Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Pleasant View Center,
(CCN: 30-5045),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-11-345

Decision No. CR2546

Date: May 31, 2012

DECISION

In this case I consider a long-term care facility's responsibility to insure that its residents are not exposed to recognized and easily-preventable hazards.

Petitioner, Pleasant View Center (Petitioner or facility), is a long-term care facility, located in Concord, New Hampshire, that participates in the Medicare program. The Centers for Medicare and Medicaid Services (CMS) has determined that, from December 2 through 3, 2010, the facility was not in substantial compliance with Medicare requirements governing staff treatment of residents (42 C.F.R. § 483.13(c)) and that its deficiency posed immediate jeopardy to resident health and safety. CMS imposed against the facility a civil money penalty (CMP) of $3,500 per day for two days. Petitioner appeals, and CMS moves for summary judgment.

For the reasons set forth below, I grant summary judgment. The undisputed facts establish that the facility was not in substantial compliance with 42 C.F.R. § 483.13(c) and that its deficiency posed immediate jeopardy. The penalty imposed is 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 New Hampshire Department of Health and Human Services (state agency) surveyed the facility from November 30 through December 3, 2010. Based on their findings, CMS has determined that the facility was not in substantial compliance with 42 C.F.R. § 483.13(c), which governs staff treatment of residents. CMS also determined that the facility's noncompliance posed immediate jeopardy to resident health and safety. CMS Exs. 1, 2.[1]

CMS has imposed against the facility a CMP of $3,500 per day for two days of immediate jeopardy – December 2 and 3, 2010. CMS Ex. 23.

Petitioner timely requested a hearing, and CMS now moves for summary judgment.

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[1] Initially, CMS also cited a deficiency under 42 C.F.R. § 483.25(c) and imposed a $5,500 per day CMP for the two deficiencies. CMS Ex. 2. It subsequently withdrew that finding and lowered the CMP to $3,500 per day. CMS Ex. 23. That CMS withdrew one of its deficiency findings does not, as Petitioner claims, "create a new basis for its enforcement decision." P. Reply at 5*; see* CMS Ex. 1 at 1-13 (survey report form setting forth in some detail the particulars of the survey findings regarding 42 C.F.R. § 483.13(c)); CMS Ex. 2 (providing notice of deficiencies cited under section 483.13(c)); CMS Ex. 22 (revised statement of deficiencies). Petitioner has had more than adequate notice as to the basis for the penalty imposed. *See also* CMS's Pre-hearing Brief at 8 (arguing that the facility's "noncompliance is illustrated by the facility's *delay in removing the plastic tie from R11's wheelchair, failure to investigate the cause* of R11's pressure ulcer, and *continued use of the plastic ties* on other residents' wheelchairs." (emphasis added)).

The parties filed prehearing briefs. CMS then submitted a motion for summary judgment and memorandum in support (CMS MSJ). Petitioner submitted a Reply. CMS has submitted 23 exhibits (CMS Exs. 1-23). Petitioner initially submitted 34 exhibits (P. Exs. 1-34). With its Reply, Petitioner submitted an additional four exhibits, P. Exs. 35-38.

CMS objects to my admitting P. Exs. 35-38, because Petitioner submitted them after the deadline set in my initial prehearing order. In that order, dated March 16, 2011, I directed the parties to submit prehearing exchanges, which included copies of each proposed exhibit, by no later than July 19, 2011 (CMS) and August 23, 2011 (Petitioner). The order warns that neither party is entitled to supplement its prehearing exchange, and a motion to supplement will be granted "based on considerations of good cause and absence of prejudice to the opposing party." Acknowledgment and Initial Pre-hearing Order at 3, ¶ 3 (March 16, 2011). Petitioner did not proffer the new exhibits until January 10, 2012, when it replied to CMS's motion for summary judgment. I agree that Petitioner has not shown good cause for admission of these exhibits. In its motion for summary judgment CMS relied solely on the evidence and arguments presented with its prehearing exchange. It raised no new issues and proffered no new evidence. P. Exs. 35-38 thus would not be admitted at a hearing, and I need not consider inadmissible evidence. *See, e.g., Law Co., Inc. v. Mohawk Const. & Supply Co., Inc.*, 577 F.3d 1164 (10th Cir. 2009). In any event, as the following discussion shows, the parties' dispute regarding the admissibility of these exhibits is purely academic. The assertions contained in those documents do not establish a material fact in dispute.

