

Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

The Harborage
Docket No. A-18-32
Decision No. 2905
October 22, 2018

**FINAL DECISION ON REVIEW OF
ADMINISTRATIVE LAW JUDGE DECISION**

The Harborage (Petitioner), a New Jersey skilled nursing facility (SNF), has appealed the decision of an administrative law judge (ALJ), *The Harborage*, DAB CR4988 (2017) (ALJ Decision). The issues before the ALJ were whether Petitioner was in substantial compliance with 42 C.F.R. § 483.25(c), and whether the imposition of a \$4,663 per-instance civil money penalty (CMP) was unreasonable. Granting summary judgment to the Centers for Medicare & Medicaid Services (CMS), the ALJ held that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(c). In addition, the ALJ sustained, as reasonable, the CMP imposed by CMS for that noncompliance.

On appeal, Petitioner argues that summary judgment was inappropriate due to the existence of genuine issues of material fact. Petitioner also argues that it was in substantial compliance with section 483.25(c), and that the CMP imposed by CMS was unreasonable. For the reasons explained below, we reject Petitioner's arguments and affirm the grant of summary judgment on all issues.

Legal Background

To participate in the Medicare program, a SNF must be in "substantial compliance" with the participation requirements in 42 C.F.R. Part 483, subpart B. 42 C.F.R. § 483.1. The term "noncompliance," as used in the applicable regulations, is synonymous with lack of substantial compliance. *Id.* § 488.301 (defining "noncompliance").¹ To be in substantial compliance, a SNF must ensure, among other requirements, that a resident who enters the

¹ On October 4, 2016, CMS issued a final rule that amended the Medicare requirements for long-term care facilities and re-designated some sections. *See* Final Rule, Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 81 Fed. Reg. 68,688, 68,807 (Oct. 4, 2016). Our analysis and decision is based on the requirements, and their code designations, as they existed in April 2016, the month in which the New Jersey State Department of Health (state agency) performed the compliance survey providing the bases for CMS's determination of noncompliance. *See Carmel Convalescent Hospital*, DAB No. 1584, at 2 n.2 (1996) (applying regulations in effect on the date of the survey and resurvey).

facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable, and that a resident with pressure sores receives the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. *Id.* § 483.25(c). Compliance with the Part 483 requirements is verified through onsite surveys performed by state health agencies. *Id.* § 488.10(a), 488.11. A state survey agency reports any "deficiency" (failure to meet a participation requirement) it finds in a Statement of Deficiencies (SOD). *Id.* §§ 488.301, 488.325(f)(1).

CMS may impose enforcement "remedies," including CMPs, on a SNF found to not be in substantial compliance. *Id.* §§ 488.400, 488.402(b), (c), 488.406. When CMS elects to impose a CMP, it sets the CMP amount based on, among other factors, the facility's history of noncompliance, and the "seriousness" of the SNF's noncompliance. *Id.* §§ 488.404(b), 488.438(f). "Seriousness" is a function of the noncompliance's scope (whether it is "isolated," constitutes a "pattern," or is "widespread") and severity (whether it has created a "potential for harm," resulted in "actual harm," or placed residents in "immediate jeopardy"). *Id.* § 488.404(b).

Factual Background²

On April 14, 2016, New Jersey state agency surveyors completed a health survey at Petitioner, finding that the facility was not in substantial compliance with the participation requirements. The surveyors cited noncompliance with seven requirements, but only the noncompliance with section 483.25(c), alleged failure to ensure that residents #9 (R. 9) and #16 (R. 16) did not develop avoidable pressures sores, is at issue here.

Resident #9

R. 9 was a 90-year-old woman who was admitted to Petitioner on January 8, 2016. CMS Ex. 4, at 1-4. Petitioner identified R. 9 as being at high risk for developing pressure sores. ALJ Decision at 3 (citing CMS Ex. 4, at 3). The facility developed an interdisciplinary care plan, which included interventions to address the resident's high risk of developing pressure sores. *Id.* (citing CMS Ex. 4, at 9). Interventions included conducting a weekly systematic skin inspection, reporting any signs of skin breakdown, providing a pressure redistribution mattress, and following a TLC program. *Id.* "TLC," a nurse employed by Petitioner told the surveyor, means "turn, lubricate [and]

² The facts stated in this section are not our findings; rather, they are from the ALJ Decision and the record. The stated facts are undisputed unless we note otherwise.

communicate.” CMS Ex. 36, at 16; CMS Ex. 1, at 4. The resident was on prescribed bed rest during the period leading up to January 19, 2016 and completely dependent on staff to keep her clean and dry. ALJ Decision at 4.³ She needed extensive assistance to turn, and was unable to reposition herself to prevent excessive pressure on her buttocks. *Id.* (citing CMS Ex. 4, at 2, 5). As of January 15, 2016, she continued to need the assistance of two individuals in order to reposition herself. *Id.* (citing CMS Ex. 4, at 21). On January 19, 2016, the facility’s staff documented a pressure sore on R. 9’s coccyx. CMS Ex. 4, at 9, 15, 18.

Resident #16

R. 16’s care plan indicated that she was at risk of developing a pressure sore. ALJ Decision at 5 (citing CMS Ex. 3, at 6). Several interventions were identified, including conducting a weekly systematic skin inspection and turning and repositioning the resident every 2 hours when in bed. *Id.* at 5-6 (citing CMS Ex. 3, at 6). Petitioner’s staff noted some redness on R. 16’s sacrum on February 25, 2016. *Id.* at 6 (citing CMS Ex. 3, at 12). On February 27, 2016, staff noticed excoriation on the resident’s coccyx. *Id.* Staff documented a pressure sore on March 13, 2016. *Id.* (citing CMS Ex. 3, at 16); CMS Ex. 17, at 11. Staff did not consult with its dietician, who is a member of the staff’s interdisciplinary team for pressure sore prevention, until March 23, 2016. ALJ Decision at 6.

