Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

The Harborage
(CCN: 31-5307),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-17-846

Decision No. CR4988

Date: December 14, 2017

DECISION

I grant summary judgment in favor of the Centers for Medicare & Medicaid Services, sustaining its determination to impose a per-instance civil money penalty of $4663 against Petitioner, The Harborage, a skilled nursing facility.

I. Background

CMS filed a brief and 39 proposed exhibits, identified as CMS Ex.1-CMS Ex. 39, in support of its motion. Petitioner filed a brief in opposition plus 24 proposed exhibits, identified as P. Ex. 1-P. Ex. 24.

I do not rule on the admission of any of these proposed exhibits into evidence. That is unnecessary inasmuch as I render a decision based exclusively on undisputed material facts. However, I cite to some of the parties' exhibits to the extent that they provide bases for facts that are not in dispute.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues are whether Petitioner failed to comply substantially with a Medicare participation requirement and whether, if non-compliance occurred, a per-instance civil money penalty of $4663 is reasonable.

B. Findings of Fact and Conclusions of Law

CMS asserts that Petitioner failed to comply substantially with the Medicare participation requirement stated at 42 C.F.R. § 483.25(c). This regulation requires a skilled nursing facility to ensure that a resident who enters that facility without pressure sores does not develop a sore unless the resident's clinical condition demonstrates that development of a sore is unavoidable. Additionally, the regulation provides that a facility must ensure that a resident who develops a pressure sore receives the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.

CMS alleges that Petitioner failed to provide the necessary care and services to prevent two of its residents, identified as Residents #s 9 and 16, from developing pressure sores. In support of its allegations CMS asserts that Petitioner failed to provide care that its own staff identified as being necessary to protect the residents from developing pressure sores.

As I shall discuss, the undisputed facts of this case amply establish that Petitioner's staff did not provide care to the two residents that Petitioner had determined was necessary to protect the residents or that was mandated by professionally recognized standards of care. These failures are plainly sufficient to establish that Petitioner failed to substantially comply with regulatory requirements.

Petitioner does not directly deny the facts recited by CMS in support of its motion. Rather, it collaterally attacks CMS's case for noncompliance. It concedes that Resident # 9 developed a pressure sore during her stay at Petitioner's facility but contends that the development of this sore was unavoidable. Therefore according to Petitioner, it is immune from assertions that it failed to comply with regulatory requirements in providing care to this resident. As respects Resident # 16, Petitioner argues that the resident did not actually develop a pressure sore, but rather, a condition that Petitioner describes as "moisture associated skin damage." Consequently, according to Petitioner, it cannot be held accountable for failure to comply with the pressure sore regulation in providing care to Resident # 16.

I find these arguments to be irrelevant to the issue of compliance. In the case of Resident # 9, whether or not the pressure sore that she developed was unavoidable is no defense because Petitioner failed to provide the resident with preventative care that the regulation

mandates. Petitioner may not evade liability by now asserting that providing obligatory care would have been futile. That is a post hoc rationalization that would let even the most deficient facility off the hook. As a matter of law, a pressure sore cannot be considered as unavoidable if a facility fails to provide the prophylactic care that it has prescribed to a resident in order to prevent the development of pressure sores. *Clement Nursing & Convalescent Ctr.*, DAB No. 1923 (2004).

Similarly, asserting that Resident # 16 did not develop a pressure sore but, in fact, developed some other skin issue, does not relieve Petitioner of its responsibility to implement the protocol that it had prescribed in order to protect the resident from developing sores. Moreover, in the case of Resident # 16, Petitioner staff identified a pressure sore on the resident. Saying now that the staff was wrong – as Petitioner argues – is simply an additional post hoc rationalization for its failure to provide mandated care.

42 C.F.R. § 488.25(c) requires a facility to provide care and treatment to address a potential for pressure sore requirement to every resident who is at risk for developing a sore. Petitioner identified Resident # 9 as being at a high risk for developing pressure sores. CMS Ex. 4 at 3. Petitioner developed an interdisciplinary care plan for the resident that it intended expressly to address that high risk. CMS Ex. 4 at 9. The care plan's mandatory interventions included, along with other interventions, conducting a weekly systematic inspection of the resident's skin, providing the resident with a pressure redistribution mattress, carrying out a program that required the staff to turn and reposition the resident regularly, and reporting any signs of skin breakdown. *Id.*

The undisputed facts show that Petitioner did not provide to Resident # 9 the care that its staff had mandated.

Most vividly, these facts demonstrate that Petitioner's staff failed to check and assess the resident for the possible development of pressure sores until after the staff identified a sore on January 19, 2016, eleven days after her admission to Petitioner's facility. CMS Ex. 4 at 1; CMS Ex. 17 at 8. There is nothing in the treatment records for Resident # 9 showing that the staff conducted the weekly systematic skin assessment mandated by the resident's care plan at any time prior to January 19 and Petitioner has not offered any facts to rebut the inference that the absence of any record of assessments establishes failure by Petitioner's staff to conduct them.

