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 DAB CR6156
(2022)

Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Civil Remedies Division

[REDACTED]

(CCN: 05-5016),
Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-20-165

Decision No. CR6156

September 14, 2022

DECISION

Petitioner, [REDACTED] a skilled nursing facility (SNF), located in Pomona, California, that participates in the Medicare program. Following a survey by the California Department of Public Health (State Survey Agency) that was completed on February 1, 2019, the Centers for Medicare & Medicaid Services (CMS) determined that the facility was not in substantial compliance

with Medicare program requirements and imposed a per-instance civil money penalty (CMP) of \$10,205.00. CMS Exhibit (Ex.) 11. Petitioner filed a timely request for hearing on December 6, 2019.

For the reasons set forth below, I sustain the determination of CMS that the facility was not in substantial compliance with Medicare program requirements and that the penalty imposed is reasonable.

I. Background

The Social Security Act (Act) sets forth requirements for SNFs to participate 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 SNF must maintain substantial compliance with program requirements. To be

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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 SNFs are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. Each facility must be surveyed annually, with no more than fifteen months elapsing

between surveys. Facilities may be surveyed 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. The state agency must also investigate all complaints. Act § 1819(g)(4).

In this case, a surveyor from the State Survey Agency went to Petitioner's facility and completed an investigation on February 1, 2019. CMS Ex. 11. Based on those findings, CMS determined that the conditions in the facility constituted noncompliance with Medicare participation requirements at section 483.25(d)(1)-(2) (F-Tag 689), and a per-instance CMP in the amount of \$10,205.00 was imposed. *Id.*

On December 6, 2019, Petitioner filed a timely request for hearing. On December 13, 2019, Judge Bill Thomas issued an Acknowledgment and Prehearing Order, setting forth prehearing procedures.¹ CMS filed a motion for summary judgment and pre-hearing brief in support (CMS Br.), along with 12 proposed exhibits (CMS Exs. 1-12), including the written direct testimony of one witness. Petitioner filed its opposition to the motion for summary judgment, a pre-hearing brief, and a request to cross-examine CMS's witness (P. Br.) with 46 proposed exhibits (P. Exs. 1-46), including the written direct testimony of two witnesses. CMS filed a Reply Brief (CMS R. Br.) and CMS Ex. 13. CMS also filed objections to Petitioner's proposed exhibits P. Ex. 23 through P. Ex. 42 and to the written direct testimony of Petitioner's witnesses in proposed exhibits P. Ex. 45 and P. Ex. 46 on the basis of relevance.

On February 24, 2022, I issued a ruling denying CMS's Motion for Summary Judgment because there were material facts in dispute, as discussed below. On April 18, 2022, I conducted a telephone prehearing conference. I first considered the objections from CMS to P. Exs. 45 and 46 on the basis of relevance. While not binding, I have considered Federal Rule of Evidence 401, which states that evidence is relevant if it has any tendency to make a fact more or less probable than it would be without the evidence. While the direct written testimony in P. Exs. 45 and 46 does include statements about other deficiencies, it also contains some personal observations of the subject resident in this case and relevant facility policies. As a result, I found the statements are relevant and I overruled CMS's objection to the admission of those exhibits.

I sustained the objections by CMS to Petitioner's proposed exhibits P. Ex. 23 through P. Ex. 42 on the basis of relevance. Those documents relate to deficiencies that are not

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before me, as discussed below, and include the records of an individual with no connection to the issues before me. These proposed exhibits identify this resident by name, contain her medical records, and contain at least two photographs of her. In addition to the lack of relevance, admission of these records would result in unnecessary disclosure of the very private information of an uninvolved resident. As a result, I sustained the objection from CMS to P. Exs. 23 through 42.

CMS filed a motion to supplement its exchange and file CMS Ex. 13. Petitioner did not file a response to this motion. As a result, this motion was considered to be unopposed. (Order). Petitioner did not object to the admission of any of the proposed exhibits of CMS. As a result, CMS Exs. 1 through 13 were admitted into the record, with the exception of CMS Ex. 9, which was provisionally admitted, subject to authentication at the hearing. Petitioner's Exs. 1 through 22 and 43 through 46 were admitted into the record.

A hearing was held in this matter on June 15, 2022 to allow for the cross-examination of CMS witness, Rosa Valencia, R.N. Based on that testimony, CMS Ex. 9 was admitted. The parties submitted post-hearing briefs (CMS PH Br., P. PH Br.). The record is closed and the matter is ready for a decision on the merits.

II. Issues

On the merits, the issues are:

- Was the facility in substantial compliance with 42 C.F.R. § 483.25(d) F-Tag 689; and
- If the facility was not in substantial compliance, is the per-instance penalty of \$10,205.00 reasonable?