ALJ Decision

The ALJ issued a decision granting summary judgment to CMS on December 14, 2017, concluding that “the undisputed facts of this case amply establish that Petitioner’s staff did not provide care to the two residents that Petitioner had determined was necessary to protect the residents or that was mandated by professionally recognized standards of care.” ALJ Decision at 2.

Regarding R. 9, the ALJ noted that “Petitioner does not directly deny the facts recited by CMS in support of its motion” but, rather “contends that the development of [R. 9’s pressure] sore was unavoidable.” *Id.* The ALJ rejected this defense as “irrelevant to the issue of noncompliance . . . because Petitioner failed to provide the resident with preventative care that the regulation mandates.” *Id.* at 2-3. The ALJ found that nothing in R. 9’s treatment records showed that staff conducted weekly skin assessments as

³ On appeal, Petitioner does not dispute the ALJ’s finding that R. 9 was on prescribed bedrest during the period leading up to January 19, 2016. Nor does Petitioner dispute CMS’s clarification that while R. 9 was originally prescribed bed rest for a six-week period, that order was changed on January 13, 2016, and she was only on bed rest for a five day period. CMS Response at 19, fn. 3 (citing CMS Ex. 4, at 9, 14, 19). After the order was changed, R. 9 participated in physical and occupational therapy. CMS Ex. 4, at 25; *see also* CMS Ex. 4, at 22-49.

mandated in her care plan prior to January 19, 2016 and that “Petitioner has not offered any facts to rebut the inference that the absence of any record of assessments establishes failure by Petitioner’s staff to conduct them.” *Id.* at 3. The ALJ further found that Petitioner’s staff “should have observed the development of a pressure sore prior to the 19th if, in fact, it was performing this care diligently and observing the condition of the resident’s skin.” *Id.* at 4. The ALJ rejected Petitioner’s argument that staff did not perform the weekly skin assessments because she was in too much pain and refused care, concluding that Petitioner did not present facts that would permit such an inference. *Id.* Likewise, the ALJ determined that staff failed to regularly reposition R. 9, and concluded that Petitioner did not offer facts supporting its argument that she resisted care due to her pain. *Id.* at 4-5. The ALJ further stated that Petitioner “offers nothing to show that Petitioner’s staff ever assessed the impact of the resident’s resistance to care if, in fact, the resident resisted care.” *Id.* at 5. Given the importance of repositioning as a measure to protect against developing pressure sores, the ALJ concluded, “Petitioner’s staff should not only have noted that resistance but considered alternative care measures in lieu of repositioning” *Id.* The ALJ also found that staff did not authorize a pressure-relieving mattress until after the pressure sore was observed on January 19, 2016. *Id.*

Addressing the care provided to R. 16, the ALJ again found that staff failed to follow the resident’s care plan to prevent the development of a pressure sore. The ALJ found the record devoid of facts showing that staff repositioned the resident or conducted weekly skin checks, as mandated by her care plan. *Id.* at 5-6. While the ALJ noted that R. 16’s TAR had checkmarks in the box for weekly skin checks, he found that “there is absolutely nothing in this record or in any other record showing that these checks were performed,” noting that “[n]o findings are recorded and no assessments or interventions are stated.” *Id.* at 6. The ALJ also found that staff failed to consult its dietician about R. 16’s condition until 10 days after staff documented the pressure sore. *Id.* The ALJ rejected Petitioner’s argument that R. 16 developed Moisture Associated Skin Damage (MASD) rather than a pressure sore, stating that it would “not relieve Petitioner of its responsibility to implement the protocol that it had prescribed in order to protect the resident from developing sores.” *Id.* at 3, 6.

The ALJ determined that Petitioner waived its right to dispute the penalty amount because it did “not argue that the \$4663 per-instance penalty that CMS determined to impose would be unreasonable if noncompliance exists.” *Id.* at 7. The ALJ also concluded that the history of noncompliance, and risks and dangers associated with the development of pressure sores, “amply justifies the penalty amount.” *Id.*

Standard of Review

We review de novo an ALJ's decision to grant summary judgment. *Southpark Meadows Nursing & Rehab. Ctr.*, DAB No. 2703, at 5 (2016). Summary judgment is appropriate when the record shows there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. See, e.g., *Livingston Care Ctr.*, DAB No. 1871, at 5 (2003) (citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986), *aff'd*, *Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs.*, 388 F.3d 168, 172-73 (6th Cir. 2004)). To defeat an adequately supported summary judgment motion, the nonmoving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010), *aff'd*, *Senior Rehab. & Skilled Nursing Ctr. v. Health & Human Servs.*, 405 F. App'x 820 (5th Cir. 2010). A party “must do more than show that there is ‘some metaphysical doubt as to the material facts . . . Where the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party, there is no genuine issue for trial.’” *Mission Hosp. Regional Med. Ctr.*, DAB No. 2459, at 5 (2012) (quoting *Matsushita Elec. Industrial Co. v. Zenith Radio, Ltd.*, 475 U.S. 574, at 587 (1986)), *aff'd*, *Mission Hosp. Reg'l Med. Ctr. v. Sebelius*, No. SACV 12-01171 AG (MLGx), 2013 WL 7219511 (C.D. Cal. May 31, 2013), *aff'd sub nom. Mission Hosp. Reg'l Med. Ctr. v. Burwell*, 819 F.3d 1112 (9th Cir. 2016).

