Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Marbridge Villa,
(CCN: 67-5923),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-518

Decision No. CR4879

Date: June 29, 2017

DECISION

Marbridge Villa (Petitioner), a skilled nursing facility (SNF), challenges the Centers for Medicare & Medicaid Services' (CMS) determination that it was not in substantial compliance with 42 C.F.R. § 483.25(h) (requirement to ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devises to prevent accidents). Petitioner also challenges CMS's imposition of a $2,000 civil money penalty (CMP). For the reasons discussed below, I affirm CMS's determination and conclude that the $2,000 CMP is reasonable.

I. Background

The Social Security Act (Act) sets forth requirements for a SNF's participation in the Medicare program and authorizes the Secretary of Health and Human Services (the Secretary) to promulgate regulations implementing those statutory provisions. 42 U.S.C. § 1395i-3. The Secretary's regulations are found at 42 C.F.R. Parts 483 and 488. To participate in the Medicare program, a SNF must maintain substantial compliance with program participation requirements. To be in substantial compliance, a SNF's

deficiencies may "pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." *Id*.

The Secretary contracts with state agencies to conduct periodic surveys to determine whether SNFs are in substantial compliance. 42 U.S.C. § 1395aa(a); 42 C.F.R. § 488.10. The Act also authorizes the Secretary to impose enforcement remedies against SNFs that are not in substantial compliance with Medicare program participation requirements. 42 U.S.C. § 1395i-3(h)(2); 42C.F.R. § 488.406. Among other enforcement remedies, CMS may impose a per-instance CMP for each instance of the SNF's noncompliance. 42 C.F.R. § 488.430(a). The authorized range for a per-instance CMP is $1,000 to $10,000.[1] 42 C.F.R. § 488.438(a)(2). If CMS imposes a CMP based on a noncompliance determination, then the facility may request a hearing before an administrative law judge (ALJ) to challenge the noncompliance finding and enforcement remedy. 42 U.S.C. §§ 1320a-7a(c)(2), 1395i(h)(2)(B)(ii)); 42 C.F.R. §§ 488.408(g), 488.434(a)(2)(viii), 498.3(b)(13).

Petitioner is a SNF located in Manchaca, Texas, that participates in the Medicare program. In response to a report of an injury sustained by a resident (Resident 1) at the Petitioner's facility, surveyors from the Texas Department of Aging and Disability Services (state survey agency) conducted a "Health Incident Investigation" survey on September 26, 2013. CMS Exhibit (Ex.) 1 at 14-15; CMS Ex. 5 at 1; CMS Ex. 7.

The surveyors completed a Statement of Deficiencies (Form CMS-2567) in which they detailed their findings. The surveyors found that a certified nursing assistant (CNA), with initials DA, attempted to transfer Resident 1 by herself, despite the facility's assessment that the resident was to be transferred by two employees. During the transfer, Resident 1 fell on top of CNA DA. Several days later, facility staff found that Resident 1 had a fractured femur. Petitioner's staff immediately attributed the injury to Resident 1's fall, and terminated CNA DA for her failure to follow the Petitioner's policies. The surveyors concluded that Petitioner failed to comply with 42 C.F.R. § 483.25(h) and that its deficient practice could place 19 residents at Petitioner's facility, who require the assistance of two staff members for transfers, at risk for injuries and decreased quality of life due to improper transferring techniques. CMS Ex. 5.

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

In an October 25, 2013 initial determination, CMS stated that, based on the September 26, 2013 survey, it found Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h) (F323) (Free of Accident/Hazards/Supervision) at the scope and severity level of "G," (Actual harm that is not immediate jeopardy).[2] CMS Ex. 9 at 5. As a result, CMS imposed a $2,000 per-instance CMP along with an optional denial of payment for new admissions (DPNA) effective October 25, 2013, and termination effective March 26, 2014. CMS Ex. 9 at 5, 7. CMS rescinded both the DPNA and termination because Petitioner achieved substantial compliance on October 1, 2013. CMS Ex. 9 at 1.

