Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
St. Michael's Nursing Center (CCN: 23-5610),	)	Date: November 25, 2009
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-09-75
	)	Decision No. CR2038
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

Petitioner, St. Michael's Nursing Center (Petitioner or facility), is a long-term care facility located in Detroit, Michigan, that, until recently, participated in the Medicare program. The Centers for Medicare & Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare requirements and has imposed penalties: denial of payment for new admissions (DPNA) and termination. Petitioner here challenges CMS's determinations, and CMS has moved for summary judgment.

For the reasons set forth below, I find that the facility was not in substantial compliance with Medicare program requirements. CMS may therefore impose remedies, including those imposed here. I have no authority to review its determination to do so, nor its selection of remedies.

I. Background

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program, and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no

greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every 12 months, and more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a), 488.308.

Here, following a complaint investigation survey, completed July 23, 2008, CMS determined that the facility was not in substantial compliance with a multitude of Medicare participation requirements, two of which it determined posed immediate jeopardy to resident health and safety. Specifically, CMS found that the facility was not in substantial compliance with the following regulations:

- 42 C.F.R. § 483.13(a) (Tag F221 – physical restraints) at a D level of scope and severity (isolated instance of noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.13(c)(1)(ii)-(iii), (c)(2)-(4) (Tag F225 – staff treatment of residents) at a D level of scope and severity;

- 42 C.F.R. §§ 483.20(d) and 483.20(k)(1) (Tag F279 – comprehensive care plans) at a D level of scope and severity;

- 42 C.F.R. § 483.25 (Tag F309 – quality of care) at a G level of scope and severity (isolated instance of noncompliance that causes actual harm that is not immediate jeopardy);

- 42 C.F.R. § 483.25(c) (Tag F314 – pressure sores) at the immediate jeopardy level of scope and severity);

- 42 C.F.R. § 483.25(h) (Tag F323 – accidents and supervision) at a G level of scope and severity;

- 42 C.F.R. § 483.25(k) (Tag F328 – special needs) at the immediate jeopardy level;

- 42 C.F.R. § 483.30(a) (Tag F353 – nursing services) at an H level of scope and severity (pattern of noncompliance that causes actual harm that is not immediate jeopardy);

- 42 C.F.R. § 483.65(a) (Tag F441 – infection control) at an F level of scope and severity (widespread noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.70 (Tag F454 – physical environment) at an E level of scope and severity (pattern of noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.75 (Tag F490 – administration) at an F level of scope and severity;

- 42 C.F.R. § 483.75(e)(8) (Tag F497 – regular in-service education) at an E level of scope and severity;

- 42 C.F.R. § 483.75(j)(1) (Tag F502 – laboratory services) at an E level of scope and severity;

- 42 C.F.R. § 483.75(l)(1) (Tag F514 – clinical records) at a D level of scope and severity.

CMS Exs. 1, 2.

Based on these findings, CMS denied the facility payment for its new admissions, effective August 30, 2008, and terminated the facility's Medicare/Medicaid provider agreement, effective October 3, 2008. CMS Ex. 2, at 2.

Petitioner timely requested a hearing.

CMS moves for summary affirmance, arguing that undisputed evidence establishes that the facility was not in substantial compliance with 42 C.F.R. §§ 483.25(h) (accidents and supervision), 483.25(k) (special needs), 483.75(e)(8) (regular in-service education), and 483.75(j)(1) (laboratory services). CMS argues that, as a matter of law, it may impose remedies based on the facility's failure to comply substantially with any one of these regulations.

Petitioner has not disputed CMS's argument that it may impose these penalties when a facility is not in substantial compliance with program requirements. However, Petitioner opposes CMS's motion, arguing that, for each of these deficiencies, genuine issues of material fact preclude the entry of summary judgment.

The parties have filed memoranda in support of their positions (CMS Br.; P. Br.). CMS has submitted 14 exhibits (CMS Exs. 1-14). Petitioner has submitted 13 exhibits, numbered P. Exs. 1-6 and P. Exs. 11-17 (P. Exs. 7-10 were not submitted).

II. Issues

I consider whether summary judgment is appropriate.

On the merits, the sole issue before me is whether the facility was in substantial compliance with program requirements. As discussed below, if the facility is not in substantial compliance, CMS may impose a remedy, including those remedies imposed here (denial of payment for new admissions and termination).

III. Discussion

Summary Judgment. Summary judgment is appropriate if a case presents no genuine issue of material fact, and the moving party is entitled to judgment as a matter of law. *Illinois Knights Templar Home*, DAB No. 2274, at 3-4 (2009), and cases cited therein.

The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law, or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to [that party's] case, and on which [that party] will bear the burden of proof at trial." *Livingston Care Center v. Dep't of Health & Human Services*, 388 F.3d 168, 173 (6th Cir. 2004) (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986)). To avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986); s*ee also Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004).

> To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact . . . .

Illinois Knights Templar at 4; *Livingston Care Center*, DAB No. 1871, at 5 (2003).

In examining the evidence for purposes of determining the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *Brightview Care Center*, DAB No. 2132, at 2, 9 (2007); *Livingston Care Center*, 388 F.3d at 172; *Guardian Health Care Center*, DAB No. 1943, at 8 (2004); *but see Brightview*, DAB No. 2132, at 10 (entry of summary judgment upheld where inferences and views of non-moving party are not reasonable). Moreover, drawing

factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cf. Guardian Health Care Center*, DAB No. 1943, at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.").

