Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Bear Hill Nursing Center, Inc.,
d/b/a Bear Hill Nursing Center of Wakefield
(CCN: 22-5272)

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-1658

Decision No. CR3564

Date: January 9, 2015

DECISION

I grant summary judgment in favor of the Centers for Medicare & Medicaid Services (CMS) and against Petitioner, Bear Hill Nursing Center, a skilled nursing facility in the Commonwealth of Massachusetts, sustaining CMS's determination to impose a per-instance civil money penalty of $2500 against Petitioner.

I. Background

Petitioner requested a hearing to challenge CMS's determination to impose the remedy that I cite in this decision's opening paragraph. CMS moved for summary judgment and Petitioner opposed the motion. In support of its motion CMS offered exhibits that are identified as CMS Ex. 1 – CMS Ex. 3. Petitioner offered two exhibits each identified as P. Ex. 1. I remark the October 22, 2014 letter regarding the informal dispute resolution (IDR) conclusions as P. Ex. 2. 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 Petitioner failed to comply substantially with Medicare participation requirements; and whether CMS's remedy determination is reasonable.

B. Findings of Fact and Conclusions of Law

There are no disputed issues of fact. All of CMS's allegations of noncompliance focus on the care that Petitioner's staff provided to a resident who is identified as Resident # 1. The resident was physically dependent on Petitioner's staff for transfers and mobility. The resident had a care plan that provided that the resident would be transferred from one location to the next (for example, from bed to a wheelchair) with the assistance of two staff members and by means of a mechanical lift. CMS Ex. 1 at 2.

Certified nursing assistants (CNAs) were responsible for delivering much of the care received by Resident # 1. These caregivers included a nursing assistant identified as CNA # 1. CNA # 1 regularly provided care to the resident and was aware of the requirements of the resident's care plan. CMS Ex. 1 at 2.

On March 2, 2014, CNA # 1 attempted to reposition Resident # 1 without the assistance of another CNA. The CNA raised the resident from a prone position in bed to a sitting position at the edge of the bed. The CNA diverted her attention momentarily while the resident was sitting and the resident fell to the floor. CMS Ex. 1 at 2. The CNA then picked up the resident without assistance or the use of a mechanical lift (both of which were required) and placed the resident in a shower chair. *Id.*

CNA # 1 attempted to cover up her failure to provide appropriate care to Resident # 1. Facility policy requires any resident who sustains a fall to be assessed by a nurse. It requires additionally that an injury report be completed that states the results of the assessment. CMS Ex. 1 at 6. However, CNA # 1 did not report Resident # 1's fall immediately to a nurse. Instead, CNA # 1 told another CNA, CNA # 2, about the accident. CNA # 2 did not relay to a nurse the information that was communicated by CNA # 1. Eventually, CNA # 1 told a nurse and a nurse supervisor that the resident had fallen when CNAs #s 1 and 2 attempted to transfer the resident via a mechanical lift. *Id.* at 2-3, 5.

One of Resident # 1's family members observed a bump on the resident's head about eight hours after the resident had fallen and reported it to Petitioner's nursing staff. A nursing supervisor questioned CNA # 1 about the injury and only then did the CNA admit the facts surrounding the resident's fall. The supervisor contacted Resident #1's

physician who ordered x-rays, the results of which revealed the resident sustained a fractured right clavicle. Resident # 1's physician determined that the fractured right clavicle was caused by the fall. CMS Ex. 1 at 3, 6-7, 10.

CMS alleges that Petitioner contravened three Medicare participation requirements. These are:

- 42 C.F.R. § 483.20(k)(3)(ii), which requires that the services provided to each resident by a facility must be provided by qualified persons in accordance with that resident's plan of care. CMS alleges that Petitioner failed to comply with this regulation because Resident # 1's plan of care explicitly required that the resident be transferred with the assistance of two persons and a mechanical lift and staff violated this directive.

- 42 C.F.R. § 483.25, which requires that a facility must provide each of its residents with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with that resident's comprehensive assessment and plan of care. CMS contends that Petitioner failed to comply with this requirement in that its staff failed to provide Resident # 1 with services and care explicitly called for by the resident's care plan, those being transfers with the aid of two individuals and the assistance of a mechanical lift.[1]

- 42 C.F.R. § 483.25(h), which requires, among other things, that each resident of a facility receives adequate supervision and assistance devices in order to prevent accidents. CMS asserts that Petitioner's staff knew that Resident # 1 needed the assistance of two persons and a mechanical lift device in order to be transferred from one location to another and that Petitioner's staff failed to provide this assistance to the resident.

The undisputed material facts plainly support CMS's allegations of noncompliance. There were explicit directions in Resident # 1's plan of care that called for transfers of the resident only with the assistance of two persons and a mechanical lift. Petitioner's staff violated those directions and then, attempted to cover up that violation. The resident's injuries were the proximate consequence of the failure to comply with the care plan.

[1] Petitioner argues that this alleged deficiency was deleted at an IDR process and that CMS subsequently concurred. *See* P. Ex. 2. However, it is evident that CMS does not now concur with the IDR finding because it is arguing this deficiency as part of its case. Moreover, even if the deficiency were rescinded by agreement of CMS, the remaining two deficiencies are more than sufficient to support the remedy in this case.

Petitioner asserts that the events leading to Resident # 1's accident and injuries were a one-time occurrence. It argues that it and its staff had an unblemished history of caring for Resident # 1 prior to the resident's fall and injuries and that it cannot be held liable for this isolated event, which it characterizes as aberrance. To do so, argues Petitioner, would be to impose an unreasonable strict liability standard against it.

I disagree. The accident sustained by Resident # 1 was not some unforeseeable occurrence or act of God that was beyond Petitioner's ability to control. I do not hold Petitioner liable simply because an accident occurred. Rather, I hold it liable because it was responsible for the conduct that caused that accident.

The accident sustained by Resident # 1 was the direct consequence of an employee's willful disregard of an explicit order. Petitioner's employees are Petitioner's agents and Petitioner bears full responsibility for their conduct. When a member of Petitioner's staff provides care to a resident that staff member is doing so on behalf of Petitioner and Petitioner is liable for the employee's misfeasance or malfeasance in providing care. Thus, Petitioner is liable for its employee's actions when an employee such as CNA # 1 willfully violates the directions in a resident's plan of care.

CMS imposed a per-instance civil money penalty of $2500 against Petitioner as a remedy for its noncompliance. That amount is one-fourth of the maximum allowable amount for a per-instance penalty and is, therefore, a modest penalty. 42 C.F.R. § 488.438(a)(2). I find it to be entirely reasonable based on the undisputed material facts. It is amply justified by the serious noncompliance established by those facts, a willful disregard of a resident's plan of care resulting in a serious injury to that resident. 42 C.F.R. §§ 488.438(f)(3); 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)).

/s/
Steven T. Kessel
Administrative Law Judge