Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Embassy Health Care Center,
(CCN: 14-5316),

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-378

Decision No. CR2226

Date: August 20, 2010

DECISION

This case is before me pursuant to a January 28, 2010 remand from an appellate panel of the Departmental Appeals Board (Board). Consistent with the dictate of the Board, I find that Petitioner was out of substantial compliance with the regulation at 42 C.F.R. § 483.25(h). I further find that the Centers for Medicare and Medicaid Services' (CMS) imposition of a $200 per day civil money penalty (CMP) from March 17 through June 8, 2008 (84 days), amounting to a total CMP of $16,800, is reasonable.

I. Background

Petitioner, Embassy Health Care Center, is a long-term care facility located in Wilmington, Illinois, that participates in the Medicare and Medicaid programs. Four surveys were conducted at Petitioner's facility during the relevant period; on March 17, 2008, April 1, 2008, May 16, 2008, and May 28, 2008, respectively. The March 17 survey involved deficiency citations concerning 42 C.F.R. § 483.13(c)(1)(ii)-(iii) and (c)(2)-(4) (Tag F225, scope and severity level (ss) D) and 42 C.F.R. § 483.25(c) (Tag F314, ss G). The April 1, 2008 survey involved a deficiency under 42 C.F.R. § 483.25(h) (Tag F323, ss G). CMS Exhibits (CMS Exs. 1, 9).

By document titled "Joint Motion to Consolidate and Stipulation of the Parties," dated October 23, 2008, the parties stipulated that the scope of the hearing would be limited to evidence relating to the F314 and F323 Tags from the March 17 and April 1 surveys and that all other deficiency findings would be uncontested.[1]

I conducted an in-person hearing in the case in December 2008 and admitted CMS Exs. 1 through 11 and Petitioner's Exhibits (P. Exs.) 8 through 29, 31, and 34 (also referenced as P. Ex. 32 (Tr. 206-07)). Petitioner did not offer a document as P. Ex. 30 (Petitioner's exchange exhibit list dated November 7, 2008). Each party submitted a post-hearing brief (CMS Br. and P. Br., respectively) and a reply brief (CMS Reply and P. Reply, respectively). A 210-page transcript (Tr.) of the hearing was prepared.

In my decision dated July 24, 2009, I sustained CMS's determination to impose per day CMPs of $200 against Petitioner for the period March 17 through June 8, 2008. *Embassy Health Care Center*, DAB CR1980 (2009). In the interest of judicial economy, I did not address the alleged violation of Tag F323, finding that Petitioner's violation of Tag F314 was a sufficient basis for the enforcement remedies proposed by CMS. Petitioner appealed my decision to the Board.

In its January 28, 2010 decision, the Board found that substantial evidence supported my conclusion that Petitioner failed to comply with Tag F314 and that a $200 per day CMP is reasonable for the period March 17 to April 1, 2008. However, the Board found that I erred in deciding that CMS's finding of noncompliance with Tag F323 from the April 1 survey was not material. The Board found it was undisputed that Petitioner had corrected the noncompliance with Tag F314 by April 1, "so that noncompliance does not provide a basis for a CMP for the period after that date." *Embassy Health Care Center*, DAB No. 2299, at 2 (2010).[2] The Board vacated my decision to uphold the $200 per day CMP for

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[1] Given the Board's instructions on remand, in the event that I did not find Petitioner violated the regulation at Tag F323, the Board directed me to consider whether I could uphold the CMP in this case for the period May 16 through June 8, 2008, based solely on the undisputed findings from the May 16 and May 28 surveys. Since I am upholding the deficiency citation at Tag F323, however, I do not consider the deficiency findings from the latter surveys.

[2] The Board also stated that "absent the finding of noncompliance from the April 1 survey, imposition of a [denial of payment for new admissions (DPNA)] effective June 17, 2008, would not have been mandatory." *Id.* The Board apparently did not consider that CMS found Petitioner in substantial compliance effective June 9, 2008, and that the DPNA never went into effect. CMS's Disposition of Remedies letter dated July 24, 2008 (attached to Petitioner's September 2, 2008 hearing request, which was docketed as C-08-749 and consolidated with C-08-505 by my Order dated October 30, 2008). CMS's Disposition of Remedies letter specifically references that the DPNA was rescinded.

(continued…)

the period April 1 through June 8, 2008, and remanded the case to me for further proceedings.

II. Discussion

I make numbered findings of fact and conclusions of law (Findings) to support my decision. I set them forth below as separate headings in bold and italic type and discuss each in detail.

