**Department of Health and Human Services**

**DEPARTMENTAL APPEALS BOARD**

**Civil Remedies Division**

Alfredo Gonzalez Texas State Veterans Home,
(CCN: 67-6063),

Petitioner,

v.

Centers for Medicare & Medicaid Services

Docket No. C-13-35

Decision No. CR3610

Date: January 30, 2015

# DECISION

This case explores (among other issues) a long-term-care facility's obligation to respect the rights of its residents.

Petitioner, Alfredo Gonzalez Texas State Veterans Home, is a long-term-care facility located in McAllen, Texas, that participates in the Medicare program. Based on surveys completed March 7, May 17, and June 7, 2012, the Centers for Medicare & Medicaid Services (CMS) determined that the facility was not in substantial compliance with multiple Medicare program requirements. CMS imposed no penalties for the deficiencies cited during the March survey. However, following the May survey, it imposed five per-instance civil money penalties (CMPs) of $2,000 apiece, and, following the June survey, it imposed an additional $2,000 per-instance CMP, for a total of $12,000 in penalties. Petitioner appealed.

For the reasons set forth below, I find that the facility was not in substantial compliance with the cited program requirements and that the penalties imposed are reasonable.

## I. Background

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months, and more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a), 488.308.

Here, the state agency surveyed the facility in March, May, and June 2012. CMS has imposed per-instance penalties of $2,000 for deficiencies cited under each of the following regulations:

- 42 C.F.R. § 483.10(b)(4) (Tag F155 – rights and services) at scope and severity level H (pattern of noncompliance that causes actual harm);

- 42 C.F.R. § 483.15(a) (Tag F241 – quality of life – dignity) at scope and severity level H;

- 42 C.F.R. § 483.15(b) (Tag F242 – quality of life – self-determination and participation) at scope and severity level H;

- 42 C.F.R. § 483.15(g)(1) (Tag F250 – quality of life – social services) at scope and severity level H;

- 42 C.F.R. § 483.75 (Tag F490 – administration) at scope and severity level H; and

- 42 C.F.R. § 483.25(c) (Tag F314 – quality of care – pressure sores) at scope and severity level G (isolated instance of noncompliance that causes actual harm).

Petitioner timely requested a hearing to challenge all of the deficiency findings for which CMS imposed a remedy. The case was initially assigned to Judge Richard Smith, and, following his departure from the Departmental Appeals Board, it was reassigned to me.

On November 6, 2013, I convened a video hearing from the offices of the Departmental Appeals Board in Washington, D.C. Counsel and witnesses appeared in Edinburgh, Texas. Transcript (Tr.) 4. Ms. Jennifer Mendola appeared on behalf of CMS, and Ms. Nancy A. Shellhorse appeared on behalf of Petitioner. I have admitted into evidence CMS exhibits (CMS Exs.) 1-3, 5-45, 48-52, 54, and 56-60 and Petitioner's exhibits (P. Exs.) 1-17. Tr. 6.

The parties have filed pre-hearing briefs (CMS Pre-hrg. Br.; P. Pre-hrg. Br.) and post-hearing briefs (CMS Post-hrg. Br.; P. Post-hrg. Br.).

## II. Issues

The issues before me are:

1. Was the facility in substantial compliance with the following program requirements:

   - 42 C.F.R. § 483.10(b)(4) (Tag F155);
   - 42 C.F.R. § 483.15(a) (Tag F241);
   - 42 C.F.R. § 483.15(b) (Tag F242);
   - 42 C.F.R. § 483.15(g)(1) (Tag F250);
   - 42 C.F.R. § 483.75 (Tag F490); and
   - 42 C.F.R. § 483.25(c) (Tag F314)

2. If the facility was not in substantial compliance with the cited regulations, are the penalties imposed – $2,000 per-instance for each deficiency – reasonable?[1]

[1] In its closing brief, CMS argues, for the first time, that the facility's deficiencies posed immediate jeopardy to resident health and safety. CMS Post-hrg. Br. at 11. But the deficiencies were cited at lower levels of scope and severity. CMS has not explained its apparent change in position nor provided adequate notice that it would argue a new issue, so the question of scope and severity is not properly before me. Even if it were, my authority to review CMS's scope and severity findings (which include a finding of immediate jeopardy) is strictly limited, and the issue would likely not be reviewable here, where the scope and severity finding does not affect the range of the CMP or the facility's nurse aide training program (assuming that it even has one, which is not

*(continues on next page)*

## III. Discussion

### *A. The facility was not in substantial compliance with 42 C.F.R. §§ 483.10(b)(4), 483.15(a),(b), and (g)(1), and 483.75 because facility staff deceived a competent resident about the nature of his admission, did not allow him to formulate his own advance directive, confined him in a locked ward without his consent, and failed to provide him with much-needed social services.*[2]

Program requirements: 42 C.F.R. § 483.10(b)(4) (Tag F155). Each resident has the right to formulate an advance directive, and the facility must inform him, in writing, of his right to accept or refuse medical treatment. If, because of an incapacitating condition or mental disorder, an adult resident is unable to receive necessary information, the facility may instead give the information to a family member or appropriate surrogate.