II. Issues

I consider whether summary judgment is appropriate.

On the merits, the issues before me are: 1) on December 2 and 3, 2010, was the facility in substantial compliance with 42 C.F.R. § 483.13(c); 2) if the facility was not in substantial compliance, did its deficiencies pose immediate jeopardy to resident health and safety; and 3) if the facility was not in substantial compliance, is the penalty imposed – $3,500 per day – reasonable?

III. Discussion

A. *CMS is entitled to summary judgment because the undisputed evidence establishes that facility staff knowingly exposed at least one vulnerable resident to an easily-preventable hazard and made no effort to determine whether other residents were also at risk, violating the facility's own policy and federal requirements prohibiting resident neglect, 42 C.F.R. § 483.13(c).*[2]

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

Summary judgment. Summary judgment is appropriate when a case presents no issue of material fact, and its resolution turns on questions of law. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986); *Livingston Care Ctr. v. U.S. Dep't.of Health & Human Servs.*, 388 F.3d 168, 173 (6th Cir. 2004); *see also Ill. Knights Templar Home*, DAB No. 2274 at 3-4 (2009), *citing Kingsville Nursing Ctr.*, DAB No. 2234 at 3-4 (2009). The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to [that party's] case, and on which [that party] will bear the burden of proof at trial." *Livingston Care Ctr.*, 388 F.3d at 173 (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986)). To avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586, n.11 (1986); s*ee also Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing & Rehab. Ctr.*, DAB No. 1918 (2004).

> To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact . . . .

Ill. Knights Templar, at 4; *Livingston Care Ctr.*, DAB No. 1871, at 5 (2003).

In examining the evidence for purposes of determining the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *Brightview Care Ctr.*, DAB No. 2132, at 2, 9 (2007); *Livingston Care Ctr.*, 388 F.3d at 172; *Guardian Health Care Ctr.*, DAB No. 1943, at 8 (2004); *but see, Cedar Lake*, DAB No. 2344 at 7; *Brightview*, DAB No. 2132, at 10 (entry of summary judgment upheld where inferences and views of non-moving party are not reasonable). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cedar Lake at 7; Guardian* at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.").

Drawing all reasonable inferences in Petitioner's favor, the undisputed facts lead to only one reasonable conclusion in this case: that the facility was not in substantial compliance with program requirements.

Program requirements. "Neglect" means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. 42 C.F.R. § 488.301. Facilities must develop and implement written policies and procedures that prohibit resident neglect. 42 C.F.R. § 483.13(c).

Section 483.13(c) "addresses a deficiency related to lack of an effective policy as opposed to one directed at the occurrence of neglect itself." *Emerald Oaks*, DAB No. 1800 at 12 (2001). However, the drafters of the regulation characterized as "inherent in [section] 483.13(c)" the requirement that "each resident should be free from neglect as well as other forms of mistreatment," 59 Fed. Reg. 56130 (November 10, 1994). The drafters also deliberately rejected the suggestion that the regulations require evidence of a negative outcome to support the finding of neglect.

> We do not accept this comment because neglect may be determined even if no apparent negative outcome has occurred. The *potential* for negative outcome must be considered.

59 Fed. Reg. at 56130 (emphasis added).

Here, consistent with these requirements, the facility's abuse prohibition policy prohibits "abuse, neglect, involuntary seclusion, and misappropriation of property for all residents. . . ." The policy defines neglect as "an act or omission which results or could result in the deprivation of essential services or supports necessary to maintain the minimum mental, emotional, or physical health and safety of an incapacitated adult." In order to prevent neglect, the policy calls for (among other practices): employee training, preventing occurrences, identifying possible incidents or allegations that need investigation, and reporting incidents, investigations, and the facility's response to its investigations. CMS Ex. 5 at 1.

