Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Hearthstone SN Health Center,
(CCN: 45-5771),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-152

Decision No. CR3256

Date: June 5, 2014

DECISION

I grant summary judgment in favor of the Centers for Medicare & Medicaid Services (CMS) and sustain CMS's determination to impose a per-instance civil money penalty of $3500 against Petitioner, Hearthstone SN Health Center.

I. Background

Petitioner is a skilled nursing facility participating in the Medicare program. It requested a hearing to challenge the civil money penalty that I cite in the opening paragraph of this decision. CMS filed 18 proposed exhibits that are identified as CMS Ex. 1 – CMS Ex. 18. Petitioner filed eight proposed exhibits that are identified as P. Ex. 1 – P. Ex. 8. CMS and Petitioner filed pre-hearing briefs. Then, CMS moved for summary judgment and Petitioner opposed the motion.

I receive the parties' exhibits into the record.

II. Issue, Findings of Fact and Conclusions of Law

A. Issues

The issues are whether the undisputed material facts establish that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.75(m)(2) and whether a per-instance civil money penalty of $3500 is a reasonable remedy.

B. Findings of Fact and Conclusions of Law

The regulation that is at issue requires a skilled nursing facility to:

> train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.

42 C.F.R. § 483.75(m)(2). Although not stated explicitly in the regulation it is evident that the regulation requires that whatever training and drills utilized by a facility to indoctrinate staff in emergency procedures be efficacious. In other words, it is not enough for a facility just to conduct training classes in emergency procedures but it must ensure that the staff understands those procedures and that the staff be able to execute them in an effective manner. Expecting anything less from a facility would frustrate the intent of the regulation, which is to assure that facility residents are protected to the maximum extent possible in emergencies.

The undisputed material facts establish that Petitioner failed to carry out the regulatory intent in providing care to one of its residents, an individual who is identified as Resident # 14. Petitioner's staff was not trained effectively to be able to remove the resident from her room in the event of an emergency demanding evacuation.

The resident was massively obese, weighing 392 pounds. CMS Ex. 9 at 29. She had extreme physical limitations due to her obesity and to other medical problems. *Id.* at 28. She was unable to get out of bed or even to sit in a chair. *Id.* at 22. Petitioner assigned a special bariatric bed to Resident # 14 in order to accommodate her bulk. The bed was 38 inches wide and it was fitted with a mattress that was 48 inches wide. CMS Ex. 12 at 20. That made the bed/mattress combination five inches wider than the doorway to the resident's room, which was 43 inches wide. *Id.*

It is obvious that special methods would be needed to remove Resident # 14 from her room in the event of an emergency that demanded evacuation. She was

effectively immobile and helpless due to her massive size and her various medical conditions. The staff could not simply roll the resident's bed out of the room with her lying in it because the bed and mattress were wider than the room's doorway. These circumstances mandated that the facility develop techniques to deal with the resident's unique circumstances and importantly, assure that the staff knew what these techniques were and be able to implement them in an emergency situation.

The facts offered by CMS are that Petitioner's staff – at least, those who were responsible for Resident # 14's care – had no idea what they were supposed to do in the event of an emergency that demanded that the resident be evacuated. At a survey of the facility conducted on July 17, 2013, surveyors interviewed six members of Petitioner's staff and asked them how they would evacuate the resident in the event of an emergency. The staff members gave widely different answers:

- Certified nursing assistant (CNA) Bertha Ortego said that it would take three people to remove the resident from her room and that removal would require the use of special equipment known as a Hoyer Lift. CMS Ex. 12 at 1. Ms. Ortego stated additionally that she had no training as to how to evacuate residents who were in bariatric beds in the event of an emergency. *Id.*

- CNA Brenda Rice said that during an emergency evacuation she would pull the release on the bariatric bed, causing the mattress to collapse to the floor. Then, she stated, two people would pull the resident out of her room with the resident lying on the mattress. CMS Ex. 12 at 1.

- Assistant Director of Nursing Ashley Williamson, R.N., averred that the resident's bariatric bed could be broken down in an emergency in order to enable the resident to be removed from her room. CMS Ex. 12 at 1.

- In contrast, Shelly Erhardt, R.N., asserted that the resident's bed could not be broken down. CMS Ex. 12 at 1. She said that she would use a Hoyer Lift and remove the resident from her room during an emergency with the assistance of one other person. *Id.* Nurse Erhardt stated that she had received no training on use of the bariatric bed. *Id.*

- CNA Carolina Trejo asserted that there was a lever on the resident's bariatric bed that could be pushed and that would cause the bed to "go in," thereby enabling the staff to roll the bed through the resident's room's doorway in the event of an emergency. CMS Ex. 12 at 1.

- Janet Goldman-Hayat, an employee of Petitioner's activities department, averred that extenders on the resident's mattress could be removed in the event of an emergency and that extenders on the resident's bed could be pushed in, thereby making the bed sufficiently narrow so that it could be rolled out of the resident's room's doorway. CMS Ex. 12 at 2.

The gross disparities in staff's understanding of what to do for Resident # 14 in the event of an emergency permit only one inference. Staff had no idea what to do because they had not been trained to deal with the special circumstances surrounding the resident. They were unprepared to deal with the unique problems presented by Resident # 14. Thus, Resident # 14 was left unprotected and that constituted a violation of the regulation.

Petitioner contends that there are disputed issues of material fact that preclude summary judgment. However, and as I shall discuss, although Petitioner challenges some of the facts offered by CMS it hasn't challenged the core facts that establish that Petitioner's staff was unprepared to deal with Resident # 14 and the special problems that this resident posed.