Petitioner timely requested a hearing before an ALJ to dispute CMS's initial determination. Following receipt of Petitioner's hearing request, I issued an Acknowledgment and Initial Prehearing Order. In that order, I directed the parties to file written direct testimony for all witnesses they wanted to present.

In compliance with my prehearing order, CMS filed a prehearing brief and 12 proposed exhibits. One of the proposed exhibits was the written direct testimony for CMS's witness (CMS Ex. 7), a state surveyor who participated in the survey that ended on September 26, 2013. Petitioner then filed its prehearing brief along with 17 proposed exhibits, which included written direct testimony from three witnesses (P. Exs. 14, 16, 17). Petitioner requested to cross-examine CMS's witness, but CMS did not request to cross-examine any of Petitioner's witnesses. Each party objected to some of the other party's exhibits. I set a hearing date and admitted CMS Exs. 1 through 11 and Petitioner (P.) Exs. 1, 4, 6 through17 into the record. Notice of Hearing at 1-2; *see also* Hearing Transcript (Tr.) at 6-7.

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

On April 11, 2016, I held a telephone hearing at which I heard testimony on cross-examination from the state surveyor. Tr. at 4, 7. After the hearing CMS and Petitioner filed post hearing briefs and CMS filed a reply brief.

II. Issues

The issues presented are:

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

2. If Petitioner was not in substantial compliance with Medicare participation requirements, is the CMP amount imposed on Petitioner reasonable.[3]

III. Findings of Fact

1. Resident 1 was first admitted to Petitioner's facility on February 11, 2003, when she was 51 years old, with diagnoses of unspecified schizophrenia, depressive disorder not elsewhere classified. CMS Ex. 1 at 1; P. Ex. 9 at 1.

2. In 2007, Resident 1 had a total hip replacement. P. Ex. 13 at 7; *see* P. Ex. 9 at 9.

3. Upon Resident 1's readmission to Petitioner's facility on February 19, 2008, Petitioner determined that Resident 1 could ambulate with a walker and two-person assist, and could be transferred using a two-person assist. P. Ex. 9 at 1; P. Ex. 10. Resident 1's weight and height were recorded respectively as 217 pounds and five feet eight inches.

4. In March 2009, a physician noted that an x-ray of Resident 1's left hip showed that the "bony structures are markedly demineralized." P. Ex. 9 at 10.

5. In February 2010, Resident 1 fell, but without causing a facture; however, the physician again noted that the x-ray showed continued demineralization of bony structures. P. Ex. 9 at 9.

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[3] CMS's determination as to the level of noncompliance of an SNF must be upheld unless it is clearly erroneous. 42 C.F.R. § 498.60(c)(2). However, the level of noncompliance found by CMS regarding an SNF is only an appealable initial determination "if a successful challenge on the issue would affect – (i) The range of the civil money penalty amounts that CMS could collect." 42 C.F.R. § 498.3(b)(14)(i). In the present case, CMS imposed a per-instance CMP, which only has only one range: $1,000 to $10,000. 42 C.F.R. § 488.438(a)(2). Therefore, the level of noncompliance is not an issue in this case.

6. On April 13, 2010, Resident 1 fell again while trying to get up on her own and, on that same date, Resident 1 was diagnosed with unspecified osteoporosis. CMS Ex. 9 at 1-2.

7. By September 2010, the physician reviewing an x-ray of Resident 1's left ankle concluded that Resident 1's bones are "very demineralized." P. Ex. 9 at 7.

8. Petitioner's Director of Nursing noted in a March 2011 summery that Resident 1: had to wear a "built up shoe on her left foot due to a length discrepancy due to removal of a hip prosthesis"; is able to propel herself in a wheelchair; "ambulate[s] only short distances and only with the use of a walker and stand by assistance of staff," and "requires assistance for all transfers from her wheelchair to bed and back or to the toilet and back to wheelchair." P Ex. 13 at 1.

