Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Parkview Care Center,
(CCN: 165306),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-1926

Decision No. CR4135

Date: August 19, 2015

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose civil money penalties of $400 per day against Petitioner, Parkview Care Center, a skilled nursing facility, for a 24-day period.

I. Background

Petitioner requested a hearing to challenge CMS's remedy determination. I held a hearing by video teleconference on April 23, 2015. At the hearing CMS offered, and I received into evidence, exhibits that are identified as CMS Ex. 1 – CMS Ex. 6. Petitioner offered, and I received into evidence, exhibits that are identified as P. Ex. A – P. Ex. I.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues are whether:

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

2. CMS's remedy determination is reasonable.

B. Findings of Fact and Conclusions of Law

CMS alleges that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h). This regulation requires that a skilled nursing facility ensure that: (1) its resident environment remains as free from accident hazards as is possible; and (2) each resident receives adequate supervision and assistance devices to prevent accidents.

CMS's noncompliance allegations center on the care that Petitioner's staff gave to a resident who is identified as Resident # 1. The resident had sustained a fall prior to her admission to Petitioner's facility that resulted in a broken hip. Her diagnoses included non-Alzheimer's dementia. CMS Ex. 1 at 32 – 69, 145.

Petitioner's staff assessed the resident to be a highly dependent individual. She displayed moderate cognitive impairment that included episodes of disorganized thinking or inattention, easy distraction, and difficulty understanding what was said to her. She was an individual who needed substantial assistance from Petitioner's staff for all of the activities of daily living. She required help with bed mobility, transfers from her bed, ambulation, dressing, personal hygiene, and toilet use. She was unsteady on her feet and needed staff assistance in order to stabilize her when she: walked; moved from a seated to a standing position; turned; got on or off the toilet; and transferred from bed to wheelchair or vice versa. CMS Ex. 2 at 2.

These limitations and impairments made Resident # 1 extremely prone to sustaining injuries from falls. CMS Ex. 1 at 100. The resident's noncompliance with staff instruction and her persistent attempts to move without assistance put her at heightened risk. The resident often attempted to transfer without assistance even though Petitioner's staff reminded her to request help with transfers. Petitioner's staff observed multiple attempts by the resident to transfer without asking for staff aid. *Id.* at 83. The staff found the resident to be "very non-compliant . . . ." *Id.* at 87. On more than one occasion the resident failed to use her call light to seek assistance from Petitioner's staff despite being reminded to do so. *Id.* at 89.

On May 21, 2014, Resident # 1 fell while unattended by Petitioner's staff. She had attempted to ambulate from her wheelchair without seeking staff assistance. CMS Ex. 1 at 120-21. She became non-responsive on May 22 and was transferred to a hospital, where she expired on May 23, 2014. Her May 21 fall was listed as a cause of death. CMS Ex. 1 at 116, 148-58, 160.

Petitioner's staff recognized that Resident # 1 was at a grave risk for injury or death resulting from a fall and it implemented measures that were intended to protect the resident. Principally, the staff instituted checks of the resident at 15-minute intervals. *See* CMS Ex. 1 at 103; 123-40. Petitioner contends that it did other things as well that were designed to protect the resident, including: physical therapy; occupational therapy; use of assistive devices; encouraging the resident to participate in activities; taking the resident to the facility dining room at meal times; taking the resident to the nurses' station; and placing the resident in a room that was close to the nurses' station. Petitioner's post-hearing brief at 3; CMS Ex. 1 at 60-61, 103-08; P. Ex. E at ¶ 27; P. Ex. F at ¶ 25.

The question is whether Petitioner took all reasonable measures necessary to protect Resident # 1. The staff certainly knew that the resident was noncompliant with staff instructions and that the resident repeatedly attempted to ambulate without support by the staff or without requesting staff assistance. The staff also knew that the resident's noncompliance with staff instructions and her attempts to ambulate without assistance were at least in part the product of her dementia.

