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Petitioner West Texas LTC Partners, Inc., d/b/a Cedar Manor (West Texas), a skilled nursing facility (SNF) in Texas, requested review of an Administrative Law Judge (ALJ) decision. The ALJ upheld determinations by the Center for Medicare & Medicaid Services (CMS) that West Texas was not in substantial compliance with Medicare participation requirements from December 18, 2013 through January 31, 2014 and that the noncompliance during the period December 18-20, 2013 posed immediate jeopardy to facility residents; the ALJ also upheld CMS's imposition of civil money penalties (CMPs) and a denial of payment for new Medicare admissions (DPNA). *West Texas LTC Partners, Inc., d/b/a Cedar Manor*, DAB CR3526 (2014) (ALJ Decision). CMS's determinations and imposition of remedies were based on two surveys at West Texas that concluded December 20, 2013 (December survey) and January 28, 2014 (January survey). The December survey found that West Texas did not comply with 42 C.F.R. § 483.13(c), 42 C.F.R. § 483.25(h)(1), (2), and 42 C.F.R. § 483.75. The January survey found that West Texas did not comply with 42 C.F.R. § 483.25(c), 42 C.F.R. § 483.65, and 42 C.F.R. § 483.75(f).

Following a de novo review of the record, the ALJ entered summary judgment for CMS on its determinations that noncompliance existed as found on the December and January surveys and that the noncompliance posed immediate jeopardy from December 18 to December 20, 2013. The ALJ also upheld the amounts of the CMPs, $6,050 per day for December 18 through December 20, 2013 and $350 per day for December 21, 2013 through January 31, 2014, finding those amounts reasonable under the applicable regulatory factors. The ALJ further concluded that CMS was authorized to impose the DPNA that took effect on January 24, 2014 and continued, along with the non-jeopardy level CMPs, through January 31, 2014. In its Request for Review (RR), West Texas argues that the Board should reverse the ALJ Decision because of what West Texas asserts are "numerous disputed genuine issues of material fact" regarding both the noncompliance findings and the reasonableness of the CMP that preclude summary judgment. RR at 1, 23, 25.

For the reasons discussed below, we reject West Texas' arguments and affirm the ALJ decision.[1]

Legal Background

To participate in the Medicare program, a long-term care facility, including a SNF, must be in "substantial compliance" with the requirements in 42 C.F.R. Part 483. 42 C.F.R. § 483.1. Under agreements with the Secretary of Health and Human Services, state survey agencies conduct onsite surveys of facilities to verify compliance with the Medicare participation requirements. *Id*. §§ 488.10(a), 488.11; *see also* Social Security Act (Act)[2] §§ 1819(g)(1)(A), 1864(a). State survey agencies conduct periodic surveys as well as surveys to investigate complaints that facilities are violating one or more of the participation requirements. 42 C.F.R. § 488.308.

A state survey agency reports any "deficiencies" it finds in a Statement of Deficiencies (SOD), which identifies each deficiency under its regulatory requirement. A "deficiency" is any failure to comply with a Medicare participation requirement, and "substantial compliance" means "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301 (defining "noncompliance" as "any deficiency that causes a facility to not be in substantial compliance").

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[1] West Texas requested oral argument on the grounds that the case has "procedural nuances . . . which can be more easily explained through oral argument . . . particularly . . . with respect to the deficiencies cited during the January 2014 survey and calculation of the proposed penalty amount" and that "the Board's ultimate decision regarding calculation of the penalty amount here has ramifications that potentially reach far beyond this proceeding." Petitioner's Reply to CMS' Response to Request for Review of Administrative Law Judge's Order Granting CMS' Motion for Summary Judgment (Reply) at 5. The request concluded by stating West Texas' belief that "oral argument will be helpful to the panel members in reaching their final conclusion . . . ." *Id*. The Board may grant requests for oral argument where necessary to assure that parties have a "reasonable opportunity" to present their cases. 42 C.F.R. § 498.85. The Board may also hold oral argument if it concludes oral argument may help its decision making. We have concluded that oral argument in this case is not necessary for either reason and deny the request. Although we are not sure what West Texas means by "procedural nuances," West Texas had ample opportunity to explain any such "nuances" in its opening and reply briefs and did fully brief the issue "regarding calculation of the proposed penalty,"which is actually an issue involving duration of noncompliance. Moreover, the Board's decision on that issue in this case does not have "ramifications that potentially reach far beyond this proceeding," as West Texas claims, because, as we discuss later, the law on that issue is already settled. We also note later in this decision West Texas' failure to fully comply with briefing rules established by the Board (*see* discussion of attempts to incorporate by reference a brief filed in the ALJ proceeding). Under these circumstances, the Board might fairly question whether West Texas is attempting to use oral argument as a substitute for written argument or to cure defects or omissions in its written argument.

[2] The current version of the Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssacttoc.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp. Table.

CMS may impose one or more remedies on noncompliant facilities, including per-day and/or per-instance CMPs. 42 C.F.R. §§ 488.402(b), (c), 488.406, 488.408(d)(1)(iii), (iv), (e)(1)(iii), (iv); 488.430(a). When CMS imposes a per-day CMP for noncompliance at a level less than immediate jeopardy, it chooses an amount within the $50-$3,000 "[l]ower range" for per-day CMPs. 42 C.F.R. §§ 488.438(a)(1)(ii), 488.408(d)(1)(iii). When CMS imposes a per-day CMP for noncompliance that it has determined poses immediate jeopardy, CMS must impose a CMP within the "[u]pper range" of $3,050-$10,000 per day. 42 C.F.R. §§ 488.438(a)(1)(i), 488.408(e)(1)(iii). The regulations define "Immediate jeopardy" as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS may impose a DPNA whenever a SNF is not in substantial compliance with Medicare requirements and must impose a DPNA if a SNF is not in substantial compliance within three months after being found out of compliance. Act §§ 1819(h)(2)(B)(i), 1819(h)(2)(D); 42 C.F.R. §488.417.

