Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Resurrection Nursing and Rehabilitation Center
(CCN: 14-5324),

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket Nos. C-09-502 and C-09-680

Decision No. CR2292

Date: December 8, 2010

DECISION

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to impose civil money penalties of $300 per day against Petitioner, Resurrection Nursing and Rehabilitation Center, for each day of a period that began on March 31, 2009 and that ended on April 21, 2009.

I. Background

Petitioner is a skilled nursing facility in Park Ridge, Illinois. It participates in the Medicare program. Its participation in Medicare is governed by sections 1819 and 1866 of the Social Security Act (Act) and by regulations at 42 C.F.R. Parts 483 and 488. Its hearing rights in this case are governed by regulations at 42 C.F.R. Part 498.

Petitioner was surveyed on several occasions in 2009 to determine whether it was complying with Medicare participation requirements. Surveys were completed on January 28, 2009, January 30, 2009 (Life Safety Code), and April 3, 2009 (April Survey). Findings of noncompliance were made at each of these surveys. CMS concurred with

these findings and determined to impose remedies against Petitioner consisting of civil money penalties of $300 per day for each day of a period that began on January 28, 2009 and that continued through April 21, 2009.

Petitioner requested a hearing to challenge CMS's determination, by letter dated June 5, 2009. The case was docketed as C-09-502 and assigned to another administrative law judge. Petitioner filed a second request for hearing dated August 25, 2009, and that was docketed as C-09-680. The two cases were consolidated under C-09-502 by order dated September 9, 2009. CMS filed a motion for partial summary judgment. Petitioner responded by conceding that it had not complied substantially with Medicare participation requirements during a period that began on January 28, 2009 and that continued through March 30, 2009. It conceded also that penalties of $300 for each day of this period were reasonable. On April 1, 2010, the administrative law judge to whom the case was then assigned issued an order granting partial summary judgment to CMS and sustaining civil money penalties of $300 per day for each day of the January 28 – March 30, 2009 period.

What remained to be heard and decided after the entry of partial summary judgment were the issues of Petitioner's compliance beginning with March 31, 2009 and continuing through April 21, 2009, and the reasonableness of the $300 per day civil money penalties that CMS had determined to impose to address the additional alleged noncompliance. The noncompliance finding that remained at issue was made at the April 3 Survey. Noncompliance findings that were made at previous surveys were no longer at issue by virtue of the uncontested issuance of partial summary judgment.

In August 2010, the consolidated case was reassigned to me. On September 13, 2010, I conducted a hearing by telephone solely to address the remaining issues of noncompliance and remedy. I received into evidence exhibits from CMS consisting of CMS Ex. 18 through CMS Ex. 35. I received into evidence exhibits from Petitioner consisting of P. Ex. 1 – P. Ex. 32. I heard the cross-examination, redirect, and re-cross examination testimony of a single witness, Ms. Cleose Shawley.

II. Issues, Findings of Fact, and Conclusions of Law

A. Issues

The issues in this case are whether:

1. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h)(2).

2. Civil money penalties of $300 per day are reasonable in amount and duration.

B. Findings of Fact and Conclusions of Law

I make the following findings of fact and conclusions of law (Findings).

1. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h)(2).

The regulation at issue requires a skilled nursing facility to ensure that each of its residents receives adequate supervision and assistance devices to prevent accidents. The regulation has been the subject of much litigation. It does not make a facility per se liable for accidents sustained by its residents. But, it does impose on a facility the duty to take all reasonable measures to protect its residents against known or foreseeable accident hazards. In practice, that means that a facility must: assess each of its residents to determine what, if any, risks that resident may encounter; plan the resident's care to account for the risks that are identified; and implement each and every element of the plan of care.

CMS's allegations of noncompliance in this case center on the care that Petitioner gave to a resident who is identified as Resident # 1. The resident was 81 years old on February 13, 2009, when he was transferred to Petitioner's facility from a hospital. CMS Ex. 24 at 1; CMS Ex. 27, at 1. On January 26, 2009, the resident had slipped and fallen on his driveway while trying to get out of his car and had fractured his left hip. CMS Ex. 26 at 4-5. The hip was surgically repaired on January 27, 2009. *Id.* at 4. The resident was then transferred into a rehabilitation unit at the hospital, where he stayed until his transfer to Petitioner's facility.