42 C.F.R. § 483.15 (Tags F241, F242, and F250). Under the quality-of-life regulation, the facility must care for its residents "in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality." 42 C.F.R. § 483.15(a). The resident has a right to "[m]ake choices about aspects of his . . . life in the facility that are significant" to him (42 C.F.R. § 483.15(b)); and the facility must provide medically-related social services so that the resident may "attain or maintain the highest practicable physical, mental, and psychosocial well-being . . . ." 42 C.F.R. § 483.15(g)(1).

42 C.F.R. § 483.75 (Tag F490). The facility must be governed in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Resident 1 (R1). R1 was a ninety-two-year-old man, living with his children until November 2011, when he fractured his hip. He was treated at the Veteran's Administration (VA) hospital and then transferred to the facility for rehabilitation in January 2012. The VA hospital described him as "always alert," and never confused, not even occasionally. CMS Ex. 8. Besides the hip fracture, his diagnoses at the time of his

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apparent from the record before me). *See* 42 C.F.R. § 498.3(b)(14); 42 C.F.R. §§ 498.3(b)(14), 498.3(d)(10); *Cedar Lake Nursing Home*, DAB No. 2344 at 9 (2010); *Evergreen Commons*, DAB No. 2175 (2008); *Aase Haugen Homes*, DAB No. 2013 (2006).

[2] My findings of fact/conclusions of law are set forth, in italics and bold, in the discussion captions of this decision.

admission to the facility included: hypertension, gastroesophageal reflux disease, osteoporosis, coronary artery disease, depression, and history of prostate cancer. CMS Ex. 10 at 1; P. Ex. 14 at 2 (Smith Decl. ¶ 6).[3]

The facility's admission documents described R1 as "alert." His long and short-term memories were "ok." His cognitive and decision-making skills were "independent." He could make himself understood and understood others. CMS Ex. 7 at 3. Similarly, nurse's notes described him as "alert and oriented [to place, time, and person]." CMS Ex. 27 at 1. The facility's social worker described him as "alert and able to communicate needs," as well as "helpful and compliant." CMS Ex. 16 at 3. In contrast to the assessment included in the hospital discharge summary, she wrote in progress notes that he had "episodes of forgetfulness/confusion." CMS Ex. 16 at 3; CMS Ex. 25 at 1. The file includes no explanation as to how she reached that conclusion, although her notes indicate that R1's daughters said that R1 had a history "of verbal abuse and sometimes is not patient with others." CMS Ex. 25, at 1

The daughter also said that R1 had a history of wandering. CMS Ex. 25 at 1; P. Ex. 15 at 2 (Cavazos Decl. ¶5). No documentation supports the assertion. An April 2011 physician assessment determined that R1 was *not* at risk for wandering. Among other factors, he had no legal guardian, was not considered dangerous, was not gravely disabled by a mental disorder, did not lack the cognitive ability to make relevant decisions, and had no physical or mental impairments (such as dementia) that increased his risk. P. Ex. 1 at 1. He had no mood or behavioral issues, although he was on medication for depression. CMS Ex. 16 at 4. According to the facility's own January 18, 2012 "wander data collection tool," R1 had *not* wandered previously and was *not* at risk. CMS Ex. 22 at 3. His MDS (minimum data set) said the same. CMS Ex. 17 at 11; *see also* CMS Ex. 7 at 7 (indicating no history of wandering, no medication causing confusion or disorientation, and *no* indications of dementia).

R1's initial psychosocial assessment, dated January 12, 2012, concluded that he was competent and able to make medical decisions for himself. He had no guardian, durable power of attorney, or surrogate. CMS Ex. 16 at 1. The facility social worker reported that he was free of any adjustment, mood, or behavior problem, although he was

[3] Petitioner claims that R1 suffered from "stage IV metastatic prostate cancer," citing an April 15, 2011 physician note. P. Post-hrg. Br. at 5; P. Ex. 1 at 1-2. Although that note lists prostate cancer as a diagnosis (apparently first diagnosed in 2001), it says nothing about stages of metastases. An October 28, 2011 dermatology note quotes R1's daughter as saying that R1 had "stage IV metastatic prostate cancer," but the assertion is in quotation marks and "stage IV metastatic" is not added to the prostate cancer diagnosis. P. Ex. 1 at 5-6.

diagnosed with depression. The social worker indicated that R1 had no history of mental health treatment and was not being followed by a psychiatrist, psychologist, or counselor. CMS Ex. 16 at 1.