Case Background[3]

A. *The December survey*

The December survey, conducted by the Texas Department of Aging and Disability Services (State agency), found West Texas out of compliance with 42 C.F.R. § 483.13(c), which requires development and implementation of policies preventing abuse and neglect; 42 C.F.R. § 483.25(h)(1) and (2), which require protection against accident hazards and adequate supervision of residents to prevent accidents; and 42 C.F.R. § 483.75, which requires effective and efficient administration to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. ALJ Decision at 2. These findings were based on the following undisputed facts involving Resident # 1 and Resident # 4.

1. Resident #1 (R.1)[4]

R.1 is a paraplegic who is totally dependent on West Texas staff for essential functions (e.g., bed mobility, transfers, personal hygiene) and must wear a catheter. ALJ Decision at 3, *citing* CMS Ex. 6, at 8, 56, 58. The resident spent his days in an electric wheelchair, and staff used a Hoyer Lift to transfer him in and out of the wheelchair. *Id*. at 3, 4, 10. A Hoyer Lift is a device operated by staff to lift a resident by using a hammock-like sling

[3] Factual information in this background is drawn from the ALJ Decision and the record before the ALJ and is not intended to substitute for the ALJ's findings of fact.

[4] We use numerical identifiers for the residents in order to protect their privacy. We use first and last name initials for West Texas staff and the State agency surveyors for similar reasons.

that is placed under the resident and has straps that are attached to the lift during the transfer. *Id*. at 3. West Texas staff chose to leave the sling on the seat of the wheelchair, evidently in order to make it easier for the staff to transfer the resident when necessary. *Id*., *citing* CMS Ex. 16, at 2. West Texas staff assessed R.1 as at risk for falling forward and injuring himself because of his paraplegia, and his care plan, prepared by West Texas, informed staff that he played with the Hoyer Lift sling straps when the sling was in his wheelchair and also unhooked the tubing of his catheter. *Id*., *citing* CMS Ex. 6, at 10. To address these problems, R.1's care plan instructed staff to assure that the Hoyer Lift sling straps and catheter tubing were tucked in so that they did not hang down and, potentially, become entangled in the wheelchair wheels. *Id*. R.1's family told staff on numerous occasions that they needed to keep the straps away from the wheels. CMS Ex. 4, at 7-8; CMS Ex. 8, at 8, 9.

On December 2, 2013, as R.1 was leaving the dining room in his wheelchair, the straps of the sling became caught in the wheelchair's wheels, and R.1 fell out of the chair, sustaining fractures to both of his femurs. ALJ Decision at 4, *citing* CMS Ex. 6, at 36-38, 44, 72.

2. Resident #4 (R.4)

R.4 was a disabled elderly woman who was confined to a wheelchair and suffered from dementia. ALJ Decision at 4, *citing* CMS Ex. 4 at 1, 9. The surveyor observed staff putting R.4 into a Hoyer Lift sling and lifting her into a wheelchair. *Id*., *citing* CMS Ex. 16, at 3, 5. Staff left the sling on the wheelchair after completing the transfer. CMS Ex. 4, at 9-10. The surveyor observed the resident propelling her wheelchair with the straps dangling at the level of the wheels. CMS Ex. 4, at 10; CMS Ex. 16, at 3. Approximately two hours later, the surveyor again observed the resident in her wheelchair with the straps dangling. CMS Ex. 4, at 10; CMS Ex. 16, at 5. When the surveyor discussed the Hoyer Lift transfer of R.4 with the certified nursing assistant (CNA) who performed it, the CNA told the surveyor she had not received training on using the Hoyer Lift. *Id*.

B. *The January survey*

The January survey found West Texas out of compliance with 42 C.F.R. § 483.25(c), which requires facilities to ensure that a resident entering a facility without pressure sores does not develop medically avoidable pressure sores and that a resident having pressure sores receives the care and treatment necessary to promote healing, prevent infection, and to prevent new sores from developing; 42 C.F.R. § 483.65, which requires facilities to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment in order to prevent the development and transmission of

disease and infection; and 42 C.F.R. § 483.75(f), which requires that nursing assistants be able to demonstrate competency in skills and techniques necessary to care for residents' needs that are identified through resident assessments and described in residents' care plans. These findings are based on the following undisputed facts involving one resident.

Resident #7 (R.7) was 91 years old and suffered from multiple illnesses. ALJ Decision at 8, *citing* CMS Ex. 11, at 77. West Texas assessed this resident as at high risk for pressure sores in August 2013. *Id*., *citing* CMS Ex. 11, at 51. West Texas developed a care plan that required staff to turn and reposition R.7 every two hours and clean her perineum with soap and water after she urinated. *Id*., *citing* CMS Ex. 11, at 5. During the survey (on January 27, 2014), the surveyor observed a CNA provide incontinence care for R.7. *Id.* During these observations, the surveyor saw two Stage II pressure sores on R.7's buttocks. *Id*., *citing* CMS Ex. 15, at 3-4. Although the CNA acknowledged the pressure sores when asked by the surveyor, the CNA had not pointed them out. *Id*. The CNA, the surveyor observed, did not perform perineal care according to the instructions in the resident's care plan and West Texas' policy for Perineal Care: she wiped R.7's inner buttocks with a wipe rather than a washcloth and did not wash her perineum with soap and water as the plan instructed. *Id*. The surveyor also observed that the nursing assistant did not ask R.7 to separate her legs as required by the facility's policy. CMS Ex. 15, at 3-4.

Standard of Review

Whether summary judgment is appropriate is a legal issue the Board addresses de novo. *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 2 (2009), *citing Lebanon Nursing & Rehab. Ctr*., DAB No. 1918 (2004). Summary judgment is appropriate when the record shows there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. *See id.* at 2, *citing Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986).

