Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Salem Healthcare and Rehabilitation Center, LLC,
(CCN: 36-5977),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-191

Decision Number CR3337

Date: August 20, 2014

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose a $2700 per-instance civil money penalty against Petitioner, Salem Healthcare and Rehabilitation Center.

I. Background

Petitioner is a skilled nursing facility doing business in the State of Ohio. It requested a hearing to challenge CMS's determination to impose the remedy that I cite above. CMS filed a pre-hearing exchange consisting of a brief plus 16 proposed exhibits that are identified as CMS Ex. 1 – CMS Ex. 16. In its pre-hearing exchange Petitioner filed a brief and 14 proposed exhibits that are identified as P. Ex. 1 – P. Ex. 18. CMS objected to my receiving one of these exhibits, P. Ex. 8. I ruled that the exhibit must be excluded.

The exhibit consists of a video reenactment of the incident that is the basis for CMS's remedy determination. I excluded the exhibit because I found it to be inherently unreliable and prejudicial to CMS. It is advocacy rather than evidence. Excluding the exhibit did not prevent Petitioner from providing me with evidence of what transpired

during the incident. Such evidence, consisting of contemporaneous records of the incident and statements by eyewitnesses, is inherently far less tainted than a staged reenactment of those events.

The parties advised me that they did not desire an in-person hearing. I afforded CMS the opportunity to file a reply to Petitioner's pre-hearing brief. CMS did so but filed it untimely, some weeks after it was due and only after being prodded at my direction by the Departmental Appeals Board Civil Remedies Division staff attorney who is assigned to work with me on this case. Petitioner objects to my receiving this brief because it was filed untimely and because it contends that it will be prejudiced if I receive it.

CMS's failure to file its brief timely plainly is annoying but it does not rise to the level of a prejudicial event. It is apparent that CMS drafted the brief timely but that its counsel or its counsel's staff forgot to mail it. That would be a fatal error if the brief consisted of a jurisdictional document. But, it is not, and I see no harm in considering it, especially inasmuch as it is advocacy only and contains no additional evidence.

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

A. Issues

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

Petitioner sometimes seems to concede that it may not have complied substantially with a participation requirement but that the scope and severity that CMS assigned to this noncompliance (a so-called "level G" deficiency) is unreasonable and that it should be reduced. If that were Petitioner's sole argument I would dismiss its hearing request, because I have no authority to address scope and severity levels of noncompliance except where the issue is a remedy that is based on immediate jeopardy level noncompliance versus a remedy that might be imposed for something that is less than immediate jeopardy. However, Petitioner also argues that it was, in fact, in compliance with participation requirements and that is an issue that I do have authority to hear and decide.

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)(1) and (2). This regulation requires that facility's resident environment be free of accident hazards and that the facility provide each of its residents with adequate supervision and assistance devices to prevent residents from sustaining accidents. The regulation has been interpreted on innumerable occasions to impose on a skilled nursing facility the duty to take all reasonable measures to protect residents against foreseeable accidents.

The noncompliance allegations revolve around the care Petitioner gave to a resident who is identified as Resident # 60 and, in particular, around the care Petitioner's staff gave to that resident on one day, July 25, 2013. As of that date, the resident was a 79-year old man who had been admitted to Petitioner's facility just two days previously. He had been discharged to Petitioner's facility from a hospital after suffering a fall and subsequent cerebral hemorrhage. He had a variety of debilitating illnesses that included Alzheimer's Disease, mental retardation, seizures, depression, anxiety, and coronary artery disease. On July 24, 2013, Petitioner's staff evaluated the resident and assessed him as having moderate to severe cognitive deficits and significantly decreased balance, gait and transfer ability. The staff found that the resident ambulated impulsively, meaning he was prone to getting up and attempting to walk without warning. The staff also found that he was unable to apply skills to untrained tasks, had poor ability to negotiate obstacles, and had reduced insight for unsafe situations. CMS Ex. 11 at 31 – 32; CMS Ex. 12 at 1, 4 – 5, 8, 10, 12, 15, 19.

Petitioner's staff concluded that Resident # 60 was at risk for: falls; further decline in functioning; immobility; and, increased dependency on caregivers. The staff decided that the resident needed one-on-one supervision, meaning that he needed to be under continuous observation by Petitioner's staff. CMS Ex. 11 at 31 – 33; CMS Ex. 12 at 1, 4 – 5, 8, 10, 15, 19.