In assessing his cognitive abilities at the time of his admission, the facility's (then) MDS coordinator reported that R1 was able to complete the interview and that a mental status assessment was not necessary. CMS Ex. 17 at 7; P. Ex. 3 at 7. He had no hallucinations or delusions and no behavioral symptoms. Again, he presented no risk of wandering. CMS Ex. 17 at 10-11; P. Ex. 3 at 10-11. He knew the day of the week, but not the month or year (or did not answer when asked) and was able to repeat two of three words and to recall them later, with cueing. CMS Ex. 17 at 6; P. Ex. 3 at 6. The MDS does not list any neurological diagnoses, which would have included dementia had the MDS coordinator determined that he suffered from it. CMS Ex. 17 at 17-18; P. Ex. 3 at 17-18. R1's later assessments yielded similar results. P. Ex. 5 at 6, 7, 10, 14-15;

The initial deception. No one seriously disputes that, at the time of his admission, R1 had the right to know that his placement was permanent. Tr. 72 (MDS Coordinator/now DON agrees); Tr. 88 (social worker agrees).

Yet, facility staff colluded with R1's daughters to deceive him as to the nature of his admission. He thought that he was there short-term for rehabilitation following his hip and foot injuries. Tr. 86. But his daughters told the facility social worker that he was in for the long-term because they could no longer care for him. They acknowledged to the social worker that the resident did not know about the nature of his placement. In progress notes dated January 12, 2012, the social worker documented their conversation, and, from all appearances, she acquiesced in the deception. At any rate, she did not discuss the issue with R1 at that time. CMS Ex. 25 at 1; P. Ex. 2 at 1; Tr. 77 (agreeing that R1 did not know that his admission was long-term and admitting that she did not discuss the issue with him); *see* CMS Ex. 16 at 1 (indicating that R1 would be staying in the facility "for more than 20 days" and did not need any community referral information).

Nor was the social worker alone in withholding from R1 this information to which he was entitled. Although his MDS indicates that both R1 and his family participated in the assessment, the family alone dictated that discharge was not feasible and that he would remain in the facility. CMS Ex. 17 at 31; P. Ex. 3 at 31. Thus, according to the MDS assessment, the MDS coordinator knew that R1's admission was long-term. She testified, however, that she was not aware that this was a long-term admission, and, had she known, she'd "definitely" have told him. Tr. 72. But, as her own documentation shows, she was aware, and she did not tell him.

Because her testimony was not consistent with her contemporaneous documentation, I find her testimony less credible. *Compare* P. Ex. 3 at 31 *with* Tr. 72.

Until March 14, 2012 – more than two months after his initial placement and a month after he began to complain – the facility did not add to R1's care plan any interventions aimed at helping him adjust to the long-term placement. P. Ex. 9 at 41.

Wanderguard and confinement. I see no evidence that R1 had any problems during his first month in the facility. He cooperated with the rehabilitation staff and made reasonable improvements. Progress notes dated February 16, 2012, however, describe R1 as "upset" and wanting to go home. CMS Ex. 25 at 2; CMS Ex. 27 at 12. The social worker spoke to his daughters, suggesting a care planning meeting at which they would finally explain to R1 that they planned a long-term stay. The daughters declined, claiming that they had already discussed the issue with their father and that he could either stay at the facility or go to the VA in San Antonio. CMS Ex. 25 at 2. San Antonio is hours away from R1's family and everyone understood that R1 would not voluntarily have agreed to go there. Tr. 78.

Nevertheless, the social worker and the MDS coordinator – who was also apparently a nurse supervisor, and is identified as such in the notes – met with R1 on February 16. R1 told them that he wanted to go home but knew his daughters would not allow it. The social worker asked if anyone else would take him, and he said that he did not think he needed to be cared for. The social worker told him that it was dangerous to ask strangers to take him home because he needed a doctor's order for discharge, and his daughters would not agree to care for him. He left the meeting, telling the social worker that he did not plan to leave the building. CMS Ex. 25 at 3.

Aside from what she reflected in her notes, the social worker did not discuss with R1 his adjustment to the facility, did not counsel him on services that would be available, and did not research alternative placements. *See* Tr. 80. Inadequate as the February 16 discussion was, it seems to have been the first time anyone at the facility even considered the possibility of finding an alternative placement or helping R1 adjust to his having to remain in the facility against his will.

Immediately after the February 16 meeting, facility staff took two actions, neither of which was compatible with regulatory requirements: 1) the social worker advised staff that R1's family wanted him to be "redirected" by threatening to send him to the VA hospital in San Antonio, a move plainly designed to frighten the resident into accepting his placement (CMS Ex. 25 at 3; Tr. 77-78); and 2) the MDS coordinator/nurse supervisor instructed a nurse to place a Wanderguard[4] on the resident. CMS Ex. 25 at 3.

