Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Good Shepherd Home - Bethlehem,
(CCN: 396108),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-17-631

Decision No. CR4945

Date: October 3, 2017

DECISION

I grant summary judgment in favor of the Centers for Medicare & Medicaid Services (CMS) sustaining its determination to impose civil money penalties of $1503 per day against Petitioner, Good Shepherd Home - Bethlehem, for each day of a period that began on July 29, 2016 and that extended through August 18 of that year.

I. Background

CMS moved for summary judgment, contending that there are no disputed issues of material fact. Petitioner, a Medicare-participating skilled nursing facility, opposed the motion. CMS filed 19 proposed exhibits in support of its motion, identified as CMS Ex.1-CMS Ex. 19, and Petitioner filed 8proposed exhibits in opposition, identified as P. Ex. 1-P. Ex. 8. I do not receive these exhibits into evidence inasmuch as I find grounds for summary judgment. However, I cite to relevant portions of the exhibits to the extent that they describe facts that are not in dispute.

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

A. Issue

Petitioner does not challenge CMS's allegation that it failed to comply substantially with the Medicare participation requirement stated at 42 C.F.R. § 483.25(h). This regulation requires that a skilled nursing facility ensure that its resident environment remains as free of accident hazards as is possible and that each resident of a facility receive adequate supervision and assistance devices to prevent accidents from occurring. However, Petitioner purports to challenge the scope and severity of CMS's determination of noncompliance and also challenges the daily civil money penalties that CMS determined to impose.

As I explain, a skilled nursing facility may challenge the scope and severity of a finding of noncompliance only in circumstances that are not applicable here. Nor may a facility challenge CMS's exercise of discretion to impose a daily civil money penalty as opposed to some other remedy. Consequently, there is only one issue that I may hear and decide in this case, that being whether the amount of the civil money penalty that CMS determined to impose, and its duration, are reasonable.

B. Findings of Fact and Conclusions of Law

It is undisputed that, between April 9 and July 29, 2016, three of Petitioner's debilitated residents sustained accidents when Petitioner's staff attempted to transfer the residents. On each occasion, the staff contravened Petitioner's written plans governing how the residents would be cared for and transferred. On one occasion involving the attempted transfer on July 29 of a resident identified as Resident 56, the resident sustained a fall due to the improper actions of Petitioner's staff, a fall that caused severe injury to the resident. These failures by Petitioner's staff to transfer its residents properly are the basis of CMS's finding of noncompliance and Petitioner neither disputes that the failures occurred nor does it contest the consequences of those failures.

The undisputed facts regarding these accidents are similar. In each instance, Petitioner's staff caused the accident by failing to follow facility procedures or a resident's plan of care while attempting to transfer a resident with the assistance of a mechanical lift. On April 9, 2016, Resident 14 slid to the floor while Petitioner's staff, two nurse's aides, attempted to transfer her from her bed to a wheelchair using a mechanical lift and sling. CMS Ex. 14 at 4; CMS Ex. 18 at 1. Upon investigating the accident, Petitioner determined that the cause was the staff's incorrect placement of the lift's sling under the resident. CMS Ex. 14 at 4, 10; P. Ex. 1 at 4. On May 13, 2016, Resident 46 fell when a nurse's aide attempted to transfer the resident via a mechanical lift, contravening explicit instructions that the resident only be transferred with the assistance of two aides. CMS Ex. 8 at 2; CMS Ex. 18 at 1-2. On July 29, 2016, Resident 56 fell when a nurse's aide

attempted to transfer the resident with a mechanical lift, contravening both the protocol for use of the lift and the facility's care plan that required two staff members to assist in transferring the resident. CMS Ex. 6 at 2; CMS Ex. 9 at 63; CMS Ex. 8 at 2. Resident 56 suffered severe injuries from the fall that included a fractured right tibia. CMS Ex. 9 at 34-35.