1. Petitioner failed to comply substantially with the requirements at 42 C.F.R. § 483.25(h).

42 C.F.R. § 483.25 regards a facility's quality of care. It requires 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.

The subsection at 42 C.F.R. § 483.25(h) references accidents and requires that:

> (h) *Accidents.* The facility must ensure that –
>
> > (1) The resident environment remains as free of accident hazards as is possible; and
> >
> > (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

In the case of *Meridian Nursing Center*, DAB No. 2265, at 3 (2009), the Board stated,

> Section 483.25(h)(1) requires that a facility address foreseeable risks of harm from accidents "by identifying and removing hazards, where possible, or where the hazard is unavoidable because of other resident needs, managing the hazard by reducing the risk of accident to the extent possible." Maine Veterans' Home – Scarborough, DAB No. 1975, at 10 (2005). Section 483.25(h)(2) requires that a facility take "all reasonable steps to ensure that a resident receives supervision and

[2] (…continued)

Although the Board directed me to consider the DPNA as a remedy along with my consideration of the $200 per day CMP for the period from April 1 through June 8, 2008 (*Embassy*, DAB No. 2299, at 14), I cannot consider it since the DPNA was rescinded.

> assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents." Briarwood Nursing Center, DAB No. 2115, at 11 (2007), citing Woodstock Care Ctr. v. Thompson, DAB No. 1726 (2000) (facility must take "all reasonable precautions against residents' accidents"), aff'd, Woodstock Care Ctr. v. Thompson, 363 F.3rd 583 (6th Cir. 2003).

The Board also relied on the State Operations Manual (SOM) in defining an accident as,

> "an unexpected, unintended event that can cause a resident bodily injury," excluding "adverse outcomes associated as a direct consequence of treatment or care (e.g., drug side effects or reactions." SOM Appendix PP, Guidance to Surveyors, Part 2, SOP 483.25 Quality of Care (Rev. 274, June 1995) (SOM Guidance).

Woodstock Care Center, DAB No. 1726, at 4 (2000).

The deficiency at issue here concerns Petitioner's care of one resident, Resident 3. The statement of deficiencies dated April 1, 2008, asserts that Petitioner "failed to supervise and assist 1 resident (R3), resulting in R3 falling backwards out of his manual wheel chair and injuring himself." CMS Ex. 9, at 1.

At the relevant time Resident 3 was a 70-year old bilateral lower-limb amputee. CMS Ex. 5, at 1. The facility describes Resident 3 after the fall as "alert" and "oriented" (CMS Ex. 5, at 11) and hospital records after the fall describe that his "[r]ecent memory is intact" and that he "experienced no loss of consciousness." CMS Ex. 5, at 22, 23. Petitioner acknowledges that Resident 3 did not suffer from any cognitive or psychological disorder which would make it impossible for him to follow instructions or wait for assistance. P. Br. at 8-9. There is no evidence of record to suggest that Resident 3 was not an accurate chronicler of events.

The facility prepared an incident/accident report on March 24, 2010. The licensed practical nurse (LPN) preparing the report, LPN Roberts, describes the incident, which occurred about 5:00 p.m., as:

> Res. was in w/c. Stated he fell backwards in w/c trying to roll himself over threshold of doorway.

CMS Ex. 5, at 9. She notes that the resident sustained a small skin tear to his right hand and right forearm. *Id*. She also notes that Resident 3 was in a new wheelchair, which he began using on the day of the fall, and that the wheelchair contributed to the fall because "[n]o stoppee guards on back of w/c." CMS Ex. 5, at 10. She also notes the resident's behaviors did not affect the use of the device. *Id*. In an undated handwritten note, she

states that she wrote her nurse's note "referring to indirect statement of falling backwards in w/c." P. Ex. 22, at 13. In another undated handwritten note she states that Resident 3 was found "lying on back facing outside in doorway and w/c was on back behind him." CMS Ex. 5, at 58.