It is unnecessary to speculate whether the resident's pressure sore developed prior to January 19, 2016. The failure by Petitioner's staff to conduct mandated skin assessments of Resident # 9 meant that the staff would have had no way of knowing whether a sore developed prior to the 19th.

Petitioner argues that Resident # 9, who was largely confined to her bed as a result of traumatic injury, was in a great deal of pain and resisted the staff's efforts to assess her.

It offers facts showing that the resident experienced pain. But, it has not offered any facts that would permit an inference that the staff failed to conduct skin assessments because the resident was in too much pain to be assessed or because resident refused this care. The records offered by the parties are devoid of any statement to that effect. Petitioner has offered no affirmative facts that suggest that the staff withheld skin assessments because of the resident's resistance or for any other legitimate reason. No member of Petitioner's staff offers testimony to that effect.

Petitioner argues that the skin folds on Resident # 9's buttocks made it difficult for the staff to visualize areas of the resident's skin and hid resident's sore. *See* CMS Ex. 1 at 4. However, Petitioner's director of nursing conceded that simply lifting the resident's skin to expose the concealed area would have revealed the sore. CMS Ex. 17 at 9. Besides, Petitioner is not contending that its staff conducted weekly skin checks and failed to notice the resident's sore because of some anatomical feature that rendered detection impossible. The undisputed facts show that the staff failed entirely to conduct the mandatory checks.

In fact, Petitioner's requirement that the staff conduct weekly skin checks of Resident # 9 understates what the care plan imposed on the staff in terms of assuring that the resident did not evidence signs of a pressure sore. The care plan required the staff to report any signs of skin breakdown exhibited by the resident as part of the daily care that it provided to her. CMS Ex. 4 at 9. The resident was on prescribed bed rest during the period leading up to January 19 and was utterly dependent on Petitioner's staff to keep her clean and dry. Providing such care required the staff to cleanse areas that included the skin on the resident's buttocks and perineal area. The staff should have observed the development of a pressure sore prior to the 19th if, in fact, it was performing this care diligently and observing the condition of the resident's skin.

One of the interventions expressly required by Resident # 9's care plan was that the resident be repositioned. CMS Ex. 4 at 9. Repositioning this resident was a critical measure to prevent the development of pressure sores because she was essentially helpless. CMS Ex. 32 at 10. Petitioner's staff found that the resident needed extensive assistance in order to turn. She was unable to reposition herself in order to prevent excessive pressure on her buttocks. CMS Ex. 4 at 2, 5. As of January 15, 2016, the resident continued to need assistance by two individuals in order to reposition herself. *Id.* at 21. Notwithstanding this clear need, there exist no facts showing that Petitioner's staff regularly repositioned the resident. The reasonable inference that I draw from this absence of facts is that Petitioner's staff was not regularly repositioning the resident.

Petitioner did not offer facts showing that its staff repositioned the resident regularly. Instead, it asserts that the resident was resistant to care due to the pain that she was experiencing. This, suggests Petitioner, provides it with an excuse for its failure to

follow its protocol, as contained in the resident's plan of care, requiring that the resident be repositioned.

But, Petitioner did not offer facts that support this argument. Although it asserts that Resident # 9 was resistant to care due to her pain, it offers no records showing that the resident resisted care or that the staff ever withheld care as a consequence of the resident's asserted resistance. Furthermore, it offers nothing to show that Petitioner's staff ever assessed the impact of the resident's resistance to care if, in fact, the resident resisted care.

In designing Resident # 9's care plan Petitioner's staff determined that regular repositioning was a necessary element of the resident's care and an important measure to protect the resident against the development of pressure sores. If, in fact, the resident resisted repositioning, then Petitioner's staff should not only have noted that resistance, but considered alternative care measures in lieu of repositioning in order to protect the resident. But, there are no facts to suggest that Petitioner's staff considered or addressed this issue prior to January 19.

Petitioner's staff failed to follow its plan of care for Resident # 9 in one other critical respect. The resident's plan of care, developed on January 8, 2016, mandated that the resident receive a pressure-relieving mattress beginning on that date. CMS Ex. 4 at 9. However, this mattress was not authorized for the resident until January 19, 2016, the date when the staff discovered the resident's pressure sore. *Id.* I do not conclude that the failure by the staff to provide the resident with a pressure-relieving mattress caused the resident to develop a sore. But, I do find that the use of a pressure-relieving mattress was a mandatory intervention to protect the resident against the development of sores that the staff failed to implement. Petitioner has not offered any explanation for this failure.

