Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Riverside Convalescent Center – Smithfield,
(CCN: 49-5332),

Petitioner,

v.

Centers for Medicare & Medicaid Services

Docket No. C-13-121

Decision No. CR4134

Date: August 19, 2015

DECISION

Petitioner, Riverside Convalescent Center – Smithfield, is a long-term care facility located in Smithfield, Virginia, that participates in the Medicare program. One of its residents sustained a serious injury while facility staff were attempting to move her. Citing the circumstances surrounding the injury, the Centers for Medicare & Medicaid Services (CMS) determined that the facility was not in substantial compliance with the Medicare requirements governing accident prevention. CMS imposed a $7,500 per instance civil money penalty (CMP). Petitioner timely appealed CMS's determination.

For the reasons set forth below, I find that the facility was not in substantial compliance with Medicare program requirements and that the penalty imposed is reasonable.

Background

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

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

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. Each facility must be surveyed annually, with no more than fifteen months elapsing between surveys. Facilities must be surveyed more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308. The state agency must also investigate all complaints. Act § 1819(g)(4).

In this case, surveyors from the Virginia Department of Health (state agency) completed the facility's annual survey on July 27, 2012, and determined that the facility was not in substantial compliance with multiple Medicare participation requirements. CMS Exhibit (Ex.) 1. CMS agreed and imposed a $7,500 per instance CMP for the deficiencies cited under 42 C.F.R. § 483.25(h) (Tag F323), which addresses supervision and accident prevention. CMS Ex. 2.[1]

Petitioner timely requested a hearing.

On January 28, 2014, I convened a hearing, via video teleconference, from the offices of the Departmental Appeals Board in Washington, D.C. Counsel and witnesses appeared in Richmond, Virginia. Ms. Noreen O'Grady appeared on behalf of CMS, and Ms. Jeannie Adams appeared on behalf of Petitioner. Transcript (Tr.) at 4.

I admitted into evidence CMS Exhibits (Exs.) 1-29 and Petitioner's Exhibits (P. Exs.) 1-21. Tr. 5, 6, 8, 10; Summary of Pre-hearing Conference at 2-3 (December 6, 2013). The parties have filed pre-hearing briefs (CMS Br.; P. Br.), post-hearing briefs (CMS Post-hrg. Br.; P. Post-hrg. Br.), and CMS filed a reply brief (CMS Reply).

Issues

The issues before me are:

- Was the facility in substantial compliance with 42 C.F.R. § 483.25(h), and

[1] Because CMS imposed no remedies for the other deficiencies cited, those findings are not reviewable. *Lutheran Home – Caledonia*, DAB No. 1753 at 4 (2000); *Schowalter Villa*, DAB No. 1688 at 2-3 (1999); *see* 42 C.F.R. §§ 488.406; 498.3(a); 498.3(b)(13).

- If the facility was not in substantial compliance, is the penalty imposed – $7,500 per instance – reasonable?

Discussion

1. The facility was not in substantial compliance with 42 C.F.R. § 483.25(h) because its staff did not provide a vulnerable resident with the supervision and assistive devices she needed to transfer safely from her wheelchair to her bed.[2]

Program requirements. So that each resident can attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with his or her comprehensive assessment and plan of care, the "quality of care" regulation mandates that the facility "ensure" that each resident's environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistive devices to prevent accidents. 42 C.F.R. § 483.25(h). The facility must therefore eliminate or reduce a known or foreseeable risk of accident "to the greatest degree practicable." *Del Rosa Villa*, DAB No. 2458 at 7 (2012), *aff'd*, *Del Rosa Villa v. Sebelius*, No. 12-71685 (9th Cir. 2013); *Clermont Nursing & Convalescent Ctr.*, DAB No. 1923 at 9-10 (2004), *aff'd*, *Clermont Nursing & Convalescent Ctr. v. Leavitt*, 142 F. App'x. 900 (6th Cir. 2005); *accord*, *Briarwood Nursing Ctr.*, DAB No. 2115 at 5 (2007) (holding that the facility must "take all reasonable steps to ensure that a resident receives supervision and assistance devices designed that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents"). A facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods must constitute an "adequate" level of supervision under all the circumstances. *Briarwood*, DAB No. 2115 at 5; *Windsor Health Care Ctr.*, DAB No. 1902 at 5 (2003), *aff'd*, *Windsor Health Ctr. v. Leavitt*, No. 04-3018 (6th Cir. 2005).