9. In December 2011, Resident 1 fell again while trying to transfer from a wheelchair to the toilet with assistance, resulting in a dislocated her right hip. P. Ex. 9 at 1; P. Ex. 13 at 4, 7, 10. Resident 1 thought that her fall was "because the elevated shoe that she usually wears on the left, simply did not land appropriately when she tried to stand up." P. Ex. 13 at 7. As a result, on December 20, 2011, a surgeon performed an operation on Resident 1 described as "Closed reduction, right total hip arthroplasty." P. Ex. 13 at 10.

10. After being readmitted to Petitioner's facility, in February 2012, a physician noted that Resident 1 had elevated pain in her left hip, refused to stand, and screams at staff if they try to stand her up. P. Ex. 9 at 6.

11. At a subsequent date, Resident 1 was discharged again, but readmitted to Petitioner's facility on March 4, 2013, with a primary diagnosis of "unspecified rehabilitation procedure," and other diagnoses of acute esophagitis, unspecified hemorrhage of gastrointestinal tract, atrial fibrillation, closed dislocation of hip with an onset of December 27, 2011, and mild hypoxic-ischemic encephalopathy. CMS Ex. 1 at 1; P. Ex. 9 at 1.

12. In April 2013, a physician reviewed an x-ray of Resident 1 and concluded that the right total hip replacement was intact. P. Ex. 13 at 3.

13. Petitioner's June 19, 2013 care plan indicates Resident 1 "uses transfer bar to assist in repositioning and transfers." P. Ex. 9 at 1. Resident 1 was described as being at high risk of falls due to psychoactive drug use, gait/balance problems, incontinence, and history of falls. P. Ex. 12 at 2-3. The care plan indicates Resident 1 can "weight bear as tolerated with staff assist transfers" and that Resident 1 "requires 1:1 staff participation with transfers," and was also 1:1

participation for toilet use, incontinent care, and reposition and turn in bed. P. Ex. 12 at 2, 7-8. In addition, the care plan states in a hand-written and initialed note, "hoyer lift ok if refusing to assist staff." P. Ex. 12 at 3. Further, the care plan states that Resident 1 has limited physical mobility. P. Ex. 12 at 8.

14. On August 15, 2013, Resident 1 slid out of bed and fell while having her brief changed. P. Ex. 12 at 10. On August 16, 2013, Petitioner updated the care plan based on Resident 1's fall, and indicated the goal of the plan change was to "have no falls over the next 30 days" and that the approaches to achieve this goal included "having 2 people to assist with brief change." P. Ex. 12 at 10.

15. On September 4, 2013, Resident was "in her room screaming and having a loud conversation with herself and I hear her say 'I can't stand it anymore I want to kill myself.'" CMS Ex. 1 at 2. Also on September 4, 2013, a nursing note stated that the Resident had been screaming in her room, and "aids reports [sic] that she fell while she was being transferred." CMS Ex. 1 at 3.

16. At some time before September 5, 2013, Petitioner posted signs in Petitioner's room and shower room indicating that two persons needed to assist Resident 1 with transfers. CMS Ex. 1 at 12; CMS Ex. 3 at 5-6.

17. On the evening of September 5, 2013, CNA DA attempted to transfer Resident 1 from her wheelchair to her bed alone, which resulted in Resident 1 falling forward and landing on top of CNA DA. CMS Ex. 1 at 4, 6; CMS Ex. 3 at 1, 5. Another CNA arrived and transferred Resident 1 using a Hoyer lift. CMS Ex. 3 at 14. Resident 1 complained of pain on her right knee and the right side of her body during the transfer. CMS Ex. 3 at 14. Resident 1 continued to yell and have outbursts. Resident 1 was noted to have full range of motion in both legs. The Resident refused to turn over, stated her head hurt, and that she was confused. A nurse called the Resident's sister to inform her of the fall. CMS Ex. 1 at 3.