A. CMS is entitled to summary judgment because the undisputed facts establish that the facility was not in substantial compliance with 42 C.F.R. § 483.25(h); it did not ensure that the resident environment remained as free of accident hazards as possible and did not ensure that each resident received supervision and assistance devices necessary to prevent accidents.[1]

Under the statute and the "quality of care" regulation, each resident must receive, and the facility must provide, the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. Act § 1819(b); 42 C.F.R. § 483.25. The regulation also requires that the facility "ensure" that the resident's environment remains as free of accident hazards as is possible. It must "take reasonable steps to ensure that a resident receives [the] supervision and assistance devices designed to meet his assessed needs and to mitigate foreseeable risks of harm from accidents." *Guardian Health Care Center*, DAB No. 1943, at 18 (2004) (citing 42 C.F.R. § 483.25(h)(2)); *Briarwood Nursing Center*, DAB No. 2115, at 5 (2007). The facility must anticipate what accidents might befall a resident and take steps to prevent them. A facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods must constitute an "adequate" level of supervision under all the circumstances. *Briarwood* at 5; *Windsor Health Care Center*, DAB No. 1902, at 5 (2003).

Resident 513 (R513). R513 was a 54-year-old man suffering from end-stage renal disease, anasarca (massive edema), dementia, bi-polar disorder, and other maladies. CMS Ex. 6, at 8. Although described as alert and oriented to name and place, he was often forgetful and confused. He had a history of behavioral problems, was verbally and physically abusive, and resisted care. CMS Ex. 6, at 18.

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

At least as early as November 2007,[2] the facility recognized that R513 was at risk for injury from falls, and set as a goal "no incident of falls, accident, trauma, or injury" for 90 days. Among the approaches listed in his care plan were to "maintain hazard free environment," "do initial fall risk assessment and up-date every 90 days," and "institute fall protocol." CMS Ex. 6, at 29. Nothing in the record explains the "fall protocol."

R513 nevertheless had a series of accidents, neither well-documented nor investigated, that resulted in minor injuries. CMS Ex. 6 at 29 (on December 29, 2007, resident found on the floor); CMS Ex. 6, at 10, (January 10, 2008 wrist injury); CMS Ex. 6, at 12, 13, 37 (February 19, 2008 "fall at dialysis" injuring head and arm). Except to note the incidents, no changes were made to his care plan following these injuries. CMS Ex. 6, at 29.

R513 required regular hemodialysis, and the facility arranged his transportation to the dialysis center. CMS Ex. 6, at 18. On February 28, 2008, the van driver charged with taking R513 to dialysis left the resident unattended, his wheelchair on the van's lift while he (the driver) went to start the van. The resident flipped backward, hitting his head on the concrete. The driver returned the bleeding resident to the facility, and he was subsequently transferred to the hospital with a left occipital abrasion and hematoma, right knee abrasion, and right rib pain. CMS Ex. 6, at 14-15, 18, 38, 134-149.

In response to this accident, facility staff told the driver never to leave residents unattended. CMS Ex. 6, at 14.

Judging from its report of the incident, the facility's investigation was perfunctory, at best, offering few details, and, aside from instructing the driver not to leave residents unattended, no suggestions for preventive measures. The report is also inaccurate. Notwithstanding R513's earlier falls (CMS Ex. 6, at 12, 13, 29, 37), it says that the resident has had no recent falls or similar incidents. CMS Ex. 6 at 14-15.

Although his November 2007 care plan called for a fall risk assessment, I find no evidence that facility staff performed one until March 19, 2008. Again, even though the record documents multiple falls and multiple injuries from falls – including the very significant incident of February 28 – R513's March 19 fall risk assessment indicates *zero* falls in the preceding three months. Even with this rather significant inaccuracy, R513 still scored 16 on the assessment, where a score of 10 or above represents high risk for falls. CMS Ex. 6, at 34. And yet, no changes were made to his written care plan.

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[2] It seems that R513 was admitted to the facility on November 9, 2007, transferred to St. Johns Hospital on November 10, was readmitted to the facility on November 13, transferred to St. Johns on February 28, 2008, and was readmitted to the facility on March 19, 2008. CMS Ex. 6, at 8.

A physician order dated March 20 calls for pelvic restraint. CMS Ex. 6, at 66. A note dated March 21, 2008 indicates that physical therapy staff evaluated R513's tendency to slide forward in his wheelchair, putting him at risk for falls. She recommended a pommel cushion[3] and "nursing to monitor." CMS Ex. 6, at 41.

An assessment dated March 23, 2008, identifies R513 as at risk for falls related to his "wandering in and out of other resident rooms," his antidepressant and antianxiety medications, and his "inability to ambulate great distances." Curiously, and inexplicably, the assessment again says that he "has had no falls noted." CMS Ex. 6, at 28.