Resident 3 (R3). R3 was an 88-year-old woman, suffering from a long list of ailments, including congestive heart failure, chronic kidney disease, anemia, diabetes, advanced vascular dementia, and depressive disorder. She resided in an assisted living facility until June 5, 2012, when she was hospitalized for heart failure and renal insufficiency. After a three-day hospital stay, she was admitted to the facility on June 8, 2012. CMS Ex. 6 at 1; CMS Ex. 9 at 7; CMS Ex. 13 at 1; P. Ex. 11 at 2.

At the time of her admission, R3 was 5 feet 6 inches tall and weighed 218 pounds. CMS Ex. 7 at 7. She required extensive assistance for most activities of daily living, including the assistance of two or more people for moving in bed, transferring from bed to chair or

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

wheelchair, and transferring from sitting to standing. CMS Ex. 7 at 5-6. Her balance was poor; her gait was unsteady. CMS Ex. 7 at 6; CMS Ex. 12 at 6. She performed poorly on her mental status interview. She did not know the day, month, or year. She was able to repeat only one of three words spoken to her and could later remember that word only after cueing. She had difficulty focusing attention. CMS Ex. 7 at 2, 3.

On June 10, the facility's director of physical therapy, Tamara Waller, assessed R3's functional capacity. The resident could stand for ten seconds "with great encouragement" but had shortness of breath and tired "very quickly." Her lack of endurance "has affected her balance in sitting and standing," according to Therapist Waller's assessment. The therapist also reported that R3 was oriented to person only (i.e., she knew who she was but did not know where she was and did not know the day/date/time). She had no safety awareness. CMS Ex. 13 at 1-2. A June 12 therapy screen described moderate hearing loss and impaired cognition and communication but also indicated that R3 was able to communicate basic wants and needs. CMS Ex. 13 at 5; P. Ex. 11 at 1.

R3's care plan entries, dated June 19, recognized that she had an unsteady gait, lost her balance, and required staff assistance for transfers. Among other instructions, the plan told staff to provide her with rest periods "as needed and/or tolerated," to provide her with assistive mobility devices as recommended by therapy, and to report any unsafe use. CMS Ex. 12 at 6.

Ten days later, on June 29, Physical Therapy Assistant Nikki Jones reported that R3 was not progressing as well as expected. Her cognitive and memory issues hindered her progress. Assistant Jones described R3's strength and endurance as "poor." She continued to need the assistance of two people to transfer from sitting to standing, and needed visual and tactile cues to stand upright. She stood with a "forward lean" and had difficulty maintaining correct posture. CMS Ex. 13 at 9; P. Ex. 11 at 6.

On July 2, Certified Occupational Therapy Assistant Debbie Frank reported that the resident had been working on strengthening her upper body to enhance her ability to care for herself. She was able to "perform short distance ambulation" to and from the toilet. However, Therapy Assistant Frank also reported that the resident was hard of hearing and "it is difficult, at times, to be sure [R3] totally is comprehending because she makes the same verbal response to mostly everything, 'Oh, yeah.'" Therapy Assistant Frank also reported that, on some days, R3 required more encouragement. CMS Ex. 13 at 10; P. Ex. 11 at 10.

Notably, in light of what happened later that day, R3 had no complaints of pain during her July 2 therapy session. CMS Ex. 6 at 3; CMS Ex. 9 at 7.

Three days later, the occupational therapist reiterated that the resident was hard of hearing and appeared to have underlying dementia. CMS Ex. 13 at 11.

The incident. On the evening of July 2, Nurse Aide Deborah Lawrence was attempting to transfer R3 from her wheelchair to her bed. Nurse Aide Lawrence reported that she "was told" by another aide that R3 could stand and pivot in order to get into bed. After several unsuccessful attempts, R3 refused to try again, complaining that she was "too tired to get up." So Nurse Aide Lawrence sought assistance from Nurse Aide Annie White. The aides decided to use a lifting device, called the Sara Lift. CMS Ex. 6 at 3; CMS Ex. 9 at 4, 7; CMS Ex. 10; P. Exs. 7, 8.

