Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Lifehouse of Riverside Healthcare Center,
(CCN: 55-5330),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-1378

Decision No. CR3845

Date: May 8, 2015

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose the following remedies against Petitioner, Lifehouse of Riverside Healthcare Center, a skilled nursing facility:

- A per-instance civil money penalty of $2500; and

- Civil money penalties of $850 per day for each day of a period that began on May 16, 2014 and that ran through July 1, 2014.

I. Background

The remedies in this case result from two surveys of Petitioner. The per-instance penalty was imposed after a survey that was completed on January 23, 2014 (January survey). The daily penalties were imposed after a survey that was completed on May 16, 2014 (May survey). Petitioner challenged the findings of noncompliance that were made at both surveys and CMS's remedy determinations.

I held a hearing on February 10, 2015. I received exhibits from CMS that are identified as CMS Ex. 1 – CMS Ex. 30 and exhibits from Petitioner that are identified as P. Ex. 1 – P. Ex. 26.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues are whether: Petitioner failed to comply substantially with Medicare participation requirements; and CMS's remedy determinations are reasonable.

B. Findings of Fact and Conclusions of Law

The allegations of noncompliance that were made at the January survey are that Petitioner failed to comply with the requirements of 42 C.F.R. §§ 483.13(b) and 483.13(c)(1)(i). These regulations provide that a resident of a skilled nursing facility has the right to be free from all forms of abuse and prohibit a facility's staff from using mental, sexual, or physical abuse or corporal punishment in dealing with a facility's residents. CMS alleges that, in the early morning hours of September 18, 2013, one of the nursing assistants on Petitioner's staff verbally and physically abused a resident who is identified as Resident # 1 in the report of the January survey. CMS Ex. 1 at 1 – 6.

Resident # 1 was an 85-year-old woman who was incontinent and who depended on Petitioner's staff for assistance in going to the bathroom. CMS Ex. 2 at 1, 5, 36. The resident's care plan specified that she would receive assistance from a member of Petitioner's staff when she needed to relieve herself. *Id.* at 12, 18.

CMS alleges that the following occurred at between 2 and 3 a.m. on the morning of September 18. The resident, who was in bed at the time, needed to use the bathroom and pressed her call light button. CMS Ex. 8 at 5, 6; CMS Ex. 14 at ¶ 10. A nursing assistant (CNA # 1) responded to the call for help. When told by the resident that she needed assistance in going to the bathroom, the nursing assistant at first responded by telling the resident to just go in her incontinence brief. CMS Ex. 8 at 5. CNA # 1 then pulled the resident out of her bed by her left arm, causing the resident to cry out in pain and to protest. *Id.* at 6. After taking the resident to the bathroom, the nursing assistant then escorted her back to bed. She grabbed the resident's arm and pulled it downwards towards the bed, causing the resident to again exclaim that CNA # 1 was hurting her. CMS Ex. 1 at 2, 3; CMS Ex. 14 at ¶ 13.

The conduct alleged by CMS unquestionably would constitute abuse by any measure. As described, CNA # 1 both verbally and physically abused Resident # 1, demeaning her by telling her to relieve herself in her incontinence brief and then, deliberately manhandling her not once, but twice.

Petitioner does not dispute that this conduct would be abuse if it occurred. Its argument is that the allegations of abuse are not credible. It casts doubt on the veracity of Resident # 1's account of the events of September 18, asserting that the resident was too confused and, possibly, demented to give an accurate recitation of what occurred. It asserts also that there is no corroboration for the resident's story. According to Petitioner, CMS's entire case is based on flimsy, unsupported evidence, and it simply should not be taken seriously.

I disagree. Petitioner's arguments notwithstanding, the evidence clearly describes abuse and it describes it convincingly.

It is true that Petitioner's staff assessed Resident # 1 as having episodes of confusion. The staff also described the resident as being moderately impaired. But, that is contradicted by assessments of the resident as not displaying any memory impairment. CMS Ex. 2 at 31. As CMS notes, the resident consistently reported the same story when she described the events of September 18, suggesting that her memory was not impaired when it came to recalling those events. CMS Ex. 1 at 2; CMS Ex. 8 at 6; CMS Ex. 14 at ¶¶ 10, 14. However, I would be reluctant to find the resident's story credible based solely on her recollection, even if there is no evidence suggesting that the resident may have been confused at times. Standing alone, the resident's account is uncorroborated hearsay.

