**Department of Health and Human Services**

**DEPARTMENTAL APPEALS BOARD**

**Civil Remedies Division**

Saint Luke Lutheran Community – Portage Lakes,
(CCN: 366280),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-177

Decision No. CR3173

Date: March 28, 2014

# DECISION

I grant the motion of the Centers for Medicare & Medicaid Services (CMS) for summary judgment against Petitioner, St. Luke Lutheran Community - Portage Lakes, a skilled nursing facility that participates in the Medicare program. I sustain CMS's imposition against Petitioner of two per-instance civil money penalties, each in the amount of $3,200.

## I. Background

Petitioner requested a hearing to challenge the imposition of the two civil money penalties that I describe in the opening paragraph of this decision. CMS moved for summary judgment and Petitioner opposed the motion. With its motion CMS offered exhibits that it identified as CMS Ex. 1 – CMS Ex. 17. With its opposition Petitioner offered exhibits that it identified as P. Ex. 1 – P. Ex. 5. I receive these exhibits into the record.

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

### A. Issues

The issues are whether:

1. Undisputed material facts establish that Petitioner failed to comply substantially with two Medicare participation requirements stated at 42 C.F.R. §§ 483.25(c) and (h); and

2. The two per-instance civil money penalties imposed by CMS are reasonable.[1]

### B. Findings of Fact and Conclusions of Law

#### 1. The undisputed material facts establish that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(c).

The regulation that applies here governs the prevention and care of pressure sores. It requires that: (1) a resident who enters a skilled nursing facility does not develop pressure sores unless the resident's clinical condition demonstrates that the pressure sores are unavoidable; and (2) a resident with pressure sores receives the necessary treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. CMS alleges and has provided evidence to show that Petitioner failed to comply with the requirements of this regulation in providing care to a Resident that is identified as Resident # 85. CMS Ex. 3 at 36-42.

CMS alleges that Resident # 85 was readmitted to Petitioner's facility on July 9, 2013, after a hospital stay. He developed pressure sores to his right heel and big toe within two days of his readmission to the facility. CMS Ex. 3 at 36-42; CMS Ex. 15 at 4-5. CMS asserts that Petitioner has offered nothing to show that these sores were unavoidable and, in fact, according to CMS, there was a step that Petitioner could have taken to protect the resident – consisting of placing a sheepskin protective cushion on the resident's foot – that it did not take.

CMS alleges additionally that Petitioner's staff failed to treat appropriately the resident's sores once they developed. It asserts that a surveyor observed the staff treating the

[1] The statements of deficiencies that were issued against Petitioner alleged numerous deficiencies in addition to the two that are the basis for CMS's remedy determination and that I address in this decision. The parties agree that these additional alleged deficiencies are not the basis for the imposition of remedies and are not at issue in this case.

resident's sores on July 31, 2013. On that occasion, according to CMS, the staff member who treated the resident failed to wash her hands during the course of treatment, a protocol that is necessary to protect against infection. The staff member also failed to change gloves in accordance with appropriate wound treatment protocol. And, the staff member was observed putting treatment supplies on a radiator surface without placing a barrier, such as a paper towel, between the supplies and the radiator, which would ward off the possibilities of contamination and infection. CMS Ex. 8 at 2-3, 8-9; CMS Ex. 15 at 6-7.

Finally, CMS alleges that by July 31, 2013, the resident had developed an additional pressure sore on his left heel, a sore that hadn't been assessed for treatment and that, furthermore, was not unavoidable. According to CMS, the staff left the resident's unprotected left heel lying directly on a mattress even though a pressure sore had developed on that heel and was observed by Petitioner's staff. CMS Ex. 15 at 7-8.