18. A September 5, 2013 post fall assessment indicates that Resident 1 had no previous history of falls and the fall was an isolated event. Resident 1's diagnoses that could cause falls included unsteady gait, incontinence, decline in cognitive skills, and psychiatric disorder. CMS Ex. 1 at 7.

19. A September 5, 2013 minimum data set for the Resident indicates she required "extensive assistance" for transfers with "two+ persons physical assist." CMS Ex. 1 at 30. The minimum date set indicated that Resident 1 was 68 inches tall and 213 pounds. CMS Ex. 1 at 38.

20. A September 6, 2013 care plan update indicates Resident 1 experienced a fall while transferring. The approaches to avoid falls included using a Hoyer lift for all transfers. P. Ex. 8, P. Ex. 12 at 11.

21. A September 6, 2013 nurse's note indicates: "Resident screaming out stating she's hurting not related to incident – very agitated." CMS Ex. 1 at 4. A nurse's note from later the same day indicates "Resident acting out yelling, States she can't use her body [increased] agitation . . ." CMS Ex. 1 at 4-5. The note further states: "No noted discomfort from fall. . . ." CMS Ex. 1 at 5. On September 6, 2013, Resident 1 complained of generalized leg pain (CMS Ex. 3 at 10), but in general, staff noted that Resident 1 was not in pain on September 6 and 7, 2013. CMS Ex. 3 at 3, 7-9, 12-13, 15-16.

22. A September 8, 2013 employee statement from CNA DA indicates "Thursday evening" she was preparing Resident 1 for a transfer "with a gait belt from the chair to the bed." CMS Ex. 3 at 5. CNA DA reported she was transferring the Resident by herself. CNA DA also stated, on the same day, but before the fall, Resident 1 was complaining of pain in her legs but never specified the exact location of her pain. CNA DA stated that after the fall, Resident 1 was not complaining of pain until later that evening when she said "it hurts, it hurts," but denied pain when asked about the source. CNA DA stated:

> I was aware of the transfer status being a two person transfer. I am aware that the transfer status is located in the cabinet as you first walk into her room and also the shower room. I have transfered [sic] her once before by myself with out [sic] any problems, however I knew that I was not following proper proceeder [sic].

CMS Ex. 3 at 5-6.

23. A September 8, 2013 corrective action form for CNA DA indicates CNA DA violated a work rule by performing an unsafe resident transfer. The incident description was "[o]n 9-5-13 you attempted a one person transfer of a resident you knew was a two person transfer." CNA DA received an unpaid suspension with a warning she would be terminated if the incident occurred again. CMS Ex. 2 at 1.

24. On September 8, 2013, Resident 1 was in bed complaining of right leg pain. CMS Ex. 1 at 5. Petitioner's staff noted that Resident 1 had swelling and bruising on her right leg and multiple bruises behind her right knee, as well as swelling from right knee to ankle, and the area was "warm to touch." CMS Ex. 1 at 5, 9; CMS Ex. 3 at 4. A nurse notified Resident 1's physician. Resident 1 received an x-ray and x-ray report on September 8, 2013, which indicated that Resident 1 had a

fracture of the right femur. Resident 1 was transported via ambulance to a hospital. CMS Ex. 1 at 5; P. Ex. 9 at 4.

25. Petitioner's September 13, 2013 Provider Investigation Report indicates that Resident 1's fall occurred at 8:00 p.m. on September 5, 2013 in the Resident's room. Resident 1's functional ability was described as "extensive" and her level of supervision was described as "no special supervision." CMS Ex. 1 at 11. The "perpetrator" was identified as CNA DA and the report indicates "resident fell on CNA during transfer." CMS Ex. 1 at 12. On September 8, 2013, Resident 1 complained of right leg pain while a CNA was applying Thrombo-Embolic Deterrent (TED) hose, and the CNA observed bruising and "immediately notified the charge nurse." A mobile x-ray was performed and the impression was a "displaced distal femoral fracture" just above the right knee. The report notes:

> [t]he only observed incident possibly contributing to the fracture was on 9-5-13 when CNA [DA] attempted a one person transfer of [Resident 1] from her wheelchair to her bed. Upon raising out of her chair, [Resident 1] fell forward ontop [sic] of the CNA. [Resident 1] is a two person transfer.