Unlike some lifts, the Sara Lift – also referred to as a sit-to-stand lift – requires the resident's active participation. The device has a strap that goes behind the resident's back, above and horizontal to the waist, and then up the sides where staff fasten it to "patient support arms." Attached to those support arms are grab handles that the resident must grip and hold. CMS Ex. 9 at 7; CMS Ex. 11. The manufacturer's instructions warn that a professional assessment should be carried out for patients who cannot hold on with one or both hands and "[f]ailure to do so could result in injury to the patient or operator." CMS Ex. 11 at 2.

Photographs that accompany the manufacturer's instructions show that the resident grips the grab handles in front of her, leaves her knees bent, and leans back into a somewhat narrow strap that should be placed relatively low on the back, a couple of inches above the waist line but well below axilla (armpit) level. CMS Ex. 11 at 4. For residents who are not capable of holding on to the hand grips as required, the instructions direct staff to support the resident's arms in front of her body during the lift. Safety also dictates that the strap remain in the proper place on the resident's back. The instructions warn, for example, that nylon nightdresses can be slippery, causing the sling to ride up the back, which causes pressure under the arms.[3] In that case, someone should hold the sling in position while lifting and lowering the resident. CMS Ex. 11 at 5.

The aides put the lift in place and, according to their statements, they showed R3 where and how to hold her hands.[4] They told her not to let go. R3 grasped the handgrips as

[3] We know that R3 was wearing a nightgown at the time of the incident, but we don't know its fabric. Tr. 161-62.

[4] The nurse aides' written statements were not prepared until August 6, 2012, after the survey and over a month after the incident occurred. This suggests that the statements were drafted in anticipation of an adverse action, and were therefore more likely to be self-serving, omitting any potentially damaging admissions. The nurse aides should have written statements as part of the investigation, but Petitioner produced only these, which were written a month after the facility completed its investigative report. CMS Ex. 9.

Nurse Aide Lawrence, who was operating the lift, turned it on, lifting the resident out of her wheel chair. But R3 never made it to a standing position. Nurse Aide Lawrence later described her as "flopping up and down while on the lift." In mid-air, with knees still bent, she announced that she "could not do it," let go of the handgrips, and started to fall. Nurse Aide White managed to grab the back of her pants and lowered her into the wheelchair. After some time in the chair, R3 was finally able to stand, pivot and get into bed, with the assistance of the two aides and a gait belt.[5] CMS Ex. 6 at 3; CMS Ex. 9 at 4; CMS Ex. 10; P. Ex. 12 at 12.

The next morning, R3's shoulder was swollen and tender, and she cried out in pain when a nurse aide attempted to lift her arm. CMS Ex. 6 at 3-5; CMS Ex. 9 at 4-5, 7. X-rays showed a fracture of the mid-clavicle. CMS Ex. 9 at 2, 3, 7.

The facility concluded that the "downward force of her weight onto the strap under the axilla [armpit] is directly related to the fracture." CMS Ex. 9 at 8. This conclusion seems consistent with the manufacturer's warnings about the danger of the sling riding up and causing pressure under the resident's arms.

Substantial noncompliance. No matter how frail, a resident should not be injured when moving (or being moved) from her wheelchair into her bed. That R3 sustained serious injuries while performing what should have been a routine transfer strongly suggests that the facility did not "take reasonable steps to ensure that [she] receiv[ed] supervision and assistance devices designed to meet [her] assessed needs and to mitigate foreseeable risks of harm from accidents." *See Clermont Nursing & Convalescent Ctr.*, DAB No. 1923 at 9-10. Petitioner faults CMS for not establishing what the nurse aides did wrong and argues that CMS changed its position as to what those purported errors were. P. Post-hrg. Br. at 1. But CMS has no obligation to explain what went wrong; rather, *Petitioner* must establish that the facility employees acted properly, providing R3 with the supervision and assistive devices she needed to keep her safe. Petitioner has not done so here.

[5] A gait belt is a thick belt that is wrapped around the resident's waist and cinched tightly. Staff hold onto the belt, instead of a resident's arm or clothing, to support the resident and prevent falls. CMS Ex. 27 at 6 (Koh Decl. ¶ 17).