In *Livingston Care Center*, DAB No. 1871, at 5 (2003), *aff'd*, *Livingston Care Center v. U.S. Department of Health & Human Services*, 388 F.3d 168, 172-73 (6th Cir. 2004), the Board described the parties' respective burdens regarding summary judgment as follows:

> The party moving for summary judgment bears the initial burden of demonstrating that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. *Celotex*, 477 U.S. at 323. This burden may be discharged by showing that there is no evidence in the record to support a judgment for the non-moving party. *Id*. at 325. If a moving party carries its initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial.'" *Matsushita Elec. Industrial Co. v. Zenith Radio*, 475 U.S. 574, 587 (1986) (quoting Fed. R. Civ. P. 56(e)). 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. *Id*. at 586, n.11; *Celotex*, 477 U.S. at 322 (moving party is entitled to summary judgment if the party opposing the motion "fails to make a showing 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").

Id. at 5-6 (emphasis in original). Summary judgment principles also provide that "[i]n order to demonstrate a genuine issue, the opposing party must do more than show that there is 'some metaphysical doubt as to the material facts . . . . Where the record taken as a whole could not lead a rational trier of fact to find for the non-moving party, there is no 'genuine issue for trial.'" *1866ICPayday.com* at 3, *quoting Matsushita,* 475 U.S. at 587. In deciding whether the record taken as a whole could not lead a rational trier of fact to find for the non-moving party, "the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor." *Id*., *citing United States v. Diebold, Inc.*, 369 U.S. 654, 655 (1962).

Under the applicable substantive law, CMS has the initial burden of coming forward with evidence that the provider was not in substantial compliance with Medicare participation requirements. However, the provider bears the ultimate burden of persuading the ALJ that it was in substantial compliance with those requirements. *See South Valley Health Care Ctr.*, DAB No. 1691 (1999), *aff'd, South Valley Health Care Ctr. v. Heath Care Financing Admin.*, 223 F.3d 1221 (10th Cir. 2000).

Analysis

A. *Summary judgment for CMS was appropriate*.

1. What West Texas calls "disputed . . . issues of material fact" in its Request for Review are either not facts or not material, and West Texas improperly relies on its prehearing brief for fact rebuttal rather than directly challenging the facts the ALJ found undisputed.

In its Request for Review, West Texas lists a number of bulleted statements under each area of noncompliance found on the December and January surveys and asserts that these statements refer to "material facts" that West Texas "will demonstrate . . . are in dispute in this case, so this case should not have been disposed of through summary judgment." RR at 6, 9, 11, 12, 19, 20. Most of the statements, however, refer to questions of law, not findings of fact, and none of the bulleted statements disputes any of the facts (recited by us above) that the ALJ found material and undisputed. Even if there is a genuine dispute about the few statements of "fact" listed by West Texas that actually involve facts (e.g.,

whether R.7 even had open pressure sores on January 26, 2014), those facts are immaterial for reasons discussed below.[5] West Texas also does not explain why any of the exhibits it cites as alleged support for the existence of factual disputes create a genuine dispute of fact, a problem also noted by the ALJ in the proceeding before him. *See* ALJ Decision at 7.

West Texas also asks the Board to rely on its prehearing brief below for West Texas' discussion of certain exhibits and law. *See* RR at 7, 22 (stating that it is incorporating by reference discussion of exhibits and law in its prehearing brief).[6] The Board's Guidelines, a copy of which West Texas received with the ALJ Decision, do not permit such incorporation by reference in briefs before the Board. *See Departmental Appeals Board, Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs (Guidelines), "Additional Rules Applicable to Both Electronic and Non-Electronic Filing*," ¶ (c) ("A submission (including the request for review) may not incorporate by reference a brief or parts of a brief previously submitted to the ALJ.").[7]

2. West Texas does not dispute any of the facts that are material to the noncompliance found on the December survey.

The facts that are material with respect to the findings of noncompliance on the December survey are those that support or, from West Texas' viewpoint, rebut CMS's findings of noncompliance with each of the three regulations cited. As relevant here, the first regulation, section 483.13(c), provides as follows:

> *Staff Treatment of Residents*. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents . . . .

[5] *See* discussion at pages 14-16.

[6] West Texas also states that it is incorporating by reference "the evidence offered to defeat CMS' motion for summary judgment [which] consists of the documents previously submitted in Petitioner's pre-hearing exchange . . . along with the medical records and facility documents previously filed by CMS." RR at 4. That evidence is already in the record, *see* ALJ Decision at 2, and thus does not need to be incorporated by reference. However, if West Texas means by this statement that it is trying to incorporate either its citations to record facts or its discussion of them from its prehearing brief, that is not permitted, as discussed above. We note that the ALJ rejected West Texas' attempt to incorporate the facts alleged in its prehearing brief as fact rebuttal rather than directly rebutting the facts in CMS's motion. *See* ALJ Decision at 8. West Texas does not challenge this rejection.

[7] The Guidelines are available at http://www.hhs.gov/dab/divisions/appellate/guidelines/ prov.html.

With respect to section 483.13(c), there is no dispute that West Texas had a policy prohibiting abuse and neglect that defined "neglect" as "failure to provide care and services necessary to avoid physical harm, mental anguish or mental illness." This language, as the ALJ noted, essentially tracks the regulatory definition of "neglect" in 42 C.F.R. § 488.301 ["failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness"] but in addition states that "negligent care includes the failure to 'properly care for a resident in the manner conducive to professional care standards.'" ALJ Decision at 5, *citing* CMS Ex. 14, at 16. There also is no dispute that West Texas had policies addressing accident prevention. CMS Ex. 14, at 20, 24. Those policies required "staff to identify those residents who are at risk for accidents or falls and to implement procedures to reduce or prevent accidents." ALJ Decision at 5. West Texas' accident prevention policies thus identify accident prevention as a "care and service[ ] necessary to avoid physical harm . . ." within the meaning of section 488.301.