On March 25, 2010, the director of nursing (DON), DON Foster, reported to the state agency that:

> On 3/24/08 @ 5:30pm, resident [3], a 70 year old white male with diagnosis of IDDM, CAD, COPD, BLE amputation, Hyperlipidemia, Depression, Hypertension, FX left $4^{th}/5^{th}$ pheblaz (sic), URI and Allergic rhinitis, was observed on the floor over the threshold of the doorway in the dining room. The resident was attempting to wheel self outside to smoke when he fell backwards in the wheelchair trying to wheel over the threshold of the doorway. A small skin tear was noted to resident right hand and right forearm. Triple antibiotic ointment was applied. Neurological checks were initiated. The resident complained of a headache i.e. refused Tylenol. Family and Dr. Shah were notified. No new orders.
>
> 8:40pm, the resident complained of back pain i.e. Tylenol given. The family was visiting at the time. Dr. Shah made aware of resident concerns. Order received to send resident to Silver Cross Hospital for an evaluation.
>
> 9:05p.m., the resident was transferred to Silver Cross Hospital for an evaluation x 2 assist. . . .
>
> 1:30am, the resident returned to the facility with diagnosis of a rib fracture i.e. administer Tylenol #3 for pain.

Id. at 15. The DON's report repeats what was noted by LPN Roberts in the nurse's notes for March 24 and 25. CMS Ex. 5, at 33-34.

The parties do not dispute that Resident 3 was given a manual wheelchair after his motorized wheelchair was taken away because of his misuse of it: Resident 3 allegedly ran over a CNA's foot with the motorized device. P. Reply at 7; P. Ex. 22, at 7, 15; CMS Ex. 5, at 44.

Petitioner's maintenance supervisor, Mr. Brazier, testified that over the last three years when Resident 3's motorized wheelchair was broken or out of service, Resident 3 used a manual wheelchair and "seemed to operate it pretty good." However, Mr. Brazier also testified that Resident 3 was without his motorized wheelchair only three times over three

years for only one or two days at a time. Tr. 96-98; *see* P. Ex. 22, at 9. Mr. Brazier further testified that Resident 3 did not always use his motorized wheelchair safely, once running his wheelchair into a door and breaking it trying to go outside to smoke, and once running over a CNA. Tr. 97-99.

On March 24 and 25, 2008, after the accident, Resident 3 was "re-educated" on the proper use of a manual wheelchair. CMS Ex. 5, at 35. The only assessment regarding wheelchair use prior to Resident 3's accident, that of Resident 3's "wheelchair mobility/management training," took place in February of 2005 as part of a physical therapy initial evaluation and plan of care. CMS Ex. 5, at 24-25. It noted that Resident 3 had "poor" sitting balance and "a tendency to fall forward . . . poor trunk control." CMS Ex. 5, at 24. It is also to be noted that the wheelchair assessed was Petitioner's motorized wheelchair ("w/c mob (electric w/c)"). *Id*. Petitioner provided no documentary evidence that Resident 3 had, at any time, been trained or assessed in how to use a manual wheelchair.

Petitioner argues that CMS has not made a *prima facie* case under either 42 C.F.R. § 483.25(h)(1) or (2), asserting that no accident occurred and that the facility did not fail to do what it could to supervise residents or provide assistance devices to minimize accident risks. P. Br. at 7-8.

Petitioner asserts that the injury Resident 3 sustained was not really the result of an accident but a "foreseeable" event given Resident 3's character. Petitioner points to the testimony of Ms. Bates, the social service director of the facility where Resident 3 moved after his discharge from Petitioner's facility, and asserts Ms. Bates' testimony shows that Resident 3 had a habit of acting out his anger and frustration; that Resident 3 had a habit of taking inappropriate self-help measures when he felt that CNAs were not responding to him with "sufficient alacrity"; that Resident 3 was capable of controlling his anger and impatience when threatened with involuntary discharge; and that Resident 3 was capable of entering into a contract to govern his future conduct. Tr. 108-10; P. Br. at 8. Petitioner asserts that on August 24, 2008, instead of simply falling from his wheelchair, Resident 3 "threw himself forward out of the wheelchair in an attempt to demonstrate his dissatisfaction with Embassy's decision to replace his motorized wheelchair in light of several recent aggressive incidents." P. Br. at 8. Petitioner asserts that there was assistance at hand, but not on the "immediate terms" Resident 3 "demanded." *Id*.

Petitioner also argues that at the time of the incident, Resident 3 was appropriately supervised. Petitioner asserts that CNA Schott was prepared to provide assistance. P. Br. at 8-9; P. Reply at 7-8. CNA Schott testified:

> I was working with another resident, and [Resident 3] wanted to go outside of the building to go outside to smoke. I told him to wait and I would help him after I was done with the other resident. He proceeded to bust through the door, and when he went out the door, he fell out of his wheelchair . . . [he] fell forward out of his chair, and after that, I went and got the nurses.

