Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

West Texas LTC Partners, Inc.,
d/b/a Cedar Manor,
(CCN: 67-6068),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-1085

Decision No. CR3526

Date: December 22, 2014

DECISION

I grant summary judgment in favor of the Centers for Medicare & Medicaid Services (CMS), sustaining its determination to impose the following remedies against Petitioner, West Texas LTC Partners, Inc., d/b/a Cedar Manor, a skilled nursing facility in the State of Texas:

- Civil money penalties of $6050 per day for each day of a period that began on December 18, 2013 and that extended through December 20, 2013; and

- Civil money penalties of $350 per day for each day of a period that began on December 21, 2013, and that extended through January 31, 2014.

I also sustain CMS's determination to impose a denial of payment for new Medicare admissions against Petitioner during a period that began on January 24, 2014, and that ran through January 31, 2014.

I. Background

Petitioner requested a hearing to challenge CMS's remedy determinations. CMS moved for summary judgment and Petitioner opposed the motion. CMS offered exhibits that are identified as CMS Ex. 1 – CMS Ex. 17. Petitioner offered exhibits that are identified as P. Ex. 1 – P. Ex. 14. I receive these exhibits into the record for purposes of this decision.

II. Issues, Findings of Fact, and Conclusions of Law

A. Issues

The issues are whether, based on undisputed material facts: Petitioner failed to comply substantially with Medicare participation requirements; CMS's determinations of immediate jeopardy noncompliance are clearly erroneous; and, CMS's remedy determinations are reasonable.

B. Findings of Fact and Conclusions of Law

CMS bases its noncompliance allegations and its remedy determinations on the results of two compliance surveys of Petitioner's facility, completed December 20, 2013 (December survey) and January 28, 2014 (January survey). CMS asserts that, at the December survey, Petitioner manifested deficiencies, all of which were so egregious as to put residents of Petitioner's facility at immediate jeopardy. Allegedly, Petitioner's immediate jeopardy level noncompliance included failures to comply with:

- 42 C.F.R. § 483.13(c), in that Petitioner's staff neglected to care appropriately for two residents who are identified as Residents #s 1 and 4. CMS alleges additionally that Petitioner failed to comply with this section by not implementing internal policies that were written to protect residents from neglect.

- 42 C.F.R. § 483.25(h)(1) and (2) by failing adequately to supervise Residents #s 1 and 4 and to protect these residents against accident hazards.

- 42 C.F.R. § 483.75 by failing to administer its facility effectively and efficiently. Specifically, CMS asserts that Petitioner's alleged failures to comply with the requirements of 42 C.F.R. §§ 483.13(c) and 483.25(h)(1) and (2) are a basis for concluding additionally that Petitioner failed to comply with the requirements of 42 C.F.R. § 483.75.

Summary judgment may be granted only where undisputed material facts are a basis for a party to prevail. I must deny summary judgment where there is a dispute as to material facts that could lead to an inference on a dispositive issue that is favorable to the party against which the motion is filed.

Here, the undisputed facts plainly establish that Petitioner contravened the requirements of 42 C.F.R. §§ 483.13(c), 483.25(h)(1) and (2) and, by extension, 483.75. Moreover, these facts establish that CMS's determination of immediate jeopardy level noncompliance is not clearly erroneous. Consequently, summary judgment is appropriate in CMS's favor as to the deficiency findings made at the December survey.

The undisputed facts concerning Petitioner's care of Resident # 1 are as follows. The resident is a paraplegic individual who is totally dependent on his caregivers for such essential functions as bed mobility, transfers, and personal hygiene. CMS Ex. 6 at 56, 58. His disability is such that he must wear a catheter. CMS Ex. 6 at 8. He spent his days while at Petitioner's facility in an electric wheelchair. CMS Ex. 6 at 4, 10. Petitioner's staff employed a device known as a Hoyer Lift to transfer the resident in and out of his wheelchair. CMS Ex. 6 at 10. I take notice that a Hoyer Lift is a device that transfers an individual by use of a hammock-like sling. The straps of the sling are attached to the lift and the lift is then used to raise the individual from his or her bed or wheelchair for purposes of transfer. Petitioner's staff opted to leave the sling and straps attached to Resident # 1's wheelchair, evidently in order to make it easier for the staff to transfer the resident when necessary. CMS Ex. 16 at 2.