The policy defines "injuries of unknown origin" as injuries that meet two conditions: 1) the source was not observed by any person or could not be explained by the resident; and 2) the injury is suspicious because of its location, e.g., it is located in an area not generally vulnerable to trauma. CMS Ex. 5 at 2. The policy requires that injuries of unknown origin be investigated to determine if abuse or neglect is suspected. CMS Ex. 5 at 3.

CMS does not fault the facility's written policy. However, the regulation requires that policies be "implemented," and implementing a policy requires more than drafting and maintaining documents. Staff must follow the policy. As the Departmental Appeals Board (Board) has long recognized, examples of neglect can demonstrate that the facility has not implemented an anti-neglect policy. *Barn Hill Care Ctr.*, DAB No. 1848 at 9-12 (2002); *Emerald Oaks*, DAB No. 1800 at 18; *see also The Cottage Extended Care Ctr.*, DAB No. 2145 at 4, n. 4 (2008); *Liberty Commons Nursing & Rehab Ctr. – Johnston*, DAB No. 2031 at 7-17 (2006), *aff'd, Liberty Nursing & Rehab Ctr. – Johnston v. Leavitt*, 2007 WL 2088703 (4th Cir. 2007); 59 Fed. Reg. 56130.

Undisputed facts. Resident 11 (R11) was a 91-year-old woman, suffering from chronic airway obstruction, deformities of her ankle and foot, difficulty walking, muscle

weakness, and osteoarthritis. CMS Ex. 6 at 119; P. Ex. 12 at 1. She was at risk for skin breakdown due to her limited mobility, incontinence, senile purpura, and fragile skin. CMS Ex. 6 at 101; P. Ex. 12 at 19, 20; P. Ex. 31 at 10 (Wareing Decl.). She had limited mobility and poor body alignment and required an adapted wheelchair. CMS Ex. 6 at 105, 117; P. Ex. 6; P. Ex. 31 at 3, 10 (Wareing Decl.).

A "physician progress note," dated July 20, 2010, which was written by Nurse Practitioner Victoria Gorveatt, identifies a dime-sized open wound on the resident's left shin "directly parallel to plastic hard tie with point sticking out, around bar on her wheelchair," and opines that the wound "probably started from there." Among other instructions, the note says: "remove plastic tie that is tied around [resident's] wheelchair close to her wound." CMS Ex. 6 at 23; P. Ex. 16 at 1.

A week later, on July 26, 2010, Nurse Practitioner Gorveatt noted that the plastic tag had not been removed, so she removed it herself. She also reported that the resident complained that her wound hurt. CMS Ex. 6 at 24; P. Ex. 16 at 2.

Everyone agrees that R11 was especially vulnerable to skin breakdown and injury. P. Reply at 10. As Petitioner asserts, even relatively "minor trauma or shearing as minimal as an insect bite or simply moving or turning in bed or wheelchair" could open a wound or cause other skin injury. P. Reply at 7. Open wounds create especially serious problems for the aged and infirm, who have difficulty healing and are vulnerable to infection. The facility thus had a heightened duty to insure that R11 was not exposed to any needless risk of skin injury.

Everyone also agrees that the plastic tag was attached to the resident's wheelchair, and was positioned in such a way that it threatened to damage the resident's vulnerable skin. According to the facility's Director of Nursing (DON), Sharon Wareing, R.N., "the opening in the top layer of [R11's] skin may have been caused by a minor trauma such as bumping against . . . a plastic identification tag that would not injure normal skin. . . ." P. Ex. 31 at 2 (Wareing Decl.). DON Wareing also agrees that "the *opening* of the top layer of [R11's] skin most likely was caused by rubbing against a tag or part of the wheelchair, or some similar very minor trauma." P. Ex. 31 at 6 (Wareing Decl.) (emphasis in original).

