Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Heritage Plaza Nursing Center,
(CCN: 67-5561),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-706

Decision No. CR4771

Date: January 17, 2017

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose civil money penalties in the amount of $1650 per day against Petitioner, Heritage Plaza Nursing Center, for a period that began on April 23, 2016, and that continued through May 21, 2016.

I. Background

Petitioner, a skilled nursing facility, requested a hearing in order to challenge CMS's findings that Petitioner had failed to comply substantially with Medicare participation requirements and CMS's remedy determination. CMS filed a pre-hearing brief and 52 proposed exhibits that are identified as CMS Ex. 1-CMS Ex. 52. Petitioner filed a pre-hearing brief without proposed exhibits. Neither CMS nor Petitioner requested that I convene an in-person hearing.

Petitioner objected to my receiving CMS Ex. 3 and 39 on the ground that these exhibits contain inadmissible hearsay. I overrule this objection. This proceeding is not governed by the Federal Rules of Evidence. I generally admit hearsay with the caveat that I may

not choose to rely on hearsay evidence if I find it to be unreliable. I note that, although I overrule Petitioner's objection to these exhibits, I do not rely on them in deciding this case.

Petitioner also objects to my receiving CMS Ex. 48-52 on the ground that CMS filed them untimely, more than a week after my deadline for pre-hearing submissions by CMS. That is plainly a violation of my pre-hearing order in this case and I considered whether to exclude these exhibits for that reason. However, the failure to submit them timely is harmless error in this case. Petitioner still had ample time to reply to these exhibits and I would have granted it an extension of time had it requested one. Moreover, I do not rely on CMS Ex. 48-52 in deciding this case.

I receive CMS Ex. 1-CMS Ex. 52 into the record. I decide this case based on the parties' written exchanges.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues are whether Petitioner failed to comply substantially with Medicare participation requirements and whether CMS's remedy determination is reasonable.

B. Findings of Fact and Conclusions of Law

CMS alleges that Petitioner failed to comply substantially with numerous Medicare conditions of participation. Principally, however, CMS asserts that Petitioner failed to comply substantially with the requirements of two regulations: 42 C.F.R. § 483.13(c), which requires a skilled nursing facility to develop and implement policies preventing neglect or abuse of residents; and 42 C.F.R. § 483.25(h), which requires a skilled nursing facility to assure that its resident environment remain free from accident hazards and to ensure that each resident receives adequate supervision and assistance devices to prevent accidents.

As I discuss below, the evidence amply supports CMS's findings of noncompliance with these two regulations. Petitioner's noncompliance was serious. Residents suffered harm as a consequence of Petitioner's failure to adequately protect them against falls. I find that Petitioner's noncompliance with the two regulations is sufficient basis to justify the $1650 daily civil money penalties that CMS determined to impose. Consequently, I find it unnecessary that I address CMS's additional findings of noncompliance.

The gravamen of CMS's case is that Petitioner failed to protect several residents who were at high risk for sustaining falls. CMS contends that Petitioner's staff assessed these residents as being at risk for falls. Residents fell – and several of them fell repeatedly

over a period of days – but, according to CMS, Petitioner failed to develop or to implement measures that might have protected them. CMS alleges that one of these residents, Resident # 18, sustained a serious injury to her knee as a consequence of falling while unsupervised by Petitioner's staff.

Resident # 18 is a relatively young woman – 67 years old at the time of Petitioner's alleged noncompliance – who entered Petitioner's facility with multiple physical impairments. CMS Ex. 24 at 3. Petitioner's staff assessed this resident as having problems with balance that required her to be assisted. *Id.* at 19. The staff found the resident to be at risk for falls. *Id.* at 10.

Shortly after admission to Petitioner's facility, Resident # 18 fell while trying to exit a shower. Her injury was serious, necessitating surgery on her right knee to repair damaged tendons. CMS Ex. 24 at 31-33, 42-44, 159-160, 181-182. A nursing assistant was present when the resident sustained this fall. However, the assistant did not assist the resident.

The evidence presented by CMS as to Resident # 18 plainly supports a finding of noncompliance with the requirements of 42 C.F.R. §§ 483.13(c) and 483.25(h). Resident # 18 was at risk for falls by virtue of her numerous physical impairments. Petitioner's staff recognized this risk and assessed the resident as being at risk for falls. The staff concluded that the resident at the least required close supervision and physical assistance. But, the staff stood by without offering assistance as the resident fell while exiting a shower, sustaining a severe physical injury.

Petitioner argues that its staff provided Resident # 18 with all of the assistance that the resident required, given the staff's assessment of the resident's limitations. It contends that the resident was weight bearing, as of the time of her admission to Petitioner's facility, and that the resident required supervision but not physical assistance in making transfers. CMS Ex. 24 at 18-19. It concedes that Petitioner's physical therapy staff assessed the resident as needing moderate assistance with transfers, but it asserts that there was insufficient time to communicate this assessment to Petitioner's staff. Petitioner acknowledges that the nursing assistant failed to physically assist Resident # 18 as she attempted to exit the shower. It states: "[The resident] only required supervision while taking and exiting the shower and that was the supervision she was provided." Petitioner's pre-hearing brief at 7.[1]

[1] Petitioner's nursing notes state that the resident fell while a nursing assistant was assisting her exit from a shower chair. CMS Ex. 24 at 5, 33. The notes do not explain what sort of assistance the nursing assistant provided. I do not infer that the assistant was attempting to provide physical assistance and support given Petitioner's admission that the assistance consisted only of supervision.