Tr. 191. CNA Schott testified that he saw Resident 3 fall. *Id*. CNA Schott also testified that he was the only CNA supervising 15 residents and, at the time Resident 3 fell, he was helping reposition another resident. He was at least 20 feet away from the door where Resident 3 fell. Tr. 192, 196, 198. Thus, it is not clear whether CNA Schott was in a position to actually see Resident 3 fall. In his contemporaneous note describing the accident, dated March 28, 2008, CNA Schott stated,

> I . . . was in the dining room caring for other residents when [Resident 3] approached the door. I asked resident to please wait and I would assist him. Instead he barged through the door resulting in a fall. I called for the nurse.

P. Ex. 28. There is no mention that Resident 3 fell forward.

Petitioner also asserts that Resident 3's forward fall was not precipitated by his use of the manual wheelchair or Petitioner's failure to assess him for the manual wheelchair. P. Reply at 7. In support of its assertion, Petitioner refers to the February 2005 assessment by its physical therapy department for wheelchair mobility and management training. Tr. 128. And Petitioner argues that it is inappropriate for CMS to infer that rear anti-tippers were installed on Resident 3's wheelchair after the accident because the lack of the anti-tipping devices had caused Resident 3 to fall backward. P. Reply at 9. Petitioner's Administrator, Ms. Bessette, notes in her statement of the incident for informal dispute resolution (IDR) that Petitioner had the necessary assistance devices (front "tipsters") on the wheelchair to prevent accidents. She asserts that Resident 3 had never tipped the chair backwards, and back "tipsters" were not a necessary safety feature for him. Petitioner asserts that Resident 3's chair did not flip backward, and maintains instead that he pulled himself out of his chair going forward. Back "tipsters" or more supervision would not, argues Petitioner, have prevented the incident.[3] P. Ex. 22, at 2. Petitioner argues also that the medical evidence demonstrates that Resident 3 fell forward. *Id.*; Tr.

[3] Petitioner has submitted two handwritten notes from one of its employees regarding discussions the employee allegedly had with residents who purportedly saw Resident 3 fall forward. The discussions allegedly took place on April 15, 2008, several weeks after the incident. I do not find these hearsay statements probative of anything. P. Ex. 22, at 3, 4.

53-55. Petitioner argues that there is no evidence that Resident 3 was more likely to fall from his manual wheelchair than from his motorized wheelchair if he were inclined to act hastily and imprudently. The only supervision that could have guaranteed that he would not fall was one-on-one supervision. P. Reply at 8.

I find Petitioner violated both 42 C.F.R. § 483.25(h)(1) and (2).

There is no question that Resident 3 was a difficult person for whom to care. He had angry outbursts and used his motorized wheelchair in an unsafe manner on several occasions — on the occasions iterated above, and also including an occasion in June 2007 when staff had to chase him in his wheelchair as he tried to reach a park outside the facility and another time when he almost ran over a child at an Easter egg hunt. CMS Ex. 5, at 45; P. Ex. 22, at 15; CMS Br. at 11; P. Br. at 4; CMS Reply at 9. It is Petitioner's responsibility, however, to make sure that its residents are safe from accidental injury. That responsibility includes making all reasonable efforts to prevent such accidents when they are foreseeable. Petitioner recognizes that Resident 3's fall was foreseeable given his character. However, Petitioner attempts to absolve itself of responsibility for Resident 3's accident by blaming Resident 3 for foreseeable behavior that was Petitioner's responsibility to manage. Petitioner simply did not provide an environment as free of accident hazards as possible and did not provide adequate assistance devices to prevent accidental injury pursuant to 42 C.F.R. § 483.25(h)(1) and (2). Moreover, the evidence does not support Petitioner's suggestions that Resident 3 fell forward from his wheelchair or threw himself from his wheelchair.

Petitioner provided Resident 1 with a manual wheelchair, but there is no evidence that Petitioner assessed his ability to use a manual wheelchair nor is there evidence that Petitioner trained him on how to use the manual wheelchair. That Resident 3 may have used a manual wheelchair for a few days over the previous three years without an accident ensuing, as testified to by Mr. Brazier, is no substitute for determining whether he could use a manual wheelchair safely given his poor assessed balance and his previous reliance on a motorized wheelchair.

That Petitioner put some form of guard on the back wheels of Petitioner's manual wheelchair to stop it from tipping backwards after the accident (variously described as anti-tipping, stopper or stopee guards) is consistent with CMS's view that at the time of the accident Petitioner believed that not having the guards on the wheelchair could have led to Resident 3's fall. Petitioner's action is also consistent with its contemporaneous description of how the accident occurred.

