Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Homestead Manor A Palace Community,
(CCN: 10-5541),

Petitioner,

v.

Centers for Medicare & Medicaid Services

Docket No. C-16-685

Decision No. CR5025

Date: February 13, 2018

DECISION

The Centers for Medicare & Medicaid Services (CMS) alleges that Petitioner Homestead Manor A Palace Community, a skilled nursing facility, failed to comply with seven Medicare conditions of participation, for which it seeks civil money penalties of $1000 per day against Petitioner for a period that began on January 26, 2016 and that ran through May 4, 2016. I find that the preponderance of the evidence establishes that Petitioner failed to comply with four conditions of participation set forth at: 42 C.F.R. § 483.75(l)(1); 42 C.F.R. § 483.25(b); 42 C.F.R. § 483.60(b), (d), (e); and 42 C.F.R. § 483.65.[1] I find that the preponderance of the evidence sustains Petitioner's assertion that it complied with the other conditions of participation that CMS alleges Petitioner failed to comply with. As a remedy for Petitioner's noncompliance I impose civil money

[1] Federal nursing home regulations substantially changed beginning on November 28, 2016. 81 Fed. Reg. 68,688 (Oct. 4, 2016). Based on the date of the survey, which preceded the regulatory revisions, I refer to the regulations that were in effect at the time of the survey.

penalties of $200 per day for each day of a period that began on April 7, 2016 and that ran through May 4, 2016.

I. Background

This case was assigned originally to another administrative law judge. It was transferred to me at the beginning of February of this year.

The parties completed pre-hearing exchanges consisting of briefs and proposed exhibits. CMS's pre-hearing exchange included 26 proposed exhibits, identified as CMS Ex. 1-CMS Ex. 26. Petitioner's exchange included 14 proposed exhibits, identified as P. Ex. 1-P. Ex. 14.

CMS did not include written direct witness testimony. Petitioner filed affidavits by 11 proposed witnesses at: P. Ex. 1-P. Ex. 9; P. Ex. 11; and P. Ex. 13. CMS did not request to cross-examine any of these witnesses. Neither CMS nor Petitioner filed objections to my receiving exhibits into the record.

There is no need for me to convene an in-person hearing inasmuch as none of the exhibits are objected to and also because CMS did not request to cross-examine Petitioner's witnesses. Consequently, I decide this case based on the parties' exchanges. I receive into evidence CMS Ex. 1-CMS Ex. 26 and P. Ex. 1-P. Ex. 14.

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 what remedies are reasonable.

B. Findings of Fact and Conclusions of Law

CMS's principal allegations are that Petitioner did not comply substantially with the requirements of 42 C.F.R. § 483.20(k)(3)(ii) and 42 C.F.R. § 483.25(h). CMS Brief (Br.) at 3-5. The first of these two regulations requires a skilled nursing facility to provide services to its residents by qualified persons in accordance with each resident's plan of care. The second regulation requires a skilled nursing facility to provide each of its residents with adequate supervision and assistive devices in order to prevent residents from sustaining accidents.

CMS contends that Petitioner contravened these two regulations in providing care to a resident who is identified as Resident 62. CMS Br. at 4. This resident was a very obese individual (she weighed 262 pounds) who suffered from a variety of serious maladies

including muscle weakness, difficulty walking, chronic obstructive pulmonary disease, and heart failure. CMS Ex. 10.

Petitioner's staff assessed the resident and found her to be highly dependent on assistance for her activities of daily living. The staff determined that she needed the assistance of two persons for all activities involving ambulation, including transfers, walking, and using the bathroom. CMS Ex. 10 at 11-12.

On January 26, 2016, Resident 62 requested assistance from Petitioner's staff in order to use the bathroom. Two certified nursing assistants (CNAs) came to the resident's aid. CMS Ex. 8 at 1. When the CNAs entered the resident's room they found her seated in a wheelchair that was too wide to pass through the bathroom door. CMS Ex. 1 at 4. The CNAs transferred the resident from her wheelchair to a rolling walker so that she could pass through the door. They assisted Resident 62 to a standing position, supported by the walker. The resident then decided that she did not wish to use the bathroom and so, the CNAs decided to change the resident's incontinence brief while she stood. CMS Ex. 8 at 1. The resident stood with the assistance of the walker as the CNAs changed her brief.