The undisputed facts make plain the common aspects of these accidents. Each of the three residents was severely debilitated at the time of his or her accident and was dependent on Petitioner's staff for assistance. Resident 56, for example, suffered from multiple sclerosis, aphasia, and dementia, among other things. CMS Ex. 9 at 10-11, 24-25. There were both facility protocols governing use of mechanical lifts and specific instructions in each resident's care plan governing how that resident should be transferred. Staff contravened these instructions and the staff's failure to follow those instructions were the proximate cause of the residents' accidents and the severe injuries sustained by Resident 56.

Moreover, the undisputed facts show that the accidents were entirely foreseeable in two respects. First, each accident was foreseeable in that it occurred as the consequence of staff's failure to follow instructions for transferring residents in general and the individual residents who sustained accidents. Second, the recurrence of accidents after April 8, 2016 should have put Petitioner's management on notice that something was seriously awry at its facility. Staff continued to contravene protocols and orders regarding transfers leading to a succession of accidents. Measures that Petitioner implemented to address each accident prior to July 29, 2016 – re-education of Petitioner's nursing staff of the appropriate transfer method for Resident 14 and, after the May 13 accident, training of staff for supervision and assistance for all unsupported sitting – plainly were inadequate measures given the accident that occurred on July 29. *See* P. Ex. 1 at 4-6.

CMS determines per-diem civil money penalties based on criteria set forth at 42 C.F.R. §§ 488.404 and 488.438. For non-immediate jeopardy level noncompliance, as occurred in this case, the range of applicable penalty amounts is from $103 to $6188 per day. There are criteria for determining where within a range a daily civil money penalty may fall. These may include: a facility's culpability; the seriousness of its noncompliance; its compliance history; and its financial condition. 42 C.F.R. §§ 488.438(f)(1)-(4); 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)).

CMS asserts, without contradiction, that Petitioner was cited in 2014 for failure to comply substantially with the requirements of 42 C.F.R. § 483.25. However, CMS's principal argument is that the seriousness of the deficiencies and Petitioner's culpability more than justify the civil money penalty amount. It points to the fact that Resident 56 suffered severe injuries that occurred as a consequence of the fall that the resident sustained due to the staff's failure to follow protocols and the resident's treatment plan. That accident and resulting injuries, according to CMS, were the culmination of a series

of similar accidents that began months prior to the July 29, 2016 fall. Petitioner's culpability for its failure to prevent the July 29 accident coupled with the seriousness of that accident are, according to CMS, more than sufficient to sustain the penalty amount.

I agree with CMS that the undisputed facts establish a level of seriousness of noncompliance that justifies civil money penalties of $1503 per day. The potential for harm and the actual harm resulting from Petitioner's noncompliance are in and of themselves sufficient to justify the penalty amount. I do not need to consider other regulatory factors in order to sustain the penalties.

Resident 56 was severely injured. By July 29, 2016, Petitioner's staff should have been hyper vigilant to the possibility of falls and injuries resulting from improper transfers, given the facility's recent history. The fact that this fall occurred notwithstanding the facility's history and, obviously, notwithstanding inadequate efforts by Petitioner to remediate prior accidents, amply supports the penalty amount. I note that the penalty amount actually is extremely modest in this case, comprising less than 25 percent of the maximum allowable amount for non-immediate jeopardy noncompliance.

Petitioner makes several arguments in opposition to CMS's motion for summary judgment, all of which I find to be without merit.

First, Petitioner appears to challenge the scope and severity of CMS's noncompliance findings. While admitting noncompliance, it seems to argue that its noncompliance was inconsequential and not something that merited imposition of remedies. That is not an argument that I have authority to hear and decide. With exceptions that are not relevant here, a skilled nursing facility may not challenge CMS's determination of the level of a facility's noncompliance. 42 C.F.R. § 498.3(b)(14); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x 181 (6th Cir. 2005).

Second, Petitioner attempts to minimize its noncompliance by asserting that the accident that occurred on July 29, 2016, was the fault of a wayward employee and not due to any omission by Petitioner's management. The facts certainly support the conclusion that it was employee misfeasance that caused the July 29 accident. However, that is no defense for Petitioner. A facility is responsible for the actions of its staff. Staff errors or misfeasance are imputed to the facility. *Springhill Senior Residence*, DAB No. 2513 at 13-14 (2013). Indeed, regulations governing skilled nursing facilities would be meaningless if facilities could shift the onus for noncompliance to their staff, because virtually all of the care provided by a skilled nursing facility is provided by a facility's staff.