In examining the evidence to determine the appropriateness of summary judgment, we view the evidence in the light most favorable to the non-moving party, and draw all reasonable inferences in that party's favor. See *Brightview Care Ctr.*, DAB No. 2132, at 2, 9 (2007); *but see Cedar Lake Nursing Home*, DAB No. 2344, at 7 (2010); *Brightview* at 10 (entry of summary judgment upheld where inferences and views of nonmoving party are not reasonable). In deciding whether a SNF has defeated an adequately supported motion for summary judgment – a motion that identifies facts sufficient to make out a prima facie case – we consider whether a rational trier of fact, viewing the entire record in the light most favorable to the SNF, and drawing all reasonable inferences in its favor, could find its presentation sufficient to carry its burden of persuasion (to show substantial compliance). *Dumas Nursing & Rehab., L.P.*, DAB No. 2347, at 5 (2010) (stating that, on summary judgment, “it is appropriate for the tribunal to consider whether a rational trier of fact could regard the parties' presentations as sufficient to meet their evidentiary burdens under the relevant substantive law”). Where the evaluation of credibility or weighing of competing evidence is required to decide whether the SNF has demonstrated substantial compliance, however, summary judgment is not appropriate. See, e.g., *Kingsville Nursing & Rehab. Ctr.*, DAB No. 2234, at 8-9 (2009); *Madison Health Care, Inc.*, DAB No. 1927, at 6 (2004).

Discussion

A. The ALJ properly concluded that undisputed facts establish Petitioner's noncompliance with 42 C.F.R. § 483.25(c).

In its Request for Review (RR), Petitioner argues that summary judgment was not appropriate because genuine issues of material fact remain in dispute. Petitioner also contends that it provided facts to show that R. 9 and R. 16 were “provided the appropriate level of care” RR at 1.

The governing regulation for pressure sore prevention and treatment, 42 C.F.R. § 483.25(c), is one of the “quality of care” requirements found in section 483.25. The overarching requirement for that section is that “each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.” 42 C.F.R. § 483.25. The specific regulation governing pressure sores provides as follows:

(c) Pressure Sores. Based on the comprehensive assessment of a resident, the facility must ensure that –

- (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and
- (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

Id. § 483.25(c). The Board has held that “a facility must provide all necessary care and services to prevent the development of pressure sores, rather than just provide prompt treatment after they develop, particularly where the residents involved were known to have a high risk of developing sores.” *Koester Pavilion*, DAB No. 1750, at 33 (2000); *see also Clermont Nursing and Convalescent Ctr.*, DAB No. 1923, at 9-10 (2004); *aff'd, Clermont Nursing and Convalescent Ctr. v. Leavitt*, 142 F. App'x 900 (6th Cir. 2005). The Board has also held that the failure of a facility to follow its own plan of care to prevent pressure sores from developing, or to promote healing and prevent infection of existing pressures sores, is evidence of noncompliance with section 483.25(c). *See, e.g., Lakeridge Villa Health Care Center*, DAB No. 1988, at 25-30 (2005), *aff'd, Lakeridge Villa Health Care Ctr. v. Leavitt*, 202 F. App'x. 903, at 6 (6th Cir. 2006) (facility failed to provide care consistent with its own plan of care to ensure avoidable pressure sores did not develop and to promote healing and prevent infection of existing pressure sores); *Livingston* at 7-23 (facility failed to follow the pressure-relieving interventions in its residents' care plans).

We conclude that the ALJ did not err in his conclusion that Petitioner failed to provide the care that it “had determined was necessary to protect the residents or that was mandated by professionally recognized standards of care.” ALJ Decision at 2. We also conclude that a rational trier of fact, viewing the entire record in the light most favorable to Petitioner, and drawing all reasonable inferences in its favor, would find that Petitioner was not in substantial compliance with the participation requirements at 42 C.F.R. § 483.25(c).

In reaching our conclusion, we have considered the facility records for the residents at issue as well as the written testimony of Petitioner’s proposed witnesses, provided in Petitioner’s pre-hearing exchange as Petitioner’s Exhibits (P. Exs.) 1-4.⁴ We find that both fail to provide evidence of a genuine dispute concerning a material fact.

R. 9

The records for R. 9, as included in Petitioner’s own exhibits, show the following undisputed facts: R. 9 had no pressure sores when admitted to Petitioner’s facility on January 8, 2016, P. Ex. 1 (Adaci Declaration), at 96 (cross-referencing CMS Ex. 4, at 3); at the time of admission, Petitioner assessed R. 9 as being at high risk for pressure sores, *id.*; at the same time, Petitioner addressed this risk in a care plan to prevent pressure sores that included, *inter alia*, the TLC program and weekly skin rounds, P. Ex. 12, at 1; P. Ex. 1 (Adaci Declaration), at 97; on January 19, 2016, Petitioner’s care staff found that R. 9 had developed a pressure sore on her coccyx, P. Ex. 15, at 5; P. Ex. 1 (Adaci Declaration), at 119-120; Petitioner’s staff assessed the pressure sore as “unstageable,” P. Ex. 17, at 2; P. Ex. 1 (Adaci Declaration), at 152⁵; on February 22, 2016, Petitioner assessed the pressure sore as Stage 3, P. Ex. 12, at 1.

Petitioner argues that R. 9’s development of a pressure sore while in its care does not constitute noncompliance with section 483.25(c) because Petitioner “developed an appropriate care plan upon R. 9’s admission to the facility and . . . complied with that care plan.” RR at 4. Petitioner also argues that the development of the pressure sore resulted from the resident’s “extensive pre-existing injuries and co-morbidities . . . ,

⁴ Petitioner resubmitted P. Exs. 2 and 4 on November 17, 2017. The only difference between the original and resubmitted exhibits was the addition of signatures of Petitioner’s proposed witnesses. We refer to Petitioner’s resubmitted exhibits as P. Ex. 2 and P. Ex. 4 for purposes of our discussion.