Then, as one of the CNAs (Emithe Dore) reached for the resident's wheelchair, which had been placed in front of the resident, the resident released her grip on the walker and fell backwards onto the other CNA (Julia Jones). P. Ex. 1; P. Ex. 2. As a consequence of her fall the resident sustained a small laceration on her head. Petitioner called Emergency Medical Services to attend to the resident. However, the resident became nonresponsive and died within a half hour of sustaining her fall. The fall was not the cause of the resident's death. The probable cause of her death was cardiac arrest precipitated by her congestive heart failure. CMS Ex. 9.

The preponderance of the evidence plainly establishes that when Resident 62 fell, Petitioner's staff was providing her with the two-person assistance called for by the resident's assessment and plan of care. The resident's plan called for her to be assisted by two staff members with all activities that involved ambulation and that is precisely what Ms. Dore and Ms. Jones were doing when she sustained her fall.

Nothing in the plan of care called for two staff members to have their hands on the resident at all times when she ambulated or stood. It was not inconsistent with the resident's assessment or with her plan of care that one of the CNAs assisting the resident turn momentarily in order to reposition the resident's wheelchair. Indeed, had the plan of care required two persons to remain in actual physical contact with Resident 62 at all times, then providing care for the resident would have required the assistance of at least three individuals, inasmuch as someone had to reposition the resident's wheelchair moments before the resident fell. That is not what the plan stated.

Furthermore, the preponderance of the evidence proves that Petitioner's staff was taking all reasonable measures to prevent Resident 62 from sustaining a fall when she fell. The requirements of 42 C.F.R. § 483.25(h) do not impose strict liability on a skilled nursing facility. It has been held many times that a facility must take all reasonable measures to prevent an accident from occurring to a resident. A facility may not be held liable for accidents that cannot reasonably be anticipated. Here, the two CNAs were acting reasonably given what they knew about Resident 62. The resident was an individual who had been ambulatory with assistance prior to her fall. She had used a rolling walker previously and had never previously sustained a fall. P. Ex. 8; P. Ex. 9. Given that, the two CNAs attending to the resident on the day of her fall had a reasonable basis for assuming that one of them could turn momentarily to reposition a wheelchair while the resident stood supported by the walker and by the second CNA.

Indeed, the most likely cause of the resident's fall was not the failure by two CNAs to support her constantly, but cardiac arrest or some other sudden event precipitated by the resident's congestive heart failure. Petitioner's staff had no reason to anticipate that an event such as that would occur.

CMS contends that Petitioner also failed to comply with another regulation, 42 C.F.R. § 483.20(e), (m). CMS Br. at 5-6. This regulation requires a skilled nursing facility to screen a new resident for possible mental illness ("second-level screen") if the resident is admitted to the facility with a diagnosis of a mental illness that meets the criteria and standards referred to as "PASARR" (pre-admission screening and annual resident review).

CMS contends that Petitioner failed to comply with regulatory requirements because it failed to perform a second level screen of a resident who is identified as Resident 33. CMS Br. at 6. It asserts that a PASSARR form completed at another facility prior to the resident's admission identified the resident as suffering from schizophrenia. CMS Ex. 17 at 5. CMS contends that this notation triggered a requirement that the resident perform a second-level screen but that Petitioner failed to do so.

I find that the preponderance of the evidence does not support this allegation. As Petitioner asserts, although the PASSARR form recorded a diagnosis of schizophrenia, it also stated that the resident did not require a second-level screen. CMS Ex. 17 at 5. None of the indicia of mental illness that would have triggered the requirement for a second-level screen were noted on the PASARR form. *See id.* at 3-4. In light of that, Petitioner was not legally required to perform a second-level screen.

CMS alleges additionally that Petitioner failed to comply with the requirements of 42 C.F.R. § 483.75(*l*)(1) and 42 C.F.R. § 483.25(b). CMS Br. at 6-7. The former regulation requires a skilled nursing facility to maintain complete and accurate clinical records for each resident. The latter regulation requires a skilled nursing facility to assist

a resident who suffers from hearing or vision impairments in making appointments and arranging for transportation to and from the office of a practitioner specializing in hearing or vision impairments so that the resident may receive proper care. CMS alleges that Petitioner failed to perform these duties as respects a resident who is identified as Resident 29.

