Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Life Care Center of Merrimack Valley,
(CCN: 22-5546),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-4177

Decision No. CR4965

Date: November 6, 2017

DECISION

I grant summary judgment sustaining the determination of the Centers for Medicare & Medicaid Services (CMS) to impose a civil money penalty of $850, for one day of noncompliance, against Petitioner, Life Care Center of Merrimack Valley, a skilled nursing facility.

I. Introduction

This case was assigned originally to another administrative law judge and was reassigned to me only recently. CMS moved for summary judgment. Petitioner opposed the motion. In support of its motion CMS filed nine exhibits, identified as CMS Ex. 1-CMS Ex. 9.[1] Petitioner filed 14 exhibits, identified as P. Ex. 1-P. Ex. 14. I make no ruling in this decision as to the admissibility of these exhibits. I cite to them only to the extent that they support findings of material facts that are not in dispute.

II. Issues, Findings of Fact and Conclusions of Law

[1] CMS later submitted an exhibit identified as CMS Ex. 10.

A. Issue

The sole issue disputed by the parties is whether Petitioner failed to comply substantially with a regulation governing its participation in the Medicare program. Petitioner offered no argument or evidence to assert that a penalty of $850 would be unreasonable if I sustain a finding of noncompliance.

B. Findings of Fact and Conclusions of Law

CMS asserts that Petitioner failed to comply substantially with 42 C.F.R. § 483.25(h). This regulation mandates a skilled nursing facility to ensure that its resident environment remain as free of accident hazards as is possible and to provide each of its residents with adequate supervision and assistance devices to prevent that resident from sustaining accidents. CMS contends that Petitioner contravened this regulation because it failed to provide a resident – identified as Resident # 1 – with adequate supervision. I find that the undisputed material facts provide ample support for this contention.

These facts are undisputed. Resident # 1 was severely impaired. He was admitted to Petitioner's facility in August 2014 suffering from the effects of a stroke and dementia. CMS Ex. 5. The resident's impairments included hemiplegia on the left side and weakness. *Id.* The extent of the resident's disability was such that he could be transferred and positioned only with the assistance of two of Petitioner's staff. CMS Ex. 1 at 8; CMS Ex. 4 at 1.

Resident # 1 was unable to ambulate independently. During waking hours the resident was confined to a Broda Chair, a kind of reclining wheelchair. His left arm was essentially non-functional, with the staff assessing it as being flaccid through the elbow and wrist, with decreased sensory function. CMS Ex. 2 at 6.

Petitioner's staff recognized that Resident # 1 was in need of close supervision, both in order to provide assistance to the resident but also to assure that the resident did not accidentally harm himself. The staff assessed the resident as being at high risk for falls. CMS Ex. 4 at 1. Furthermore, the staff concluded that the resident had decreased safety awareness. CMS Ex. 5. Staff observed that Resident # 1 required frequent monitoring due to his tendency to scoot around in the Broda Chair and to move the left arm-supporting pillow. CMS Ex. 6 at 3. Petitioner's staff sometimes observed the resident's left arm hanging over the Broda Chair. *Id.* at 6, 9, 13, 15, 17, 19, 21, 23, 25. Petitioner directed its staff to monitor Resident # 1's environment for hazards. The resident's physician ordered that the resident's left, non-functional arm rest on a pillow at all times. CMS Ex. 1 at 8.

The resident spent much of his time in the day room of Petitioner's facility. CMS Ex. 1 at 9. However, after lunch on March 28, 2015, Resident # 1 requested to watch television in his room. Two of Petitioner's nurses positioned the resident's Broda Chair in the room so that he could watch television. CMS Ex. 1 at 7, 10; CMS Ex. 2 at 1-2. They observed the resident to be sliding in the chair and repositioned him. CMS Ex. 2 at 2; CMS Ex. 6 at 13.

At 2:30 p.m. on the afternoon of March 28 a nurse concluded (evidently based on observation) that the resident was positioned in his room in the Broda chair with his left arm on a pillow. No staff member visited the resident between 2:30 and 3:15 p.m. At 3:15 p.m., a certified nursing assistant (CNA) observed the resident's Broda chair to be next to a baseboard heating unit in the room. His left arm was dangling over the Broda Chair and his fingers were resting on the baseboard heater. CMS Ex. 1 at 10-11; CMS Ex. 2 at 3; CMS Ex. 7 at 1. As a consequence, the resident sustained burns on the thumb and two fingers of his left hand. CMS Ex. 1 at 11.