CMS Ex. 1 at 12. The "investigation summary" also indicates "no other incidents occurred after the 9/5/13 transfer incident." CMS Ex. 1 at 13.

26. A September 13, 2013 corrective action form for CNA DA states:

> On 9-5-13 you transferred a resident who you admitted knowing was a two person transfer by yourself. The resident fell during this transfer. It was discovered two days later that the resident has a femur fracture. This action constitutes neglect.

CMS Ex. 2 at 2. The form indicates CNA DA was terminated due to this incident. CMS Ex. 1 at 12; CMS Ex. 2 at 2.

IV. Conclusions of Law and Analysis

My conclusions of law are in italics and bold.

1. ***Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h) because Petitioner's staff failed to provide an environment as free as possible from accident hazards, and failed to provide safe and appropriate transfers, resulting in an accidental fracture to Resident 1's femur.***

CMS asserts that Petitioner violated 42 C.F.R. § 483.25(h), which states:

> (h) 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.

CMS primary argues that Petitioner violated this regulation because CNA DA attempted to transfer Resident 1 from her wheelchair without additional assistance, leading to Resident 1's fall and subsequent fractured right femur. CMS Ex. 5 at 1. Petitioner responds that Resident 1's care plan in effect at the time of the September 5, 2013 fall (i.e., the June 2013 care plan) only required one person to assist Resident 1 with transfers and, in any event, Resident 1 was not injured due to her fall because Resident 1's femur fractured spontaneously a few days after the fall because Resident 1's bones were demineralized. P. Ex. 12 at 7-8; P. Ex. 14 at 7. Petitioner asserts that Resident 1's June 2013 care plan stated it is "ok" for the staff to use a Hoyer lift if Resident refuses to bear weight; however, the care plan never states that a Hoyer lift is required. P. Ex. 12 at 3.

Based on a review of the record as a whole, I conclude that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h). The relevant portion of the June 2013 care plan states that Resident 1 was at high risk of falls due to psychoactive drug use, gait/balance problems, incontinence, and a history of falls. P. Ex. 12 at 1-3. Indeed, Resident 1 had a history of falls at Petitioner's facility, including two in 2010 and one in 2011, which required surgery. P. Ex. 9 at 1-2, 9; P. Ex. 13 at 4, 7, 10. Significantly, the June 2013 care plan had to be updated shortly before the September 5, 2013 fall to require two persons to assist when changing Resident 1's brief because Resident 1 fell from her bed while resisting an attempt by one of Petitioner's employees to change her brief. P. Ex. 12 at 10. Petitioner also specifically set a goal for Resident 1 not to have any falls in the next 30 days. P. Ex. 12 at 10. This care plan change, taken in conjunction with the June 2013 care plan's hand-written and initialed note that "hoyer lift ok if refusing to assist staff" shows that Petitioner's staff knew Resident 1 was at high risk of falls due to her mental and physical condition, and would likely require Hoyer lift use if refusing to assist staff. P. Ex. 12 at 3.

Consistent with Petitioner's goal to avoid Resident 1 falling and the clear need to provide additional assistance to ensure no falls, the evidence in the record supports that Petitioner had in fact determined that Resident 1 was a two person transfer in all situations, but had simply not updated the care plan to reflect this. According to a September 8, 2013 corrective action form signed by Petitioner's administrator, CNA DA violated a work rule by performing an unsafe resident transfer. The incident description was "[o]n 9-5-13 you attempted a one person transfer of a resident **you knew was a two person transfer**."

