Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Lompoc Healthcare District	)	Date: July 22, 2009
Convalescent Care Center,	)	
(CCN: 05-5256),	)	
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-08-568
	)	Decision No. CR1978
Centers for Medicare & Medicaid	)	
Services.	)	
	)	

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose a per-instance civil money penalty of $3,000 against Petitioner, Lompoc Healthcare District Convalescent Care Center. I also sustain CMS's determination to impose a denial of payment for new Medicare admissions against Petitioner for a period that began on May 22, 2008 and which ran through June 3, 2008.

I. Background

Petitioner is a skilled nursing facility doing business in the State of California. It participates in Medicare. Its participation in that program is governed by sections 1819 and 1866 of the Social Security Act and by implementing regulations at 42 C.F.R. Parts 483 and 488.

CMS determined to impose against Petitioner the remedies that I describe in the opening paragraph of this decision. CMS based its determination on noncompliance findings made at a survey of Petitioner's facility that was completed on April 11, 2008 (April survey). Petitioner requested a hearing and

the case was assigned to me for a hearing and a decision. I scheduled an in-person hearing. However, the parties agreed that the case could be heard and decided based on their written submissions.

CMS filed 40 proposed exhibits which it identified as CMS Ex. 1 – CMS Ex. 40. Petitioner filed 24 proposed exhibits which it identified as P. Ex. 1 – P. Ex. 24. CMS moved that I exclude portions of some of Petitioner's exhibits. I denied that motion. I receive into evidence CMS Ex. 1 – CMS Ex. 40 and P. Ex. 1 – P. Ex. 24.

II. Issues, findings of fact and conclusions of law

A. Issues

The issues are whether:

1. Petitioner failed to comply substantially with Medicare participation requirements; and

2. CMS's remedy determinations are reasonable.

B. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below as a separate heading.

The noncompliance findings of the April survey include allegations that Petitioner failed to comply substantially with several Medicare participation requirements. In this decision I address one of those findings, Petitioner's alleged failure to comply with the requirements of 42 C.F.R. § 483.25(h). As I discuss below the weight of the evidence strongly supports the noncompliance finding. Petitioner's noncompliance with this regulatory requirement is sufficient to sustain CMS's remedy determinations. Therefore, it is unnecessary that I address the other noncompliance findings.

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

A skilled nursing facility must ensure that each of its residents receives adequate supervision and assistance devices to prevent accidents. 42 C.F.R. § 483.25(h)(2). This requirement imposes several duties on a facility. First, the facility must assess each of its residents in order to identify every known or knowable risk of

accidents that the resident is at risk of encountering. Second, the facility must plan the resident's care in accordance with its assessment in order to assure that every reasonable measure is taken to protect the resident. Finally, the facility must implement its care plan so as to provide actual protection to the resident.

The process of caring for a resident is dynamic as are the duties owed by a facility to its residents. A resident's condition is rarely static and the facility's knowledge of the resident's condition and the hazards that he or she may encounter evolves with the passage of time. A facility must continuously readjust its assessment of each resident's risks and problems as the staff learns more about the resident's condition or the resident's condition evolves. New or amended assessments must be translated into revised care plans and these must be implemented.

CMS's allegations of noncompliance focus on the care that Petitioner gave to two residents who are identified in the April survey report as Residents #s 14 and 7. The facts pertaining to these two residents differ but CMS's core allegations concerning each of them are essentially identical. CMS contends that Petitioner was remiss in assessing, planning care for, and implementing needed supervision and assistance for each of these residents. It asserts that each of these residents is an individual who is at high risk for sustaining falls. CMS argues that various incidents established clearly that the assessments and interventions that Petitioner had developed were not working adequately to protect each of these residents. According to CMS, Petitioner's staff failed to take new information into account to adjust the assessments they had made of each resident's condition and to develop and implement new interventions to replace interventions that were not protecting each resident adequately.

The weight of the evidence strongly supports CMS's noncompliance allegations. The evidence establishes a persistent failure by Petitioner's staff to make meaningful assessments of residents' accident risks or to implement effective interventions to protect the residents even in the face of facts that should have caused the staff to act urgently.

Resident # 14 was aged 91 as of the April survey. She had been assessed by Petitioner's staff as being at high risk for sustaining falls. CMS Ex. 16, at 16. She had suffered a stroke and her physical problems included an impaired gait. *Id.*, at 99.