⁵ CMS surveyor Karen Callahan stated in her declaration that an unstageable pressure sore “is the most serious type of pressure injury and is described as ‘[f]ull-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar.’” CMS Ex. 36, at 9-10 (citations omitted). She further stated that “[i]f the slough or eschar is removed from an unstageable pressure injury, a Stage 3 or Stage 4 injury will be revealed.” *Id.* at 10 (citation omitted). As discussed above, Petitioner did stage the pressure sore at Stage 3 on February 22, 2016.

rather than from a lack of mandated care rendered by Petitioner.” *Id.* However, the record does not contain any evidence supporting a finding that the facility provided all of the pressure sore prevention interventions required by her care plan, as would be necessary to support a claim that the pressure sore was unavoidable. *See Gooding Rehab. & Living Ctr.*, DAB No. 2239, at 15 (2009) (A facility cannot claim unavoidability unless it first shows that it furnished all necessary treatment and services).

As stated above, the facility drafted a pressure sore prevention care plan for R. 9 on the date of her admission, January 8, 2016, identifying several interventions to begin on that date. P. Ex. 1, at 97; P. Ex. 12 at 1; *see also* CMS Ex. 4, at 9. The listed interventions included implementation of a TLC program, conducting a systematic skin inspection weekly, reporting any signs of skin breakdown, and providing a pressure redistribution mattress. *Id.* Petitioner’s Director of Nursing (DON) states in her sworn declaration that the TLC program includes “turning, positioning, skin lubrication and communication with team members” P. Ex. 3, at 2-3; *see also* CMS Ex. 36, at 16 (discussing Unit Manager’s telling her that “TLC” means “turn, lubricate and communicate.”)

The TLC program was scheduled to begin on January 8, 2016. P. Ex. 12, at 1. The ALJ found, and Petitioner does not dispute, that repositioning the resident was critical “to prevent the development of pressure sores because she was essentially helpless.” ALJ Decision at 4 (citing CMS Ex. 32, at 10). The resident was diagnosed with a fracture of the upper and lower right side of the pelvic bone, fracture of the upper right arm, and subdural hematoma. CMS Ex. 4, at 1-4. The resident was on bed rest from January 8, 2016 until January 13, 2016. CMS Ex. 4, at 5, 14. The resident required total assistance to turn, bathe, dress and toilet. *Id.* at 2. The resident’s care plan indicated that, on January 8, 2016, she was “unable to freely turn on her side during care due to Pubic Rami and humeral fracture.” *Id.* at 9. One of the goals listed on the care plan was that R. 9 “will be able to fully turn on both of her sides with extensive assistance.” *Id.* As of January 15, 2016, the resident, according to the facility’s assessment, continued to require the assistance of two persons to turn from side to side and to sit up in bed, transfer in and out of bed, and toilet. *Id.* at 21.

Despite R. 9’s assessed need for assistance with repositioning, her care plan “d[id] not include a specific turning and repositioning schedule, including frequency and specific method of positioning.” CMS Ex. 36, at 16 (Surveyor Callahan Declaration); P. Ex. 12, at 1 (care plan). Petitioner’s witness, Nelia Adaci, stated in her declaration that the facility “[d]efined and implemented interventions that are consistent with Resident needs, Resident goals and recognized standards of practice.” P. Ex. 1, at 19. However, Ms. Adaci’s statement does not specifically address the standard of practice regarding repositioning for a resident in R. 9’s situation, including the frequency with which she should have been repositioned. In her declaration, surveyor Callahan stated that “because

the resident was difficult to position due to her injuries, there should have been an exact outline of how the aides should do it.” CMS Ex. 36, at 16. She also stated that the standard of care for frequency is at least every 2 hours. CMS Ex. 36, at 8. Although the January TAR shows that staff interacted with R. 9 every shift to do certain cares (e.g. checking arm sling, putting compression socks on and off, checking for pillow elevating calves), repositioning is not one of the cares stated on the TAR, and the TAR does not otherwise show that staff were repositioning R. 9 during cares. CMS Ex. 4, at 19. Moreover, the Interdisciplinary Progress notes do not contain any indication that R. 9 was repositioned on any schedule until after staff discovered the pressure sore on January 19, 2016. P. Ex. 15, at 6; CMS Ex. 4, at 16; *see also* CMS Ex. 4, at 11-15. Given the lack of specificity in Ms. Adaci’s statement regarding the standard of care for repositioning a resident in R. 9’s condition, Petitioner’s failure to dispute the surveyor’s statement about that standard of care, and Petitioner’s failure to present documentation of repositioning on any schedule prior to discovering Petitioner’s pressure sore, we cannot conclude that Petitioner has raised a genuine dispute of fact regarding CMS’s finding that it failed to follow R. 9’s care plan with regard to repositioning prior to discovering the pressure sore.

R. 9’s care plan also called for conducting weekly “systematic skin inspections” and for CNAs and nursing staff to “report any signs of skin breakdown (sore, tender, red or broken areas).” P. Ex. 12, at 1; CMS Ex. 4, at 9. The ALJ found, “There is nothing in the treatment records for [R. 9] showing that the staff conducted the weekly systematic skin assessment mandated by the resident’s care plan at any time prior to January 19 and Petitioner has not offered any facts to rebut the inference that the absence of any record of assessments establishes failure by Petitioner’s staff to conduct them.” ALJ Decision at 3. Although Petitioner does not directly challenge this finding, we conclude, as explained below, that the finding is not entirely accurate. However, we also conclude that the record supports a conclusion on narrower grounds that Petitioner did not fully implement this weekly skin inspection requirement.