Petitioner did not produce relevant written policies regarding resident transfers, so I must look to other sources to determine the methods the facility had in place to prevent accidents while transferring its vulnerable residents.[6] An August 8, 2011 document summarizes the training the facility provided to its nurse aides. In a program that addressed "proper resident transferring," the facility instructed staff to "[b]e sure to refer to the transfer sheets for each resident for proper transferring method," and warned (in capital letters):

> DO NOT ATTEMPT TO TRANSFER A RESIDENT IN ANY WAY OTHER THAN WHAT IS LISTED ON THE TRANSFER SHEET.

P. Ex. 13 at 4. The document then tells staff where the transfer sheets are kept (in front of restorative books on both units).

The facility's director of nursing (DON), Judy Simmons, confirmed that the facility kept a book on each unit that listed each resident, her room number, and her appropriate method of transfer. She confirmed that nursing staff were supposed to check that list before attempting to transfer a resident. Tr. 174-75.

But, here, the nurse aides did not consult the transfer list. According to Nurse Aide Lawrence, she decided to try "stand-and-pivot" because another nurse aide suggested it. P. Ex. 8. Even though R3's assessment called for a two-person assist with transfers, Nurse Aide Lawrence initially attempted to do it without additional assistance. CMS Ex. 7 at 5; CMS Ex. 10 at 2. In fact, it appears that she did not assist the resident at all, but positioned the chair "and asked her to stand to get into the bed," which the resident attempted to do. CMS Ex. 9 at 4; CMS Ex. 10 at 2; P. Ex. 8; *see* CMS Ex. 27 at 3 (Koh Decl. ¶ 7). Only after R3 failed repeatedly in those efforts did Nurse Aide Lawrence ask Nurse Aide White to help.

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[6] The record includes just one general policy that is titled "Use of Mechanical Lifts," which I find unhelpful. CMS Ex. 29 at 4. It says that nursing staff will use mechanical lifts for "residents who need repositioning that requires a mechanical lift" and that the type of lift used "depends on the resident's size, condition, and other needs." But the procedures listed seem to describe a more passive lift; they do not correspond to the Sara Lift instructions. For example, they refer to supporting the resident's legs "as the resident and lift are moved away from the bed." For the Sara Lift, the resident's feet are placed on a foot rest and the knees are positioned against a "knee reaction pad," neither of which are referred to in this policy. CMS Ex. 11 at 5.

How they decided to use the Sara Lift is a mystery; each nurse aide attributes that decision to the other. Nurse Aide Lawrence claimed that Nurse Aide White "instructed me to get the standup lift." CMS Ex. 10 at 2; P. Ex. 8. Nurse Aide White, on the other hand, wrote that Nurse Aide Lawrence approached her and asked for help putting R3 on the Sara Lift, which suggests it was Nurse Aide Lawrence's idea. CMS Ex. 10 at 1; P. Ex. 7.

Had they consulted the transfer list, they'd have seen that the Sara Lift was not an approved method of transfer for R3. Although the facility did not produce the transfer list instructions, and its witnesses were not completely consistent in describing what those instructions said, no one has claimed that they included the Sara Lift. According to DON Simmons, R3 was supposed to be transferred by means of a gait belt. Tr. 176. Physical Therapist Waller claimed that R3 was assessed for transfer using the stand-and-pivot method. She did not mention the use of a gait belt. P. Ex. 20 at 2 (Waller Decl. ¶ 7).

According to David Koh, a Board-certified geriatric clinical specialist, R3 should have been transferred with the stand-and-pivot augmented by a gait belt. Clinical Specialist Koh is probably correct inasmuch as his opinion incorporates the testimony of both facility witnesses, and the nurse aides used this method when, eventually, they managed to complete R3's transfer from wheelchair to bed. CMS Ex. 27 at 6 (Koh Decl. ¶ 17).

Petitioner dismisses the significance of the transfer lists, however, suggesting (in a footnote) that the nurse aides "were apparently not aware" that they were supposed to consult the transfer list and that the August 8 training directive – "DO NOT ATTEMPT TO TRANSFER A RESIDENT IN ANY WAY OTHER THAN WHAT IS LISTED ON THE TRANSFER SHEET"—"did not find its way into any identifiable policy." P. Post-hrg. Br. at 7 n.2. I reject Petitioner's assertion for several reasons:

- Petitioner did not produce policies explaining how staff would know which method of transfer to use for a particular resident, so I am not inclined to accept its unsupported statements as to the contents of such policies;

- DON Simmons confirmed the existence of the transfer lists and testified that staff were supposed to check the appropriate list before attempting to transfer a resident (Tr. 174-75);

- Why have the lists if staff were free to ignore them?