[4] A Wanderguard system attaches sensors to exit doors and/or windows, causing them either to lock or sound an alarm when approached by a resident wearing a corresponding bracelet/anklet.

These actions seem to have been arrived at *ad hoc*. I see no evidence that the facility considered other options. It seems that the nurse supervisor unilaterally decided to attach the Wanderguard, and the social worker unquestioningly accepted the daughters' suggestion that R1 be controlled by threatening to send him far away. No one even consulted the resident, much less asked for his consent.

Facility staff added to R1's care plan the application of the Wanderguard and dated that entry February 16. CMS Ex. 58 at 3 (Cortez Decl.); P. Ex. 9 at 23. I see no evidence that the issue was discussed by an interdisciplinary team, the last team conference having been held on January 23, more than three weeks prior to this intervention. P. Ex. 9. at 1-25. The form authorizing use of the Wanderguard is unsigned, with a note at the bottom saying "verbal received by [a facility nurse] given by daughter . . . ." CMS Ex. 23.

The facility's written policy instructed staff to discuss with the resident the need for a Wanderguard and to obtain his written approval as well as a physician order. CMS Ex. 33 at 2. Staff did not discuss the issue with R1 and did not obtain his written approval.[5]

R1 met his goals and was discharged from physical therapy on February 24, 2012, able to transfer and ambulate with a rolling walker or pushing a wheelchair. CMS Ex. 28. A few days later, on February 27, he apparently told the receptionist that he was leaving the facility; he no longer needed to be there because his foot had healed. The social worker then called R1's daughter, recommending that he be placed in the facility's locked unit because he was threatening to leave. Initially, his daughter balked; she did not think that R1 would benefit from being in a locked area. According to the social worker's note, she told R1's daughter that, if her father continued threatening to leave or attempted to leave, "memory support unit placement would be determined by [the facility] for his safety." They scheduled a meeting for March 1. CMS Ex. 25 at 4-5.

But that meeting did not take place. Instead, on February 28, R1 told the social worker that he was going to walk home. The social worker called his daughter, who agreed to place her father in a locked ward. No one discussed the placement with R1, even though he was responsible for his own medical decisions. CMS Ex. 25 at 6. The decision was made without an additional assessment, team meeting, or consideration of less restrictive alternatives. *See* CMS Ex. 58 at 2 (Cortez Decl.). The decision was made without regard to the facility's written policy, which required a "[p]rimary medical diagnosis of

[5] Although nurse's notes document staff discussions with R1's daughter, the record contains no written authorization from her or anyone else. Of course, because R1 was the only one authorized to make decisions for himself, his daughter's written consent would not have been sufficient.

Alzheimer's Disease or related disorder." CMS Ex. 35 at 2.[6] Although the facility eventually added the intervention to R1's care plan, that hand-written entry is not dated and was most likely written after February 28 because other entries dated February 28 are typed. Again, the plan refers to a January 23 team conference date, so the drastic intervention of placing the unwilling resident in a locked ward was imposed without benefit of an interdisciplinary team conference. P. Ex. 9 at 25.

The record includes a physician order authorizing the confinement "per family request," but it is not signed by a physician. CMS Ex. 12 at 2. Petitioner points to no documentation of an actual conversation with R1's physician, so I cannot tell whether staff spoke to the physician or merely accepted the daughter's representation that the physician approved (which would, of course, have been inappropriate). *See* CMS Ex. 25 at 6; P. Ex. 14 at 3 (Smith Decl. ¶ 12) (indicating that the social worker spoke to the daughter who said that the physician approved, but does not claim that a nurse or anyone else from the facility spoke to the physician); P. Ex. 15 at 3 (Cavazos Decl. ¶ 14); CMS Ex. 27 at 35 (nurse's notes for February 28 that do not mention contact with the physician).

On the same day, a state nursing home ombudsman was in the facility for a meeting. R1 complained to her about his situation. The ombudsman questioned the facility's holding R1 against his will and warned the social worker that the facility could not justify locking him up in the memory support unit. CMS Ex. 25 at 6-7. When informed of the ombudsman's concerns by Petitioner's Administrator, the daughter's reluctant consent changed to insistence that R1 be held in a locked ward. After some initial resistance (see below), the facility complied, again without regard to the resident's wishes.