The resident’s TAR shows initials in the boxes for weekly skin inspections on January 14 and 21, 2016. CMS Ex. 4, at 19. However, because the second part of the ALJ’s statement addresses the absence of any assessment records in connection with the skin inspections (the back of the TAR contains a space for those assessments), we read the ALJ’s finding as essentially stating that the check mark alone is not sufficient evidence that skin inspections were conducted on those dates. The question for summary judgment, therefore, is whether the absence of any assessment on the date of either or both skin checks supports summary judgment for CMS on the issue of whether Petitioner did the skin checks required by R. 9’s care plan.

When reviewing summary judgment, we are required to view all evidence in the light most favorable to the non-moving party, and “draw only reasonable inferences . . .” in favor of that party. *Cedar* at 7 (2010); *see also Brightview* at 10. Construing the evidence most favorably to Petitioner, we do not find that the presence of a check mark alone (with no assessment information written on the back of the TAR) is inadequate to raise a dispute of material fact as to whether Petitioner completed a “systematic skin inspection” on January 14, 2016. The record contains no evidence as to the date the skin changes that resulted in the pressure sore discovered by staff on January 19, 2016 began. It may be reasonable to infer, as the ALJ did, that the staff member doing the skin check on January 14, should have noted and documented some change in the resident’s skin on that date, given the advanced nature of the pressure sore when care staff discovered it five days later. ALJ Decision at 4 (“The staff should have observed the development of a pressure sore prior to the 19th if, in fact, it was performing this care diligently and observing the condition of the resident’s skin.”). It would also be reasonable to infer, however, (although Petitioner does not propose such an inference) that the staff member whose initials appear in the box on the TAR conducted a skin inspection on January 14 but found no need to complete the back of the form because there were no skin changes requiring assessment and documentation as of January 14. Accordingly, with respect to January 14, 2016, we conclude there is a dispute of material fact with regard to whether Petitioner conducted the weekly skin inspection required by R. 9’s care plan.

On the other hand, staff discovered R. 9’s pressure sore on January 19, 2016. P. Ex. 15, at 5; P. Ex. 1 (Adaci Declaration), at 119-120. Yet, for the weekly skin inspection allegedly performed on January 21, 2016 (according to the check mark), no information about the resident’s skin condition is reported on the back of the TAR. The surveyor testified (and Petitioner does not dispute) that the absence of any documented skin assessment findings on January 21 – despite the checked box – is at odds with the fact that by that date, the facility had documented an unstageable pressure sore. *See CMS Ex. 36*, at 15. We conclude that the only reasonable inference one can draw from these undisputed facts is that the person entering the check mark on January 21, 2016, did not conduct the “systematic skin inspection” required by R. 9’s care plan on that date.⁶

⁶ Petitioner has not argued, we note, that the care plan did not require the staff member doing weekly skin inspections to put assessment information on the TAR if a pressure sore had already been identified and assessed in other facility records. We conclude, at least absent such argument, that Petitioner’s unqualified statement of the required interventions in the care plan must be taken at face value as requiring staff to report any skin changes on the TAR at the time of the weekly skin inspections, regardless of what information appears in other facility records.

Petitioner argues that the ALJ dismissed or failed to sufficiently address evidence it provided addressing asserted limitations on staff's ability to care for R. 9 due to her pain, depression, and refusal of care. RR at 2, 6-8. The facility asserts that testimony by R. 9's treating physician "provided facts that [R. 9's] functional status declined as a result of her severe pain and injured state which limited mobility and caused depression and anxious mood 'including refusal to fully participate in other aspects of her therapeutic regimen.'" *Id.* at 6 (quoting P. Ex. 2 ¶ 17). Petitioner also points to a nurse's note of January 18, 2016, stating that R. 9 verbalized to staff that she was "feeling like giving up," that "she may not want to go through therapy if she may pass next week" and that "she would rather 'bit[e] the bullet than to 'fight it.'" *Id.* at 6-7; *see also* P. Ex. 1, at 11 (written testimony of Nelia S. Adaci addressing her review of this nurse's note). Additionally, Petitioner points to testimony by its Director of Nursing (DON) that "the pain management challenges of [R. 9] caused her to be uncooperative and unmotivated." RR at 7 (citing P. Ex. 3, at ¶ 15).

The ALJ addressed Petitioner's argument regarding R. 9's resistance to care, but concluded that Petitioner "ha[d] not offered any facts that would permit an inference that the staff failed to conduct skin assessments because the resident was in too much pain to be assessed or because [the] resident refused this care. The records offered by the parties are devoid of any statement to that effect." ALJ Decision at 4. He also concluded that Petitioner did not offer facts supporting its argument that it was unable to provide care required by the resident's care plan because of her resistance to care, noting that the facility "offers no records showing that the resident resisted care or that the staff ever withheld care as a consequence of the resident's asserted resistance." *Id.* at 4-5.

We find no basis to disturb the ALJ's conclusions. As indicated above, when reviewing summary judgment, we are required to view all evidence in the light most favorable to the non-moving party, and "draw only reasonable inferences..." in favor of that party. *Cedar* at 7 (2010); *see also Brightview* at 10. Applying this rule, we accept that Petitioner provided some evidence that R. 9 expressed feelings of depression and experienced significant pain (although she did receive pain medication) due to her rather extensive injuries. We also accept that at times these factors may have complicated staff attempts to reposition or turn the resident. However, we find it unreasonable to infer from the evidence Petitioner cites, or the record as a whole, that the facility's failure to implement its care plan for the prevention of pressure sores can be attributed solely, or even substantially, to the resident's physical limitations or refusal of care.