Since West Texas had policies prohibiting neglect, as well as policies addressing accident prevention, the remaining legal issue with respect to whether there was noncompliance with section 483.13(c) is whether West Texas implemented those policies with respect to avoiding the risk West Texas identified as being posed by Hoyer Lift sling straps left in R.1 and R.4s' wheelchairs. The facts material to answering that question on summary judgment are undisputed. The facility's own documents, including R.1's care plan and the report on his fall, and the unchallenged surveyor observations of R.4 in her wheelchair, show that staff failed to secure the straps for both residents despite recognition that dangling straps posed an accident hazard, a recognition expressly acknowledged in R.1's care plan. CMS Ex. 6, at 10.

We agree with the ALJ's conclusion, quoted below, that these undisputed facts establish noncompliance with section 483.13(c):

> The undisputed material facts plainly establish that Petitioner contravened the requirements of 42 C.F.R. § 483.13(c). They show, first, that Petitioner neglected the needs of [R.1 and R.4]. The term "neglect" is defined by implementing regulations to mean "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 488.301. Petitioner's staff recognized that [R.1] was at risk for serious injury if Hoyer Lift straps became entangled in his wheelchair. The staff should have known that [R.4] presented similar issues. And, yet, the staff allowed both residents to roam Petitioner's premises with dangling Hoyer Lift straps, putting these residents in danger. In the case of [R.1], the

> staff not only knew that the resident was at risk, but the staff was warned repeatedly by the resident's father and stepmother that he was in danger. And, yet, despite this knowledge and the warnings received, the staff did not abate the risk. That is neglect under any definition of the term.
>
> * * *
>
> Additionally, Petitioner has policies that command its staff to identify those residents who are at risk for accidents or falls and to implement procedures to reduce or prevent accidents. [citation omitted]
>
> The undisputed material facts show clearly that Petitioner and its staff failed to implement these policies in providing care to [R.1] and [R.4]. . . .

ALJ Decision at 4-5.

West Texas asserts legal error with respect to the ALJ's interpretation of section 483.13(c) because, West Texas argues, "F224 [the survey "tag number" corresponding to the regulation] is not a policy implementation tag or generalized neglect tag . . . ." RR at 7. As its only alleged support for that assertion, West Texas cites the ALJ decision in *Heron Pointe Health and Rehabitation*, DAB CR1401 (2006). RR at 6, 7.[8] ALJ decisions do not bind the Board or even other ALJs. *Britthaven of Chapel Hill*, DAB No. 2284, at 9-10 (2009). Furthermore, the quantitative analysis the ALJ used in *Heron Pointe* (stating he would not infer a failure to implement an anti-neglect policy from the single incident of "neglect" alleged) has been rejected by the Board in a number of cases. *See, e.g., Oceanside Nursing & Rehab. Ctr.*, DAB No. 2382, at 11 (2011) (holding that noncompliance with section 483.13(c) based on failure to implement an anti-neglect policy is not based on the number or nature of the alleged incidents of neglect but, rather, on whether the facts surrounding the alleged incident or incidents "demonstrate an underlying breakdown in the facility's implementation of the provisions of an anti-neglect policy").

West Texas also asserts that it had "an aggressive neglect prohibition program," and that staff who worked with R.1 were trained "on how to use the new wheelchair and how to account for the [H]oyer lift sling straps (placing them behind the resident)." RR at 7, 8. West Texas blames R.1's fall and fractures on his propensity to play with or untie the straps and disconnect the catheter tubing. *Id*. We reject, as did the ALJ, West Texas' attempt to blame R.1 for the failure of its staff to follow the instructions in R.1's care plan to secure the straps and catheter tubing so that they would not dangle near the

[8] West Texas cites to "*Heron Pointe v. CMS*." RR at 6, 7. We presume West Texas is relying on the *Heron Pointe* decision that we discuss here, which we note was not appealed to the Board.

wheels of his wheelchair.[9] RR at 8; ALJ Decision at 5. Nursing home staff knew that R.1 had a propensity to play with the straps and unhook his catheter tubing when they developed his care plan and, in fact, noted that propensity in the plan. If the plan was not adequate to protect R.1 in light of that propensity, staff should have revised it and should also have watched R.1 more closely and intervened to secure the straps and tubing when they dangled near the wheels. Yet, as the ALJ found,

> . . . Petitioner has not offered a single fact to show that its staff dealt meaningfully with the hazard caused by the resident untying and playing with the Hoyer Lift straps. There were obvious measures that Petitioner's staff might have taken to protect the resident, ranging from keeping the resident under observation and retying the straps whenever the staff saw them untied, to simply removing the sling and straps from the resident's wheelchair. But, Petitioner offered not even a suggestion that it attempted to implement any of these measures. . . .

ALJ Decision at 5.

The ALJ concluded that the same undisputed facts discussed above show noncompliance with sections 483.25(h)(1) and (2), which provide as follows:

> *Accidents*. The facility must ensure that –
>
> (1) The resident environment remains as free of accident hazards as is possible; and
>
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

The ALJ concluded that by allowing R.1 and R.4 to propel their wheelchairs with lift straps and catheter tubing dangling near the wheels, despite knowing this was an accident hazard, West Texas did not ensure that the environment in which R.1 and R.4 lived at the facility was as free of accident hazards as possible or provide supervision or assistance devices adequate to prevent accidents:

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[9] West Texas claims in its argument regarding R.1 that "photographs offered by CMS confirm that the straps on the chair are not long enough to reach the wheel of the chair." RR at 8, *citing* CMS Ex. 17, at 1. The ALJ did not address the photos in CMS Exhibit 17. However, even construing those photos most favorably to West Texas would not raise a genuine dispute of material fact as to whether the straps of R.1's sling were long enough to get caught in the wheels of his wheelchair because undisputed facts show that they did get caught in R.1's wheelchair wheels, causing him to fall out of the chair. Moreover, there is no evidence that any of the wheelchair photos show R.1's wheelchair (as opposed to R.4's, for example), and at least one of the photos in the exhibit does show a strap dangling close enough to a wheel to get caught. *See* CMS Ex. 17, at 3.