Petitioner's staff assessed Resident # 1 and concluded that he was at risk for falling forward from his wheelchair and injuring himself due to his paraplegia. CMS Ex. 6 at 10. The staff concluded that the resident played with the Hoyer sling straps that were attached to his wheelchair and also unhooked the tubing of his catheter. *Id.* To address these problems, Petitioner's staff prepared a care plan for Resident # 1 that enjoined the staff to assure that the resident's Hoyer lift straps and catheter tubing were tucked in so that they did not dangle and, potentially, become entangled in the mechanism of the resident's wheelchair. *Id.*

Petitioner's care plan for the resident notwithstanding, the Hoyer lift straps on Resident # 1's wheelchair were often left dangling, near the chair's wheels. CMS Ex. 16 at 2. The resident's father alerted Petitioner's staff on numerous occasions to the dangers posed by dangling Hoyer lift straps. CMS Ex. 16 at 2. Petitioner's staff was generally not responsive to complaints uttered by the resident's father and stepmother about dangling lift straps. CMS Ex. 16 at 2-3.

Petitioner contradicted none of these facts. Petitioner asserts that the lift straps that were attached to the resident's wheelchair were not inherently dangerous. Petitioner's Response to CMS's Motion for Summary Judgment (Response) at 4. It asserts that, to the extent that the straps were a hazard, they became so only because of the resident's constant playing with them. Response at 4-5.

I assume Petitioner's assertions about the Hoyer Lift straps to be true for purposes of this decision. But, these assertions do not gainsay the fact that the straps frequently dangled so that they could become entangled with the wheels of the resident's electric wheelchair. Nor do they rebut the facts showing that the resident's parents brought this hazard to the attention of Petitioner's staff without avail. So, whether or not the resident's playing with them caused the straps to dangle, they were an evident and obvious safety hazard that Petitioner's staff was aware of, but that Petitioner did not address.

The undisputed facts establish that on December 2, 2013, Resident # 1 was leaving Petitioner's dining room in his electric wheelchair when the Hoyer Lift straps became entangled in the wheelchair's wheels. CMS Ex. 6 at 36, 38. As a consequence, the resident fell out of his wheelchair and sustained fractures to both of his femurs. CMS Ex. 6 at 37, 44, 72.

The following are undisputed facts relevant to Resident # 4's care by Petitioner and its staff. As of December 2013, the resident was an elderly woman suffering from dementia and a variety of other disabling conditions that left her confined to a wheelchair. CMS Ex. 4 at 1, 9. During the December survey a surveyor observed Petitioner's staff putting the resident, who was in a high-backed wheelchair, into a Hoyer sling and lifting her. CMS Ex. 16 at 3, 5. The sling was left on the resident's wheelchair after the transfer (I infer that the resident sat on the sling). The surveyor observed the resident propelling her wheelchair down a corridor with the straps dangling at the level of the chair's wheels. CMS Ex. 16 at 3. Approximately two hours later the surveyor saw the resident again and noted that the straps were still dangling at wheel level. CMS Ex. 16 at 5. The surveyor discussed the transfer of Resident # 4 with the nursing assistant who performed it and the nursing assistant told the surveyor that she had not received training on using the Hoyer Lift. CMS Ex. 16 at 5.

Petitioner does not dispute any of these facts. It asserts that Resident # 4 never sustained a fall and, based on that, it contends that its care of the resident is essentially irrelevant to the issue of its compliance with Medicare participation requirements. I accept as true Petitioner's assertion that the resident never fell. That does not rebut any of the facts offered by CMS for reasons that I explain below.

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 Residents #s 1 and 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 Resident # 1 was at risk for serious injury if Hoyer Lift straps became entangled in his wheelchair. The staff should have known that Resident # 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 Resident

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.

Petitioner asserts that what happened to Resident # 1 was beyond its staff's ability to control. It contends that the staff was instructed to assure that the Hoyer Lift straps were tied behind the resident's wheelchair in order to prevent them from dangling. It argues that it was the resident, and not Petitioner's staff, who caused the straps to dangle, and this hazard, it asserts, was simply unavoidable.

But, 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. The facts of this case show only that there was a hazard caused by dangling straps, that Petitioner's staff was made aware of that hazard, repeatedly, and that it did nothing meaningful to ameliorate it.