The rehabilitation unit sent documents to Petitioner's facility along with the resident. These documents contained both assessments of the resident's condition and recommendations about the care that he should receive. They included a Patient Information and Transfer form that was completed on February 13, 2009. CMS Ex. 26. Resident # 1 was assessed as alert but forgetful. *Id.* at 2. The rehabilitation center recommended that the resident be given a commode chair and a rolling walker. *Id.* at 3; P. Ex. 20.

The resident received an occupational therapy evaluation by Petitioner's staff on February 13, 2009, the date of his admission to the facility. CMS Ex. 27 at 15; P. Ex. 11. The occupational therapist assessed the resident's mental functioning as being within normal limits. *Id.* The resident was found to require moderate assistance in daily activities, including using the bathroom. *Id.*

On February 14, 2009, the resident received a physical therapy evaluation at Petitioner's facility. The resident told the physical therapist that he felt very weak. CMS Ex. 27 at

13; P. Ex. 23. The physical therapist assessed the resident as having impaired: joint mobility; motor function; balance; ability to transfer; and gait and ability to walk. She also noted that the resident was experiencing pain. *Id.*

Petitioner developed a care plan to address the resident's safety issues. CMS Ex. 27 at 3; P. Ex. 22, at 2. The care plan identified the resident as being at risk for injuries from falls. *Id.* However, the plan made no mention of providing the resident with a walker or with a commode chair, or with other devices designed to protect him against falling. The care plan contained an apparently pre-printed line, which enabled Petitioner's staff to list any assistance devices that were being supplied to the resident. The staff left this line blank. Nor did the care plan attempt to reconcile and resolve the conflicting assessments of the resident's memory.

On the afternoon of February 14, 2009, Resident # 1 sustained a fall while alone in his room. CMS Ex. 27 at 9. The resident explained to the nursing assistant who discovered him that he had wanted to go to the toilet but had slipped and fallen while attempting to walk unaided. *Id.* The resident was transferred from Petitioner's facility back to the hospital later on February 14, after it was determined that he had fractured his right hip. *Id.* at 11.

I find that these facts plainly establish a failure by Petitioner to take all reasonable measures to protect Resident # 1. Petitioner's staff failed to assess the resident to determine whether or not he needed the assistance devices that had been recommended by the hospital's rehabilitation center and failed to make a definitive determination about whether the resident might have memory problems that required special assistance.

Petitioner's staff was put on notice when the resident arrived at the facility on February 13, 2009, that this resident might need some special assistance to protect him against falling. The rehabilitation center at which the resident had resided for approximately two weeks prior to his transfer to Petitioner's facility had assessed the resident as needing a rolling walker and a commode chair to facilitate his toileting. These devices were explicitly recommended as part of the transfer documentation. The recommendations put the burden on Petitioner's staff to either supply Resident # 1 with the recommended devices, or to explain why, in their judgment, it was not appropriate to supply him with them. At the least, the staff had the obligation to make an informed judgment as to whether the recommendations made by the rehabilitation center were necessary interventions for the resident. However, the staff failed to make such an assessment. There is nothing in the record of this case showing that the staff even considered whether the resident might benefit from a walker or a commode chair.

The staff was also faced with conflicting advice as to whether Resident # 1 suffered from memory impairment. The rehabilitation center, after having treated the resident for about two weeks, found him to be alert but forgetful, suggesting that he might suffer from some

cognitive deficit. In contrast, Petitioner's occupational therapist assessed the resident's mental functioning to be within normal limits. It was important for the staff to resolve this issue, because, if the resident did suffer from memory problems, it might affect his ability to remember advice given to him by the staff. However, nothing in the record shows that the staff addressed the conflicting assessments and came to a conclusion as to whether or not the resident in fact suffered from memory deficit.