On April 4, 2008, the facility reported that R513's left femur had been fractured, although no one knew how or when the injury occurred. CMS Ex. 6, at 16, 48. In a report dated April 11, 2008, the facility's director of nursing (DON), Kafi Wilson, RN, indicated that on March 27, 2008, R513 complained of discomfort and slight edema, but x-rays of his left ankle, tibia, fibula and knee showed no fracture. *See* P. Ex. 14, at 1, 4, 5. A week later, after he complained of discomfort on his left side, x-rays of his left hip and pelvis showed "slightly displaced intertrochanteric fracture" of left femur. *See* CMS Ex. 6, at 94, 95, 96. He went to the hospital where he underwent surgery to repair the fracture. CMS Ex. 6, at 111-114. According to DON Wilson, interviews with staff, the resident, and his roommate "revealed resident had not sustained any recent falls, trauma or injury since the occurrence on 2/28/08; however, he continued to attempt unassisted transfers, ambulation, and resistance to care since that time." She concluded that "aside from the occurrence on 2/28/08, we are unable to substantiate how this fracture occurred." CMS Ex. 6, at 18-19; *see* CMS Ex. 6, at 20-25.

Staff apparently developed for R513 a new care plan, dated April 13, 2008, which refers to the resident's history of falls, and sets as goals to "identify the least restrictive and most effective restraint," and to minimize the use of restraints within 60 days. Among other approaches, the plan calls for consultation with physical therapy staff "for restraint evaluation," releasing him from his restraints every two hours, and "frequent short contacts with resident to assess needs." CMS Ex. 6, at 31; P. Ex. 14, at 11. The call for a physical therapy consult is puzzling because staff had *already* consulted the physical therapist, who had recommended a pommel cushion and nurse monitoring. CMS Ex. 6, at 41. Yet the new care plan does not refer to that recommendation, and does not call for a pommel cushion or any other new intervention. Further, nurses' notes document that the facility had been restraining R513 at least as early as January 2008, even though restraints were not then incorporated into his care plan. CMS Ex. 6, at 35 ("resident sitting in [wheelchair with] belt, restraint in place"); *see also* CMS Ex. 6, at 40 (March 20 telephone order for "pelvic restraint for maintain safety").

[3] A pommel cushion is a seat cushion designed to provide seating stability.

On June 3, 2008, R513 was found on the floor of his room with a deep cut in his forehead, and was again transferred to the hospital. Staff suggested obtaining an order for a restraint, and a medication assessment, as well as placing him in a low bed to prevent injury. CMS Ex. 6 at 26-27, 51-52, 98, 201-219. But, again, none of these recommendations were added to his care plan.

Petitioner has not disputed any of these facts, but points to the declaration of Licensed Practical Nurse (LPN) Peggye Jackson, a former nurse supervisor at the facility. LPN Jackson provides absolutely no details regarding when, how, or why facility staff implemented interventions to prevent R513 from falls, although she lists generally some preventive measures that she says the facility took: wheelchair use, geri chair use, pommel cushion to prevent sliding, pelvic restraint, and a low bed "when it was appropriate." She also notes that R513 was administered psychotropic medication to control his agitation. P. Ex. 13 (Jackson Decl.).

I accept that, at some time, the facility implemented each of these measures;[4] however, it does not follow that the facility was therefore ensuring an environment as free of accident hazards as possible, or that it was adequately supervising R513. First, not one of the interventions mentioned by LPN Jackson was incorporated into R513's care plan. In fact, the written care plan seems geared toward improving a resident's ability to stand and walk (assess and assist with posture and gait, provide proper shoes, exercise extremities, mop up spills and remove clutter, encourage balance and exercise for long distance ambulations). In contrast, the interventions described by LPN Jackson seem designed for an individual who is unable to stand and walk safely, and must be restrained in a chair. Similarly, DON Wilson's April 4, 2008 accident report suggests that R513's accidents were caused by his unassisted transfers, ambulation, and resistance to care. CMS Ex. 6 at 18-19.

If DON Wilson's opinion as to the causes of R513's falls was correct, and the interventions described by LPN Jackson were the more appropriate, those problems and interventions should have been incorporated into R513's care plan after a comprehensive assessment had been performed. *Ad hoc* measures do not satisfy the regulation, which requires that care and services be provided "in accordance with the comprehensive assessment and plan of care." 42 C.F.R. § 483.25.[5]

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[4] For example, staff initially suggested a low bed in June 2008. I accept that he was eventually provided such a bed, although the record is silent as to when.

[5] Notwithstanding DON Wilson's report, LPN Jackson's declaration, and R513's medical records, Petitioner suggests that R513 ambulation was improving, because he was "actually receiving physical therapy." In a remarkable and wholly unsupported statement, Petitioner claims that "[i]t makes no sense that someone with a falls problem

(…continued)

The record here shows that from November 2007 until at least April 2008 (when staff discovered his unexplained fracture) the facility's principal response to R513's accidents was to ignore or deny them. For most of his injuries, the record shows no investigation. For the more serious incidents, the facility reports only perfunctory investigations.

Although called for in his November 2007 care plan, I see no evidence of any fall risk assessment until March 2008, four months later. CMS Ex. 6, at 34. And, to the extent that facility staff were performing any such assessments, they did not accurately reflect R513's situation. In their assessments and investigations, staff repeatedly reported erroneously that R513 had suffered no falls. CMS Ex. 6, at 14-15 (no recent falls or similar incidents); CMS Ex. 6, at 34 (zero falls in preceding three months); CMS Ex. 6, at 28 (no falls noted). The facility thus did not even accurately describe the extent of the resident's problems. Such errors and inconsistencies show that the facility was not taking reasonable steps to ensure the resident's safety.