> Both [R.1] and [R.4] were exposed to palpable hazards. Staff knew that these residents could be injured seriously if Hoyer Lift straps became entangled in their wheelchairs. Staff knew also that these residents were traveling around Petitioner's facility with dangling straps that could become entangled in their wheelchairs' wheels. In the case of [R.1], the Resident's father and stepmother told the staff repeatedly about the problem. And, yet, Petitioner and its staff allowed the problem to persist until [R.1] was grievously injured. Perhaps worse, even *after* the injury sustained by [R.1], Petitioner's staff continued to allow another resident, [R.4], a demented and helpless individual, to propel herself around the facility with dangling Hoyer Lift straps.

ALJ Decision at 6 (italics in original). We agree with the ALJ's analysis as to why these material, undisputed facts evidence noncompliance with section 483.25(h)(1) and (2) as well as section 483.13(c).[10]

West Texas argues that the ALJ erred in finding noncompliance regarding its care of R.4 under sections 483.25(h) and 483.13(c) because there is no evidence R.4 (who the surveyor twice saw using her wheelchair with straps dangling near the wheels) sustained a fall or other adverse effects. RR at 7, 10. The ALJ properly rejected that argument. Section 483.13(c) contains no requirement that any harm result from a facility's failure to implement its anti-neglect policy before CMS may find noncompliance with that regulation, and the Board has upheld findings of failure to implement anti-neglect policies in situations where no harm resulted from the failure. *See, e.g.*, *Liberty Commons Nursing & Rehab Ctr. – Johnston*, DAB No. 2031 (2006) (upholding finding of noncompliance based on failure to implement policy designed to protect residents identified as allergic to latex from being exposed to latex without evidence that a resident actually suffered an allergic reaction to the nurse aide's use of latex gloves), *aff'd*, *Liberty Commons Nursing & Rehab Ctr. – Johnston v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007). Moreover, the Board has long rejected the argument that an accident must actually occur before a facility can be cited for noncompliance with section 483.25(h) for either failure to ensure that the resident environment be kept as free from accident hazards as possible or for failure to provide supervision adequate to prevent accidents. *See, e.g.*, *Clermont Nursing & Convalescent Ctr.*, DAB No. 1923 (2004) (holding that CMS may find noncompliance with section 483.25(h) where the facility has not reduced or eliminated foreseeable risks to the highest practicable degree, regardless of whether an accident or injury actually occurred), *aff'd*, *Clermont Nursing & Convalescent Ctr. v. Leavitt*, 142 F. App'x 900 (6th Cir. 2005).

[10] We need not separately discuss why these same facts also support CMS's findings of noncompliance under section 438.75 beyond saying that we agree with the ALJ that "[a]t bottom, the ineffective implementation of [West Texas'] policies and the absence of meaningful protection of [R.1 and R.4] is a failure of management [in that] [i]t is management's responsibility in a facility to assure that policies are implemented and that regulatory requirements are complied with." ALJ Decision at 7.

West Texas also asserts with respect to R.1's accident that "there is no way this particular accident could have been foreseen or prevented[ ]" and that the ALJ was somehow applying a "strict liability" standard. RR at 8. West Texas does not develop these assertions, and they are baseless. In its assessment of and plan of care for R.1, West Texas expressly recognized that due to his paraplegia, R.1 could be injured by falling forward and that dangling Hoyer Lift sling straps posed a hazard for this reason when he was in his wheelchair. CMS Ex. 6, at 10. Thus, regardless of whether the particular type of accident in which R.1 was injured had ever occurred before, West Texas specifically recognized beforehand that this type of accident could happen to R.1. Moreover, the ALJ's determination of noncompliance, insofar as it was based on findings of fact regarding R.1's care and treatment, was not based on R.1's fall *per se* but, rather, on West Texas' failure to take the steps West Texas had identified as necessary to prevent a fall caused by dangling Hoyer Lift sling straps. Indeed, as we discussed above in connection with R.4, a determination of noncompliance can be made for failure to provide the care and services necessary to prevent a fall regardless of whether a fall occurs.

For all of the reasons stated above, we uphold the ALJ's conclusion, after finding no material dispute of fact, that West Texas was not in substantial compliance with the three regulations cited as noncompliant on the December survey.

3. West Texas does not dispute any of the facts material to establishing the noncompliance found on the January survey.

Based on the January survey, CMS found noncompliance with 42 C.F.R. §§ 483.25(c), 483.65 and 483.75(f).[11] Section 483.25(c) provides as follows:

> *Pressure sores*. Based on the comprehensive assessment of a resident, the facility must ensure that –
> (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and

[11] The State agency surveyors found on the January survey that West Texas had completed correction of the deficiencies found on the December survey, including those found under sections 483.13(c), 483.25(h) and 483.75, and listed the date of correction as January 16, 2014. P. Ex. 10, at 1. CMS does not dispute that West Texas completed correction of the deficiencies found on the December survey by January 16, 2014, but does dispute that the correction of those deficiencies put the facility in substantial compliance, an issue we discuss later. We note that the findings of noncompliance on the January survey included a deficiency under section 483.75, which regulation was also found unmet on the December survey. However, the deficiency under that regulation on the January survey involved subsection (f), one of the specific administration requirements listed under section 483.75, rather than the broad-scope administration requirement stated at the beginning of that regulation.

> (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

Section 483.65 provides as follows:

> *Infection control*. The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.