Sandra Currid, N.P., a second nurse practitioner who makes rounds at the facility, agreed that Nurse Practitioner Gorveatt's initial assessment that R11's wound began as a skin tear caused by the plastic identification tag on her wheelchair "seems logical." P. Ex. 33 at 3.

In a consultation note dated December 3, 2010, the facility's medical director, Gary Sobelson, M.D., wrote that the "ulcer" on R11's lower left extremity was "likely initially traumatic due to a tag/label on wheelchair." CMS Ex. 6 at 15; P. Ex. 20 at 1.

Everyone also agrees that staff did not remove the tag when Nurse Practitioner Gorveatt directed them to do so.

Petitioner suggests that R11's injuries were not caused by the tag but were probably caused by her rubbing against some part of her wheelchair, a screw or metal bar. P. Reply at 14-15. In support of this proposition, Petitioner cites an occupational therapy note dated August 3, 2010 that says "wound on shin area due to [wheelchair] screw" (P. Ex. 8) and an occupational therapy (OT) assessment, also dated August 3, 2010, that says R11 has "two dressing[s] on [her] left calf reported to be areas of breakdown [related to] left leg resting against metal bar of foot rest." P. Ex. 27 at 4. Even drawing every reasonable inference in Petitioner's favor, this evidence does not establish that the tag did not pose a risk to R11's safety. First, the therapists assessed the wheelchair's safety more than a week *after* Nurse Practitioner Gorveatt removed the tag.[3] They simply had no way of knowing whether the tag caused the wound or posed a risk, because they did not see the tag (although they saw other risks).

Moreover, the OT evidence supports CMS's claim that the facility inadequately investigated the cause of R11's wound. The therapists examined the wheelchair *two weeks after* the wound appeared, which shows that the facility exposed R11 to a potentially hazardous situation without even assessing the hazard, much less implementing the relatively minor interventions (padding the screw and the metal bar) identified as necessary to prevent further injury.[4]

Ultimately, I need not find that the tag (or any particular part of her wheelchair) actually caused R11's leg wound. The uncontroverted evidence establishes that facility staff exposed a vulnerable resident to a hazard with the potential for causing her significant harm. The resident's nurse practitioner brought the danger to staff's attention and asked them to remove it. They did not, even though removing the tag was obviously a simple task. The facility therefore failed to provide the resident with the services she needed to avoid physical harm and was not in substantial compliance with 42 C.F.R. § 483.13(c).

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[3] Whether the therapists performed an assessment is highly questionable. One wrote a brief note, and the other wrote what was "reported." However, drawing all inferences in Petitioner's favor, I accept, for summary judgment purposes, that these were assessments.

[4] In this regard, Petitioner also suggests that the facility was not required to investigate formally, because the nature of the wound "obviously" was not in a category" that "*might* trigger a suspicion that the cause was abuse." P. Reply at 15 (emphasis in original). But the facility's policy, which it was bound to follow, applies to any injury of unknown origin, and provides that potential neglect must also be investigated. P. Ex. 5.

The parties quibble about whether Nurse Practitioner Gorveatt issued an actual physician's order. Petitioner belatedly submitted a written declaration from Nurse Practitioner Gorveatt in which she confirms the contents of her July 20 note, and admits that she also "orally recommend[ed] to a nurse . . . that she or someone at the facility should evaluate the wheelchair and the plastic tie," but she asserts that her directions were not "orders," and she did "not intend [her] suggestion to trigger the consequences CMS now suggests." P. Ex. 35 at 2, 3.[5] This disagreement does not create a dispute of material fact. First, whether the characterization of the written instruction is even a "fact" (as opposed to a conclusion based on undisputed facts) is questionable. More important, the dispute is not material. No matter how you characterize Nurse Practitioner Gorveatt's written and verbal instructions, she unquestionably observed a potential danger and brought it to staff's attention, but staff failed to act.