The facility should also have carefully investigated each of the accidents involving R513 and accurately re-assessed the resident's condition. It should have developed approaches reasonably related to the resident's situation, and incorporated them into his care plan. It then should have implemented those approaches, and documented their effectiveness.

Finally, Petitioner evidences an unacceptably narrow view of its responsibilities for keeping the resident safe when it disavows any responsibility for R513's February 28, 2008 fall, arguing that the fall was "due to the van driver's negligence," and characterizing the responsible party as "a transportation company that was entirely unrelated by ownership or control" to the facility. P. Br. at 28-29. According to Petitioner, the van driver failed to secure the resident's wheelchair, so it tipped back and he fell and was injured. P. Br. at 28-29; P. Ex. 13 (Jackson Decl.) ("This resident[']s fall on 2/19/08 was strictly the negligence of the van driver leaving the resident at the edge of the elevated ramp not anchored or strapped down.") I agree that R513's injuries were likely the result of negligence on the part of his caregivers. However, I do not agree that

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[5] (continued…)
would be receiving physical therapy if he was actually declining in that regard." P. Br. at 29. In fact, the opposite is true. A resident whose condition is declining would more likely be referred to physical therapy. As LPN Jackson asserts, R513 was receiving physical therapy "to prevent further decline and try to maintain or improve his level of functioning." P. Ex. 13 (Jackson Decl.). Moreover, the physical therapy records describe the resident's decreasing strength, decreasing range of motion and decreasing functional level. P. Ex. 14, at 15-21; CMS Ex. 6 at 56. For purposes of summary judgment, I need not accept the unsupported assertions of counsel. In any event, whether R513's ability to walk was improving is not material to my resolution of this case.

the facility avoids responsibility by distancing itself, administratively, from the transportation company engaged to convey its resident to the dialysis center.

Facilities frequently contract out services, but doing so does not relieve them of their responsibility for the quality of those services. *See* 42 C.F.R. § 483.20(k)(3) (services "arranged by the facility must . . . meet professional standards of quality").

Moreover, as the Departmental Appeals Board ruled in *Liberty Nursing and Rehabilitation Center – Mecklenberg County*, DAB No. 2095 (2007) and *SunBridge Care and Rehabilitation for Pembroke*, DAB No. 2170 (2008), the regulatory term "resident environment" must be construed broadly to protect the residents whose care the facility has undertaken to provide. *Liberty Nursing*, DAB No. 2095, at 8; *SunBridge*, DAB No. 2170, at 28. Specifically applying this principle to transportation, the Board held that "when a facility transports residents under its care in a van, the van is the resident environment, and the regulations [483.25(h)] apply." *Liberty* at 9; *Sunbridge* at 29.

Nor is the facility exempt here because it did not own the van service. In *Eastwood Convalescent Center*, DAB No. 2088 (2007), the Board held the facility accountable for a resident's injuries where, with the knowledge and approval of the facility administrator, the resident's husband undertook to transport her back to the facility. *Eastwood Convalescent Center* at 12-14.

Here, no one disputes that R513 was a seriously ill resident whose behavior problems and resistance to care made him difficult to control. Yet, the facility sent him, unsupervised, to hemodialysis, under the sole "care" of a van driver, without verifying that driver's competence or training to provide R513 the level of supervision he obviously required. By itself, this practice establishes that the facility was not taking reasonable steps to ensure the R513 received the supervision that he needed.

The parties dispute whether R513 was "acting out" when the accident occurred. Pointing to statements from the van driver, CMS claims that he was. Despite having no actual witness or other evidence to suggest otherwise, Petitioner denies that R513 was displaying any behavior problems at the time of his accident. I could simply dismiss Petitioner's claims, since it has not come forward with evidence establishing a dispute of fact. In any event, this purported dispute of fact is not material. Entrusting to the care of a lone van driver an erratic and behaviorally-challenged resident, by itself, violates the regulation.

R513 was not the only resident for whom the facility failed to provide necessary supervision and assistance devices to mitigate foreseeable risks of harm from accidents.

Resident 515 (R515). At the time of the survey, R515 was a 45-year-old woman suffering from bipolar disorder, seizure disorder and other impairments. CMS Ex. 7, at 6.

She apparently used a wheelchair, and the undisputed evidence establishes that she experienced multiple falls.

- A nurse's note dated January 7, 2008, indicates that the nurse, responding to the resident's call light, went to her room and found her on the floor by her bed. The resident reported that she had been attempting to make the bed when she tipped over out of her wheelchair. CMS Ex. 7, at 40. Shortly thereafter, according to a January 9 physical/occupational therapy note, R515 was seen for a falls evaluation. According to the note, the resident did not remember how she lost her balance. Nevertheless, the note says that R515 "is able to transfer" from bed to wheelchair to toilet and back. No recommendations were made. CMS Ex. 7, at 42.

- On January 22, 2008, R515 was found on the floor of her bathroom, with injuries to her right knee and femur that required x-rays. She had fallen while trying to transfer from her wheelchair to the toilet. Staff's response was to encourage her to use her call light to request assistance. CMS Ex. 7, at 7-8, 39.