CMS's allegations, as supported by the facts that it offers, are a basis for finding that Petitioner failed to comply with regulatory requirements. CMS makes a prima facie showing that Petitioner did not adequately anticipate that the resident, upon his readmission, might develop pressure sores. Additionally, CMS demonstrates that Petitioner's staff failed properly to treat the sores that the resident developed, failed to prevent the development of an additional sore, and failed to assess and develop a treatment plan for that sore.

Petitioner contends that there is a dispute of fact as to whether those sores were unavoidable. But, Petitioner has offered no facts that challenge CMS's assertions. Petitioner argues that Resident # 85 was in a very debilitated state when he was readmitted to its facility in July 2013 and that the resident's physician concluded that he must wear a brace on his right leg to promote healing of a fracture. That decision by the physician, according to Petitioner, overrode any options that might otherwise have been available to Petitioner and made prevention of pressure sores impossible.

I find these assertions to be unpersuasive. It is certainly undisputed that the resident was in very poor condition when he was readmitted to Petitioner's facility and I do not question that the resident's physician ordered that the resident wear a brace on his right leg as a paramount treatment option. But, Petitioner only speculates that these facts made it unavoidable that the resident would develop pressure sores. It has not offered any evidence to show that the development of pressure sores was a necessary consequence of the resident's condition and his treatment for a fracture. Certainly, the resident's physician hasn't offered that opinion nor has any other expert. Petitioner has offered absolutely nothing to show why protective measures couldn't have been prescribed to the resident to deal with the risks presented by the resident's condition and the brace that he needed to wear. Indeed, Petitioner has not attempted to answer this basic question: given the resident's condition and his treatment why didn't the facility anticipate that he might

develop pressure sores and begin immediately to implement protective measures such as elevating the resident's foot or putting protective materials on the foot?

Furthermore, even if the development of pressure sores was unavoidable, Petitioner has not even attempted to rebut the facts offered by CMS showing that the staff improperly treated those sores that the resident developed. Nor has Petitioner explained why the resident's development of a pressure sore on his left heel, weeks after he was readmitted to the facility, was unavoidable, and it has offered nothing to explain why no treatment plan had been developed or implemented by the staff as of July 31, 2013.

**2. The undisputed material facts establish that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h).**

The regulation governing accidents and their prevention requires a skilled nursing facility to ensure that: (1) its resident environment remains as free from accident hazards as is possible; and (2) each of its residents receives adequate supervision and assistance devices to prevent accidents from occurring. CMS makes several allegations, and has offered supporting facts, to show that Petitioner was in several respects deficient in complying with the regulation's requirements. First, CMS presents facts relating to the care that a resident who is identified as Resident # 17 received from Petitioner's staff. This resident, a frail, elderly, and demented individual, fell out of her bed on July 11, 2013 while receiving care from a nursing assistant. CMS Ex. 6 at 3. The resident sustained a laceration to her head and a fractured femur as a consequence of the fall. CMS alleges that the staff member who provided care to the resident on July 11 failed to keep the resident safely positioned while providing care to her.

CMS alleges further that Petitioner's staff failed to comply with the resident's own care plan and failed to implement precautionary measures that were designed to protect the resident against accidents. Effective January 2013 the resident's care plan ordered that the resident be supplied with a low bed as an obvious measure to protect the resident from sustaining an injury from falling out of bed. CMS Ex. 6 at 11. However, the resident's bed was in a "high position" when the resident sustained her fall on July 11, 2013. *Id.* at 3. The order for a low bed was continued after July 11. However, on July 30, 2013 a surveyor observed that the resident remained in a high bed, notwithstanding the continued directions in the care plan. CMS Ex. 14 at 6. Two days later, a surveyor observed that the resident continued to be in a high bed. *Id.*

Furthermore, the resident's care plan was amended after July 11, 2013 to include a requirement that padding be placed on the floor next to the resident's bed as an additional measure to protect the resident from being injured by a fall. CMS Ex. 6 at 10. But, on July 30 and August 1, 2013, a surveyor observed that cushioning was absent on the side of the bed that the resident had fallen from. CMS Ex. 14 at 6.