Petitioner argues that it was not reasonably foreseeable that Resident # 1 would attempt to get out of bed on his own on the 14th of February. Additionally, it asserts that it had taken reasonable measures to address the resident's risk of falling. I find these arguments not to be persuasive.

Petitioner concedes that Resident # 1 presented a high risk for falling. But, according to Petitioner, it addressed that risk in the resident's care plan by keeping a call light button within reach of the resident while he was in bed. Petitioner's Final Brief at 6; CMS Ex. 27 at 3. This intervention, according to Petitioner, constituted "reasonable and appropriate supervision" to address the resident's risk of falling. Petitioner's Final Brief at 6. Petitioner predicates this argument on its contention that the resident was not cognitively impaired and that it had no reason to assume that he was cognitively impaired and would not have known how to use the call light. As support, Petitioner relies on the testimony of the resident's treating physician, one of its nurses, and the nursing assistant who cared for Resident # 1. P. Ex. 26 at ¶ 8; P. Ex. 25 at ¶¶ 11-14; P. Ex. 30 at ¶¶ 9-12.

I find Petitioner's arguments and the supporting testimony to constitute a post-hoc rationalization for its staff's failure to address the possibility that the resident suffered from memory deficit. As I have discussed, the staff was faced with conflicting opinions as to whether Resident # 1 had memory deficit. Obviously, the staff assumed that the resident had no memory deficit or, possibly, they simply did not consider the issue of memory in planning the resident's care. But, in fact, they had at least some evidence suggesting that the resident did have a memory deficit. That was the conclusion of the staff at the rehabilitation center, where the resident was a patient for approximately two weeks just prior to coming to Petitioner's facility.

Petitioner now contends that its staff's interactions with Resident # 1 during the day that he was in the facility provide unequivocal proof that the resident suffered no cognitive impairment. I find this assertion to be unpersuasive for two reasons. First, there is no evidence that Petitioner's staff systematically addressed the issue of the resident's cognition. Nothing in the record shows that the staff tested the resident's memory to determine whether it was safe to rely on a call light in lieu of other assistance devices. There is nothing in the record showing how the occupational therapist concluded that the resident's cognition was within normal limits. It is unclear how long she spent with the resident or what type of interview she conducted.

Furthermore, the testimony of Petitioner's witnesses that Resident # 1 suffered from no cognitive deficits is not dispositive of this question. Dr. Joseph Sadowski avers that he examined the resident on February 14, 2009, and that he found him to be "alert, awake and oriented x3." P. Ex. 26 at ¶ 5. He asserts that the resident understood his instructions and did not display any signs of confusion, agitation, or forgetfulness. *Id.* But, Dr. Sadowski does not aver explicitly that he tested the resident's short term memory or made objective findings as to whether the resident suffered from a memory loss.

Kristine Ignacio is a registered nurse who provided care for Resident # 1. She avers that the resident was able to recall: the current season; location of his own room; staff names/faces; and that he was in a skilled nursing facility. P. Ex. 25 at ¶ 13. However, she does not aver that the resident was ever tested to determine whether he could remember to use the call light in his room when he needed assistance.

Ms. Angelina Toscano, the nursing assistant who cared for Resident # 1, avers in her declaration that the resident was able to understand instructions and was able to express his needs and communicate in a very clear and concise manner. P. Ex. 30 at ¶ 12. However, there is nothing in Ms. Toscano's background or training to suggest that she is competent to assess a resident's cognitive functioning. Moreover, when Ms. Toscano was interviewed by a surveyor during the April Survey, she told the surveyor that she found Resident # 1 to be forgetful. CMS Ex. 29 at 16.

Petitioner's staff chose to rely on a device – a call light – that would only be a reliable protection against the resident falling if the resident suffered from no memory deficit. They chose to rely on that device in lieu of any other assistance device that would protect the resident against falling if he attempted to leave his bed. Given that choice, it was incumbent on the staff to rule out any possibility that the resident might not remember how or whether to use the call light if he needed assistance. In view of the resident's history of forgetfulness at the rehabilitation center, that meant that the staff needed to test the resident carefully and systematically to assure that he could understand how to use the call light. It meant also that the staff should have resolved any doubts that might exist about the resident's memory, even if that meant consulting with the staff at the rehabilitation center. They failed to take these measures. I conclude that relying on the call light, to the exclusion of other safety measures, was not a reasonable decision by the staff, given their failure to assure that the resident's memory and cognitive functioning were unimpaired.