Do Not Resuscitate (DNR) instructions. According to R1's January 11, 2012 care plan, R1 was "full code." CMS Ex. 14 at 1. The patient transfer form, dated January 11, indicates "full code." CMS Ex. 8. A physician order, dated January 10, 2012, says "full code." CMS Ex. 10 at 1; *but see* CMS Ex. 11 at 1 (indicating a "DNR" advance directive, also dated January 10, 2012, but attributed to a different physician).[7]

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[6] When questioned about the facility's policy for placing people in the locked ward, the MDS coordinator/now DON's response was evasive, confusing, inconsistent, and not credible. Tr. 62-68.

[7] The physician order sheet identifying R1's advanced directive as "full code" was attributed to Dr. Hines, who was identified as R1's "primary" physician at the time. CMS Ex. 7 at 1. The "DNR" was attributed to Dr. Gutierrez, who was listed as his "alternate physician." CMS Ex. 7 at 1. Such inconsistent directives, purportedly entered on the same day, demonstrate serious problems with the facility's practices in formulating advance directives in accordance with 42 C.F.R. § 483.10(b)(4).

The record includes a DNR order, dated January 13, 2012, which is signed by R1's daughter. CMS Ex. 21. Neither R1 nor any physician signed it.

In her January 12, 2012 progress note, the social worker wrote that the resident's daughters had selected "DNR status" for R1. CMS Ex. 25 at 1; *see* CMS Ex. 21. In R1's initial psychosocial assessment, the social worker noted, falsely, that R1 was satisfied with the DNR. CMS Ex. 16 at 1. In fact, no one asked or told R1 about his DNR status until much later. But the DNR (to which he had not agreed) was incorporated into R1's January 23 care plan: "[R1] desires no resuscitation in the event of cardiopulmonary arrest," so he would receive none. P. Ex. 9 at 20.

On March 12, 2012, staff met with the daughter, and they agreed that R1 would not be discharged and that he would continue with DNR status. CMS Ex. 25 at 11.[8] More than a week later, on March 21, 2012, social services staff finally spoke to the resident about his code status, telling him that his daughters had signed the DNR form. He then also signed an out-of-hospital DNR form, according to the social service progress notes. CMS Ex. 25 at 11. But on May 7, 2012, according to the notes, R1 refused to sign another advance directive. CMS Ex. 25 at 12. On May 9, 2012, after staff explained advance directive code status to him, he said that he "doesn't want his chest compressed" and agreed to sign the DNR. CMS Ex. 25 at 13.

Substantial noncompliance. Petitioner mischaracterizes the nature of the deficiencies cited under sections 483.10 and 483.15, suggesting that CMS is penalizing the facility because it protected R1 by not allowing him to leave the facility unsupervised. To the contrary, CMS faults the facility because: 1) it admitted R1 under false pretenses, withholding from him the true nature of his admission; 2) it offered him virtually no counselling, placement, or other social services, which he plainly needed; 3) when R1 learned of the deception, expressed his dismay and threatened to leave, facility staff attached a Wanderguard and – worse – locked him up against his will, without consulting him or considering less restrictive alternatives; and 4) the facility instituted a DNR order without consulting him.

Citing a January 10, 2012 physician order, Petitioner argues that, because R1 required skilled care, no other placement was possible, so the facility justifiably declined to address his desire to leave. CMS Ex. 10 at 4. No one disputes that, at the time of his

[8] This meeting was apparently memorialized in an unusual care plan entry, dated March 14. The entry reflects the *daughter's* statements and directions rather than the resident's needs and choices. It says that the *daughter* declared that she was the decision-maker and that she wanted her father to stay in the facility. She wanted staff to tell him that he had to remain and to limit his use of the phone so that he could not call her. P. Ex. 9 at 44.

admission to the facility, R1 required skilled care – rehabilitation for his broken hip. R1 himself willingly entered the facility for this purpose. But he met his rehabilitation goals and was discharged from physical therapy on February 24. CMS Ex. 28.

Petitioner also justifies its disregard of R1's rights by claiming that he was demented and incapable of making his own decisions. The main problem with this position is that the facility's own admission records say otherwise. Had facility staff legitimately questioned R1's competence, they should have made and documented that assessment at the time of his admission. But Petitioner has not shown that R1 was demented at the time of his admission. Indeed, no reliable evidence suggests that anyone at the facility seriously questioned R1's competence. In fact, as late as February 28 and March 1, 2012 – when R1's daughter pressed to confine him in a locked unit – the facility administrator reminded her that R1 had not been diagnosed with dementia. CMS Ex. 25 at 8. His March 5, 2012 VA medical certification, which was signed by his primary care physician (Dr. Hines) and the facility social worker, describe his mental and behavioral status as alert and agreeable, not confused or disoriented. The form indicates that dementia is not a primary diagnosis; the resident does not suffer from mental illness; and has not received mental services within the past two years. CMS Ex. 9.