Petitioner's testimony and documentation does not establish that the resident, despite her pain and mobility issues, ever refused to participate in her TLC program or weekly skin checks. Petitioner repeatedly points to testimony (by Nelia Adaci and Dr. Rastogi) citing the January 8, 2016 entry in the resident's care plan that R. 9 was "unable to fully turn on

her side during care due to pubic rami and humeral fracture.” RR at 6, 7; *see also* P. Ex. 12, at 1 (the care plan). However, this falls far short of a statement that the resident refused care or even that she could not be turned with assistance, as opposed to fully turning herself. Moreover the goals and approaches Petitioner set (on the same date) for meeting this problem anticipated that care could be given: “[Petitioner] will be able to fully turn on both of her sides [with] extensive assistance”; “systematic skin inspection weekly”; “[g]entle handling during care and transfers”; and, “TLC program.” *Id.* There is no evidence that staff ever reconsidered these goals and approaches based on either a refusal of R. 9 to cooperate in her TLC program or skin checks, or staff documentation of inability to turn or reposition her due to her pain and limitations of mobility. Absent such evidence, it is unreasonable to infer that the care plan notation on which Petitioner relies supports Petitioner’s assertion that the resident refused care. Likewise, the nursing notes on which Petitioner relies (*see* RR at 6-7) regarding Petitioner’s state of mind merely indicate episodic expressions of feelings of depression or frustration, not that the resident refused care.

Without contemporaneous documentation or testimony that supports inferences in Petitioner’s favor, we are left to conjecture about the frequency of attempted repositioning, when or whether the resident resisted or refused particular care measures, and what, if any, alternative measures were considered. We cannot find a dispute of material fact requiring reversal of summary judgment based on conjecture.

We also note that the resident’s treatment encounter notes show that she was able to participate in daily physical and occupational therapy during the period of January 9-19, 2016. P. Ex. 1, at 121-135; CMS Ex. 4, at 22-29, 34, 39-49. The surveyor stated in her affidavit, and Petitioner does not dispute this testimony, that the physical and occupational therapists confirmed to her that the resident was out of bed daily for therapy. CMS Ex. 36, at 18 (citing CMS Ex. 1, at 5). The physical therapy included performing sit to stand, stand and pivot transfers, sitting and standing balance exercises, and exercises targeting hip flexors, hip abductors, knee flexors and extensors to increase strength, flexibility, functional mobility and ambulatory skills, albeit with maximum assists from caregivers. *Id.* (citing CMS Ex. 4, at 26). Occupational therapy status updates submitted by Petitioner indicate that as early as January 12, 2016 the resident, “tolerated therapy well” with therapeutic rest periods, despite experiencing pain during some sessions. P. Ex. 1, at 126-131. This undisputed evidence, together with the absence of any indication in the treatment notes during this period that the resident’s pain prevented repositioning and skin checks, undercuts Petitioner’s attempt to attribute its failure of care to the Resident’s physical injuries and pain.

Based on the foregoing, we find that Petitioner did not provide all of the care required by R. 9's care plan for the prevention of pressure sore development. Accordingly, we conclude that the ALJ did not err in concluding that Petitioner had not raised a material dispute of fact precluding summary judgment for CMS that Petitioner was not in compliance with section 483.25(c) with regard to its care of R. 9.⁷

Resident #16

The ALJ found, and we agree, that Petitioner failed to implement interventions included in its own plan of care for R. 16. ALJ Decision at 5-7. The resident's pressure sore care plan, created on July 22, 2015, mandated interventions including turning and repositioning every two hours while in bed, and conducting a weekly systematic skin inspection. CMS Ex. 3, at 6. The ALJ found nothing in the evidentiary record showing that the turning and repositioning was ever performed prior to the discovery of the resident's pressure sore. ALJ Decision at 5-6. While Petitioner states generally that it disputes the ALJ's conclusion that Petitioner failed to implement R. 16's care plan, *see* RR at 11, Petitioner raises no dispute about this particular finding, and our own review of the record reveals no contrary evidence. The ALJ also found that, while the resident's TAR showed checkmarks indicating that it performed the weekly skin inspections, the record is devoid of any evidence that staff documented the findings of these skin checks. ALJ Decision at 5; CMS Ex. 3, at 1-4. As we discussed with respect to R. 9, we conclude for purposes of summary judgment that the TAR may not have required documentation beyond a check mark on dates when a skin check found no change in the resident's skin condition. However, we further conclude that the TAR required completing the assessment section once staff found a change in the resident's skin condition, that is, on and after February 25. Petitioner's failure to provide evidence of such documentation on and after that date supports summary judgment for CMS.

⁷ In reaching this conclusion, we do not rely on the ALJ's finding that the facility did not authorize the pressure redistribution mattress required by her care plan until it discovered her pressure sore. ALJ Decision at 5. The evidence on that issue is mixed. The surveyor testified that the dynamic pressure relieving mattress the facility supplied on January 19, after it discovered the pressure sore, should have been provided earlier. CMS Ex. 36, at 16. Petitioner does not dispute that testimony or the ALJ's finding. However, the surveyor also acknowledged in her testimony that the resident had a basic static pressure redistribution mattress (one supplied to all residents) from the time of her admission, and there are medical articles in the record (submitted by CMS) that at least potentially put into question whether R. 9 needed the enhanced pressure relieving mattress before her pressure sore was discovered. *See, e.g.*, CMS Ex. 20, at 13-14; CMS Ex. 32, at 10-11 ("Although dynamic surfaces are usually recommended for more severe [pressure sores], no conclusive evidence favors dynamic over static surfaces"). Accordingly (and even though Petitioner does not make this argument), we draw the inference most favorable to Petitioner, that it did provide R. 9 with the pressure reduction mattress required by her care plan on January 8, 2016.