The resident also suffered from cognitive and memory problems consistent with Alzheimer's disease. CMS Ex. 16, at 98. The staff assessed her as having both short and long-term memory problems and concluded that the resident's cognitive skills were moderately impaired for daily decision making. *Id.*, at 180, 184, 189. She had episodes of disorganized speech and was only sometimes capable of

understanding others. *Id.*, at 177-193. In May 2007, Petitioner's staff concluded that the resident's cognitive loss was so severe that she didn't recognize the staff nor could she identify the location of her room. *Id.*, at 52. The resident's son told the staff that the resident displayed confusion, anxiety, nocturnal agitation, memory lapses, and episodes of paranoia. P. Ex. 7, at 17.

Resident # 14 sustained multiple falls while residing at Petitioner's facility. These falls had common features. Nearly all of these falls occurred while the resident was in the vicinity of her bathroom or attempting to use it, and all of them occurred after 6:00 p.m. and before 8:00 a.m. They included falls sustained on October 22, 2007, November 26, 2007, January 9, 2008, January 15, 2008, and March 29, 2008. CMS Ex. 16, at 11-15. This series of falls culminated with a fall that the resident sustained on March 30, 2008. On that occasion, the resident fell again while attempting to use her bathroom and she fractured her hip. *Id.*, at 10.

There was a pattern to the falls that put Petitioner's staff on notice that Resident # 14 was at very high risk for falling when she attempted to use her bathroom during the night and early in the morning. The resident's falls history and the common circumstances of these falls mandated that Petitioner address the issue by assessing the resident to determine exactly what problems she faced when she attempted to use the bathroom at night and in the early morning hours and to develop interventions to attack the problems that the staff identified.

On November 21, 2007, Petitioner's staff revised Resident # 14's care plan in apparent response to the Resident's October 22, 2007 fall. CMS Ex. 16, at 44. The intervention that was directed as of that date was to remind the resident to use her call light, especially at night, and to assure the resident that she would not bother anyone if she used the light. *Id.* After the resident's November 26, 2007 fall, her care plan was revised to tell Petitioner's staff to remind Resident # 14 that she should use a walker when she ambulated. *Id.* The plan was again revised on February 15, 2008. On that date staff was instructed to use "facility toileting protocol" to ask the resident if she needed to use the bathroom, and to move the resident's personal alarm to her upper back where it would be out of sight, in an apparent effort to minimize the chances that the resident would deactivate the alarm on her own. *Id.*

These minimal interventions were obviously unsuccessful. Staff should have known that they would be inadequate. It should have been evident to Petitioner's staff that it would likely have been futile to instruct the resident to use her call light when she needed to go to the bathroom or to use her walker when she ambulated. Not only did these measures not work – as is demonstrated by the resident's repeated falls – but there was scant likelihood that they would work given the resident's obvious dementia. It is simply not reasonable to conclude that

a resident who was so mentally compromised could be protected adequately by verbal reminders.

Moreover, if the staff thought that the resident might be protected adequately with verbal reinforcement, they had at least the duty to make a thorough assessment of the resident in order to determine whether such reinforcement actually would work. There is nothing in the resident's treatment record to suggest that the staff did that.

What is also evident from the resident's record is that Petitioner's staff neither considered nor attempted other measures that might have protected Resident # 14 better. For example, the staff never attempted to put the resident on a regular schedule of nighttime bathroom visits. Nor did it implement enhanced observation or surveillance of the resident. *See* CMS Ex. 37, at 26-27

The facility toileting protocol that is referred to in the February 15, 2008 revision to the resident's care plan would have had had the staff ask the resident at intervals whether she needed to use the bathroom. Petitioner's director of nursing told one of the surveyors who participated in the April survey that this intervention was not implemented because the staff concluded that the resident would be uncooperative. CMS Ex. 16, at 5. But, there is no documentation in the resident's record showing that the staff attempted this intervention and were rebuffed by the resident. And, if the intervention was attempted and failed, the record is devoid of any assessment to determine what other possible interventions might have succeeded in lieu of implementing the facility's toileting protocol.

Resident # 7, like Resident # 14, was an individual who had cognitive and memory loss and who was at risk for falling. She was admitted to Petitioner's facility on August 14, 2007. CMS Ex. 9, at 1. On admission the staff noted that the resident had a history of falls and that she wore a waist restraint. *Id*., at 7-8. The staff assessed the resident as having very poor safety awareness and judgment due to her dementia. P. Ex. 4, at 20.

The resident wore the waist restraint throughout the period beginning with her admission and continuing up through the April survey.[1] The waist restraint consisted of a belt that was attached to the resident's wheelchair and which, in theory, the resident could not release on her own initiative. CMS Ex. 9, at 11.

[1] The waist restraint was changed on April 23, 2008 to a belt that tied behind the resident's wheelchair. P. Ex. 4, at 43. This intervention occurred after the April survey.