It is necessary at this point to also specify the issues that are *not* before me for adjudication. In its brief, Petitioner indicates that "CMS only attempted to substantiate the findings of F-Tag 689. CMS offered no evidence to substantiate any of the other alleged

deficiencies.” P. Br. at 2. As a consequence, it argues that CMS should be precluded from relying on information relating to the other F-tags deficiencies noted to support the F-Tag 689 deficiency or “any enforcement remedy based thereon.” P. Br. at 2-3.

It is initially noted that CMS, appropriately, did not attempt to substantiate the findings of any other deficiencies cited in the Statement of Deficiencies (SOD). CMS Ex. 1. The relevant regulations clearly state that an initial determination under 42 C.F.R. § 498.3(b)(13) only includes those findings of noncompliance “leading to the imposition of enforcement actions specified in § 488.406, § 488.820, or § 488.1170.” The Board has long held that neither the Act nor the regulations provide a right to a hearing for a finding

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of noncompliance absent the imposition of an enforcement remedy specified by the regulations. *Generations at Regency Ctr.*, DAB No. 2950 at 6 (2019) (citing *San Fernando Post Acute Hosp.*, DAB No. 2492 at 2, 6-8 (2012)). While several deficiencies were cited in the SOD, CMS imposed a CMP or “remedy” only for the noncompliance with 42 C.F.R. § 483.25(d)(1)-(2), F-Tag 689. CMS Ex. 11. As a result, consideration of any other deficiency is not authorized under § 498.3(b)(13), the governing regulation.

Petitioner's second argument appears to be that CMS cannot use the deficiencies cited in the SOD as support for any "enforcement remedy," which I assume refers to consideration of the issue of whether the amount of the CMP was reasonable. P. Br. at 2-3. As discussed below, while the facility's history of non-compliance, including repeated deficiencies, is a factor to be considered in assessing the reasonableness of a CMP², I see no reference whatsoever to this factor in the briefs submitted by CMS on the issue of enforcement remedy. CMS Br.; CMS R. Br. As a result, there is no basis for Petitioner's argument on this issue.

III. Discussion

1. The facility was not in substantial compliance with 42 C.F.R. § 483.25(d).³

Section 1819(b)(2) of the Act provides that a facility must ensure that each resident receives, and the facility provide, the necessary care and services to allow its residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. To this end, the "quality of care" regulation mandates, among other requirements, that the facility "ensure" that each resident's environment remains as free of accident hazards as possible, and that each resident receives adequate supervision and assistance devices to prevent accidents. 42 C.F.R. § 483.25(d)(1)-

(2).The question in this case is whether Petitioner provided adequate supervision and assistance devices to prevent the fall and resulting injury that occurred on October 21, 2018.

In regard to the burden of proof, CMS must make a *prima facie* case that the SNF failed to comply substantially with federal participation requirements and, if this occurs, the SNF must, in order to prevail, prove substantial compliance by a preponderance of the evidence. *Hillman Rehab. Ctr.*, DAB No. 1611 at 8 (1997); see *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, *Batavia Nursing &*

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Convalescent Ctr. v. Thompson, 129 F. App'x 181 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800 (2001).

The following facts before the October 21, 2018 fall are not in dispute. Resident # 43 (R43), who was 91 years old at the time of the incident in question,⁴ was re-admitted to the facility on September 23, 2017 with diagnoses including heart failure, atrial fibrillation, dysphagia, osteoarthritis, chronic pain, lumbar stenosis, and a history of falling. CMS Ex. 2 at 1-2. In a Skilled Nursing Resident Care Plan Conference dated October 6, 2017, Petitioner was noted as being a fall risk, with a two-person assist recommended for activities of daily living, transfers, and toileting. CMS Ex. 6 at 1. In a Minimum Data Set analysis dated September 20, 2018, a one-person physical assist with bed mobility, transfer, locomotion on the unit,

dressing, toilet use, and personal hygiene was recommended. CMS Ex. 3 at 24. After a Functional/Rehabilitation Potential assessment, R43 was started on Restorative Nurse Assistant (RNA) exercises. CMS Ex. 4 at 19.

On June 17, 2018, nursing notes indicated a certified nursing assistant (CNA) notified the charge nurse that, during a transfer from the power chair to the commode, the resident's knees gave out and she was eased to the floor. CMS Ex. 5 at 3. There were no visible injuries, and she was assisted in the use of the commode by two CNAs. *Id.* Following this fall, R43 underwent a Rehabilitation Screening, with the recommendations to use a gait belt when assisting with transfers, do sit-to-stand exercises after transfer back to bed, and a two-person assist at times. CMS Ex. 5 at 1. The care plan was amended on June 17, 2018 to address the risk of falls by adding the requirement for a two-person assist for transfers to the commode. CMS Ex. 4 at 34. Daily sit-to-stand exercises with an RNA were added to the care plan on June 20, 2018. *Id.* Subsequently, R43 refused these exercises on many occasions, often indicating she was weak or in pain. CMS Ex. 6 at 12, 14, 16, 18, 22, 26.