Furthermore, the ALJ found that Petitioner failed to notify its dietician when a change to the resident's skin condition was first documented. ALJ Decision at 6. Staff documented redness on the resident's sacrum on February 25, 2016, excoriation to her coccyx on February 27, 2016, and a pressure sore on her coccyx on March 13, 2016. CMS Ex. 3, at 12, 16. Despite the worsening condition of the resident's wound, the dietician was not informed until March 23, 2016, 27 days after staff first documented a change to the resident's skin condition, and 10 days after the discovery of a pressure sore.⁸ CMS Ex. 17, at 11-12. The ALJ noted that "diet is an important element of pressure sore prevention." ALJ Decision at 6 (citing CMS Ex. 20, at 9-10; CMS Ex. 32, at 15; CMS Ex. 33, at 3; CMS Ex. 34, at 22-24; CMS Ex. 35, at 1, 7). Thus, notifying the dietician of the resident's change in skin condition was necessary to ensure that she did not develop a pressure sore.

In her sworn declaration, the surveyor testified to an interview with the facility's Unit Manager in which the Unit Manager stated that changes in skin condition should prompt a wound assessment and be reported to the dietician (CMS Ex. 37, at 7) and that the Unit Manager is required to update the care plan with that information (*id.* at 11). According to the surveyor, the Unit Manager then stated to the surveyor, "I have to take ownership of that. I forgot to notify the Registered Dietician and update [R. 16's] care plan." *Id.*

On appeal, Petitioner does not dispute any of these ALJ findings. Nor does Petitioner proffer any testimony by the Unit Manager disputing the surveyor's testimony that the Unit Manager knew she was required to report the pressure sore to the dietician and update the resident's care plan but failed to do so. Accordingly, the surveyor's testimony on this issue stands undisputed, as does the ALJ's finding that Petitioner's staff did not inform the dietician of the changes in R. 16's skin condition until 27 days after those changes were first noted.

Instead of disputing the ALJ's findings, Petitioner argues that R. 16's condition did not meet the requirements of a significant change in status, and, thus, a care plan meeting was not required. RR at 12. This argument is not material since the ALJ did not base his decision on whether the facility should have held a care plan meeting. Petitioner also argues that R. 16's wound was not a pressure sore, but rather MASD, a "fact" which, it claims, "serves as a basis for all other determinations regarding appropriate care" *Id.* at 11, 13; P. Ex. 1, at 17. Petitioner bases its assertion on the opinions of the DON and Ms. Adaci. *See* P. Ex. 3, at 4; P. Ex. 1, at 17-18. The DON states that, "[f]rom

⁸ There is no dispute that the pressure sore identified on March 13, 2016 involved the same wound (excoriated area) noted on February 27, 2016. In fact, Petitioner states, "This area identified by the nurse [on March 13, 2016] was the exact same area of excoriation noted in the record of January [sic] 27, 2016 that was at the time under a physician's order to be treated with Sivladene [sic] cream for 14 days." RR at 13.

information and training available to us at this time, the area in question would be the definition of” MASD. P. Ex. 3, at 4. The DON also states that “it is now recognized that measuring and staging wounds by multiple staff members can lead to the incorrect conclusion.” *Id.* Finally, the DON states that a pressure sore usually takes between 2-4 months to heal, while R. 16’s wound was “completely resolved” within a month, indicating that the wound was likely MASD. *Id.* at 5.

This after-the-fact contradiction of Petitioner’s own assessment and documentation of R. 9’s wound as a pressure sore – which included assessment and documentation by Petitioner’s wound care nurse – does not raise a genuine dispute of material fact. The record shows that the wound care nurse first documented R. 16’s wound as a pressure sore on March 13, 2016, and continued to document it as a pressure sore (assessed at Stage 3) on March 15, 2016, March 23, 2016, and March 31, 2016. P. Ex. 1, at 178, 183, 184; CMS Ex. 3, at 16-17. On March 13, 2016, the resident’s pressure sore care plan was updated to reflect that treatment was in progress as ordered by the medical doctor. P. Ex. 1, at 173; *see also Lineville Nursing Facility*, DAB No. 1868, at 16 (2003) (Board found it “significant” that the resident’s physician treated the wound as a pressure sore). On March 15, 2016, staff described the pressure sore discovered on March 13, 2016 as “Stage III” and described it as 1.3 cm long, .5 cm wide, and .1 cm deep, contained a scant amount of serous exudate, and had 50% slough and granulation. P. Ex. 1, at 182; *see also id.* at 184 (resident progress note giving the same description)⁹. The surveyor was “specifically told” that R. 16 developed a Stage III pressure sore at the facility during the survey conducted on April 15, 2016. CMS Ex. 37, at 2 (citing CMS ex. 2, at 4). The Board has repeatedly affirmed the importance of contemporaneous clinical documentation. *See, e.g., Putnam Center*, DAB No. 2850, at 20 (2018) (affirming the ALJ’s rejection of physician’s testimony that was not supported by contemporaneous documentation) (citing *Autumn Ridge Rehab. Ctr.*, DAB No. 2467, at 20 (2012) (citing 42 C.F.R. § 483.75(1) – which provides that a SNF must maintain complete and accurate clinical records), and *Embassy Health Care Ctr.*, DAB No. 2327, at 6 (2010) (holding that the duty to document a resident’s condition is part of the quality of care requirement in section 483.25)). Given the extensive contemporaneous documentation of the resident’s pressure sore by staff, and the importance the Board has ascribed to such contemporaneous documentation, we fail to see how a reasonable person could conclude that the post hoc opinions of the DON and Nelia Adaci – that the resident’s wound was actually MASD – create a genuine dispute of fact material to our decision. Even if we were to accept their opinions and credit them over the contemporaneous documentation,