The evidence sustains this allegation. On admission to Petitioner's facility Resident 29 was identified as having a moderate hearing deficit. CMS Ex. 16 at 8, 10, 17, 28. Despite identifying that issue, Petitioner failed to evaluate the resident's hearing deficit and failed to make an appointment with a specialist in order to evaluate or treat the resident's hearing deficiency. The evidence shows also that Petitioner did not maintain accurate records of residents with hearing loss. CMS Ex. 1 at 14-16.

Petitioner does not rebut this evidence directly. Rather, it contends that the resident's hearing loss was moderate at most and that Petitioner's staff was solicitous of the resident's needs. P. Br. at 9-10. But, that assertion begs the question. Petitioner had an obligation to arrange for the resident to see a hearing specialist and it failed to comply with that obligation.

CMS also alleges that Petitioner failed to comply with the requirements of 42 C.F.R. § 483.60(b), (d), and (e). CMS Br. at 7-8. The regulation governs a facility's storage of drugs and biological substances. 42 C.F.R. § 483.60(e) explicitly requires that narcotic medications be stored in a separately locked, permanently affixed cabinet. CMS presented persuasive evidence showing that Petitioner failed to comply with this requirement in that it failed to have a permanently affixed narcotics storage cabinet. CMS Ex. 1 at 28-30. It presented additional persuasive evidence showing that the refrigerator that Petitioner used to store narcotic medications did not have a double locking device as is required by Petitioner's own policy. CMS Ex. 1 at 28-30; CMS Ex. 21.

Petitioner offers evidence that it contends shows that it stored its narcotics medication securely. P. Br. at 10-11; P. Ex. 6. However, Petitioner failed to prove that it complied with regulatory requirements. It offered no proof that it stored narcotics in an affixed cabinet nor did it prove that its refrigerator had the double locking device required by Petitioner's policy.

CMS contends also that Petitioner failed to comply with the requirements of 42 C.F.R. § 483.65. CMS Br. at 8-9. This regulation mandates a skilled nursing facility to establish an infection control program that helps prevent the transmission of disease. CMS presented convincing evidence – not rebutted by Petitioner – that a housekeeper stored a water bottle, a purse, and a notebook on shelves that were designated for storage of clean resident clothing protectors, in direct contravention of the facility's own policy. CMS Ex. 1 at 32; CMS Ex. 25. In response, Petitioner asserts a sort of "no harm, no foul"

defense, contending that the housekeeper's items were not in contact with other, stored items. P. Br. at 11-12. I find that argument to be unpersuasive. Petitioner was not following its own infection control policy and a potential for more than minimal harm existed.

CMS determined that Petitioner's noncompliance began on January 26, 2016. That is predicated on Petitioner's alleged failures to protect Resident 62 from falling, allegations that I find to be rebutted by the preponderance of the evidence. Surveyors identify the deficiencies that I sustain at a survey conducted on April 7, 2016. I find that to be the initiation date of these deficiencies for purposes of imposing a remedy. Petitioner did not prove that it corrected these three deficiencies prior to May 4, 2016. Therefore, the duration of Petitioner's noncompliance is from April 7, 2016 through May 4, 2016.

I find no basis to sustain civil money penalties of $1000 per day as CMS originally determined to impose. Those penalties are based on the most egregious alleged failures to comply with regulatory requirements. I have found that the preponderance of the evidence supports Petitioner's contention that it complied with these requirements. The remedies may be based solely on the four findings of noncompliance that I have sustained. CMS determined that these instances of noncompliance all were at a minimally severe level of severity.

Regulations governing the imposition of civil money penalties establish a framework for deciding on penalty amount. 42 C.F.R. §§ 488.438(f)(1)-(4), 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)). In determining penalty amounts I may consider factors including the severity of a facility's noncompliance, its compliance history, its culpability, and its financial condition. CMS has not addressed these factors except to assert that Petitioner's alleged noncompliance with the requirements of 42 C.F.R. § 483.20(k)(3)(ii) and 42 C.F.R. § 483.25(h) caused actual harm to residents and to assert that Petitioner was culpable for its noncompliance. But, the record does not sustain these allegations, leaving only the minimally severe instances of noncompliance that I sustain. I impose penalties of $200 per day for each day of the noncompliance period to remedy this noncompliance. The low penalty amount fully reflects the low level of scope and severity of these deficiencies.

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