Petitioner argues that whatever the staff did or failed to do in the case of Resident # 4 is irrelevant because the resident did not sustain an accident. I find this "no harm, no foul" argument to be without merit. It is unnecessary that a resident sustain an injury in order to be neglected within the meaning of 42 C.F.R. § 483.13(c). The regulation governs the services that must be provided to a resident. Failure to provide those services is neglect whether or not a resident is injured as a consequence of the failure to provide them. Moreover, Resident # 1 *was* injured and, in this case, the undisputed facts strongly support the conclusion that his injuries were the proximate consequence of Petitioner's neglect.

Petitioner violated 42 C.F.R. § 483.13(c) in another respect by failing to implement its anti-neglect policy in providing care to Residents #s 1 and 4. Petitioner's policy explicitly tracks the language of 42 C.F.R. § 488.301 in defining neglect. CMS Ex. 14 at 16. Its anti-neglect policy goes further to state that negligent care includes the failure to "properly care for a resident in the manner conducive to professional care standards." CMS Ex. 14 at 16. 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. CMS Ex. 14 at 24.

The undisputed material facts show clearly that Petitioner and its staff failed to implement these policies in providing care to Residents #s 1 and 4. As I have discussed

above, the staff identified obvious and serious hazards, but then did nothing of significance to protect the residents against those hazards.

Petitioner argues that, as a matter of law, it cannot be held to have violated the requirement that it develop and implement policies to prevent neglect. Response at 5-6. It premises this argument on its assertion that it did not neglect either Resident # 1 or Resident # 4. I reject that argument because it is plain – from the undisputed facts – that the needs of both of these residents were neglected. As I have discussed, these residents were at risk of serious injury, Petitioner knew or should have known about the hazards that these residents were being exposed to, and yet, Petitioner did not protect them.

The undisputed facts also establish that Petitioner failed to comply with the requirements of 42 C.F.R. § 483.25(h)(1) and (2). Both Residents #s 1 and 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 Resident # 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 Resident # 1 was grievously injured. Perhaps worse, even *after* the injury sustained by Resident # 1, Petitioner's staff continued to allow another resident, Resident # 4, a demented and helpless individual, to propel herself around the facility with dangling Hoyer Lift straps.

Petitioner argues that Resident # 4 never had an "accident" and that, therefore, her care is no basis to find Petitioner liable. Response at 6. That is the same "no harm, no foul" argument that I rejected above and I reject it again, here, for the same reasons. Compliance with the requirements of 42 C.F.R. § 483.25(h)(1) and (2) is not outcome-dependent. A facility does not earn a pass for its failure to protect residents against accident hazards or its failure to provide adequate supervision if, fortuitously, no accident occurs in spite of the facility's failure. The failure to protect Resident # 4 is evident in this case. The resident – and Petitioner – were fortunate that no accident occurred. But that favorable outcome does not relieve Petitioner from liability.

As for Resident # 1, Petitioner asserts that its staff was trained frequently and routinely to identify and protect residents against accident risks. It characterizes the accident that Resident # 1 experienced as a one-off event, something from which no generalization can be made. Response at 6-7. I disagree.

I will accept for purposes of this decision that Petitioner's staff was trained – even frequently and routinely – to identify and protect residents against accident risks. That training was obviously ineffective because it failed to protect Residents #s 1 and 4 against risks that any competent staff member should have been alerted to. The staff assessed Resident #1 as being at risk for injury from dangling Hoyer Lift sling straps and yet staff

allowed the resident to roam Petitioner's facility in a motorized wheelchair with the straps dangling. That happened, despite repeated requests from the resident's family that he be better protected. Training, even frequent and routine training, is no defense here if it is ineffective. Moreover, it is evident that not all of Petitioner's staff received appropriate training. CMS offered facts that Petitioner did not rebut establishing that the nursing assistant who provided care to Resident # 4 and who transferred that resident by means of a Hoyer Lift had not been trained in safety procedures concerning use of the lift.

Finally, the undisputed facts establish that Petitioner's noncompliance with 42 C.F.R. §§ 483.13(c) and 483.25(h)(1) and (2) are a basis for finding noncompliance with 42 C.F.R. § 483.75. At bottom, the ineffective implementation of Petitioner's policies and the absence of meaningful protection of Residents #s 1 and 4 is a failure of management. It is management's responsibility in a facility to assure that policies are implemented and that regulatory requirements are complied with. The failure here is evident.

Petitioner argues that it had an aggressive staff training and supervision program in place. But, even if that is so, that does nothing to refute the facts that show that Petitioner's implementation of its policies in the cases of Residents #s 1 and 4 was woefully inadequate.