- Staff training should reflect the facility's policies and procedures and should be uniformly applied; staff who miss training must learn and follow the instructions that were presented at training.

Determining which methods of transfer are safe for a severely disabled resident, like R3, requires a professional assessment. According to DON Simmons, the facility's physical therapy and nursing staffs collaborated to make those determinations. Tr. 174. Yet Petitioner now argues that the nurse aides, on their own, were capable of deciding which transfer method to use. I do not accept that the nurse aides were free to select a transfer method that was not listed on R3's transfer sheet. Because the Sara Lift was not listed as an approved method of transfer, and no evidence suggests that facility professionals ever assessed its safety for R3, the nurse aides should not have employed it. Thus, even if, after-the-fact, the Sara Lift proved to be a safe method of transfer for R3 (which it did not), I would still find substantial noncompliance because unqualified staff used a transfer device that facility professionals had not determined to be safe.

Petitioner argues that its professionals were not required to assess the safety of the Sara Lift because R3 was weight-bearing, "able to perform a stand-pivot transfer with minimal assistance of two," and capable of holding on to hand grips. P. Post-hrg. Br. at 3-5. Its professional employees echo this opinion. P. Ex. 16 at 1-2 (Lapacak Decl. ¶ 3); P. Ex. 17 at 2-3 (Ward Decl. ¶ 8); P. Ex. 20 at 4 (Waller Decl. ¶ 16). CMS presents the testimony of its own health care professionals who maintain that nurse aides are not competent to assess the safety of a particular lift and should not have used the Sara Lift without a professional assessment. CMS Ex. 25 at 2-3 (Jones Decl. ¶ 5); CMS Ex. 27 at 4-5 (Koh Decl. ¶¶ 11-15).

I reject Petitioner's position. R3's abilities to stand and pivot (which she could do only if she had enough assistance) and to hold on to hand grips (which she evidently could not be relied upon to maintain) were only two of multiple factors that should have been considered in assessing the safety of the Sara Lift. Did R3 have the cognitive ability to understand and follow directions? Could she remember to keep her hands in place? Both Physical Therapy Assistant Jones and Occupational Assistant Frank had recently questioned her ability to understand instructions. CMS Ex. 13 at 9, 10. Would she panic if placed in an unfamiliar device? *See* P. Ex. 6 at 15 (noting that residents who become frightened during transfer in a mechanical lift may exhibit resistance movements that can result in avoidable accidents); Tr. 94. Was she able to hold on for the necessary length of time? Even if capable of performing the necessary tasks during a morning physical therapy session, would she still be capable late in the day when she was tired? If she required a two-person assist in order to stand safely, does the Sara Lift require the assistance of three – one to operate the lift and two to assist R3 in standing?[7] Perhaps the

[7] Although Petitioner suggests that "[b]oth [nurse aides] remained beside" R3 (P. Post-hrg. Br. at 6), the configuration of the lift made that impossible. As the photographs and diagrams show, the machine stands between its operator and the resident. CMS Ex. 11. The operator would not be in a position to assist if the resident experienced problems, as, indeed, occurred here. With R3 flailing, Nurse Aide Lawrence was not able to do anything more than to lower the lift. CMS Ex. 10 at 2; P. Ex. 8.

Sara Lift could have been a safe method of transfer – provided R3 understood and remembered what to do and did not panic – but the nurse aides were not competent to make that determination. Qualified professionals, operating in a safe environment, should have determined whether the lift was appropriate for R3, and, if they determined it was appropriate, they should have familiarized her with its use. CMS Ex. 27 at 4-5 (Koh Decl. ¶¶ 12-15).