- On March 8, 2008, R515 was again found on her bathroom floor, with skin abrasions to her right arm. The intervention recommended was "staff to assist with dressing." CMS Ex. 7, at 9-10. According to a separate nurse's note, the resident had put on her call light. When the nurse responded, finding R515 on the floor, the resident said that she had leaned forward to put on her shirt and fell off the toilet. The nurse described a scratch and reddish-blue discoloration on the resident's right arm. Both knees were red. The nurse advised R515 that staff would assist her with dressing. CMS Ex. 7, at 38.

- On March 14, 2008, R515 was found, uninjured, on the floor, although the incident report does not say where, nor does it suggest any preventive measures. CMS Ex. 7, at 11-12. A nurse's note explains that R515 was on the floor in her room. The resident reported that she had been trying to get from her wheelchair to her bed, when she slipped and fell on the floor. Later that day, she complained of right knee pain. CMS Ex. 7, at 37.

- R515 apparently suffered a fall on May 10, 2008, although the record contains no incident report. According to the nurse's note, the nurse responded to the resident's call light, and found the resident on the bathroom floor. The resident said that she was trying to use the toilet, but when she stepped from the wheelchair, she fell to the floor. She complained of hip and leg pain and x-rays were ordered. CMS Ex. 7, at 31, 17.

- On June 9, 2008, R515 was found on the floor of her room. She said that she had been trying to reach her wheelchair. Staff told her to "use the call light for safety." CMS Ex. 7, at 16, 17, 29.

The resident apparently told the surveyor that staff did not respond to her call light. CMS Ex. 1, at 42.

Petitioner does not deny that all of these falls occurred. Petitioner faults the surveyor for purportedly failing to corroborate the resident's statement regarding staff response to her call light, pointing out that R515 had a history of substance abuse, and was considered "manipulative." P. Br. at 29-30; P. Ex. 15, at 6. According to LPN Jackson, R515's "fall activity was mostly related to her attention seeking behavior of sliding out of her chair when she got angry with the [n]urses if she could not have pain medication at non-scheduled times." LPN Jackson also opines that the resident's refusal to rest promoted the "possibility for falls." P. Ex. 13 (Jackson Decl.). LPN Jackson does not identify any specific intervention instituted by the facility to prevent falls.

For summary judgment purposes, I accept Petitioner's claims regarding R515's drug history, efforts to manipulate, and general unreliability. Drawing all inferences in the light most favorable to Petitioner, I accept that R515 lacks credibility, and dismiss, as unreliable, her complaints. However, based solely on the facility's own documents and the allegations of its witness, I find that the facility was not providing R515 adequate supervision and assistance devices to prevent her falls.

I note first that the resident's mental illness and behavior problems do not relieve the facility of its duty to protect her from falls. To the contrary, accepting as true LPN Jackson's claim that R515's falls were attributable to her behavior problems, the facility should have assessed the impact her behavior had on those falls, and implemented interventions to protect her. Facility staff should then have reviewed periodically the effectiveness of those interventions, particularly after she experienced a fall.

But R515's care plans do not identify her behaviors as causes for falls, much less provide any strategy for protecting the resident. Although a plan dated January 8, 2009 describes inappropriate behaviors – depressive neuroses, verbal aggression, agitation, belligerence, lack of cooperation, mood swings, and attention-seeking behavior – it does not mention falls. The plan sets two goals: decreasing episodes of verbally abusive language and attention seeking behavior toward staff, and increasing episodes of accepting care and treatment. The plan says nothing about the resident deliberately sliding out of her chair when angry nor her refusal to rest. P. Ex. 15, at 1.

Nor does the plan even offer any approaches for addressing the problems it identifies. It contains a lengthy check-list of possible approaches with directions to "check all that apply." None are checked. P. Ex. 15, at 1.

A second plan, which is undated, identifies the "potential for injury and trauma." Someone has hand-written onto the printed form references to six falls – those of January 22, March 8, March 14, May 10, June 9 and August 8. The plan's goal is to "prevent injury . . . no incident of falls, accident, trauma or injury in 90 days." The plan then lists a number of general interventions: nursing to assess resident for signs and symptoms of incorrect posture, sliding out of chair, assist resident in correcting posture as necessary; keep call light within reach;[6] provide passive range of motion exercises to extremities, as needed; siderails for safety and mobility; monitor body alignment, encourage balance of rest and exercise; acknowledge the resident's ability to function independently; do initial fall risk assessment and up-date every 90 days; institute fall protocol. At the bottom of the printed form, someone has added half side rails for mobility and safety, although that entry is undated. Under "resolved date/evaluation date" are written 3/12/08 (which, in light of the 90-day review provision, suggests that the plan originated about December 12, 2007) and 6/11/08. P. Ex. 15, at 6.

Aside from the short January 9 physical therapy note saying that R515 was able to transfer among her bed, wheelchair, and toilet, I see no evidence of any assessments. Certainly, by March 14, 2008 – which was the second or third time she fell while attempting to make the transfer – staff should have revisited that January 9 assessment, and should have recognized that the interventions the facility purportedly had in place were inadequate to prevent her from falling.

Based on these undisputed facts, I find that Petitioner failed to take all reasonable steps to prevent R515's falls.

The facility was thus not in substantial compliance with 42 C.F.R. § 483.25(h) and, as discussed below, CMS is authorized to impose penalties.