On July 25, Resident # 60 was in a wheelchair and seated at a table in Petitioner's dining room. A nurse's aide was assigned to sit with the resident. Another resident's Wanderguard bracelet sounded at a nearby elevator. The nurse's aide rose from her seat and walked a couple of steps in order to gain a clear view of the elevator and to determine what was happening there, thus ceasing to observe Resident # 60 and physically separating herself from him. As the aide did that, Resident # 60 attempted to stand from his wheelchair. The chair moved because it was not locked. The resident took a few steps and fell to the floor, fracturing his hip. CMS Ex. 11 at 32 – 35; CMS Ex. 12 at 2, 6 – 11, CMS Ex. 13 at 41 – 44, 86 – 100.

These facts plainly describe a failure by Petitioner to protect Resident # 60 against a foreseeable event consisting of the likelihood that he would fall if not supervised adequately. Petitioner's staff assessed the resident as being at a high risk for falling as a result of his physical infirmities and his mental impairments. He was not only unstable but he had a tendency to ambulate impulsively, meaning that he might attempt to get out of his chair and ambulate at any time and without warning. That is why Petitioner assigned one-on-one supervision to the resident.

One-on-one supervision meant that the resident needed to be under continuous observation. Nothing short of that would suffice given the resident's many infirmities

coupled with his impulsiveness and lack of judgment. A staff member needed not only to watch the resident continuously but be close enough to the resident so that the staff member could intervene and protect the resident if he began to stand and walk.

That level of protection obviously was lacking on July 25, 2013. The nurse's aide assigned to provide one-on-one supervision to Resident # 60 allowed herself to be distracted just long enough to enable the resident to stand and to begin walking. And, at that moment, the aide had moved sufficiently far enough away from the resident so that she was unable to provide the resident with physical support and protection as he lost his balance and began to fall.

It is no defense to argue that the aide's distraction was only momentary. The one-on-one observation that the staff ordered was supposed to be continuous and seamless. The idea was that someone would be assigned to the resident who could watch him constantly and to be available at all times should there be a need for assistance. Any disruption in that observation – no matter how brief and no matter how well-intentioned it may have been – deprived the resident of the level of supervision that he needed and put the resident at risk for precisely the fall and injury that he sustained.

Petitioner argues that it provided Resident # 60 with several levels of protection, including floor mats at his bedside, bed and chair alarms, and one-on-one supervision and that his fall and resulting injury were sustained despite all of the protection that he received. In other words, Petitioner essentially argues that it did its best and should not be penalized for an accident that occurred despite Petitioner's best efforts to protect the resident.

The facts belie this assertion. As I have discussed, Petitioner's staff assessed this resident – and with good reason – as needing *continuous* observation and protection. Providing the resident with less than continuous observation and protection constituted a failure to give the resident what Petitioner's own staff concluded that he needed.

Petitioner argues also that the nursing assistant who was assigned to the resident on July 25 had no choice but to stand and to move away from the resident – even if momentarily – because there was a pillar blocking her view of the facility elevator. The assistant had to step around the pillar in order to observe the elevator area and ascertain why another resident's Wanderguard alarm had sounded.

However, the entire point of assigning one-on-one supervision to Resident # 60 was to ensure that whatever staff member assigned that responsibility would not have other and potentially distracting responsibilities. The nursing assistant should not have diverted her attention from the resident to ascertain the reason for the Wanderguard sounding. Either the staff member violated her responsibilities by responding to the Wanderguard, or, the

staff member should never have been assigned the responsibility of observing Resident # 60 *and* responding to distractions such as another resident's Wanderguard sounding.

Petitioner argues also that another nursing assistant was in a position to respond immediately to Resident # 60 after he sustained his fall. That may be true but it is no justification for leaving the resident unsupervised, even momentarily.

The remedy that CMS imposed in this case, a $2700 per-instance civil money penalty, is near the low end of the range of permissible per-instance penalties of from $1000 to $10,000. 42 C.F.R. § 488.438(a)(2). In this case the penalty amount of $2700 is amply justified by the seriousness of Petitioner's noncompliance. 42 C.F.R. § 488.438(f)(3) (incorporating 42 C.F.R. § 488.404 by reference). Petitioner does not contest the penalty amount. Rather, it argues that, even if the penalty amount is justified, the scope and severity of its noncompliance (level "G") is not. As I have discussed, I have no authority to address that argument. 42 C.F.R. § 498.3(b)(14)(i).

/s/
Steven T. Kessel
Administrative Law Judge