CMS Ex. 2 at 1 (emphasis added). Similarly, a September 13, 2013 corrective action form, signed by Petitioner's administrator, detailed the reasons to terminate CNA DA's employment:

> On 9-5-13 you transferred a resident who **you admitted knowing was a two person transfer** by yourself. The resident fell during this transfer. It was discovered two days later that the resident has a femur fracture. This action constitutes neglect.

CMS Ex. 2 at 2 (emphasis added). CNA DA's own statement of September 8, 2013, is consistent with Petitioner's position at the time:

> **I was aware of the transfer status being a two person transfer. I am aware that the transfer status is located in the cabinet as you first walk into her room** and also the shower room. I have transfered [sic] her once before by myself with out [sic] any problems, however I knew that I was not following proper proceeder [sic].

CMS Ex. 3 at 5-6 (emphasis added). The survey also revealed that it was common knowledge among Petitioner's employees that two employees were needed to transfer Resident 1. CMS Ex. 6 at 10 ("Always a 2 person transfer. I have never seen anyone try to transfer her w/ 1 person."), 11 ("[Resident 1] was a 2 person transfer."), 18 ("before [Resident 1] fractured her tibia she needed 2 person help before that due to her bipolar."); CMS Ex. 7 at 5-7. In fact, Petitioner's administrator noted in his investigation report of Resident 1's fall that "[u]pon raising out of her chair, [Resident 1] fell forward ontop [sic] of the CNA. [Resident 1] is a two person transfer." CMS Ex. 1 at 12. The administrator also stated: "It was discovered that the fall on 9/5/13 by the resident during the transfer, occurred with only one CNA transferring the resident not two. The resident was a two person transfer according to the transfer status posted." CMS Ex. 1 at 12. These statements by Petitioner's administrator helped form the basis of the surveyor's conclusion that transfer cards indicating a two person assist were posted for Resident 1 (Tr. at 42), and the administrator's testimony in this case does not explain or contradict his repeated prior statements that Resident 1 needed the assistance of two persons when transferring. *See* P. Ex. 16.

Regarding current transfer status being displayed in the resident's room, Petitioner's own Gait Belt Use Policy and Procedure states:

> If you cause an injury to a resident by not following transfer guidelines (i.e. use of gait belt, proper number of employees to transfer) you will receive disciplinary action for this and

> may face termination depending on the severity of the injury. . . Transfer status lists are posted in several areas to identify residents requiring one or two person transfers. **Two person transfers are also indicated with a picture hung on the resident's wall.**

CMS Ex. 4 at 1 (emphasis added).

The record is clear that Resident 1 was at risk for falls, had fallen several times, needed a two person assist to change her briefs to avoid falling out of bed, and had signs posted that Resident 1 needed two persons to assist her with transfers. Although Petitioner provided testimony from two nurses that states that a single person assist was appropriate on September 5, 2013, because Resident 1's care plan only required that, neither of these nurses provide testimony that the care plan was correct as of September 5, 2013. P. Ex. 14 at 5-6; P. Ex. 17 at 2-3. The evidence of record shows that Petitioner determined that Resident 1 was in fact, by September 5, 2013, properly a two person transfer, and that this simply had not been formally made part of the care plan. It is significant that Petitioner terminated CNA DA for failing to follow that determination.