I find these arguments to be unpersuasive. Petitioner's arguments notwithstanding, Resident # 18 was a known falls risk and an individual who the staff assessed as needing help. Yet, the staff stood by and allowed the resident to attempt to exit a shower – a clearly hazardous activity – without providing necessary assistance to the resident.

As Petitioner acknowledges, its physical therapy staff found that Resident # 18 needed physical assistance with transfers. Petitioner provided no evidence to support its contention that there was inadequate time to communicate this assessment to the remainder of Petitioner's staff. Indeed, a finding such as the one made by the physical therapy staff should have been communicated *immediately* to Petitioner's general staff given the resident's obvious vulnerability. Petitioner's arguments notwithstanding, Resident # 18 was a known falls risk and an individual who the staff assessed as needing help.

CMS argues that Petitioner failed to provide necessary assistance to a second resident, identified as Resident # 12, notwithstanding that the resident sustained multiple falls during a period of several days. Resident # 12 was 89 years old during the period in question. She suffered from multiple physical impairments and dementia. CMS Ex. 18 at 19-20. Petitioner's staff concluded that this resident was at a high risk for falls and that she required extensive assistance with her activities of daily living. *Id.* at 24, 111-114. In other words, this resident was essentially helpless due to her cognitive and physical impairments and she depended on Petitioner's staff for help with all of her activities.

Resident # 12 fell ten times during a period that ran from March 20 through April 13, 2016. CMS Ex. 18 at 25-62. On one day during this period – March 24 – the resident fell three times. *Id.* at 46. On one occasion – March 20 – the resident sustained a laceration to her head and a hematoma from a fall, necessitating that she be sent to a hospital emergency room. *Id.* at 31-33. She paid another visit to the emergency room after her multiple falls on March 24. *Id.* at 46.

CMS contends that Petitioner implemented no new interventions designed to protect the resident during the course of the three-week period that she sustained multiple falls. Petitioner strongly contests this assertion. According to Petitioner, it implemented numerous interventions during the period. These included putting needed items within reach of the resident as she sat in her wheelchair, placing the resident near Petitioner's nursing station so that she could receive increased supervision, putting an anti-roll back device on the resident's wheelchair, and supplying the resident with a chair alarm pursuant to a physician's order. Petitioner also contends that its staff expressed concern to Resident # 12's physician about the possibility that the resident's medication might be making her drowsy, thereby contributing to her risk for falling. Petitioner contends additionally that it raised the issue of the resident's medication with a pharmacy consultant.

I agree with Petitioner that it provided Resident # 12 with new or enhanced interventions during the period that the resident sustained multiple falls. The question remains, however, whether those interventions were adequate. I find that they were not. Petitioner could have and should have done more to protect this resident. The measures that Petitioner took do not justify its failure to take additional reasonable and necessary measures.

Petitioner acknowledges that there was one additional measure that its staff could have implemented during the period when the resident sustained her many falls but that it did not implement. That would have been to provide the resident with continuous supervision, at least during the hours when the resident was awake. Petitioner's justification for not providing this measure was that this measure would have been a restraint, something that is not permitted by applicable regulations. It also asserts, baldly, that nursing facilities simply aren't equipped to provide such supervision to their residents.

I disagree with these contentions. Continuous supervision is not a restraint. Restraints are something that physically restricts a resident's freedom of movement or his or her ability to make choices and decisions. Historically, restraints have consisted of devices that tie a resident to a wheelchair or a bed or that sedate a resident sufficiently so that the resident loses the will or incentive to move. Supervision is totally different. It may be as benign as simply watching a resident in order to assure that the resident does not engage in risky or dangerous activities. It may be more active, including keeping the resident's attention diverted from possibly dangerous actions. But, supervision does not and should not include restraining the resident.

Petitioner acknowledges that all of the measures it took to protect Resident # 12 failed. The resident fell often, including multiple falls on one day, and she injured herself on more than one occasion. She was at grave risk for injury every moment that she was not supervised and Petitioner's staff should have recognized that risk to the resident. In this case, close supervision was necessary, at least until Petitioner's staff devised alternative means of protecting Resident # 12.

I do not accept Petitioner's assertion that close supervision of the resident wasn't feasible. It has offered neither explanation for this assertion nor evidence to support it.