B. CMS is entitled to summary judgment because the undisputed facts establish that the facility did not provide or obtain laboratory services to meet resident needs, as required by 42 C.F.R. § 483.75(j).

A facility must provide or obtain laboratory services to meet the needs of its residents, and is responsible for the quality and timeliness of the services. 42 C.F.R. § 483.75(j)(1).

CMS lists multiple instances in which the facility failed to provide or obtain ordered laboratory tests:

[6] I note that for at least two of the six cited falls, the nurse states specifically that she was answering the resident's call light, which shows that R515 used the light on those occasions.

Resident 522 (R522). R522 was a 37-year-old man suffering from cerebral palsy, who was dependent on a tracheostomy tube for breathing. In June 2008, he was transferred from the facility to the hospital with sepsis and profound electrolyte disturbances. He was treated with antibiotics and was hydrated aggressively. When stable, he was readmitted to the facility, but staff noted significant edema and he returned to the hospital on June 6, 2008. Among other treatment, hospital physicians ordered that his BUN (blood urea nitrogen) and creatinine be monitored and that his urine output be strictly monitored. CMS Ex. 11, at 42-43, 50. He returned to the facility on June 11, 2008 with a transfer order to monitor BUN. CMS Ex. 1, at 87. On June 12, his physician ordered a complete blood count and electrolyte panel. CMS Ex. 11, at 5. No such tests were performed. On June 26, 2008, R513 suffered a heart attack and died. CMS Ex. 11, at 54-56.

Petitioner concedes that it failed to perform the ordered tests, but claims that since the tests were not ordered "stat," the facility was not required to perform them immediately, and the resident died before they could be performed. LPN Jackson declares that "[r]outine labs can be drawn within [one] week unless otherwise stated by the physician." P. Ex. 13 (Jackson Decl.). For purposes of summary judgment I accept that LPN Jackson is qualified to opine on such issues. I also accept her claim as to the standard of care. *But see Golden Living Center – Frankfurt*, DAB CR1981, at 9-11 (2009). Drawing inferences in the light most favorable to Petitioner, I am even willing to accept that these were "routine" tests (notwithstanding the resident's acute condition and problems with fluid balance). This still means that the tests should have been performed no later than June 18 and 19, and the facility's failure to perform them violated even the somewhat lax standard of care articulated by LPN Jackson.

Resident 527 (R527). R527's physician ordered for her a complete blood count (CBC) every three months. CMS Ex. 12 at 2. At the time of the survey, July 2008, her last CBC had been performed five months earlier, in February 2008. CMS Ex. 1, at 88. Petitioner concedes that the labs were not performed as ordered, but claims that the resident "often refused to have labs drawn," and points out that in July 2008 (at the time of the survey) staff were able to "encourage her to have the lab." P. Br. at 30; P. Ex. 13 (Jackson Decl.); P. Ex. 16, at 8-9. That the resident refuses a blood draw does not justify the two month delay in obtaining ordered laboratory tests. If staff are truly unable to obtain the ordered labs, they should inform the physician, who can then modify his orders. They are not free simply to disregard those orders. Moreover, the surveyors found no record that R527 refused to have her blood drawn at the time the tests were due (May 2008), even though they saw documentation of earlier refusals (in January and February 2008). CMS Ex. 1, at 87-88. Petitioner has neither claimed nor provided any evidence of a May

refusal. Nor does Petitioner claim or provide any evidence of subsequent efforts to comply with the physician's order, prior to the time of the survey.[7]

Resident 528 (R528). R528's physician ordered a monthly CBC, but, according to CMS, tests were not performed in April, May or June 2008. CMS Ex. 1, at 88; CMS Ex. 13, at 2. Again, Petitioner concedes that the tests were not performed as ordered, although it produces (without argument or other explanation for its significance) evidence that blood was drawn on March 31, and test results were reported on April 1, suggesting that it may have complied with the order for the month of April.[8] For summary judgment purposes, I accept that the order was satisfied as of April 1. Nevertheless, no lab tests were performed for more than three months thereafter. As with R527, Petitioner claims that R528 would "periodically" refuse to have blood drawn, and that the labs were drawn "with encouragement" at the time of the survey. P. Ex. 13 (Jackson Decl.). Again, although I accept these assertions as true, I do not consider "periodic" refusals sufficient justification for the facility's three-month-long failure to comply with the physician order. P. Ex. 16, at 6-7. I note also that Petitioner again neither claims nor provides evidence of any specific refusal at that time, nor any staff efforts to comply with the physician's order, prior to the time of the survey.

Resident 511 (R511). R 511 was a 71-year-old man suffering from dementia, seizure disorder, and Dilantin toxicity. CMS Ex. 14, at 5. On May 29, his physician ordered a urinalysis. CMS Ex. 14, at 10. None was performed. Petitioner again concedes that the test was not performed, but points to LPN Jackson's claim that he "did not like giving urine samples and would refuse on almost all attempts." P. Br. at 31; P. Ex. 13 (Jackson Decl.)[9] For purposes of summary judgment, I accept the assertion that R511 regularly refused to provide the sample, but I do not consider this, by itself, sufficient justification for the facility's ongoing failure to follow the physician's order. The facility provides no evidence of staff efforts to obtain a sample from this seriously demented individual. Accepting LPN Jackson's claim that his physician "was advised" of the refusal and opted

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[7] The resident's care plan must describe any required services that have not been provided due to the resident's refusal. 42 C.F.R. § 483.20(k)(1)(ii).