However, the waist restraint clearly failed to protect Resident # 7 against sustaining falls. On November 27, 2007, the resident fell and was found lying on the floor of her room. CMS Ex. 9, at 4. Petitioner's staff concluded that the resident had "released her waistbelt." *Id.* The resident's care plan was amended on December 5, 2007 to show that a "blue mat" had been placed on the floor next to the resident's bed, evidently as an intervention designed to cushion the resident from a potential fall from the bed to the floor. *Id.*, at 16. Additionally, a personal alarm was added to the resident's wheelchair effective February 29, 2008. *Id.* But, there is nothing in the care plan addressing the potential problems arising from the resident's apparent ability to release her waist belt. There is no record that the staff conducted a thorough investigation into how the resident could have released her waist belt or the exact circumstances of the resident's fall. Nor is there any evidence showing that the staff engaged in intensive planning to prevent a future fall from occurring under similar circumstances.

It is not surprising that the resident fell again on April 4, 2008 given the staff's failure to thoroughly assess the reasons for the resident's first fall and to plan her care accordingly. CMS Ex. 9, at 13; P. Ex. 4, at 39. On this occasion Petitioner's staff found Resident # 7 sitting on the floor in her room. The staff concluded that the resident had removed her waist belt and had attempted to transfer herself into her bed. *Id.* As was the case with the November 2007 fall, the resident's care record is devoid of evidence to show that Petitioner's staff made a comprehensive investigation of the fall's causes. The staff finally decided, on April 23, 2008, to change the type of waist belt that the resident wore to a design that fastened behind her and which she could not self-release. P. Ex. 4, at 43. However, that decision was made about three weeks after the resident sustained her fall and after completion of the April survey.

I have considered Petitioner's allegations and arguments concerning the care that it gave Residents #s 14 and 7 and I find them to be unpersuasive.

Petitioner's principal argument concerning the care that it provided to Resident # 14 is that the care was consistent with the resident's expressed wishes. That, according to Petitioner, excused it from responsibility for the many falls that the resident sustained while under Petitioner's care. The premise for this argument is that Resident # 14 was far from being significantly demented. Petitioner contends that CMS demeans the resident by referring to her as being confused and demented. Petitioner characterizes this resident as only "slightly confused, but capable of independent decision-making, observation and socializing with her friends." Petitioner's closing brief at 19. It asserts that the resident's alleged resistance to supervision and assistance was a "conscious decision" that should not "have been overridden by restraining her against her will, or against the wishes of her family." *Id.*

Petitioner's contentions fail in two respects. First, Petitioner mischaracterizes the true state of the resident's mental condition. Petitioner's records do not show the resident to have been only slightly cognitively impaired. To the contrary, Petitioner's records show that the resident suffered from fairly profound dementia typical of Alzheimer's disease. CMS Ex. 16, at 98. It is not CMS that first identified Resident # 14 as being confused and demented. Petitioner's staff assessed the resident as being so confused that she could not identify her own room or members of Petitioner's staff. CMS Ex. 16, at 52. And, it was Petitioner's staff who concluded that Resident # 14 had both short and long-term memory problems and who concluded that the resident's cognitive skills were moderately impaired for daily decision making. *Id.*, at 180, 184, 189.

Thus, Petitioner's own records refute Petitioner's argument that Resident # 14 was sufficiently lucid that she could intelligently refuse the care options that Petitioner offered to her. Moreover, the record is devoid of evidence that Petitioner actually assessed the resident to determine whether she was capable of refusing care or profiting from the interventions that Petitioner's staff offered. For example, reminding the resident to use her call light when she needed assistance was a principal intervention that Petitioner's staff developed and, apparently, relied on. In spite of that Petitioner has not pointed to a single assessment of the resident that shows that she was capable of remembering to use her call light. Nor does the record contain documents proving that the staff developed appropriate interventions (such as a nighttime toileting plan or closer surveillance during the night), offered them to the resident, and were rebuffed by her.

Second, Petitioner posits the care options that were available for Resident # 14 as being a choice between not providing greater assistance and supervision to the resident and restraining her against her will. To this end, Petitioner offers the testimony of its director of nursing who asserts that she decided to discontinue the resident's waist restraint after discussing the matter with the resident and her family. P. Ex. 14, at 7.[2]

[2] The director of nursing also asserts that she had many conversations with Resident # 14 in which she warned her about the risks that came with attempts by the resident to transfer herself or to walk without assistance. *Id.* Petitioner evidently offers this testimony to show that its staff diligently attempted to use verbal advice in order to protect the resident. However, even the best advice loses its value if the resident is unable to remember or understand it.

This argument presents a false choice. CMS has not argued that Petitioner needed to restrain Resident # 14 against her will in order to protect her. There were options falling far short of restraints – for example, checking on the resident periodically and simply having her use the bathroom at regular intervals – that Petitioner could have tried but never attempted.