However, there is significant corroboration for the resident's assertions. First, and foremost, there is the account of Resident # 1's roommate, Resident # 2, which corroborates Resident # 1's account in almost every detail. CMS Ex. 1 at 2; CMS Ex. 5; CMS Ex. 7 at 1, 9; CMS Ex. 8 at 6; CMS Ex. 14 at ¶ 13. Resident # 2 was sufficiently concerned about the events of September 18 as to report them voluntarily. There is no evidence that Resident # 2 suffered from memory problems or confusion. CMS Ex. 3 at 3. Indeed, this resident was considered so trustworthy by her fellow residents that she served as the elected president of the Resident Council at Petitioner's facility. CMS Ex. 8 at 1. She also was in a position to understand the significance of the events that she witnessed because she was a former nursing assistant. CMS Ex. 3 at 1. Petitioner has offered no evidence that undercuts Resident # 2's corroborating account except to describe it as hearsay. I find it to be credible and reliable.

There is also physical evidence that supports the accounts of Residents # 1 and # 2 consisting of bruises that were sustained by Resident # 1. Petitioner's executive director interviewed Resident # 1 on September 20, 2013, just two days after the incident in question, and observed two red bruises on the resident's arm, consistent with the accounts that Residents # 1 and # 2 gave about Resident # 1 being grabbed and pulled by CNA # 1. CMS Ex. 5; CMS Ex. 7 at 9; CMS Ex. 8 at 6. Bruised areas were observed again a week later by the surveyor who conducted the January survey. CMS Ex. 9; CMS Ex. 14 at ¶ 11.

Petitioner attempts to undermine the significance of these bruises by asserting that when the surveyor observed them, more than a week had elapsed since the 18th of September and by arguing that other, intervening events might have caused the bruises. However, that argument does not account for the fact that Petitioner's own executive director observed the same bruises nearly contemporaneously with the incident reported by Resident # 1. These bruises are entirely consistent with what the resident claimed to have occurred and I find that they provide important corroboration for her assertions.

Petitioner has not offered evidence that credibly contradicts the accounts of Residents # 1 and # 2. It relies to some extent on the statement given by CNA # 1. She admitted to committing verbal abuse, in that she acknowledged that she told the resident to relieve herself in her incontinence brief. CMS Ex. 8 at 5. She denied physically abusing the resident. However, she admitted that she grabbed the resident's arm in order to stabilize her.[1] The CNA's statement, self-serving as it is, actually does more to corroborate the residents' assertions than to undercut them.

CMS determined to impose a per-instance civil money penalty of $2500 as a remedy for the abuse that occurred on September 18, 2013. I find that amount to be entirely reasonable. The abuse that occurred was serious. Resident # 1 – frail and dependent – could have been injured far more seriously than she was when CNA # 1 forcibly grabbed her and pulled her by the arm. The penalty that CMS determined to impose was only one-quarter the maximum per-instance civil money penalty that CMS could have imposed for this abuse. 42 C.F.R. § 488.438(a)(2). It is quite modest considering the seriousness of the abuse.

The allegations of noncompliance that were made at the May survey are that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h). CMS Ex. 15. This regulation requires a facility to maintain a resident environment that is as free of accident hazards as is possible and to provide each of its residents with adequate supervision and assistance devices to prevent accidents from occurring. The regulation has been interpreted universally to require a facility to take all reasonable measures necessary to protect its residents against accidents.

CMS's allegations of noncompliance center around the care that Petitioner gave to a resident who is identified as Resident A. The resident was, as of the May survey, a highly debilitated and utterly dependent individual. Among other problems the resident exhibited poor impulse control, involuntary muscle spasms, and contractures in both of her arms. CMS Ex. 17 at 1-2, 7, 17-18. She was totally dependent on Petitioner's staff

[1] Petitioner's management found CNA # 1 not to be credible and discharged her after receiving this statement from her. Indeed, this shows that Petitioner originally found the abuse allegations made by Resident # 1 to be credible and substantiated. CMS Ex. 5 at 3.

for bed mobility. Petitioner's staff assessed the resident as being at a high risk for falls, assessing the resident's risk at a level of 22 on a scale in which any score above 10 established that the assessed individual was at risk for falling. *Id.* at 15, 19, 30.