The facility did not send R1 out for a psychiatric assessment until after the March survey. That March assessment, which was performed by a physician assistant, is somewhat suspect; it describes R1's functional ability as "total dependent care." CMS Ex. 30 at 4. Nothing in his treatment record or any other assessment supports this extreme conclusion. But accepting the validity of this assessment would only establish that R1's faculties deteriorated dramatically between January and March so that he was no longer competent; it would not justify staff's ignoring his rights back in January when, by all accounts, he was competent. Nor does it justify the facility's ongoing failure to provide social services.

Petitioner also cites a "letter to acknowledge a resident incompetent," signed by Dr. Alberto Gutierrez, and argues that R1's attending physician determined that he could not make medical decisions on his own behalf. P. Ex. 11 at 1. But, again, this letter was not generated until months after R1's admission, and does not reflect his abilities at the time

of admission. Nor does the letter explain how R1's cognition could have taken such a dramatic turn – from high cognitive functioning upon admission to mentally incompetent within months.[9]

To justify consulting R1's daughter rather than R1 on issues related to his medical care and quality of life, Petitioner points out that a dermatologist previously discussed R1's medical treatment and condition with R1's daughter. P. Br. at 4, *citing* P. Ex. 1 at 5. Significantly, each time the dermatologist discussed R1's care, he carefully documented that the patient had given permission. P. Ex. 1 at 5 (indicating on October 28, 2011 that "pt gave verbal permission to discuss his medical conditions and care with his daughters"; on November 7, 2011, "pt. gave permission to me to discuss his medical treatment and conditions with [his daughter]"). Facility staff here did not even tell R1 that they were consulting his daughter instead of him. Moreover, at the time of the dermatology consults, October and November 2011, R1 was living with his daughter and, from all appearances, they were in agreement on his treatment. By the time R1 was admitted to the facility, their positions on basic issues affecting his life were diametrically opposed (as facility staff well knew), which makes it far less likely that he would have consented to her speaking for him.

Finally, I see no evidence that the facility provided on-going psychosocial services to assist R1 in adjusting to the facility. Nor does the record show that, prior to the May survey, the facility's social services department seriously explored the possibility of a new placement. CMS Ex. 25 at 12-17.

By not advising him that his admission was permanent, by administering a Wanderguard bracelet and then confining him in a locked ward without his consent, and by imposing a DNR on him without his knowledge or consent, the facility plainly violated R1's rights. In doing so, the facility violated the regulations requiring that he be allowed to formulate an advance directive, to accept or refuse treatment, and to make choices about his life in

[9] Moreover, the letter itself raises a lot of questions. It is typed but undated, although someone handwrote "5-3-12" next to what may be the physician signature. The signature itself is not legible. A physician progress note is attached to the letter. It refers to itself as an assessment and is dated May 6, 2012, three days *after* the handwritten date on the letter. Assuming the letter was signed on May 3, it could not have been based on the attached assessment. The progress note appears to have been signed by someone other than the individual who signed the letter. Again, the signature is not legible and the name of the physician who prepared the progress note is not indicated. These faults might have been corrected had Petitioner explained the exhibit. However, no physician testified or subjected himself to cross-examination. No one else explained the assessment or explained the letter.

the facility. The facility did not provide the social services he needed so that he could attain the highest practicable physical, mental, and psychosocial well-being. It was therefore not in substantial compliance with 42 C.F.R. §§ 483.10(b)(4) and 483.15(a), (b), and (g)(1).

Administration. A deficiency citation alleging noncompliance with section 483.75 (administration) may be derived from findings of noncompliance with other participation requirements. *Stone County Nursing & Rehab. Ctr.*, DAB No. 2276 at 15-16 (2009); *see Asbury Ctr. at Johnson City*, DAB No. 1815 at 11 (2002); *Odd Fellow & Rebekah Health Care Facility*, DAB No. 1839 at 7 (2002). As the above discussion establishes, at least two critical members of the facility staff – the social worker and the MDS coordinator, who was also a nurse supervisor – violated the regulations and disregarded the facility's own policies when they deceived R1 about his admission, allowed his daughter to determine his advance directive without his consent, administered the Wanderguard without his consent, and placed him in a locked ward without his consent. The facility provided him virtually none of the social services he so desperately required.

Because facility staff violated its resident's rights, did not allow him to make choices about significant aspects of his life, and failed to provide him necessary social services, the facility was not governed in a manner that enabled it to use its resources effectively so that he could attain or maintain the highest practicable physical, mental and psychosocial well-being and was not in substantial compliance with 42 C.F.R. § 483.75.