Petitioner offered no facts to rebut CMS's determination that the deficiencies identified at the December survey put residents of Petitioner's facility at immediate jeopardy. "Immediate jeopardy" is defined to mean noncompliance that is so egregious as to cause, or to be likely to cause, serious injury, harm, impairment, or death to a resident or residents of a facility. 42 C.F.R. § 488.301.
The undisputed material facts establish not only that Petitioner's noncompliance created a likelihood of serious injury or worse to residents but that it caused actual grievous injury to Resident # 1.

Petitioner offered nothing specific to rebut the facts that I have discussed. Rather, it says only that there are issues of material fact in dispute, citing to some of its exhibits without explaining why these exhibits create a genuine fact dispute. Response at 10. That is inadequate to create a genuine fact dispute. The facts offered by CMS, which Petitioner did not rebut, clearly establish the existence of immediate jeopardy level noncompliance.

CMS raises issues of additional noncompliance by Petitioner addressing alleged noncompliance that was identified at the January survey of Petitioner's facility. CMS alleges that the additional noncompliance included failures by Petitioner to comply with:

- 42 C.F.R. § 483.25(c), which requires: that a facility ensure that a resident entering a facility without pressure sores not develop them unless their development is medically unavoidable; and that a resident having pressure sores receives the

necessary treatment and services to promote healing, prevent infection, and to prevent new sores from developing.

- 42 C.F.R. § 483.65, which requires that a facility establish and maintain an infection control program that is designed to provide a safe, sanitary and comfortable environment in order to prevent the development and transmission of disease and infection.

- 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 those residents' needs that are identified through resident assessments and described in residents' care plans.

Undisputed facts establish Petitioner's noncompliance with these three regulatory requirements albeit at a level of noncompliance that was less egregious than immediate jeopardy. All of these facts relate to care that Petitioner's staff gave to a resident who is identified as Resident # 7. As of the January survey, Resident # 7 was 91 years old and she suffered from multiple illnesses. CMS Ex. 11 at 77. In August 2013, Petitioner's staff assessed this resident as being at a high risk for developing pressure sores. *Id.* at 51. Petitioner developed a care plan for the resident that required the staff to turn and reposition the resident every two hours and to clean the resident's perineum with soap and water after she urinated. *Id.* at 5.

On January 27, 2014 (during the January survey) a surveyor observed a nursing assistant providing incontinence care for Resident # 7. The surveyor observed two Stage II pressure sores on the resident's buttocks. CMS Ex. 15 at 3-4. The nursing assistant did not remark on the presence of these sores although she acknowledged that they were present when questioned by the surveyor. The nursing assistant wiped the resident's inner buttocks with a wipe, but did not perform the perianal care directed by Resident # 7's care plan. *Id.* Specifically, she did not wash the resident's perineum with soap and water as was directed by the care plan.

Petitioner does not rebut these asserted facts directly. Indeed, it does not confront them at all in its response to CMS's motion but, rather, refers to its pre-hearing brief as a fact rebuttal to CMS's findings. Response at 10.

I have looked closely at Petitioner's pre-hearing brief (P. Ph. Br.) and it does not rebut the material facts offered by CMS. The thrust of Petitioner's argument in its pre-hearing brief is that care provided by its staff to Resident # 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.

But, CMS does not allege that the resident developed avoidable pressure sores as a result of a failure of care by Petitioner's staff. Had CMS alleged that, the likelihood is high that CMS would have alleged immediate jeopardy level deficiencies. The deficiencies that were identified at the January survey focus on something else, that being whether Petitioner's staff provided the perianal care that was mandated by Resident # 7's care plan and whether the failure by staff to provide such care establishes that the staff did not comply with infection control requirements. 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 Resident # 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.

Petitioner contends that the resident did not develop a pressure sore between July 2013 and January 26, 2014, conceding that the resident did manifest two "small reddened areas" on that latter date. P. Ph. Br. at 10. I accept that assertion as true, but that does not respond to CMS's contentions that Petitioner's staff did not provide care plan-directed care to the resident on January 27, 2014. Petitioner asserts also that the staff protected the resident against the development of pressure sores by applying a barrier cream to the resident's buttocks. I also accept that assertion as true but, once again, it begs the question of whether the staff provided the perianal care directed by the resident's care plan.