[8] Petitioner also provides evidence that blood was drawn on March 17, 2008, and reported March 18, which it characterizes as the "March report," but offers no explanation for performing the test again two weeks later, rather than a month later. P. Ex. 16, at 4-5.

[9] LPN Jackson also claims that the refusals are "well-documented" but Petitioner provides no such documentation. R511's clinical record does not appear to support her claim. CMS Ex. 14. Nevertheless, for purposes of summary judgment, I draw all reasonable inferences in the light most favorable to Petitioner, and accept her claims.

to obtain the information he wanted from blood tests, the facility should nevertheless have obtained updated physician orders reflecting the change in strategy.

C. CMS is entitled to summary judgment because the undisputed evidence establishes that it failed to provide to all of its nurse aides at least 12 hours of in-service education annually, as required by 42 C.F.R. § 483.75(e)(8).

Facilities are required to provide each nurse aide with regular in-service education, based on the outcome of the aide's annual performance review. The training must be sufficient to ensure the continuing competence of the nurses aides, "but must be no less than 12 hours per year." It must address the area of weakness determined in the performance reviews, and may address the residents' special needs. 42 C.F.R. § 483.75(e)(8).

CMS alleges that the facility failed to provide the required in-service education for five of its nurse aides. For each of these employees, CMS counts the number of education hours from employment anniversary date to employment anniversary date. Petitioner characterizes this method as "arbitrary," and points out that the regulations do not specify any particular means for selecting a 12-month period. But Petitioner proffers no evidence as to the facility's policy for calculating in-service education hours. I do not agree that a facility satisfies the regulation merely by demonstrating 12 hours of training during any 12-month period. The problem with this approach is that it allows for overlapping periods, and thus double-counting of training hours. At a minimum, the facility must show a consistent policy, assuring that each employee has a minimum of 12 in-service education hours each year.

Petitioner limits its argument to one employee, Jamilla Blanding, and claims that "in 2007 alone[,] she had well over the required 12 hours of education," which suggests that the facility calculates employee education hours per calendar year. P. Br. at 32.

Jamilla Blanding was hired on March 24, 1998. CMS has produced the facility's computer print-out for the period March 24, 2007 to March 24, 2008. It shows 8.5 education hours for that year. CMS Ex. 10, at 6. Petitioner produces a similar, but not identical, computer print-out, which shows that CNA Blanding earned only 7.5 education hours in 2007. P. Ex. 17, at 29. I note also that Petitioner's print-out generally lines up with CMS's print out, except that it adds an additional two education hours (purportedly earned on August 28, 2007 and March 24, 2008). However, for reasons it does not explain, Petitioner's print-out runs from March 24, 2007 to September 1, 2008.[10]

[10] According to Petitioner's print-out, between March 24, 2007 and March 24, 2008, CNA Blanding earned 10.5 education hours, short of the mandatory 12.

Nevertheless, Petitioner has also produced some sign-in sheets for training sessions. These show that, in addition to the 2007 hours reflected in Petitioner's computer print-out, Jamilla Blanding signed in for training sessions on January 11, 2007 (P. Ex. 17, at 2), February 21, 2007 (P. Ex. 17, at 4), February 28, 2007 (P. Ex. 17, at 3), March 9, 2007 (P. Ex. 17, at 5), March 13 or 15, 2007 (P. Ex. 17, at 9) and March 16, 2007 (P. Ex. 17, at 11). Accepting all of these submissions for purposes of summary judgment, I agree that Petitioner has pointed to material facts in dispute with respect to CNA Blanding's in-service education requirements.[11]

Similarly, although CMS's computer print-out shows that CNA Katherine Hilton completed 10 training hours between her employment anniversary dates (June 29, 2007 to June 29, 2008), Petitioner's computer print-out shows three additional classes for that period. Notwithstanding the questions raised regarding the discrepancies between the two print-outs, Petitioner has established material facts in dispute regarding CNA Hilton's in-service education hours.[12] CMS Ex. 10, at 5; P. Ex. 17, at 31.

However, Petitioner has not demonstrated material facts in dispute with respect to other employees. According to CMS's computer print-out, Deon King completed 9.5 hours of education between January 11, 2007 (the anniversary of his hiring) and January 11, 2008. CMS Ex. 10, at 3. Petitioner's print-out shows one additional class, August 28, 2007 (for which it provides no staff sign-in sheet), but still falls short of the 12-hour requirement. P. Ex. 17, at 27. Moreover, accepting as true Petitioner's suggestion that it calculated compliance based on calendar year, rather than employment anniversary, CNA King would have completed only 9.5 hours for 2007. The training sign-in sheets that Petitioner supplied reflect the same sessions listed on the computer print-outs (although not the August 28, 2007 session) and do not establish any additional training. P. Ex. 17, at 5, 6,

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[11] But if this matter were not decided on summary judgment, Petitioner would have a lot to explain regarding its documentation of training. Here, for example, why does its computer print-out include the additional August 28, 2007 and March 24, 2008 education hours that are missing from the print-out it provided to the surveyor at the time of the survey? Why are there no sign-in sheets to verify her attendance for that additional training session? Why is Nurse Aide Blanding's signature on the April 4 sign-in sheet markedly different from her signature on the other sign-in sheets? Why does it appear to be the same as the signatures of four other purported attendees (including Deon King and Felice Dillard) whose names immediately precede hers? Why does Deon King's signature differ so markedly on all but two of the sign-in sheets? *Compare* P. Ex. 17 at 5-6, *with* P. Ex. 17, at 10, 12, 13, 14.