These facts are a solid basis for finding that Petitioner failed to comply with regulatory requirements. Most significantly, they establish that Petitioner's staff did not implement the measures that were developed to protect the resident from accidents, neither putting her bed in a low position nor supplying her with protective floor cushioning.

Petitioner argues that there is a legitimate dispute as to whether the nursing assistant who was providing care to the resident on July 11, 2013 complied with all appropriate safety precautions. It argues that the facts can be interpreted to support a conclusion that the resident fell despite the staff's best measures. But, that assertion – even if it raises a legitimate dispute of fact as to the nursing assistant's performance in positioning the resident on July 11 – fails to come to grips with CMS's evidence showing a plain and repeated failure by Petitioner's staff to supply the resident with the protective measures and equipment that was mandated by her care plan. Petitioner's arguments notwithstanding, it is undisputed that the resident's bed was in a high position when the resident fell on July 11. It is undisputed that the bed had not been lowered as of July 30 and August 1, 2013. And, it is equally undisputed that Petitioner failed to supply the resident with the protective cushioning ordered by her care plan. These undisputed facts are more than sufficient basis for me to grant summary judgment.

Petitioner argues that it was necessary to have the bed in a high position on July 11, 2013, when the resident fell, in order to provide care to her. According to Petitioner its staff could not have provided needed care without raising the bed. I will accept that assertion as true for purposes of this decision. However, if the bed needed to be raised in order to provide care, Petitioner should have addressed this circumstance in the resident's care plan and planned to protect the resident in that circumstance. It did not, and the care plan is silent about raising the bed while care is provided. Furthermore, Petitioner's contention goes only to the circumstances on July 11. It does not address subsequent dates when the surveyor observed the resident lying in a raised bed when care was not being provided to the resident.

CMS makes an additional allegation of noncompliance with 42 C.F.R. § 483.25(h). It asserts that a surveyor observed one of Petitioner's nursing staff failing to use appropriate safety measures while transporting a portable oxygen tank. CMS Ex. 3 at 48. The nurse was observed putting the tank directly on the floor next to a medication cart in a hallway at Petitioner's facility without first securing the tank in a protective container. *Id.* Petitioner has offered no facts to rebut this allegation that Petitioner's staff created a hazardous situation with its handling of the oxygen tank.

**3. The two per-instance civil money penalties of $3,200 are reasonable.**

The authority to impose a per-instance civil money penalty is stated at 42 C.F.R. §§ 488.408(d)(1)(iv), (e)(1)(iv), and 488.438(a)(2). A penalty of between $1,000 and $10,000 may be imposed for any instance of failure to comply substantially with

participation requirements whether or not there is harm or immediate jeopardy. 42 C.F.R. § 488.438(a)(2).

A basis to impose per-instance civil money penalties exists here. The undisputed material facts establish that Petitioner did not comply substantially with two participation requirements, stated at 42 C.F.R. §§ 483.25(c) and 483.25(h)(1) and (2).

There are regulatory factors stated at 42 C.F.R. § 488.438 that are to be used to determine the reasonable amount of a civil money penalty, whether that penalty is a per-diem penalty or a per-instance penalty. However, there is no need for me to make findings as to how the regulatory factors would apply here because Petitioner did not challenge the amounts of the per-instance penalties. Rather, it argues only that the penalties should not be imposed because it complied substantially with participation requirements. I have addressed those arguments previously. Thus, I conclude that there is no basis for me to find the two per-instance penalties to be unreasonable.[2]

/s/

Steven T. Kessel
Administrative Law Judge

---

[2] As a matter of law Petitioner loses its authority to conduct a nurse aide training and competency program (NATCEP) because loss of NATCEP authority is automatic with civil money penalties totaling $5,000 or more. The combined civil money penalties in this case are $6,400. 42 C.F.R. § 483.151(b)(2)(iv), (f).