These facts establish an obvious failure by Petitioner's staff to supervise Resident # 1 consistent with the requirements of 42 C.F.R. § 483.25(h). Resident # 1's disabilities, both physical and mental, rendered the resident essentially helpless. The resident was unable to ambulate and unable to use his left arm, which was flaccid from the elbow down. Staff assessed the resident to be at risk, a risk that was elevated by the resident's own lack of safety awareness. The staff knew also that the resident needed to be supervised in order to keep him safe and protected. Despite that, they left the resident unattended for a period of 45 minutes on March 28, 2015, resulting in an accident that caused the resident to sustain burns on his left hand.

Petitioner makes several arguments in opposition to CMS's motion. I find these arguments to be without merit.

First, Petitioner asserts that at two levels of informal review state and federal authorities found Petitioner not to be culpable and ordered that the allegations of noncompliance be removed. That may be so but it has no bearing on the outcome of this case. As Petitioner concedes, CMS may reject informal dispute resolution findings and it plainly did so here. Furthermore, I am not bound by the outcome of informal review processes. In adjudicating this case I am charged with examining the evidence de novo. Here, I have looked at the allegations of noncompliance solely in light of the undisputed facts and I find that these facts establish a regulatory violation.

Petitioner also claims that there is a disputed issue of fact concerning what happened to Resident # 1 on March 28, 2015. In its motion CMS contends that Petitioner's staff initially positioned Resident # 1 close to the baseboard heating unit in his room and in a way that enabled the resident's left hand to come into contact with the unit if the arm fell off the Broda Chair. Petitioner disputes this, contending that the staff initially positioned

the resident away from the baseboard heating unit and in a safe location. Petitioner posits that the resident must have somehow repositioned the Broda Chair, thus enabling contact with the heating unit.

This fact dispute is irrelevant. I do not find Petitioner to be noncompliant because of the manner in which the staff initially positioned Resident # 1. Noncompliance is a consequence of the failure of the staff to supervise the resident for a period of 45 minutes on March 28, 2015. Indeed, if the resident was able to move his chair close to the heating unit while unsupervised and the resident was known to lack safety awareness, that underscores the need for supervision and the consequences of not supervising the resident.

Petitioner asserts that CMS is unreasonably holding it to a standard of strict liability, a standard that is not contemplated by the regulation. According to Petitioner: "The plain language of the regulation makes clear that the law does not make a nursing facility the guarantor of its residents' safety. . . ." Petitioner's Prehearing Brief and Reply to CMS' Motion for Summary Judgment, at 15. I disagree. The regulation plainly *does* make a skilled nursing facility the "guarantor of its residents' safety." That is evident in the regulation's requirement that a skilled nursing facility provide its residents with the necessary supervision and assistance devices to avoid accidents. The Departmental Appeals Board has held on innumerable occasions that the regulation requires a facility to take all reasonable measures to protect its residents.

Here, the undisputed facts unequivocally establish that the resident was not only helpless but that he was at risk for harm due to poor safety awareness. Petitioner's staff knew that the resident had no motor function in his left arm, at least from his elbow to his wrist, and the staff knew also that the resident's arm had a tendency to dangle from the Broda Chair in contravention of the resident's physicians' order that the resident's arm rest on a pillow at all times. This knowledge imposed a burden on Petitioner and its staff to assure that the resident received adequate supervision and assistance to avoid precisely the type of accident that the resident sustained.

That is not to suggest that Petitioner is strictly liable for any accident sustained by Resident # 1. The regulation, while it requires a facility to do its utmost to guarantee a resident's safety, does not contemplate that a facility anticipate and address hazards or risks that would not be apparent to a reasonable and diligent observer. But, here, the danger to Resident # 1 was not only apparent, it had been noted by Petitioner's staff. The staff knew that the resident was at risk for injury resulting from his left arm falling from the armrest of his Broda Chair. That knowledge imposed on the staff a duty to supervise the resident to assure that such events were minimized. Petitioner's staff failed to meet its obligations when it left the resident unattended for 45 minutes on March 28, 2015.

Petitioner also questions the severity of the burns suffered by Resident # 1, asserting that the resident required only minor first aid. The potential for harm is evident from the very real injuries sustained by the resident, whether or not they were minor. In addition, I find this "no harm, no foul" argument to be irrelevant. The issue is not whether the resident suffered a severe injury but whether there was a foreseeable possibility that the resident could suffer harm from the staff's failure to supervise him adequately. That possibility is evident from the staff's assessment of the resident.

/s/
Steven T. Kessel
Administrative Law Judge