Most important, Petitioner's staff knew that the 15-minute checks that it had implemented for Resident # 1 were ineffective.[1] On various occasions Petitioner's staff noted that the resident was noncompliant *despite* the staff's implementation of 15-minute checks. For example, on May 9, 2014, the staff noted that the resident was "non-compliant [with] asking for help to get out of bed . . . ." CMS Ex. 1 at 79. On May 11, the staff found that the resident had made multiple attempts to get up and ambulate without assistance. *Id.* at 83. On May 13, the staff observed that the resident was "very non-compliant [with] her transfer status . . . ." *Id.* at 87. The following day, May 14, 2014, staff noted that that the resident was non-compliant with using her call light for assistance. *Id.* at 89. And, on May 16, 2014, the staff concluded that Resident # 1:

> Attempted several times to get out of bed [without] assistance [and] attempt to ambulate despite 15 minute checks. [Resident] is not using her call light. Despite teaching [and] reminders from staff . . . .

Id. at 93. Later on that date, the resident was observed being up by herself and headed for her bathroom. *Id.*

Petitioner contends that there were only six days – out of the resident's 24-day stay at its facility – in which staff noted that the resident was noncompliant with the staff's

[1] There is a dispute as to whether 15-minute checks were performed on the date when Resident # 1 sustained her fatal fall. I find it unnecessary to resolve this dispute. The checks were ineffective even if they were being performed punctually.

instructions respecting assistance. Petitioner's post-hearing brief at 8. It argues that the resident was generally compliant and that this is proof that Petitioner did not have to consider undertaking additional steps to protect her. But, the fact is that the resident was often noncompliant with staff instructions. As I have discussed, the staff noted her noncompliance on numerous occasions. This resident needed assistance from the staff at all times when she attempted to ambulate. Even a few isolated incidents of noncompliance with staff instructions should have put the staff on notice that its protections were not adequate.

I find that Petitioner failed to fulfill its duty to protect Resident # 1 against accidents in light of its staff's knowledge that the protective measures that it had implemented – including the 15-minute checks – were ineffective. A facility's duty to protect a resident from accidents is to take all reasonable measures that are necessary to provide protection. It is not enough for the staff to identify an accident risk and to implement some protective measures. The staff must continually assess whether those measures work. If the staff determines that measures aren't working then it is incumbent on the staff to come up with additional or replacement measures that might be more effective. The point is that the process of assessment and adjustment is continual.

Here, Petitioner knew that the measures that its staff had taken to protect Resident # 1 weren't working. The staff identified repeated instances in which the resident had been noncompliant with staff instructions and was attempting to ambulate without assistance. That knowledge should have triggered a thorough review by the staff of the measures it had undertaken to protect the resident – including 15-minute checks – and the staff should have considered implementing replacement measures or additional measures. But, in this case the staff neither reviewed the efficacy of its measures nor did it implement new or additional measures. It simply continued doing what it had been doing despite the knowledge that previously implemented measures weren't working. That is not compliance with the requirements of 42 C.F.R. § 483.25(h).

Petitioner contends that it is being held accountable to an unattainable and unlawful standard. It argues, essentially, that CMS would penalize it simply because Resident # 1 sustained a fall. Petitioner likens CMS's allegations of noncompliance to an assertion of a strict liability standard. Petitioner's pre-hearing brief at 12-13.

I disagree. Petitioner's noncompliance in this case is not the result of Resident # 1 falling. I would find Petitioner to have been noncompliant even if the resident had *never* sustained a fall while she was at Petitioner's facility. Petitioner's noncompliance is the consequence of its failure to respond appropriately to knowledge that the measures that it had taken to protect the resident were ineffective. As I have stated, Petitioner's staff knew that the resident was continuing to attempt to ambulate unassisted despite the fact that the staff had implemented 15-minute checks. It therefore knew that the checks were

not protecting the resident. Given that, the staff was obligated to consider other protective measures. Petitioner's noncompliance relates directly to Petitioner's failure to consider and/or take other measures.

Petitioner argues also that the 15-minute checks that it implemented were actually effective inasmuch as the resident had not sustained a fall prior to May 21, 2014 while residing at Petitioner's facility. Petitioner's post-hearing brief at 9-10. I find this argument to be without merit. The fact that the resident sustained no falls prior to May 21 was not the consequence of 15-minute checks. That she hadn't fallen was simply fortuitous. The checks obviously were not doing what they were intended to do, which was to prevent the resident from ambulating without assistance. The staff's notes show that the resident actually attempted to ambulate without assistance many times despite the implementation of 15-minute checks. On at least one occasion the staff observed the resident ambulating without assistance. CMS Ex. 1 at 93.