Petitioner's argument that Resident 3 purposely threw himself forward from the wheelchair, essentially in a fit of pique, is also without record support. Petitioner's reliance on CNA Schott's latter description of the accident — that Resident 3 fell

forward — is not credible, as his contemporaneous statement of the event does not refer to Resident 3 falling forward. And what is more, CNA Schott was distant from the door and fully occupied with another resident at the time Resident 3 fell.

Petitioner's reference to medical evidence supporting a view that Resident 3 fell forward is without adequate support. While Petitioner discusses Resident 3's medical records as support for its assertion that Resident 3 fell forward, the only testimony Petitioner cites about those records comes from Petitioner's cross-examination of Surveyor Henson-Walker. Surveyor Henson-Walker's only response to Petitioner's counsel's query regarding whether Resident 3's fractured ribs were consistent with a forward fall was "I don't know. You have to speak with the radiologist." P. Br. at 9, citing Tr. 55.

Most important, Resident 3 asserts that he fell backward. Petitioner has nowhere shown that Resident 3 is not a credible chronicler of events. The contemporaneous documentation, prepared by Petitioner's staff, supports Resident 3's statement, and supports a conclusion that Petitioner fell backward while trying to go through the dining room doors to smoke.

It is, however, not even necessary for me to decide whether stoppers were put on the back wheels or whether Resident 3 fell backwards or forwards to decide that Petitioner was deficient. Petitioner provided no evidence that it ever specifically assessed or trained this bilateral lower-limb amputee with poor balance in the use of a manual wheelchair. That failure alone supports my conclusion that Petitioner did not provide an environment as free of accident hazards as possible or provide an adequate assistance device.

Petitioner also failed to provide adequate supervision to prevent an accident. Petitioner's accident was foreseeable. Petitioner knew Resident 3 had a volatile temper, knew Resident 3 was capable of using a wheelchair in a dangerous manner, knew Resident 3 was impatient when he wanted to go outside for a smoke, knew Resident 3 had a history of flouting instructions, and knew Resident 3 had a propensity to ignore CNAs when he wanted to go out to smoke. Petitioner knew that Resident 3 previously had forced his way through the dining room doors when agitated. Yet, knowing this, and having just removed the motorized wheelchair upon which Resident 3 depended for his mobility, Petitioner failed utterly to address Resident 3's behaviors and left Resident 3 in a room (where he had previously forced his way through doors) with only one CNA supervising 15 residents.

2. The amount of the CMP imposed by CMS is reasonable.

Having determined that Petitioner failed to comply substantially with participation requirements from April 1 to May 16, 2008, I must determine whether the $200 per-day CMP for that period is reasonable.

In determining the amount of the CMP, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of non-compliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404; and (4) the facility's degree of culpability.

The lower range of CMP, from $50 to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii).

As noted in my original decision, neither party has contended that the penalty amount should be affected by Petitioner's compliance history or financial condition. Thus, my inquiry is only to whether the deficiency is serious and whether Petitioner is culpable.

The deficiency determination at 42 C.F.R. § 483.25(h) supports a $200 per day CMP. The deficiency is serious and Petitioner is culpable. Petitioner failed to provide an environment as free of accident hazards as possible and failed to provide adequate supervision and assistance devices to Resident 3, such that he fell from his wheelchair and sustained an injury, constituting actual harm. Petitioner's culpability is enhanced by its insistence that it was Resident 3's throwing himself from his wheelchair that caused the injury, not an accidental fall or a failure on Petitioner's part to supervise the resident. Petitioner's argument shows that even now Petitioner fails to understand that it was required to assure that Resident 3 could safely use the manual wheelchair. Given Resident 3's history and mood, one on one monitoring during the transition period might have been required for adequate supervision. At a minimum, however, Petitioner should have assessed and trained the resident on the manual wheelchair, and assured that there was sufficient supervision of the resident while he adjusted to the manual wheelchair to prevent injury to Resident 3 or any of Petitioner's other residents.

III. Conclusion

For the foregoing reasons, I conclude that there is a basis for imposition of a CMP and that a $200 per day CMP for the period April 1 to June 8, 2008, is a reasonable remedy for Petitioner's noncompliance. Thus, the $200 per day CMP imposed by CMS from March 17 through June 8, 2008, amounting to a total CMP of $16,800, is reasonable.

/s/
Richard J. Smith
Administrative Law Judge