CMS alleges additionally that Petitioner neglected the needs of a third resident, Resident # 11. This resident was 93 years old during the time period that is at issue here. She suffered from multiple physical and mental impairments. Petitioner's staff assessed the resident as being at a high risk for falls due to her unsteady gait and her impaired cognitive status. CMS Ex. 17 at 3, 74. This resident fell often. She fell eight times during a period running from January 19 through February 15, 2016. *Id.* at 3-39, 97-99, 106-110. CMS contends that Petitioner failed to evaluate the effectiveness of whatever

interventions it had put in place for the resident or to modify or replace interventions as needed, notwithstanding that the interventions that were in place failed to protect the resident against sustaining falls.

Petitioner asserts that various interventions were in place during the period that the resident sustained multiple falls, including placing non-slip strips in the resident's room and bathroom, re-education of the resident in how to request assistance, increased supervision, and treatment of a urinary tract infection that the resident sustained. However, Petitioner does not address CMS's central argument: Petitioner's failure to assess the efficacy of its interventions notwithstanding the plain evidence that the resident continued to fall despite the actions taken by Petitioner and its staff. As is the case with Resident #12, Petitioner contends that close supervision of Resident # 11 was out of the question. But, again, Petitioner does not explain *why* this measure could not have been implemented.

Finally, CMS contends that Petitioner neglected to care for the needs of, and to supervise adequately, a fourth resident, Resident # 20. This resident, a 20-year old woman, suffered from numerous physical impairments, including partial paralysis on her left side. CMS Ex. 26 at 7-8. Petitioner's staff assessed the resident as being greatly impaired and at a high risk for falls. *Id.* at 11-13. She required extensive assistance by one person for most transfers and assistance by two or more persons for toilet use. *Id.* at 39-42.

Petitioner had a policy covering transfers requiring the assistance of two or more individuals. In that circumstance use of an assistance device known as a "gait belt" was mandatory. CMS Ex. 47 at 40. CMS contends, based on a report by the resident, that Petitioner's staff never used a gait belt in transferring Resident # 20.

Petitioner's failure to use a gait belt in assisting Resident # 20 violates regulatory requirements. The fact that use of a gait belt was mandatory policy meant that Petitioner's staff had determined that employment of such a device was absolutely necessary in order to safely transfer gravely impaired residents such as Resident # 20. The staff might conclude in an individual case that the use of a gait belt would be unnecessary or even counterproductive. But, in that event, it would be incumbent on the staff to explain *why* it wasn't following Petitioner's mandatory policy. Nothing of the sort was done here. The staff simply did not use the gait belt in transferring Resident # 20 and it offered no explanation for its failure to do so.

Petitioner offers nothing to refute the resident's report that the staff never used the belt. It effectively concedes that its staff didn't use the belt. Petitioner argues that there is no regulatory policy requiring its staff to use a gait belt and that the staff's repeated violation of facility policy in the case of Resident # 20 does not rise to the level of a regulatory violation.

I disagree. The policy requiring use of a gait belt meant that this was an intervention that the staff had to use in transferring Resident # 20. As I have discussed, use of the belt was absolutely necessary barring an assessment that the belt's use was unnecessary or counterproductive. The repeated failure to use a gait belt in transferring Resident # 20 plainly was a failure to implement a necessary intervention and it constituted both neglect and a failure to provide the resident with a necessary assistance device.

The evidence establishes a pattern of neglectful behavior by Petitioner's staff and a consistent failure to protect residents against evident accident hazards or to provide those residents with necessary assistance devices. CMS determined that this noncompliance caused residents to experience actual harm. On that basis CMS determined that a civil money penalty of $1650 per day was reasonable. It also determined that the penalty should be applied for each day of a period extending from April 23 through May 21, 2016, because Petitioner did not correct its deficiencies prior to May 21. I find CMS's remedy determination to be reasonable.

For non-immediate jeopardy level deficiencies, such as the ones that I address here, the permissible range of per-diem penalties is from $50 to $3000 per day. 42 C.F.R. § 488.438(a)(1)(ii). Where within that range a penalty amount falls depends on assessment of factors that include the seriousness of a facility's noncompliance, its culpability, its compliance history, and its financial condition. 42 C.F.R. §§ 488.438(f)(1)-(4), 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)).

CMS asserts, and I agree, that the seriousness of Petitioner's noncompliance justifies the penalty amount. The penalty amount of $1650 is only slightly more than one-half the maximum amount for non-immediate jeopardy level deficiencies. That is eminently reasonable given the nature of Petitioner's noncompliance and the fact that residents suffered harm as a consequence. As I have discussed, this case involves a pattern of neglectful behavior by Petitioner's staff.

Petitioner does not object to the duration of the penalty. It argues only that the penalty amount is unreasonable because it contends that it was in compliance with regulatory requirements. I have explained why I disagree with Petitioner's assertions of compliance.

At the inception of this decision I stated that it was unnecessary that I rule on the validity of CMS's assertion that Petitioner failed to comply with additional regulatory requirements beyond the two that I addressed. The gravity of Petitioner's noncompliance with 42 C.F.R. §§ 483.13(c) and 483.25(h) is sufficient to justify both the penalty amount and duration.

_____/s/_____
Steven T. Kessel
Administrative Law Judge