Petitioner addressed the resident's falls risk in part by assigning her to a bed that could be lowered to within six inches of the floor. CMS Ex. 15 at 2; CMS Ex. 17 at 84. The intent was to leave the bed in a lowered position so that the resident would not fall far if she fell out of the bed while unattended. CMS Ex. 15 at 4, 6.

The resident's physical problems meant that she had to be positioned while she was in bed. The resident could not tolerate lying on her back. However, she was not capable of maintaining her position independently when she was placed on her side. CMS Ex. 15 at 3-4. Petitioner's solution to this problem was to place the resident in the center of her bed so that she did not roll off the bed and to stabilize her position (on her side) with pillows. *Id.*

CMS asserts that, on March 8, 2014, a CNA raised the resident's bed to waist level (the CNA is five feet, eight inches tall, so I infer that the bed would have been elevated to about three feet above the floor) in order to provide care to the resident. CMS Ex. 15 at 4-5. The CNA left the resident unattended for a brief period, with the resident lying on her side and not stabilized by pillows. *Id.* While unattended the resident fell from the bed, sustaining facial fractures. CMS Ex. 18 at 12; CMS Ex. 23 at 2.

The care given to Resident A, as described by CMS, is evident noncompliance. Petitioner's staff had assessed this resident as being at a very high risk for falling due to her extreme debilitation and helplessness. The staff had addressed this risk by giving the resident a low bed and by stabilizing her with pillows while she was in bed. However, on March 8, the staff failed to assure that the resident received these protections, disregarded the risks to the resident, and the staff's omissions on that date contributed to the resident's fall and resulting severe injuries.

Petitioner does not deny that its staff attempted to address Resident A's fall risk by providing her with a bed that could be lowered. Nor does it deny that the intent was that the bed be kept in a lowered position while the resident was unattended. However, Petitioner argues that it would have been impossible to provide care to Resident A while her bed was lowered. Thus, according to Petitioner, it was necessary on March 8 to raise the bed.

But, that doesn't excuse Petitioner for the accident that occurred on that date. If it was necessary to raise the bed in order to provide care to Resident A, then the staff never should have left the resident unattended while the bed was raised. The CNA invited the accident that did occur by walking out of the resident's room into the bathroom and leaving her unattended in a raised bed.

Petitioner also asserts that there is no regulatory requirement that Resident A be in a lowered bed or be stabilized with a pillow. From that, it seems to argue that the staff was not remiss on March 8 when it failed to lower the bed or stabilize the resident. That argument avoids the fact that it was Petitioner's *own staff* that determined that lowering the bed and stabilizing the resident were necessary.

The regulations do not prescribe precisely what measures a facility must take in order to protect a resident against accidents. The regulations require that a facility take all reasonable measures to protect its residents. Here, the staff had determined that lowering the bed and stabilizing the resident were reasonable and necessary measures. It was obligated, then, to provide those protections until and unless it determined either that they were unnecessary or that alternative measures needed to be employed. That is not what happened here. In this case, the resident was left unprotected in a raised bed and without stabilization. That is obvious noncompliance.

Petitioner also asserts that it was reasonable that the resident be left without stabilization on March 8 because the CNA had determined that it was necessary to leave her unstabilized while he provided care to her. But, the CNA was not providing care when the resident fell. He had walked out of the room, albeit briefly. In that circumstance the resident either needed to be stabilized or observed by someone in a position to protect her. Leaving her unattended and unstabilized was – by Petitioner's own assessment – a risky and dangerous action.

CMS imposed a per-diem civil money penalty of $850 for each day from May 16 through July 1, 2014. Petitioner has not challenged the duration of the noncompliance. It has not argued that, if it was noncompliant, it corrected its deficiencies sooner than the date determined by CMS. Nor has Petitioner challenged the daily penalty amount as unreasonable. Consequently, I sustain both the duration of noncompliance and the penalty amount as a reasonable remedy for Petitioner's noncompliance.

/s/
Steven T. Kessel
Administrative Law Judge