### *B. The facility was not in substantial compliance with 42 C.F.R. § 483.25(c) because it failed to take all necessary precautions to prevent pressure sores from developing.*

Program requirements. Under the statute and the "quality of care" regulation, each resident must receive, and the facility must provide, the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. Act § 1819(b); 42 C.F.R. § 483.25. To this end, the facility must (among other requirements) ensure that a resident who enters the facility without pressure sores does not develop them, unless his clinical condition shows that they were unavoidable, based on the resident's comprehensive assessment. 42 C.F.R. § 483.25(c)(1). If the resident has pressure sores, the facility must ensure that he receives the treatment and services necessary to promote healing, prevent infection, and prevent new sores from developing. 42 C.F.R. § 483.25(c)(2). In assessing the facility's compliance with this requirement, the relevant question is: did the facility "take all necessary precautions" to prevent new sores from developing. If it did, and the resident developed sores anyway, I could find no deficiency. But if the evidence establishes that the facility fell short of taking all necessary precautions, then the regulation is violated.

*Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 13 (2010), *aff'd*, *Senior Rehab. & Skilled Nursing Ctr.* v. HHS, No. 10-60241 (December 20, 2010); *Koester Pavilion*, DAB No. 1750 at 32 (2000).

Resident 7 (R7). R7 was an 81-year-old man, confined to a wheelchair, who was admitted to the facility in September 2010 and readmitted on March 2, 2012. CMS Ex. 42 at 18-19, 27, 53. He suffered from a variety of ailments, including angina pectoris, Type 2 diabetes, paralysis agitans (Parkinson's Disease), peripheral vascular disease, and multicystic kidney disease. CMS Ex. 42 at 49.

R7 had no pressure sores at the time of his readmission. His March 9, 2012 skin assessment indicated that he was at less than a mild risk for developing them, measuring 20 on the Braden scale, with scores of 15 to 18 denoting mild risk. CMS Ex. 42 at 6; P. Ex. 12 at 1. But the assessment is puzzling, because it disregards R7's well-documented risk factors and is inconsistent with his other medical records in significant ways. For example:

- The assessment indicated that R7 had no sensory deficit that would limit his ability to feel pain or discomfort. CMS Ex. 42 at 6; P. Ex. 12 at 1. In fact, since at least September 2010, he suffered from peripheral neuropathy, which, according to his care plan, put him at risk for skin breakdown. P. Ex. 12 at 2.

- The assessment said that he was capable of making "major and frequent changes in position without assistance." CMS Ex. 42 at 6; P. Ex. 12 at 1. On the other hand, he scored a "2" in "friction and shear," which means that he "moves feebly or requires minimum assistance." Moreover, according to his MDS, he required extensive assistance to move to and from a lying position, turn from side to side, and position himself in bed. He did not walk, but used a wheelchair. CMS Ex. 42 at 26-27.

- The assessment also said that he was usually dry. CMS Ex. 42 at 6; P. Ex. 12 at 1. But, according to his records, he was incontinent and wore adult diapers/briefs and eventually had an indwelling catheter. P. Ex. 12 at 11, 12.

Moreover, R7's physician plainly considered him at risk because, since September 2010, he had ordered a weekly skin assessment to prevent skin breakdown. CMS Ex. 42 at 52. R7's care plan called for a weekly "systematic skin inspection" by a nurse and daily inspections by a nurse aide. P. Ex. 12 at 2. Staff were to apply a moisture barrier to his perineal area and to encourage physical activity, mobility, and range of motion. P. Ex. 12 at 3.

In stark contrast to R7's March 9 skin assessment, his March 5, 2012 MDS indicated that he was at risk of developing pressure sores. CMS Ex. 42 at 35. Moreover, in May, when a pressure sore developed, staff attributed the skin breakdown to R7's decreased sensory perception, moisture/incontinence, decreased activity, and impaired mobility, all factors that were characterized as "no impairment" on the skin assessment. CMS Ex. 42 at 1; P. Ex. 12 at 1.

By May 25, 2012, R7 had developed a stage II pressure sore (1 cm X 1 cm) on his right buttock. CMS Ex. 42 at 7, 15; P. Ex. 12 at 5. He subsequently developed a second pressure sore on his buttock, which was first documented on June 5. CMS Ex. 42 at 8, 12; P. Ex. 12 at 6.

The facility did not take all necessary precautions to prevent those sores. R7's care plan did not include any interventions designed to relieve pressure areas. According to his March 5 MDS, he had a pressure-reducing device for his chair, a pressure-reducing device for his bed, and was on a turning/repositioning program. CMS Ex. 42 at 37. A physician's order, dated March 26, 2012, authorizes the use of a low alternating air pressure mattress at all times to relieve pressure areas, and the mattress was apparently provided. P. Ex. 12 at 11; CMS Ex. 42 at 52.