Further, even if Petitioner was still following the care plan, it would not have been appropriate to transfer Resident 1 with a single person assisting on September 5, 2013. The Resident was not capable of assisting staff with her transfers by September 5, 2013, and use of a Hoyer lift and/or multiple staff would have been appropriate, a situation foreseen by Petitioner's own care plan. A September 4, 2013 nurse's note indicates Resident 1 was "in her room screaming and having a loud conversation with herself and I hear her say 'I can't stand it anymore I want to kill myself.'" CMS Ex. 1 at 2. Later on September 4, 2013, a nursing note indicates Resident 1 had been screaming in her room, and "aids reports that she fell while she was being transferred." CMS Ex. 1 at 3. Further, at the time of the fall, Resident 1 was a substantial person - 68 inches tall and weighing 213 pounds. CMS Ex. 1 at 38. It is telling that Petitioner immediately moved to updated Resident 1's minimum data set on September 5, 2013, to indicate two or more employees were needed for transfers and the care plan on September 6, 2013, to require using a Hoyer lift for all transfers. CMS Ex. 1 at 30; P. Ex. 8, P. Ex. 12 at 11. These changes were made before Petitioner knew that Resident 1 was injured in the fall.

Petitioner also argues that Resident 1 refused to wait for a second person to perform the transfer and that Resident 1 had a right to refuse additional assistance. P. Ex. 3 at 6; P. Ex. 14 at 6; P. Ex. 17 at 3. However, the State Operations Manual states, in relevant part:

> The facility is responsible for providing care to residents in a manner that helps promote quality of life. This includes respecting residents' rights to privacy, dignity and self

> determination, and their right to make choices about significant aspects of their life in the facility.
>
> For various reasons, residents are exposed to some potential for harm. Although hazards should not be ignored, there are varying degrees of potential for harm. It is reasonable to accept some risks as a trade off for the potential benefits, such as maintaining dignity, self-determination, and control over one's daily life. The facility's challenge is to balance protecting the resident's right to make choices and the facility's responsibility to comply with all regulations.
>
> The responsibility to respect a resident's choices is balanced by considering the potential impact of these choices on other individuals and on the facility's obligation to protect the residents from harm. . . .
>
> **Consent by resident or responsible party alone does not relieve the provider of its responsibility to assure the health, safety, and welfare of its residents, including protecting them from avoidable accidents.** While Federal regulations affirm the resident's right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, legal surrogate, or representative to demand the facility use specific medical interventions or treatments that the facility deems inappropriate. **The regulations hold the facility ultimately accountable for the resident's care and safety. Verbal consent or signed consent forms do not eliminate a facility's responsibility to protect a resident from an avoidable accident.**

State Operations Manual, § 483.25(h) Accidents (emphasis added). Therefore, Resident 1's alleged consent to a single person transfer does not relieve Petitioner of responsibility. In addition, due to Resident 1's previously described significant mental health issues, including decline in cognitive skills and a psychiatric disorder, Petitioner's argument that they relied upon her consent in performing a single person transfer is not reasonable.

Petitioner also argues the Resident 1 suffered no injury from the fall, and that Resident 1's fracture was the result of a spontaneous fracture on another date. To support this, Petitioner notes that Resident 1 was not observed to have an injury to her leg until September 8, a few days after the fall, and relies on testimony from two nurses that Resident 1 was predisposed to spontaneous fractures due to her diagnosis of osteoporosis

and severe demineralization of her bones. CMS Ex. 1 at 4-9; CMS Ex. 3; P. Ex. 6; P. Ex. 7; P. Ex. 14 at 4, 7, 9; P. Ex. 17 at 3.

Although Petitioner is correct that chronologically the fall occurred two to three days before overt signs and symptoms emerged showing Resident 1's fracture, the investigation into the fracture by Petitioner's administrator and director of nursing concluded that the likely cause of the fracture was the September 5, 2013 fall. Petitioner's September 9, 2013 report to the state survey agency states that "[a]t this time it is suspected that a failed transfer on the evening of 9-5-13 may have contributed to the fracture." CMS Ex. 1 at 15. Further, following completion of the investigation, the September 13, 2013 Provider Investigation Report signed by Petitioner's administrator states:

> **[t]he only observed incident possibly contributing to the fracture was on 9-5-13** when CNA [DA] attempted a one person transfer of [Resident] from her wheelchair to her bed. Upon raising out of her chair, [Resident] fell forward ontop [sic] of the CNA. [Resident] is a two person transfer.