The care that Petitioner provided to Resident # 16 betrays the same deficiencies as with Resident # 9. Once again, there is a failure to implement the resident's plan of care. This failure was compounded by the staff's failure to act appropriately after they concluded that the Resident developed a pressure sore.

Resident # 16's plan of care stated that she was at risk of developing a pressure sore. CMS Ex. 3 at 6. The plan directed the staff to implement several interventions in order to protect the resident, most notably, requiring the staff to reposition the resident every two hours when she was in bed. *Id.*

However, the record is devoid of any facts showing that Petitioner repositioned the resident per the requirements of her care plan. CMS Ex. 3, at 1-4, 6. In the absence of such facts the only reasonable inference that I may draw is that Petitioner failed to reposition the resident. In its brief, Petitioner states as a conclusion that interventions were implemented that included turning and repositioning the resident. Petitioner's pre-

hearing brief at 12. But, it offers no facts to support that conclusion. It has not offered any records that show that the resident was repositioned nor has it offered testimony to that effect.

Similarly, there are no facts showing that Petitioner's staff actually conducted the comprehensive skin checks required by the resident's plan of care. The resident's treatment administration record has checkmarks in it next to the box for weekly skin checks. CMS Ex. 3 at 1-4. But, there is absolutely nothing in this record or in any other record showing that these checks actually were performed. No findings are recorded and no assessments or interventions are stated. Nor has Petitioner asserted – and provided supporting facts – to show that the staff performed skin checks meeting the facility's own requirements for such service.

Beginning on February 25, 2016, Petitioner's staff noted changes in the condition of Resident # 16's skin. On that date the staff noted some redness on the resident's sacrum (the base of her spine). CMS Ex. 3 at 12. Two days later, Petitioner's staff noticed excoriation on the resident's coccyx. *Id.* On March 13, 2016, the staff assessed the wound and concluded that the resident manifested a Stage III pressure sore. *Id.* at 16.

Petitioner updated Resident # 16's care plan to include some additional interventions to address the change in the resident's condition. However, the undisputed material facts show that these interventions failed to comply with the standards of care governing treatment of pressure sores. In particular, for more than a month after the staff identified redness on the resident's sacrum, the staff failed to consult about the resident's condition with its dietician, who is a member of the staff's interdisciplinary team for pressure sore prevention and treatment. A resident's diet is an important element of pressure sore prevention. CMS Ex. 20 at 9-10; CME Ex. 32 at 15; CMS Ex. 33 at 3; CMS Ex. 34 at 22-24; CMS Ex. 35 at 1, 7. Petitioner's staff did not apprise the dietician of the resident's condition until March 23, 2016.

Petitioner does not dispute any of these facts. Instead, it relies on its contention that the wound developed by Resident # 16 was not a pressure sore. But, as I have stated, the possibility that the resident did not develop a pressure sore does not excuse it from implementing the interventions that it had developed for the resident. The possibility that the resident may not have developed a pressure sore did not, for example, excuse Petitioner's staff from its obligation to reposition the resident in order to prevent the development of pressure sores. Nor did it excuse staff from its duty to record the findings made during skin checks and to assess those findings.

Furthermore, the undisputed facts establish that Petitioner's staff identified the wound on Resident # 16's coccyx as a pressure sore. Even if that assessment may in retrospect be incorrect, that doesn't excuse the staff from planning care consistent with the assessment at the time that the staff made it.

Petitioner argues at some length that the wound developed by Resident # 16 was not a significant change in the resident's medical condition but that the staff consulted with the resident's physician nevertheless. It is unnecessary that I decide whether this wound constituted a significant change requiring consultation. The basis for the allegations of noncompliance in this case is failure by Petitioner to implement its protocol and directives for preventing and treating pressure sores. That failure is evident whether or not Resident # 16 experienced a significant medical change and whether or not Petitioner's staff consulted with the resident's physician.

Although Petitioner disputes CMS's assertions of noncompliance it does not argue that the $4663 per-instance penalty that CMS determined to impose would be unreasonable if noncompliance exists. I find that Petitioner waived its right to dispute the penalty amount. I also conclude that the penalty amount is reasonable. It constitutes less than half the amount that CMS is authorized to impose for per-instance noncompliance, a very modest sum given the risks and dangers that are associated with the development of pressure sores by elderly and debilitated individuals. 42 C.F.R. § 488.438(a)(2). As CMS notes, the deficiencies established here are part of a long history of noncompliance by Petitioner with Medicare participation requirements. CMS Ex 18, at 1-4. That history, coupled with the potential for harm of Petitioner's noncompliance in this case, amply justifies the penalty amount.

/s/

Steven T. Kessel
Administrative Law Judge