But R7 spent the bulk of his day sitting up in his wheelchair or in his recliner. His care plan does not address that practice. P. Ex. 12; CMS Ex. 59 at 4 (Harwell Decl.). No physician order calls for a pressure-relieving device suitable for a chair or recliner. Instead, the facility provided a "cushion" for R7's use with his wheelchair. Petitioner does not claim that this cushion was a pressure-relieving device. P. Ex. 14 at 4 (Smith Decl. ¶ 16); *see* CMS Ex. 42 at 15 (wound report indicating that R7 had no gel cushion or similar pressure-relieving device). Surveyor Michael Harwell examined that cushion. It was square, approximately two inches thick, with a section cut out. The idea was that R7's coccyx and inner buttocks would hover over the cut-out, thus avoiding contact with the seat itself. The problem was, as R7 explained to Surveyor Harwell, that the cushion was too soft, allowing R7's buttocks to hit the seat of the wheelchair when he sat, causing him pain. CMS Ex. 59 at 2 (Harwell Decl.). Even though the facility policy for preventing pressure sores required staff to "monitor fit of immobilizing devices/adaptive equipment," it seems that no one checked to see whether the cushion adequately protected the resident. CMS Ex. 59 at 4 (Harwell Decl.).

Because the facility did not provide R7 with a pressure-relieving device to protect him when he was sitting, it did not take "all necessary precautions" to prevent new sores from developing. At a minimum, when the cushion proved ineffective and he developed the first pressure sore, the facility should have known that its intervention was inadequate.

Petitioner suggests that its alternative would have been to force R7 to remain in bed, where he had a pressure-relieving mattress. No, the alternative was to protect him from developing pressure sores while sitting up by providing an appropriate pressure-relieving device. Because it failed to do so, the facility was not taking all necessary precautions and was not in substantial compliance with 42 C.F.R. § 483.25(c).

### *C. The penalties imposed are reasonable.*

To determine whether a CMP is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating factor. The factors in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the section 488.438(f) factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848 at 21 (2002); *Community Nursing Home*, DAB No. 1807 at 22 *et seq.* (2002); *Emerald Oaks*, DAB No. 1800 at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638 at 8 (1999).

CMS imposes a very modest penalty of $2,000 per-instance for each of the deficiencies cited. $2,000 is at the low end of the per-instance penalty range ($1,000 to $10,000). 42 C.F.R. §§ 488.408(d), 488.438(a)(2). *See Plum City Care Ctr.*, DAB No. 2272 at 18-19 (2009) (observing that even a $10,000 per-instance CMP can be "a modest penalty when compared to what CMS might have imposed.").

CMS does not contend that the facility's history justifies a higher CMP. Petitioner has not argued that its financial condition affects its ability to pay the relatively small penalty.

With respect to the other factors, I find that the scope and severity of the deficiencies cited more than justify the modest penalties. Both R1 and R7 suffered actual harm. R1's profound unhappiness with his situation is well-documented. CMS Ex. 25 at 3 ("he wanted to go home and . . . he was going to ask someone to take him."); CMS Ex. 27 at 12 ("I want to go home."). On March 6, he complained to the visiting ombudsman; he complained to Surveyor Elma Garza during the March survey ("I was told that my stay was going to be short visit in the secured unit."; "I don't know why I am here."; "[My doctor] told me I was just coming for rehab and that I would be released."). CMS Ex. 5

at 6; CMS Ex. 57 at 2 (Garza Decl.). He was depressed, complaining that he "did not like it here" and "had never been locked up before." He asked for alternative living arrangements. CMS Ex. 30 at 2.

In May, he told Surveyor Asencio Cortez that he "felt like crying." He complained that staff put the Wanderguard on his ankle and then moved him to a locked unit. They would not allow him to leave the facility. He said that he could live with his three sons and had a provider who would care for him. Surveyor Cortez described the resident as "alert and oriented," and easily able to express his feelings about his family, facility staff, and his stay at the facility. CMS Ex. 58 at 3 (Cortez Decl.). Knowing that his situation left him frustrated and depressed, facility staff nevertheless disregarded his rights and failed to provide services that he sorely needed. This suggests indifference to or disregard for his care, comfort and safety, and the facility is culpable.

Similarly, R7's risks for developing pressure sores were well-documented, and facility staff knew or should have recognized the importance of providing him with pressure-relieving devices. Yet, they gave him with a wholly-inadequate seat cushion and did not ensure that it functioned properly. Even after he developed the first sore, staff did not investigate and did not provide him an adequate pressure-relieving device so that he could sit safely. The facility is also culpable for these failures.

For these reasons, I find the penalties imposed reasonable.

## IV. Conclusion

CMS properly determined that the facility was not in substantial compliance with 42 C.F.R. §§ 483.10(b)(4), 483.15(a), (b), and (g)(1), 483.75, and 483.25(c). I affirm, as reasonable, the penalties imposed.

/s/
Carolyn Cozad Hughes
Administrative Law Judge