CMS Ex. 1 at 12 (emphasis added). It is important that although Petitioner's administrator had only suspended CNA DA prior to the investigation, on the same date as he signed the September 13, 2013 Provider Investigation Report, he increased the discipline imposed on CNA DA to termination because "[i]t was discovered two days [after Resident 1's fall] that the resident has a femur fracture. This action constitutes neglect." CMS Ex. 2 at 2. Therefore, Petitioner took action based on its conclusion that the September 5, 2013 fall was directly related to Resident 1's fracture.

Although there is a September 8, 2013 report of an x-ray that showed Resident 1 had a fractured femur, the record does not otherwise provide a physician's assessment as to the cause of the fracture. P. Ex. 9 at 4. Petitioner has provided testimony from two nurses who opine Resident 1 had a spontaneous fracture, but Petitioner's evidence also shows that Resident 1's health condition made her at risk for fractures in general. P. Ex. 7 at 1. Therefore, Resident was placed in great danger of bone fractures by fall. Based on the record as a whole, it is simply too coincidental to conclude that Resident 1 had a spontaneous fracture in her femur within days of falling.

I conclude that Petitioner violated 42 C.F.R. § 483.25(h) based on its failure to properly assist Resident 1 in transferring from her wheelchair to her bed on September 5, 2013, resulting in a fall and a fracture of Resident 1's right femur.

2. CMS's determination of the amount of CMP is reasonable.

In determining whether the per-instance CMP amount imposed against Petitioner is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f). 42 C.F.R. § 488.438(e)(3). These factors include: (1) the facility's history of compliance; (2) the facility's financial condition; (3) the factors specified at 42 C.F.R. § 488.404; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort, or safety. The absence of culpability is not a mitigating factor. The factors at 42 C.F.R. § 488.404 include: (1) the scope and severity of the deficiency; (2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and (3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies. Unless a facility contends that a particular regulatory factor does not support the CMP amount, the ALJ must sustain it. *Coquina Ctr.*, DAB No. 1860, at 32 (2002).

In the present case, CMS imposed a $2,000 per instance CMP on September 26, 2013. CMS Ex. 9 at 1. I note that a $2,000 CMP is in the lower range for per instance penalties (i.e., per-instance CMPs can be from $1,000 to $10,000). 42 C.F.R. § 488.438(a)(2).

Petitioner has a history of noncompliance as can be seen by deficiencies cited in 2010 through 2013. The relevant deficiencies range from "D" through "H," indicating lower to moderate levels of noncompliance, providing some support for the current CMP. CMS Ex. 8.

Petitioner has not asserted that its financial condition would make the CMP amount difficult to pay.

I consider Petitioner to have a fairly high degree of culpability in this case. Petitioner's staff did not appear to consider the possibility that Resident 1 had suffered an injury during the fall. Petitioner indicated that Resident 1 reported no pain after the injury. However, Resident 1's reports of pain varied significantly. Given the Resident's significant mental issues, it is unlikely to think that she would have been a reliable reporter of any possible injuries. Also, given that Petitioner was at high risk for bone fractures, it should have ensured that all transfers were safely done and, if a fall resulted, that extensive efforts were made to assess Resident 1 for fractures. Resident 1 was completely dependent on Petitioner to keep her safe during transfers and all other activities of daily life and, barring that, to care for her injuries. She could not communicate the injuries she received during the transfer. Petitioner's staff needed to be

careful to respond to any potential injury with such a resident. This is especially so given that Resident 1 had fallen several times and, in 2011, needed surgery to correct the injury to her hip from a fall.

Based on the factors above, I conclude that the $2,000 per-instance CMP is reasonable.

V. Conclusion

I conclude that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h). Further, I conclude that a $2,000 per-instance CMP is reasonable.

/s/
Scott Anderson
Administrative Law Judge