Petitioner's principal argument is that there are disputed issues of fact that make summary judgment inappropriate. That argument has two aspects. First, Petitioner

asserts that there are facts showing that the accidents that occurred happened in the face of numerous and intensive efforts by Petitioner to protect residents from sustaining accidents. That, according to Petitioner, diminishes its culpability and renders the penalties excessive. Second, Petitioner asserts that the July 29 accident was at worst an isolated incident and it contends that it should not be penalized for that one event in light of its long history as a high quality facility.

I accept as true Petitioner's representations concerning the efforts it made to prevent accidents from occurring on its premises. However, they do not gainsay the undisputed facts that show that, despite these efforts, accidents of a similar nature occurred repeatedly at Petitioner's facility. Petitioner's staff continued to attempt inappropriate transfers of residents notwithstanding the training that they may have received and notwithstanding all of Petitioner's protocols, guidelines, instructions, and plans of care. These repeated accidents render irrelevant the facts offered by Petitioner concerning its accident prevention efforts. The only reasonable inference that I can draw from these recurring accidents of a very similar nature is that Petitioner should have known that its remediation efforts were inadequate and that it should have done more.

I do not accept Petitioner's characterization of the July 29 accident as isolated. Petitioner has not offered facts that justify that characterization. As I have stated, the July 29 accident was not isolated but was, in fact, the culmination of a series of very similar accidents that began months previously.

The gravamen of Petitioner's argument is that its culpability for the accidents, including the July 29 accident, is diminished in the face of all of the efforts it made to protect its residents. I do not predicate my finding that the penalty amount is reasonable on Petitioner's culpability; specifically, I do not weigh Petitioner's compliance history against Petitioner's proffered facts about the quality of care that it provides or the accident protection measures that its staff undertook. Rather, I premise my conclusion that the penalty amount is reasonable based exclusively on the seriousness of noncompliance that occurred *despite* Petitioner's accident prevention measures. The undisputed facts establish that the residents of Petitioner's facility who required transfer assistance were extremely debilitated individuals who were dependent on Petitioner's staff for assistance. These residents' vulnerability required the staff to be extraordinarily vigilant in providing care to them. The undisputed facts plainly establish that the necessary vigilance wasn't present. Moreover, the potential for harm – and the actual harm – caused by Petitioner's noncompliance was very high. Any of these residents could have been severely injured or worse as a consequence of a fall. Resident 56, in fact, was severely injured as a consequence of the staff's failure to follow directions in providing care to him.

Petitioner makes additional arguments that I find to be without merit. First, it asserts that CMS should have imposed a per-instance penalty rather than per-diem penalties, against

it. I have no authority to address this assertion. 42 C.F.R. § 488.408(g)(2). The authority to choose an appropriate remedy lies solely within CMS's discretion. Per-diem penalties plainly are authorized in this case. 42 C.F.R. § 488.408(d). That CMS had the authority to impose some other remedy does not confer authority on me to decide whether it ought to have done so.

Second, Petitioner argues that CMS should have offered it the opportunity to correct its noncompliance prior to CMS determining whether imposition of remedies was appropriate. That argument raises an issue of whether any remedies are appropriate in this case. Here, too, I lack authority to consider the merits of the argument. As I have stated, CMS has the discretion to impose the remedy that is at issue here. I have no authority to question that exercise of discretion.

Finally, I find no disputed facts addressing the duration of the penalties – 21 days – that CMS determined to impose. Petitioner did not offer affirmative proof showing that it corrected its noncompliance sooner than CMS determined that it had been corrected. Indeed, Petitioner did not allege in its plan of correction that it would attain substantial compliance prior to October 2, 2016.

_____/s/_____
Steven T. Kessel
Administrative Law Judge