Petitioner asserts that it had a plan that was designed to deal with emergencies. Petitioner's Response to Respondent's Motion for Summary Judgment (Response) at 11. This document, entitled "Disaster Planning Manual" contains specific instructions for dealing with bedridden residents, according to Petitioner. *Id.*; P. Exs. 1-2. But, the fact that Petitioner had a plan for dealing with emergencies is meaningless if the staff doesn't understand what that plan says. And, it is especially meaningless if the staff is unable to articulate how it would be implemented in the case of a resident like Resident # 14, who suffered from specific disabilities that made standard evacuation methods impossible in her case.

Resident # 14 was not just a disabled resident. She was an individual who manifested unique problems that called for the staff to develop a unique approach to dealing with her in the event of an emergency. It should have been apparent to Petitioner and its staff that, given the resident's enormous weight and her utter helplessness, normal evacuation methods simply would not work for this resident in the event of an emergency.

Petitioner argues that it did not specifically train its staff in the evacuation of a resident in a bariatric bed because facility doorways were too narrow to accommodate a bed that is so wide. Response at 12. That is obvious. That made it imperative that Petitioner train its staff effectively to utilize an alternative to attempting to roll a bariatric bed through too-narrow doorways. That is clearly something that Petitioner failed to do, as is evident from the absence of any facility plan to deal with Resident # 14 and her specific needs.

Petitioner contends that it trained its staff in a removal technique that it calls the "Blanket Drag." Response at 13. This technique involves placing a disabled resident to be evacuated on a blanket and dragging the resident through a doorway and out of the room. *Id.* None of the six staff members interviewed by surveyors on July 17, 2013 cited the "Blanket Drag" technique as a way of removing Resident # 14 from her room. One of them, CNA Brenda Rice, thought that the resident could be removed from her room by dragging her out while she lay on the bed's mattress. That is not the "Blanket Drag" technique and not a workable functional equivalent inasmuch as the mattress utilized by the resident is five inches wider than her room's door.

Petitioner suggests that the surveyors' interview questions to the staff were misleading because they focused on how the staff would deal with Resident # 14 instead of on their general training to handle emergencies. Response at 14. But, the training that the staff would utilize to evacuate Resident # 14 was precisely what the surveyors wanted to know about given the resident's unique problems and circumstances. Indeed, the surveyors would have been remiss if they had kept their questions limited to the general issue of emergency training and had not questioned staff about the specific issues presented by Resident # 14.

Petitioner offers the testimony of only one of the six staff members that the surveyors interviewed. That is the testimony of Ashley Williamson, R.N. P. Ex. 6. She contends that a surveyor told her, and that she witnessed other staff members being told by the surveyor, that the "Blanket Drag" was not an acceptable technique for removing a resident from her room in the event of an emergency. According to Ms. Williamson:

> I remember staff initially telling the surveyor that the resident in the bariatric bed would be moved by blanket drag. The surveyor would tell the staff member that blanket drag was not an option. The staff member would then pick another option.

P. Ex. 6 at 2.

Ms. Williamson's testimony raises credibility issues about the surveyors' reports of what the other staff members said. I would rule that there is no basis for summary judgment in this case if it were necessary for me to resolve these issues.

That is not the case, however. That is so because even if *all* of the staff members told the surveyors that they had been trained to use the "Blanket Drag" to remove disabled residents from their rooms in emergencies, *none* of them, including Ms.

Williamson, offered any explanation as to how that technique would be used for Resident # 14 in light of her special needs.

How does one move a 392-pound individual who is helpless to the point of not being able to sit without assistance from her bed to a blanket placed on the floor? How many staff members would be needed to accomplish that task? Was there sufficient space in the resident's room to be able to maneuver the resident from her bed to the floor? How many staff members would be needed to drag a 392-pound individual from her room? What special precautions would be needed to protect the resident from injury – given her bulk and her helplessness – while dragging her? How would the resident be transported once she was out of her room? How much time would be allotted to accomplishing all of this in an emergency and would the staff be able to do what was necessary for Resident # 14 quickly enough? What plans did Petitioner write to deal with Resident # 14's specific problems? What specific training did Petitioner give to its staff *vis a vis* Resident # 14?

Answering these questions is vital given the resident's special needs. Having a general plan in place to remove disabled residents via the "Blanket Drag" is meaningless for a resident like Resident # 14 unless that plan is adapted for her special needs and unless the staff is well-versed in implementing those adaptations. And, yet, Petitioner offered nothing at all to show that it and its staff had considered any of the critical questions posed above much less did it offer any facts showing that the staff had been trained to address the special needs of Resident # 14. Thus, I find no dispute of fact as to the inadequacy of Petitioner's plans to deal with Resident # 14 and her special needs even if I accept as true every word of Ms. Williamson's declaration.

The surveyors cited Petitioner's noncompliance with the requirements of 42 C.F.R. § 483.75(m)(2) as being at the immediate jeopardy level of noncompliance. The level of Petitioner's noncompliance is not an issue that I may address in this decision: CMS's determination to impose a per-instance as opposed to a per-diem civil money penalty precludes consideration of whether the noncompliance on which the penalty is based is at the immediate jeopardy level. 42 C.F.R. § 488.408(d)(1)(iv), (e)(1)(iv).

However, the amount of the penalty, as opposed to the level of noncompliance, is potentially an issue in every case in which a per-instance civil money penalty is imposed. But, Petitioner did not challenge the penalty amount here. It did not argue that the penalty amount of $3500 is unreasonable even if it is found to be

noncompliant with regulatory requirements. For that reason I sustain the civil money penalty without considering the factors that underlie the determination of penalty amount.

/s/
Steven T. Kessel
Administrative Law Judge