Petitioner contends that the two falls sustained by Resident # 7 "resulted from her (or her son's) releasing the resident's waist restraint. . . ." Petitioner's closing brief at 17. From this assertion it seems to suggest that its staff should be absolved from responsibility for protecting the resident due to the resident's son's alleged acts. It also contends that its staff adequately addressed the resident's falls through discussions with the resident's family and by planning the resident's care. Petitioner's closing brief at 17. Additionally, Petitioner asserts that it addressed the resident's second fall in April 2008 by giving the resident a waist restraint with loops which she could not untie and a wheelchair with anti-tip bars and footrests. *Id.*

Petitioner identified nothing in the resident's treatment record which supports its theory of how Resident # 7 sustained her falls. The assertion that the resident's son released her waist belt is belied by Petitioner's staff's contemporaneous notes which do not mention a cause for the resident's falls other than the resident releasing the waist belt on her own volition. CMS Ex. 9, at 4, 13. The evening shift coordinator at Petitioner's facility, who testified on behalf of Petitioner, averred that on the occasion of the April 2008 fall the resident released herself from her waist belt. P. Ex. 19, at 3.

Petitioner's present speculation about how Resident # 7 fell simply underscores the reality that its staff never conducted an investigation of either fall that pinpointed its precise cause. The record is singularly devoid of evidence that the staff comprehensively addressed either of Resident # 7's falls. As I discuss above, the care planning that Petitioner did for Resident # 7 in the wake of each of the resident's falls is woefully lacking in any comprehensive analysis of the cause of the resident's falls and how to prevent future falls.

Furthermore, Petitioner was not relieved from its obligation to protect Resident # 7 by the possibility that the resident's son may have released her belt on occasion. If Petitioner's staff knew that to be true, that knowledge imposed on them the obligation to plan the resident's care accordingly. But, there is nothing in the resident's care plans which shows that the staff addressed this issue aside from a single entry on June 26, 2007:

Son has been informed not to remove waist belt, he may forget.

CMS Ex. 9, at 12. That notation was made more than three months prior to the resident's first fall in November 2007. The plan was not updated after either that fall or the subsequent fall in April 2008 to show additional communications with the resident's son. Nor does the plan contain any analysis of how to assure that the son did not release his mother's waist restraint.

Petitioner avers that it addressed Resident # 7's falls through care planning with the resident's family. It contends that it "actively designed care plans to prevent Resident 7 from falling" in accordance with its own internal guidelines and applicable regulations. Petitioner's closing brief at 17. I find this assertion to be unpersuasive. To be sure, Petitioner developed care plans for Resident # 7. But, these plans could not have systematically addressed the risks faced by the resident because Petitioner's staff never really pinpointed those risks.

2. CMS's remedy determinations are reasonable.

CMS determined to impose two remedies to address Petitioner's noncompliance consisting of a $3,000 per-instance civil money penalty and a denial of payment for new admissions for each day of a period that began on May 22, 2008 and which ran through June 3, 2008. I find these remedies to be reasonable.

Per-instance civil money penalties may be imposed by CMS for each instance of noncompliance with regulatory requirements and may fall within a range of between $1,000 and $10,000 per day. 42 C.F.R. § 488.438(a)(2). The exact amount of a penalty within this range depends on evidence relating to regulatory factors that are set forth at 42 C.F.R. §§ 488.438(f)(1) – (4) and 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)). These factors include the seriousness of a facility's noncompliance, its compliance history, its culpability, and its financial condition.

The civil money penalty that CMS determined to impose against Petitioner is modest when considered in the context of the permissible range of such penalties and minute when measured against the duration of Petitioner's noncompliance. CMS could have opted to impose civil money penalties of up to $3,000 per day against Petitioner for its noncompliance. 42 C.F.R. § 488.438(a)(1)(ii). Such noncompliance clearly extended over a period of at least several weeks if not longer.

I find the penalty amount to be well-justified by the seriousness of Petitioner's noncompliance. Petitioner's staff failed adequately to assess and document the risks encountered by two of its residents. It failed to plan their care in a careful and meaningful way. And, it failed to implement interventions that might have protected the residents. That was a very serious breach of Petitioner's duty and it left these residents vulnerable to harm.

Petitioner has provided no argument or evidence that would justify reduction of the penalty amount. Indeed, Petitioner failed to address the issue of penalty amount in either its opening or closing brief.

CMS may impose denial of payment for new admissions, as a matter of discretion, whenever a facility is not in compliance with Medicare participation requirements. 42 C.F.R. § 488.415(a). Petitioner has not made any arguments challenging CMS's authority to impose the remedy in this case. Therefore, I sustain it.

/s/
Steven T. Kessel
Administrative Law Judge