Petitioner has offered no cogent explanation for its staff's failure to provide the resident with other recommended assistance devices including a commode chair and a rolling walker. Both of these devices had been recommended by the rehabilitation center and these devices were obviously thought of by that entity as protection against the resident falling. Yet, Petitioner failed to address either of them in its planning for Resident # 1's

care. There is simply nothing in the record suggesting that the staff considered whether or not the resident needed these devices.

Petitioner argues that the discharge form did not call for a bedside commode but merely had the words "commode chair" circled. Petitioner's Final Brief at 8. From this, and based on the evaluation of Resident 1 by Petitioner's occupational therapist, Petitioner asserts that there was really no recommendation that the resident receive a commode. I disagree. The rehabilitation center clearly intended its recommendation that the resident receive a commode. That is the only possible inference that one can draw from the fact that the term is circled on the Patient Discharge Form that the rehabilitation center supplied to Petitioner. CMS Ex. 26 at 3; P. Ex. 20. Arguably, there is ambiguity in that the form does not explicitly specify that the commode be at the resident's bedside, although logically, that is where one might expect that a commode be situated. But, that possible ambiguity does not mean that the rehabilitation center made no recommendation, only that the recommendation needed to be clarified. If nothing else, Petitioner's staff could have spoken with the rehabilitation center to determine exactly what was being recommended. There is no evidence that they did so.

Petitioner now offers the testimony of Ms. Elizabeth Leak, the occupational therapist who wrote the recommendation that a commode chair be given to the resident. She avers that she wanted the commode chair to be used in the resident's bathroom to assist the resident to position himself on the toilet. She avers also that she did not believe that the resident needed a bedside commode. P. Ex. 32 at ¶ 7.

I have no reason to doubt the veracity of this testimony. However, none of this was known to Petitioner's staff at the time that Resident # 1 went to the facility. It is arguable, with hindsight, that Petitioner's staff might have concluded reasonably that no commode was necessary for the resident's bedside had they consulted with Ms. Leak when the resident first arrived. But, the staff conducted no consultation and had no way of knowing precisely what Ms. Leak was recommending other than that she recommended that the resident receive a commode chair.

Furthermore, Petitioner failed to carry out Ms. Leak's recommendation even as subsequently clarified by her. Had staff consulted with her, they would have known that she at least recommended that a commode chair be placed in the resident's bathroom to guard against his falling there. They did not consult, and they did not carry out this recommendation.

Petitioner has offered no explanation for its failure to supply Resident # 1 with a rolling walker. That device was recommended by the rehabilitation center, and it was consistent with the fall risk assessed both by that center and Petitioner's own staff. Yet, Petitioner never supplied one to the resident, nor has it offered any evidence showing that its staff made a reasoned determination that a walker was not needed.

2. CMS's remedy determination is reasonable.

The remedy that is at issue here is a $300 per day civil money penalty that CMS imposed for each day of a period that began on March 31, 2009 and that ended on April 21, 2009. Petitioner has not argued that it corrected its noncompliance earlier than April 21, nor has it offered any argument that the penalty amount is unreasonable. The failure of Petitioner to raise the issues of duration and penalty amount is reason enough for me to sustain CMS's remedy determination.

Moreover, the evidence of record establishes CMS's penalty determination to be reasonable. The penalty amount – $300 per day – is quite low, comprising only ten percent of the maximum allowable penalty for noncompliance that is not at the immediate jeopardy level. 42 C.F.R. § 488.438(a)(1)(ii). The seriousness of Petitioner's noncompliance, moreover, provides ample reason to sustain the penalty amount. The evidence proves that Petitioner failed to take all reasonable measures necessary to protect Resident # 1 against accidental falls. That failure put the resident at risk for injury.

/s/
Steven T. Kessel
Administrative Law Judge