Section 483.75(f) provides as follows:

> **Administration.**
>
> A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.
>
> * * *
>
> (f) *Proficiency of Nurse aides*. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

The ALJ concluded that undisputed facts regarding care West Texas staff gave R.7, as observed by the surveyor on the January survey, showed a violation of all three requirements. The record, which we have reviewed de novo, supports the ALJ's conclusion. It is undisputed that the facility had assessed R.7, a 91-year-old woman, as being at high risk for developing pressure sores. CMS Ex. 11, at 51 (Braden Scale – For Predicting Pressure Sore Risk completed by facility staff). It is also undisputed that West Texas developed a care plan that, in relevant part, required staff caring for the resident "to cleanse [R.7's] perineal area with soap and water following each urination . . . ." *Id.* at 5 (R.7's Care Plan). West Texas also had a Perineal Care policy that, in addition to containing general cleansing and infection and odor control guidelines, required staff providing urinary incontinence care to female residents to use the following specific procedures: (1) ask the resident to open her legs; (2) put on disposable gloves; (3) use a wet washcloth to make a mitt and apply soap lightly; (4) use one gloved hand to stabilize and separate the labia and the other gloved hand to wash from front to back; and (5) rinse and pat dry with a towel. CMS Ex. 14, at 10-11. In an interview with the surveyor, the DON further stated that CNAs are taught to wipe from front to back and switch gloves before applying creams. CMS Ex. 9, at 4.

On January 27, 2014, a surveyor observed a CNA give urinary incontinence care to R.7 that did not accord with R.7's care plan or the facility policy. CMS Ex. 9, at 3-4 (SOD); CMS Ex. 15, at 2-5 (declaration of surveyor C.A., R.N.). The surveyor's observations included the CNA's failure to wash the resident's entire perineal area with a washcloth; rather than following this required procedure, the CNA used a wipe to wipe the resident's inner buttocks once. *Id*. The surveyor further observed that the CNA did not remove or change gloves during the entire perineal care process and did not ask the resident to open her legs. *Id*.

After noting these observations of improper perineal care, the ALJ stated: "Petitioner has offered nothing to rebut those assertions by CMS. It does not deny that on January 27, 2014, the nursing assistant providing care to [R.7] failed to wash the resident's perineum as was required by the resident's care plan, nor does it offer any evidence to show that this failure was harmless." ALJ Decision at 9. The ALJ then found the undisputed facts "sufficient to establish noncompliance by Petitioner with [all three] regulatory requirements." *Id*. With respect to section 483.25(c), the ALJ concluded that the "undisputed material facts establish that Petitioner's staff failed to follow the explicit instructions contained in [R.7's] care plan [for pressure sore prevention] in that they did not provide the perineal care that is directed by that plan." *Id*. The ALJ concluded that the same undisputed facts showed a violation of section 483.65 because "[k]eeping [R.7's] perineum as germ-free as possible by washing it with soap and water after the resident urinated was basic infection control and Petitioner's staff failed to comply with that requirement." *Id.* Finally, the ALJ concluded that the same undisputed facts "establish that Petitioner failed to comply with the requirements of . . . [section] 483.75(f) . . . [because] [b]eing trained to carry out the requirements of a care plan is a basic element of nursing assistant competence." *Id*.

On appeal, as below, West Texas does not directly dispute the facts on which the ALJ based his conclusion that West Texas was out of compliance with the three cited regulations because staff did not provide perineal care for R.7 in accord with the resident's care plan and facility policies. West Texas suggests without explanation that there is unaddressed evidence undercutting the ALJ's reliance on the surveyor's observations of perineal care. *See* RR at 16-17 (stating that "the Director of Nursing [DON] confirms that the surveyor's observations were inaccurate" – citing P. Exs. 4 and 12). We find no factual basis at all for this suggestion, much less a genuine dispute of material fact. Neither of the exhibits West Texas cites shows that the DON was present when the surveyor made her perineal care observations or that she was otherwise in a position to dispute the accuracy of those observations. Petitioner Exhibit 4 contains a one-page statement by the DON in which she asserts that the surveyor called her into R.7's room to ask if she knew about the pressure sores on R.7's buttocks and when she responded she had not known, showed her the pressure sores. P. Ex. 4, at 4. The DON's statement further asserts that in order for her to view the pressure sores, a CNA had to wipe off barrier cream that had previously been applied over the pressure sores. *Id*.

However, the DON's statement does not say that she was with the surveyor during the surveyor's perineal care observations or that any perineal care occurred during the DON's observations of the pressure sores. Indeed, the statement says nothing about perineal care. In addition, it is undisputed that the surveyor discovered the pressure sores during her observation of perineal care, and that after the perineal care, the CNA applied barrier cream. CMS Ex. 9, at 3, 4; CMS Ex. 15, at 2, 3. Thus, as a matter of timing and context, the DON's asserted observations could not have occurred during the surveyor's perineal care observations.

Petitioner Exhibit 12 is similarly incapable of raising a genuine dispute of fact about the improper perineal care given to R.7, as observed by the surveyor. The exhibit is the DON's affidavit, submitted in opposition to CMS's summary judgment motion. In her affidavit, the DON states, "With respect to the surveyor's allegations regarding the provision of perineal care, the surveyor's observations were inaccurate (Ex.4)." P. Ex. 12, at 3. However, as we have already discussed, the DON's statement in Petitioner Exhibit 4 does not state that the DON observed the perineal care with the surveyor (or discuss perineal care at all) and, timing-wise, indicates that the DON could not have been with the surveyor when she made those observations.[12] We conclude that West Texas' unsupported speculation about the accuracy of the surveyor's observations of R.7's perineal care does not even create "metaphysical doubt," much less raise a genuine dispute of material fact as required to preclude summary judgment. *See 1866ICPayday.com* at 3, *quotin*g *Matsushita*, 475 U.S. at 587.