Petitioner contends also that the only recourse that was left open to it was to use "physical and/or chemical restraints" as a means to protect Resident # 1 from falling. Petitioner's pre-hearing brief at 13. I am not persuaded by this argument. CMS is not contending that Petitioner ought to have utilized some specific protocol to protect the resident and it certainly is not advocating for the use of physical or chemical restraints.[2] But, there clearly are measures that are within reason that Petitioner might have implemented but that it did not attempt. For example, Petitioner does not explain why it did not implement heightened surveillance of the resident. It asserts that it positioned the resident at the facility's nurses' station from time to time but it doesn't explain why it couldn't have done that more often or for longer periods. It does not explain why it did not use bed and/or chair alarms to protect the resident.

Petitioner asserts that it is a "no alarm/no restraint" facility. Petitioner's pre-hearing brief at 13. Evidently, it contends that not supplying Resident # 1 with a bed or a chair alarm was consistent with facility policy. There is nothing in regulations governing a skilled nursing facility that prohibits a facility from using a bed or a chair alarm in appropriate circumstances. But, if a facility opts not to use alarms (and that certainly was Petitioner's right) then it must come up with alternatives designed to protect its residents that work. In this case, not employing an alarm meant that the facility needed to increase its surveillance of the resident, given that 15-minute checks were not protecting her.

Petitioner asserts that the measures it undertook to protect Resident # 1 – including 15-minute checks – were consistent with the applicable standards of care governing fall-prone residents in skilled nursing facilities. It cites various protocols to support this

[2] The use of physical or chemical restraints is prohibited under most circumstances.

argument. Petitioner's post-hearing brief at 11-13. But, nothing cited by Petitioner suggests that it was limited to implementing 15-minute checks or that it was immune from a finding of noncompliance if it implemented such checks.

Petitioner argues additionally that no remedy may be imposed against it because the measures it took to protect Resident # 1 were consistent with the resident's care plan. Petitioner's pre-hearing brief at 15. A facility may be held to be noncompliant with regulatory requirements when it fails to implement a care plan for one of its residents. But, implementing a care plan does not protect a facility from a finding of noncompliance if implementation does not provide the resident with adequate protection. That is precisely the case here. Petitioner may have implemented its care plan, which called for 15-minute checks of the resident, but that was palpably not enough to protect her. Here, implementation was inadequate to attain compliance with regulatory requirements.

I find that the civil money penalties that CMS determined to impose against Petitioner, $400 per day for 24 days of noncompliance, are reasonable. Although Petitioner contends that it was in fact complying with participation requirements, it has not argued that it corrected the noncompliance identified by CMS at an earlier date than that which was determined by CMS. Thus, CMS's determination as to duration of noncompliance is unchallenged by any evidence offered by Petitioner.

That leaves only the question of penalty amount. Regulations governing civil money penalties permit CMS to impose daily penalties of between $50 and $3000 for any noncompliance that does not constitute immediate jeopardy for a resident or residents of a skilled nursing facility. 42 C.F.R. § 488.438(a)(ii). The penalty amount of $400 per day falls within the $50 - $3000 range.

What is reasonable within a range of penalties depends on consideration of a number of factors including the seriousness of a facility's noncompliance, its history of compliance, and its ability to pay a civil money penalty. 42 C.F.R. § 488.438(f), incorporating 42 C.F.R. § 488.404 into 42 C.F.R. § 488.438(f)(3). CMS has not asserted that Petitioner's noncompliance history should be considered as a reason for imposing penalties of $400 per day. Rather, it premises the penalty amount on the seriousness of Petitioner's noncompliance.

I find that the seriousness of the noncompliance amply justifies the penalty amount. The noncompliance in this case was serious. Petitioner's staff knew that Resident # 1 was at grave risk for injury from falling, it knew that the resident was engaging in behavior that was endangering herself, and it knew that the measures it had implemented to protect the resident were ineffective. Despite this knowledge Petitioner did not consider or implement new or additional measures that might have provided the resident with more protection. That is a serious breach of regulatory requirements because the potential for harm to the resident from noncompliance was very high. A penalty amount of $400 per

day is actually quite modest, only slightly more than ten percent of the allowable maximum and it is certainly reasonable given the seriousness of Petitioner's noncompliance.

Petitioner offered no evidence showing that it lacks the wherewithal to pay the penalties imposed by CMS.

/s/
Steven T. Kessel
Administrative Law Judge