Additional use of tags. The facility used the tags to coordinate wheelchairs with their leg rests/leg extensions, and the parties agree that, as late as the time of the survey, the tags were still in use. CMS Ex. 6 at 7; CMS Ex. 21 at 3 (Collins-Spiller Decl. ¶ 7); P. Ex. 31 at 12 (Wareing Decl.). Notwithstanding the potential hazard, which staff should have recognized, the facility did not investigate to determine whether other residents were at risk of injury from the tags. Making no effort to identify and prevent risk violates the facility's neglect policy and puts the facility out of substantial compliance with 42 C.F.R. § 483.13(c).

The parties argue about the tags themselves. According to CMS, they were designed for non-medical uses. CMS Ex. 20 at 2-3 (Small Decl. ¶ 6); CMS MSJ at 4-5, 13. Petitioner claims that such "identification tags with soft plastic ties . . . are commonly used in health care settings to secure tubes, equipment, etc., because they are not considered to present any danger or hazard." P. Ex. 31 at 12 (Wareing Decl.). Again, I find this dispute immaterial. These tags may well be considered safe for most purposes, but, here, they were identified as a potential hazard to certain vulnerable residents, notably R11. Staff should have immediately removed that hazard when it was recognized as such, and checked to insure that the tags did not present risk of injury to others. Their failure to do so puts the facility out of substantial compliance with 42 C.F.R. § 483.13(c).

B. CMS's determination that the facility's deficiency posed immediate jeopardy to resident health and safety is not clearly erroneous.

Immediate jeopardy exists if a facility's noncompliance has caused or is likely to cause "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's

[5] As noted above, Nurse Practitioner Gorveatt's declaration is likely inadmissible and need not even be considered.

determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy, and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1931 at 27-28 (2004), *citing Koester Pavilion*, DAB No. 1750 (2000); *Daughters of Miriam Ctr.*, DAB No. 2067 at 7, 9 (2007).

Here, the tag left on R11's wheelchair probably caused – and certainly was likely to cause – a skin injury. Such an open wound can be especially dangerous to the aged and infirm, subjecting them to risks of infection and other serious consequences. The staff's disregard for the facility's anti-neglect policy, as evidenced by their failure to remove immediately an identified risk to R11 and their failure to determine whether other vulnerable residents were exposed to similar risks shows a situation likely to cause serious injury.

CMS's immediate jeopardy determination is therefore not clearly erroneous.

C. The penalty imposed is 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; *Cmty. Nursing Home*, DAB No. 1807, at 22 *et seq.* (2002); *Emerald Oaks*, DAB No. 1800, at 9; *CarePlex of Silver Spring*, DAB No. 1638, at 8 (1999).

CMS imposed a penalty of $3,500 for two days of immediate jeopardy, which is at the very low end of the range for situations of immediate jeopardy ($3,050-$10,000). 42 C.F.R. §§ 488.408(e)(iii); 488.438(a)(1)(i). The facility's compliance history alone more than justifies this relatively modest increase beyond the minimum penalty. As

CMS points out, in 2008, deficiencies were cited under regulations governing notification of change, comprehensive care plans, accidents and supervision, pharmacy services and clinical records. The most serious deficiency (accidents and supervision) caused actual harm (referred to as a "G level" deficiency). CMS Ex. 4 at 6.

The facility does not claim that its financial condition affects its ability to pay the CMP.

I need not consider the remaining factors to sustain the penalty imposed. But the deficiency is not minor. Facility staff could easily have removed an identified hazard. Inexplicably, they did nothing, for which the facility is culpable. The penalty imposed is therefore reasonable.

IV. Conclusion

I grant CMS's Motion for Summary Judgment, because the undisputed evidence establishes that the facility was not in substantial compliance with 42 C.F.R. § 483.13(c), that its deficiency posed immediate jeopardy to resident health and safety, and that the penalty imposed is reasonable.

/s/
Carolyn Cozad Hughes
Administrative Law Judge