Rather than offer evidence capable of raising a genuine dispute of material fact about the improper perineal care, Petitioner's argument here, as below, focuses on whether R.7 had the number of pressure sores identified by the surveyor, on what date the acknowledged pressure sores developed and whether the pressure sores developed due to inadequate preventive care by West Texas staff. *See* RR at 13-16; ALJ Decision at 8-9.[13] However,

[12] Petitioner Exhibit 4 also contains a two-page hand-written statement by a facility nurse, but that statement addresses R.7's pressure sores, not the surveyor's observations of perineal care, and, thus, is incapable of undercutting the accuracy of the surveyor's observations regarding perineal care. P. Ex. 4, at 1-2. The exhibit also contains a one-page document with two post-survey hand-written notes (one dated "2/17/14"; the other dated "6/2") by CNA L.R., the CNA observed by the surveyor giving improper perineal care. *Id.* at 3. While the first statement discusses perineal care given to R.7 at some time, it does not state the date of that care or allege that the surveyor was present during the care. *Id.* The second note also says nothing about perineal care but merely asserts that on some unnamed date, the "state lady" asked if she "spoke Spanish to everyone . . . ." *Id.* These documents, like the other documents in Petitioner Exhibit 4, do not raise any genuine dispute about the facts on which the ALJ relied, including the surveyor's observations of improper perineal care.

[13] As we indicated earlier, the ALJ took note of West Texas' attempt to use its prehearing brief as fact rebuttal rather than responding directly to the facts in CMS's Motion for Summary Judgment. The ALJ went on to state that he looked closely at the arguments in West Texas' pre-hearing brief and concluded, "The thrust of Petitioner's argument . . . is that care provided by its staff to [R.7] prevented the resident from developing avoidable pressure sores between July 2013 and January 26, 2014 and that sores that the resident manifested on January 27, 2014 and thereafter were unavoidable." ALJ Decision at 8.

the ALJ found that CMS did not allege as the basis for the noncompliance that staff failures of care resulted in R.7 developing avoidable pressure sores, and, accordingly, did not rely on allegations of pressure sore development for his decision. ALJ Decision at 9. We concur with the ALJ that although CMS discussed the surveyor's observations of R.7's pressure sores and the CNA's failure to note them until prompted by the surveyor, CMS's determination of noncompliance was based on a conclusion that the inadequate perineal care observed by the surveyor and undisputed by West Texas evidenced noncompliance with subsection (2) of section 483.25(c). *See* CMS Ex. 9, at 1 (SOD citation to the requirements of subsection (2) as the reason for finding section 483.25(c) unmet). Subsection (2), unlike subsection (1), does not focus on development of avoidable pressure sores but, rather, on whether a resident receives the "necessary treatment and services to promote healing [of existing pressure sores], prevent infection and prevent new sores from developing." As the facility's care plan for R.7 (CMS Ex. 11, at 44) evidences, proper perineal care was an important part of the facility's plan for preventing R.7's development of pressure sores because R.7's incontinence put her at risk for pressure sore development. Furthermore, West Texas' Perineal Care and Incontinence Care policies evidence the connection between proper incontinence care and infection prevention. CMS Ex. 14, at 10, 13. Thus, the ALJ did not err in relying on the CNA's failure to provide proper perineal care to find noncompliance with section 483.25(c).

West Texas also disputes the surveyor's allegation that in addition to providing perineal care that was not consistent with the procedures in R.7's care plan and facility policies for cleansing the perineal area, the CNA was rough when wiping R.7. *See* CMS Ex. 9, at 3; RR at 17. However, the ALJ Decision does not provide any indication that the alleged rough care was part of the ALJ's basis for concluding that West Texas was not in substantial compliance. The ALJ Decision does not discuss that particular allegation at all, and a finding on that issue was not necessary to support the ALJ's conclusion. The CNA's failure to follow R.7's care plan and the facility's policies when providing perineal care, as discussed by the ALJ and undisputed by West Texas, is sufficient to sustain the ALJ's award of summary judgment to CMS.

For the reasons stated above, we conclude that the ALJ did not err in granting summary judgment for CMS, upholding CMS's determination that West Texas was not in

substantial compliance with federal requirements for SNFs on the December and January surveys.[14]

B. *West Texas' argument that the penalty amounts were miscalculated – in essence an argument about the duration of its noncompliance – has no merit.*

The heading for the final section of West Texas' Request for Review is "FACT ISSUES REGARDING REASONABLENESS OF ENFORCEMENT REMEDIES (BOTH SURVEYS)" (capital letters in original). RR at 23. The title notwithstanding, West Texas does not challenge the ALJ's determination that the CMPs imposed by CMS were reasonable in amount based on the levels of noncompliance and application of the factors in 42 C.F.R. §§ 488.438(f)(1)-(4) and 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)). *See* ALJ Decision at 9-11. Rather, West Texas asserts that it was found in substantial compliance as of January 16, 2014 and that no new deficiencies were cited between January 16 and January 24 and, therefore, the $350 per-day CMP imposed based on the December survey should have ended on January 16 and the DPNA scheduled to take effect January 24, 2014 (if West Texas had not achieved substantial compliance by that date) should not have taken effect. RR at 23-24. In essence, as the ALJ observed, West Texas is making an argument that "CMS's determination of the *duration* of its noncompliance is incorrect." *See* ALJ Decision at 10 (italics in original). West Texas bases its argument on entries on a Post-Certification Revisit Report form (Report) the surveyors filled out at the time of the January survey which states "Correction Completed 01/16/2014" next to a recitation of each deficiency cited on the December survey. RR at 23-24, *citing* P. Ex. 10. West Texas cites these entries as "undisputed" evidence "that as of January 24, 2014, [West Texas] was in substantial compliance with all applicable state and federal regulations." *Id*. at 24. West Texas further asserts that the ALJ's "ruling to the contrary is simply in error because it is undisputed that once a survey team 'clears' a facility's deficiencies, the 'clearance' date is retroactive to the date on the facility's plan of correction, and this is precisely what is reflected in the . . . document introduced as Pet[itioner] Ex[hibit] 10." *Id*.