Thus, Petitioner does not rebut the facts offered by CMS. I find that these facts are sufficient to establish noncompliance by Petitioner with regulatory requirements. First, Petitioner failed to comply with the requirements of 42 C.F.R. § 483.25(c). The undisputed material facts establish that Petitioner's staff failed to follow the explicit instructions contained in Resident # 7's care plan in that they did not provide the perianal care that is directed by that plan. Second, the facts show that Petitioner failed to comply with the requirements of 42 C.F.R. § 483.65. Keeping Resident # 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. Third, the undisputed facts establish that Petitioner failed to comply with the requirements of 42 C.F.R. § 483.75(f). Being trained to carry out the requirements of a care plan is a basic element of nursing assistant competence.

In the opening paragraph of this decision I recite two remedies that CMS imposed against Petitioner: $6050 per-diem civil money penalties for each day of the period that ran from December 18 through December 20, 2013; and $350 per-diem civil money penalties for each day of the period that ran from December 21, 2013 through January 31, 2014. These remedies are sustained, in duration and amount, by the undisputed material facts.

Although Petitioner denies that it was noncompliant it has offered no facts to show that, assuming noncompliance, it abated its immediate jeopardy level deficiencies prior to

December 21, 2013. I have sustained those deficiencies and, consequently, the duration of Petitioner's immediate jeopardy level noncompliance is not an issue. As to the reasonableness of the penalty amount, Petitioner has offered nothing to show that CMS's determination is unreasonable other than to deny its noncompliance.

The undisputed facts establish the penalty amount to be reasonable. Regulations governing penalty amounts provide that immediate jeopardy level per-diem penalties must fall within a range of from $3050 to $10,000. 42 C.F.R. § 488.438(a)(1)(i). Factors which may be used to assess penalty amounts may include the seriousness of a facility's noncompliance, its compliance history, its culpability, and its financial condition. 42 C.F.R. §§ 488.438(f)(1) – (4); 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)).

The immediate jeopardy level penalties that CMS imposed were at slightly more than 60 percent of the maximum allowed by regulation. CMS avers, and I agree that Petitioner's noncompliance was very serious. The failure to provide adequate care to Resident # 1 certainly contributed to the accident he sustained and to his injuries. The likelihood of additional harm to other residents, including Resident # 4, was very high. Moreover, Petitioner does not deny that it has a poor compliance history. As CMS notes, Petitioner has been cited for noncompliance on nine occasions since September 2010 and there have been four compliance enforcement actions against Petitioner subsequent to that date.

I find also that the $350 daily penalty amounts for Petitioner's non-immediate jeopardy level noncompliance are reasonable. They constitute barely more than one-tenth of the maximum allowable non-immediate jeopardy penalty amount. 42 C.F.R. § 488.438(a)(1)(ii). That is an exceedingly modest penalty amount and it is amply justified by the seriousness of Petitioner's noncompliance.

Petitioner has not challenged the reasonableness of the non-immediate jeopardy level penalty amount by offering facts to show it to be unreasonable. It has asserted that CMS's determination of the *duration* of its noncompliance is incorrect. According to Petitioner, the Texas State agency certified that it had attained compliance on January 16, 2014, with the regulations cited at the December survey. Thus, according to Petitioner, CMS may not impose civil money penalties for the period between January 16 and January 27, even if it was noncompliant as of that latter date.

I disagree. First, Petitioner 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. Rather, it relies exclusively on its assertion that the Texas State agency told it that those deficiencies were abated. Second, even if that assertion is true, CMS's findings of noncompliance take precedence over those made by the State. 42 C.F.R. § 488.452(a)(2)(i). Therefore, what the State may have told Petitioner is irrelevant in the

absence of facts proving that Petitioner actually abated its deficiencies earlier than the date determined by CMS.

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 perianal care on that date. The finding of noncompliance addressed a lack 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.

CMS also imposed a denial of payment for new Medicare admissions effective January 24, 2014, as a remedy. That denial of payment remained in force through January 31, 2014. Petitioner argues that the denial of payment could not have been imposed between January 24 and January 28, 2014, because its previous noncompliance had been determined by the Texas State agency to be abated during that period. I disagree, for the reasons that I discuss above. CMS may impose a denial of payment for any period of substantial noncompliance. 42 C.F.R. § 488.417. As I have found, Petitioner was noncompliant on January 24, 2014, and thereafter through January 31, 2014. So, CMS is authorized to impose a denial of payment on dates beginning January 24, 2014, and continuing through January 31, 2014.

/s/
Steven T. Kessel
Administrative Law Judge