Petitioner's witnesses are less than forthright in describing R3's cognitive abilities. In an effort to establish that, notwithstanding her dementia, she was able to understand and follow directions, they cherry-pick the evidence. For example, Physical Therapist Karma Lapacek claims that R3 was "oriented X2 or X3 throughout her stay. . . ." P. Ex. 16 at 3 (Lapacek Decl. ¶ 10). But she disregards the physical therapy assessment indicating that R3 was only oriented to person. CMS Ex. 13 at 1. Only one nursing assessment, and no physical therapy assessment, indicates that R3 was fully oriented. P. Ex. 12; CMS Ex. 13. For the most part, R3 is assessed as "oriented X2," which is hardly a ringing endorsement of her abilities to remember and to act safely. When "oriented X2," she required "frequent direction" in "several situations" regarding cognition, recall, and safety/judgment. CMS Ex. 13 at 3. Further, Physical Therapist Lapacek disregards the well-documented finding that R3's abilities to focus attention and remember fluctuated significantly. CMS Ex. 7 at 3; CMS Ex. 8 at 3.

Dr. Joseph L. Ward, the facility's medical director, and DON Simmons cite notes that describe R3 as "bright" and "spry," with an "excellent sense of humor." P. Ex. 17 at 2 (Ward Decl. ¶ 6); P. Ex. 18 at 2-3 (Simmons Decl. ¶ 10). But those notes describe R3 as she was months earlier, before her hospitalization for heart failure and renal insufficiency. R3's condition had unquestionably deteriorated and those notes do not accurately reflect her mental state on July 2, 2012.

Petitioner claims that the two nurse aides "had been trained numerous times in transfer lifts" and used the Sara Lift "in accordance with the manufacturer's instructions." P. Post-hrg. Br. at 2, 7; P. Ex. 19 at 2 (Voigtmann Decl. ¶ 6). I see no reliable evidence to support these claims. The nurse aides had not performed this particular transfer before. Tr. 88. Based on the training sign-in sheets Petitioner submitted, it seems that they had minimal training in performing transfers of any kind. And, even for the few sessions they attended, Petitioner has not established what the training included or that it was effective. Specifically:

- The sign-in sheets show that neither aide attended a May 9, 2011 Transfer Safety Workshop. P. Ex. 13 at 1-2.

- Nurse Aide White's name appears on an apparently random "attendance record," but that document is undated, and includes no program title or any other information. P. Ex. 13 at 3.

- As noted above, Petitioner concedes that neither aide attended the August 8, 2011 program on "proper resident transferring," and their names do not appear on the attendance record. This is virtually the only training document that includes a relevant summary of the topic presented. P. Ex. 13 at 4.

- Nurse Aide White apparently attended a September 21, 2011 "annual safety fair," but the record includes no information as to what the program entailed. P. Ex. 13 at 5-12.

- Nurse Aide Lawrence's name appears on only one training attendance record, a November 16, 2011 in-service on "new mechanical lift," but, again, nothing in the record describes the content of this training or even the type of lift referred to in the program title. Under "summary," where one would expect to see a description of the training, someone wrote "flu shots," which I find perplexing and which Petitioner has not explained. P. Ex. 13 at 15.

- Neither aide is listed among the attendees at a January 9, 2012 program titled: "Viking M (Mechanical Patient Lift)." P. Ex. 13 at 19.

- The nurse aides did not attend an April 10, 2012 "transfer workshop make-up." P. 13 at 26.

I find no evidence establishing that the facility's physical therapy professionals, or any other qualified person, had ever assessed whether these aides were able to use the Sara Lift properly. *See, e.g.*, CMS Ex. 9 at 8. I do not accept Petitioner's claims that, in fact, the nurse aides operated the Sara Lift correctly when they attempted to transfer R3. Even though they were the sole witnesses (besides R3) to what transpired, the nurse aides did not testify. Instead, Petitioner relies on the statements of others, who were not there and are not in any position to know what the nurse aides did. *See, e.g.*, P. Ex. 20 at 4 (Waller Decl. ¶ 16). At the hearing, DON Simmons claimed, for the first time, that during her investigation of the incident, she asked the nurse aides to demonstrate how they applied the lift, and they applied it correctly. Tr. 182. I did not find this credible. Petitioner produces no notes reflecting such a demonstration. DON Simmons did not mention this in her direct testimony. Her investigative report does not say that the nurse aides properly demonstrated use of the lift. In fact, following her investigation, the facility directed the therapy department to provide the aides involved in the transfer with one-on-one in-service training, which should not have been necessary if they had already demonstrated their proficiency with using the lift. CMS Ex. 9 at 7-8.