[12] Based solely on calendar year 2007, I see evidence that she completed 13 hours of education, although, again, questions arise regarding Petitioner's documentation. P. Ex. 17, at 3, 4, 5, 7, 8, 9, 10, 12, 20.

10, 12, 13, 14. The undisputed evidence thus establishes that CNA King did not satisfy the minimum in-service education requirements.

CMS's computer print-out shows that Nurse Aide Linda Moultire completed 11 hours of education between her employment anniversary dates (January 10, 2007 to January 10, 2008). CMS Ex. 10, at 4. Petitioner's print-out reflects the same number of hours between those two dates. P. Ex. 17, at 23. The training sign-in sheets add no additional hours for calendar year 2007; they reflect some of the classes listed on the print-outs. P. Ex. 17, at 4, 6, 10, 12, 14. The undisputed evidence establishes that CNA Moultrie did not satisfy the minimum in-service education requirements.

Finally, both CMS's and Petitioner's computer print-outs reflect only 10 hours of in-service education for Felece Dillard from January 3, 2007 until January 3, 2008, her employment anniversary dates. CMS Ex. 10, at 7; P. Ex. 17, at 25. The sign-in sheets provided reflect attendance at the sessions listed on the print-outs. P. Ex. 17, at 4, 6, 9, 10, 12, 15, 16. Nor has Petitioner suggested any 12-month period during which she would have completed the requisite training hours.

Thus, the undisputed evidence establishes that at least three of the facility's nurse aides failed to complete the required in-service training, so Petitioner was not in substantial compliance with 42 C.F.R. § 483.75(e)(8).

D. Because the facility was not in substantial compliance with program requirements, CMS may impose a remedy, including termination, and I have no authority to review CMS's determination to impose a remedy nor its choice of remedies.[13]

CMS argues – and Petitioner does not dispute – that "any one of these deficiencies is sufficient to support the remedies appealed by the facility" (denial of payment for new admissions and termination of the facility's provider agreement). CMS Br. at 3.

The statute gives CMS the authority to impose one or more enforcement remedies whenever a facility is not in "substantial compliance," i.e., its deficiencies pose no actual harm but have the potential for causing more than minimal harm. Act § 1819(h); *see also* 42 C.F.R. §§ 488.301, 488.402, 488.406. A facility may not appeal the choice of remedy. 42 C.F.R. §§ 488.408(g)(2), 498.3(d)(11), 498.5 (CMS's choice of remedy is not an initial determination and is therefore not reviewable).

[13] Because the deficiencies discussed above, either individually or collectively, establish that the facility was not in substantial compliance and that CMS therefore has the authority to impose the remedies it has imposed, I need not consider the facility's compliance with 42 C.F.R. § 483.25(k).

The regulations also explicitly allow CMS to terminate a facility's provider agreement if it finds that the facility is not in substantial compliance with program requirements, regardless of whether immediate jeopardy is present. 42 C.F.R. §§ 488.412(a), 488.456(b); *Rosewood Living Center*, DAB No. 2019, at 8-9 (2006).

Thus, because I find that the facility was not in substantial compliance with program requirements, CMS is authorized to impose the remedies it has imposed.

E. The facility must meet program participation requirements without regard to the quality of the survey.

Finally, Petitioner's principal complaint centers around the conduct of the state surveyor, which, it suggests, taints the entire process and shows that "none of the factual allegations in the [statement of deficiencies] can be trusted." P. Br. at 27-28. As the above discussion shows, the facility's own documents and the statement of its witness establish its substantial noncompliance, without regard to surveyor testimony or the allegations set forth in the statement of deficiencies. The issue here is not whether a state surveyor meticulously followed CMS instructions and guidelines, which, though useful, do not constitute enforceable, substantive rules. *Beverly Health & Rehab. Services v. Thompson*, 223 F.Supp. 2d 73, at 99-106 (D.D.C. 2002); *Oakwood Community Center*, DAB No. 2214, at 16 (2008); *Aase Haugen Homes, Inc.*, DAB No. 2013, at 15 (2006). The issue is the facility's own compliance or lack thereof. In this regard, the regulations are explicit: "Inadequate survey performance does not 1) relieve a [skilled nursing facility] or [nursing facility] of its obligation to meet all requirements for program participation; or 2) invalidate adequately documented deficiencies." 42 C.F.R. § 488.318(b).

IV. Conclusion

Accepting as true all of Petitioner's factual assertions, I find that the facility was not in substantial compliance with the Medicare requirements governing quality of care – accidents (42 C.F.R. § 483.25(h)); laboratory services (42 C.F.R. § 483.75(j)); and in-service education (42 C.F.R. § 483.75(e)(8)). CMS was therefore authorized to impose penalties, including denial of payment for new admissions and termination of the facility's Medicare provider agreement. I therefore grant CMS's motion for summary judgment.

/s/
Carolyn Cozad Hughes
Administrative Law Judge