⁹ This exhibit indicates (through a nurse’s editing) that a prior progress note erroneously described the same pressure sore as “Stage II.”

they would not be material since, as discussed below, we agree with the ALJ that the material facts here are the facility's failure to implement interventions designed to prevent development of potential pressure sores.¹⁰

As the ALJ stated, “the possibility that the resident did not develop a pressure sore does not excuse it from implementing the interventions that it had developed for the resident.” ALJ Decision at 6; *see also id.* at 3 (“[A]sserting that [R. 16] did not develop a pressure sore but, in fact, developed some other skin issue, does not relieve Petitioner of its responsibility to implement the protocol that it had prescribed in order to protect the resident from developing sores.”). We agree with the ALJ's assertion that section 483.25(c) “requires a facility to provide care and treatment to address a potential for pressure sore . . . to every resident who is at risk for developing a pressure sore.” *Id.* at 3 (emphasis added); *see also Livingston*, 388 F. 3d 168, 175 (“Th[e] preventive focus of the regulation directs facilities to provide a certain standard of care to prevent the risk of pressure sores for its residents, even if no pressure sores actually develop.”).

We find no error in the ALJ's conclusion that Petitioner did not raise a material dispute of fact precluding summary judgment for CMS that Petitioner was not in compliance with section 483.25(c) with regard to its care of R. 16.

B. The ALJ properly concluded that the CMP amount is not unreasonable.

CMS may impose a per-instance CMP “for each instance that a facility is not in substantial compliance. . . .” 42 C.F.R. § 488.430(a). When CMS imposes a CMP for an instance of noncompliance, it sets the penalty within the range of \$1,000 - \$10,000 per instance. *Id.* §§ 488.408(d)(1)(iv), 488.438(a)(2); 45 C.F.R. § 102.3. A SNF may challenge the reasonableness of the amount of any CMP imposed. *Golden Living Center – Superior*, DAB No. 2768, at 26 (2017)) (citing *Lutheran Home at Trinity Oaks*, DAB No. 2111, at 21 (2007)). An ALJ reviews the amount of the CMP de novo based on the evidence in the record. *Pearsall Nursing and Rehab. Ctr. – North*, DAB No. 2692, at 10 (2016). The ALJ and the Board may consider only the factors specified in 42 C.F.R. § 488.438(f). *See* 42 C.F.R. § 488.438(e)(3).

There is also a presumption that “CMS considered the regulatory factors in choosing a CMP amount and that those factors support the penalty imposed.” *Crawford Healthcare and Rehabilitation*, DAB No. 2738, at 19 (citing decisions). “Accordingly, the burden is not on CMS to present evidence bearing on each regulatory factor, but on the SNF to demonstrate, through argument and the submission of evidence addressing the regulatory

¹⁰ In addition, even if we were to conclude based on these post-hoc opinions that Petitioner's failures of care with respect to R. 16 did not constitute noncompliance (which we do not), we would continue to find noncompliance based on Petitioner's failures of care with respect to R. 9.

factors, that a reduction is necessary to make the CMP amount reasonable.” *Id.* (quoting *Oaks of Mid-City Nursing & Rehab. Center*, DAB No. 2375, at 26-27 (2011) (internal quotation marks omitted)); *see also Brian Ctr. Health & Rehab./Goldsboro*, DAB No. 2336, at 12 (2010) (“[T]he burden is on the [facility] to demonstrate, through argument and the submission of evidence addressing the regulatory factors, that a reduction is necessary to make the CMP amount reasonable.”).

Here, the ALJ found that Petitioner failed to argue that the \$4,663 per-instance penalty amount imposed by CMS would be unreasonable if noncompliance exists, and therefore waived its right to dispute the issue. ALJ Decision at 7. The ALJ also concluded that the CMP amount was reasonable, stating as follows:

It constitutes less than half the amount that CMS is authorized to impose for per-instance noncompliance, a very modest sum given the risks and dangers that are associated with the development of pressure sores by elderly and debilitated individuals. 42 C.F.R. § 488.438(a)(2). As CMS notes, the deficiencies established here are part of a long history of noncompliance by [Petitioner] with Medicare participation requirements. CMS Ex. 18, at 1-4. That history, coupled with the potential for harm of [Petitioner’s] noncompliance in this case, amply justifies the penalty amount.

Id.

Petitioner contends that, contrary to the ALJ’s finding that it did not dispute the amount of the CMP, it argued before the ALJ that the CMP “should be deleted as unreasonable.” RR at 14. We find no merit in this argument. In its request for hearing, Petitioner stated “that the CMP of \$4,663.00 is clearly erroneous and should be removed.” Request for Hearing at 3. In its prehearing brief, Petitioner stated that, “[i]f a deficiency is found to be used in error, then any associated CMP should be deleted as unreasonable.” Petitioner’s Brief at 20. These statements constitute the totality of Petitioner’s arguments regarding the penalty amount before the ALJ. Petitioner did not make any argument as to why the penalty amount is unreasonable based on the factors listed in section 488.438, factors the ALJ considered. Since Petitioner does not challenge the ALJ’s consideration of the regulatory factors found at section 488.438, and since we have found above that noncompliance existed, we sustain his conclusion that the CMP was reasonable. *See Bivins Memorial Nursing Home*, DAB No. 2771, at 13 (2017) (affirming a CMP against a SNF that failed to present an argument based on the regulatory factors).

Conclusion

For the reasons stated above, we affirm the ALJ Decision.

/s/
Christopher S. Randolph

/s/
Leslie A. Sussan

/s/
Sheila Ann Hegy
Presiding Board Member