The more reliable evidence suggests that the nurse aides made some serious mistakes. First, Nurse Aide Lawrence plainly did not understand R3's limitations. She initially directed the resident to transfer from wheelchair to bed without any assistance, or, at

most, with only a one-person assist. CMS Ex. 10 at 2. Second, the nurse aides' own written descriptions of their actions omit some critical factors. While they were careful to describe the hand grips, they did not mention the back strap at all. CMS Ex. 10; P. Exs. 7, 8. I see no evidence that they properly positioned the strap, made sure that it remained in place, or even that they recognized the importance of keeping it low on the back, away from the armpits. Given her injuries, it seems likely that they did not.[8] According to the physical therapy notes, R3 required visual and tactile cues in order to stand upright. CMS Ex. 13 at 9; P. Ex. 11 at 6. Yet, Nurse Aide Lawrence was not in any position to provide tactile cues, and Nurse Aide White claims that she "showed her where and how to hold her hands," but does not mention following up with tactile cues.

Because two nurse aides attempted to transfer a vulnerable resident, by an untested and unapproved means, the facility did not reduce a foreseeable risk of accidents to the greatest degree practicable and was not in substantial compliance with 42 C.F.R. § 483.25(h).

2. The penalty imposed – $7,500 per instance – is reasonable.

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

I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the section 488.438(f) factors. I am neither bound to defer to CMS's factual assertions nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848 at 21 (2002); *Cmty. Nursing Home*, DAB No. 1807 at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800 at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1683 at 8 (1999).

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[8] The investigative report suggests that DON Simmons may not have fully understood how to use the lift properly. She describes an incorrect – and potentially dangerous – positioning of the strap. She writes: "This lift has a strap that goes behind the back *under the axilla*. . . ." CMS Ex. 9 at 7. As the manufacturer warns, the strap must stay well below the axilla – closer to the waist – to avoid causing excessive pressure under the arms. CMS Ex. 11 at 5.

Here, CMS imposed a penalty of $7,500 per-instance, which is in the middle-to-higher range for a per-instance CMP ($1,000-$10,000) and is modest considering what CMS might have imposed. 42 C.F.R. § 488.408(e)(1)(iv); *see Plum City Care Ctr.*, DAB No. 2272 at 18-19 (2009) (observing that even a $10,000 per-instance CMP can be "a modest penalty when compared to what CMS might have imposed").

The facility has a significant history of substantial noncompliance. During its previous annual survey, completed May 27, 2011, it was also out of substantial compliance with multiple program requirements, including 42 C.F.R. § 483.25(h). Its deficiencies also caused serious actual harm to one of its residents, fracture of her cervical spine. CMS Ex. 28. Petitioner claims that its earlier deficiency "was not of the same nature" as that cited here. P. Ex. 19 at 3 (Voigtmann Decl. ¶ 8).[9] But sections 488.438(f) and 488.404 do not require that the circumstances underlying the deficiencies be identical. All of the historical substantial deficiencies should be considered, with even greater weight attached to those similar to the deficiencies cited for which the penalty is imposed ("in general and specifically with reference to the cited deficiencies"). Both the 2011 and 2012 surveys found multiple serious deficiencies, which included the facility's failure to ensure that its residents received adequate supervision and assistive devices to prevent accidents, in violation of 42 C.F.R. § 483.25(h). Thus, the facility's history, by itself, justifies a significant penalty.

Petitioner does not claim that its financial condition affects its ability to pay this relatively small CMP.

With respect to the remaining factors, the facility's professionals had determined that R3 required a two-person assist with gait belt. Yet, the nurse aides responsible for her care did not know this and did not follow the procedures the facility had in place for finding out the approved method of transfer. On their own, they decided to attempt a transfer that they had never before performed, using a mechanical lift for which the demented and tired resident had never been assessed, and with which she was unfamiliar, resulting in an accident and serious injury. The facility is culpable for their actions.

I therefore find that the $7,500 per-instance CMP is reasonable.

[9] The 2011 deficiency involved a seriously demented resident with a history of falls who, without a physician's order, was administered a sedative medication to which she was allergic. She fell and sustained the serious injury. CMS Ex. 28 at 7-14.

Conclusion

The facility was not in substantial compliance with 42 C.F.R. § 483.25(h). The relatively small CMP imposed – $7,500 per-instance – is reasonable.

/s/
Carolyn Cozad Hughes
Administrative Law Judge