[14] We note that although West Texas disputes the ALJ's conclusion that it was not in substantial compliance on both surveys, West Texas does not dispute the ALJ's decision to uphold CMS's determination that the deficiencies found on the December survey posed immediate jeopardy to facility residents from December 18 through December 20, 2013. Accordingly, we uphold the immediate jeopardy determination without further discussion except to note that (1) CMS's determination of immediate jeopardy is a determination of the level of noncompliance and, as such, "must be upheld unless it is clearly erroneous," 42 C.F.R. § 498.60(c)(2), and (2) the ALJ stated that "Petitioner [had] offered no facts to rebut CMS's determination that the deficiencies identified at the December survey put residents . . . at immediate jeopardy." ALJ Decision at 7.

The ALJ rejected this argument, noting that West Texas was relying solely on the statement of the correction date on the Report and "has not offered any facts to show that it actually abated all of the deficiencies that were found at the December survey as of January 16, 2014." ALJ Decision at 10. The ALJ further concluded that even if the Report meant that the State agency had found the facility in substantial compliance as of January 16, 2014, "CMS's findings of noncompliance take precedence over those made by the State." *Id.*, *citing* 42 C.F.R. § 488.452(a)(2)(i).

We conclude, albeit with a somewhat expanded legal analysis, that the ALJ correctly rejected West Texas' argument that it came into compliance earlier than the date determined by CMS. As the ALJ indicated, West Texas has the substantive burden of proving that it achieved substantial compliance earlier than the date CMS determined; CMS does not have the burden of showing that noncompliance continued on or after January 16, 2014. *See Chicago Ridge Nursing Ctr.*, DAB No. 2151, at 26 (2008) (stating that "CMS was under no obligation to prove lack of substantial compliance on or after" the date on which the facility claimed to have returned to substantial compliance because CMS may impose remedies on a facility found out of substantial compliance "beginning as early as the date that the facility was first out of substantial compliance and continuing in effect until the facility establishes that it has achieved substantial compliance or is terminated from the program."). As the ALJ noted, West Texas has provided no evidence that it actually achieved compliance by January 16, 2014 but only cites the dates the State agency determined it corrected the previously cited deficiencies. Even assuming the State agency determination is correct as to correction of the previously cited deficiencies (and West Texas has not provided any independent evidence it is), the Board has made it clear that "a finding that deficiencies have been corrected is not the same as a determination that a SNF has achieved substantial compliance with all participation requirements." *Meadowbrook Manor – Naperville,* DAB No. 2173, at 13 (2008), *aff'd sub nom. on other grounds, Butterfield Health Care II, Inc. v. Johnson*, No. 1:08cv-03604 (N.D. Ill. June 16, 2009). In *Meadowbrook Manor*, the Board rejected essentially the same argument made here, that a Post-certification Revisit Report found the facility in substantial compliance where the report contained no statement to that effect, even though the report indicated that a deficiency from the prior survey had been corrected.

The Board's holding is consistent with the regulations. Once it finds a SNF out of compliance, CMS is authorized to impose one or more of the alternative remedies listed in section 488.406 – including CMPs and a DPNA – beginning as early as the date that the facility was first out of substantial compliance and continuing in effect until the facility establishes that it has achieved substantial compliance or is terminated from the program. 42 C.F.R. §§ 488.440(a), 488.454(a). Thus, remedies imposed after previously cited deficiencies have been corrected remain in effect until such time as CMS determines the facility has achieved substantial compliance. Here, CMS clearly did not determine that West Texas was in substantial compliance with all federal requirements at the time of the January survey because it determined West Texas was out of compliance

with sections 483.25(c), 483.65 and 483.75(f). Indeed, CMS ultimately determined, based on a February 18, 2014 revisit, that West Texas did not achieve substantial compliance until February 1, 2014. *See* CMS Ex. 2, at 1-2 (stating that the remedies for noncompliance continued through January 31, 2014 and that payments to the facility could resume on February 1, 2014).

West Texas takes issue with what it calls the ALJ's "rul[ing] that it was reasonable to 'infer' that Petitioner was out of compliance under [the regulations cited on the January survey] prior to January 27." RR at 24. This appears to be a reference to the following statement by the ALJ:

> Moreover, even if Petitioner abated its December survey deficiencies by January 16, 2014, that does not mean that the deficiencies that were found at the January survey necessarily had as their beginning point January 27 or 28, 2014. The noncompliance that the surveyor identified on January 27 was not simply that a nursing assistant failed to perform peri[ne]al care on that date. The finding of noncompliance addressed a lack [of] understanding by the nursing assistant of her duties and responsibilities. That was a fundamental failure of training and supervision and it is not reasonable to assume that this failure commenced on January 27 and not at an earlier time.

ALJ Decision at 11. We do not necessarily agree with Petitioner's characterization of this statement as a "ruling" that "inferred" continuing noncompliance. However, we do not need to decide whether or not it would be reasonable to infer from the facts surrounding the improper care observed by the surveyor that the CNA had provided similar improper care prior to that observation. Since we have already rejected on legal grounds West Texas' argument that there was a "gap" in its noncompliance between January 16 and January 27, 2014, there is no need to address whether the deficiencies in perineal care found on the January survey somehow date back to fill that compliance "gap."[15]

[15] West Texas also argues, without any explanation, that the fact that CMS declined the State agency's recommendation to impose an additional $200 CMP beginning January 17, 2014 somehow supports its "gap" argument. *See* RR at 25; CMS Ex. 2 at 2. Apart from the absence of any explanation, we find this fact, even if true, irrelevant since the previously imposed $350 per-day CMP continued through January 31, 2014.

Conclusion

For all of the reasons stated above, we affirm the ALJ Decision.

/s/
Leslie A. Sussan

/s/
Susan S. Yim

/s/
Sheila Ann Hegy
Presiding Board Member