In a Resident Progress Note dated October 19, 2018, it was reported that a CNA asked a nurse to assist with the transfer of R43. CMS Ex. 5 at 26. The CNA noted that the resident said she could do it by herself and she declined the gait belt. *Id.* The nurse reported that she spoke with the resident about the benefits of the gait belt and the assistance of two persons with transfers. *Id.* The resident stated she didn't feel there was a need for those interventions. *Id.* The

nurse and the CNA then assisted the resident to the commode. The note indicated staff would continue to encourage two-person assists along with gait belt usage for transfers. *Id.*

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A Resident Progress Note dated October 21, 2018 indicated that, at 11:39 am, a nurse was called to R43's room and found the resident sitting on the floor. CMS Ex. 5 at 27. The CNA who was present and the resident both stated that, during the transfer from the easy chair to the shower chair, the resident's knees gave out and she was slowly assisted to the floor. *Id.* R43 complained of right foot and ankle pain. *Id.* Ice and pain medications were provided and X-rays were ordered. *Id.* R43 was transferred to the Emergency Room, where a fracture of the right distal tibia and fibula was diagnosed. CMS Ex. 7 at 5. She subsequently underwent open reduction and internal fixation of the fracture. CMS Ex. 7 at 9.

CNA 1, the CNA involved in the incident on October 21, 2018, provided several statements. In an interview conducted on October 22, 2018, CNA 1 stated she answered the call light of the resident in 37A (R43), who indicated she wanted to go to the restroom. P. Ex. 5 at 1. She was going to ask another staff person to help, but the resident became upset and refused to wait, stating she normally transfers with the walker to the shower chair. *Id.* According to CNA 1, R43 demanded she help her with the walker and started grabbing the walker. *Id.* As soon as R43 held onto the walker, her legs started giving out. *Id.* The CNA noticed that R43's legs were wobbling and

she started to fall. *Id.* CNA 1 indicated she gently assisted the resident to the floor. *Id.* She noticed the resident's right foot was sideways when she was sitting on the floor. *Id.* CNA 1 called for help immediately, and the charge nurse came and assessed the resident. *Id.*

During an interview with the surveyor on January 31, 2019, CNA 1 stated she had been hired 7-8 months earlier. CMS Ex. 1 at 14. When asked about R43's fall on October 21, 2018, CNA 1 stated she was covering for the other CNAs during their breaks when she saw R43's call light on. *Id.* CNA 1 stated she asked R43 if she needed assistance and R43 stated she needed to use the restroom. *Id.* CNA 1 then told R43 she needed another person because R43 required a two-person assist for transfers, but R43 stated she did not need anybody else. *Id.* CNA 1 reported that R43 started to stand and CNA 1 assisted R43, when suddenly R43 stated she was feeling dizzy and her legs were weak. *Id.* CNA 1 stated she assisted R43 down to the floor while holding R43 by her pants. *Id.* Once CNA 1 lowered R43 to the floor, CNA 1 noticed R43's right foot was folded backwards and "fixed it" (moved the foot). *Id.* CNA 1 stated she then pulled the emergency call light in the restroom and the charge nurse entered the resident's room. *Id.*

In a subsequent interview, CNA 1 stated "she answered the call light alone to assess what the resident needed, and to determine if it was a simple request that she could complete independently such as

getting the resident water or a pillow and if it was a is [sic] a simple request such as water or a pillow, she would be able to accommodate resident.” P. Ex. 7 at 1.

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Basically, this case comes down to these facts.⁵ As of June 17, 2018, R43’s care plan contained a provision that required a two-person assist for transfers to the commode.⁶ CMS Ex. 4 at 34. On October 21, 2018, a CNA responded to R43’s call light. CMS Ex. 1 at 14; P. Ex. 5 at 27; CMS Ex. 5 at 1. R43 indicated she wished to go to the restroom and was unwilling to wait for another person to assist with her transfer. *Id.* She attempted to get out of the chair and began to fall. *Id.* She was helped to the floor, but sustained a fracture of the right tibia/fibula in the process. *Id.*; CMS Ex. 7 at 5.

There is no dispute that the care plan in effect at the time of the subject fall contained a provision requiring a two-person assist with transfers to the commode.⁷ On June 17,

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2018, the care plan was amended to minimize the risk for falls and fall-related injury by including a “2 person assist to transfer to commode.” CMS Ex. 4 at 34. Petitioner does not allege that a two-person assist to transfer to the commode was provided to R43 on October 21, 2018. The Departmental Appeals Board (Board) has held that “[o]nce a facility adopts a policy that incorporates the

measures that are appropriate to assure that residents receive adequate supervision and assistance devices to prevent accidents . . . the facility is held to follow through on them.” *Heritage Plaza*, DAB No. 2829 at 20 (2017). Moreover, the Board has stated, “[t]he fact that the regulations do not specify that a particular type of care is necessary to meet a requirement does not prevent a finding of noncompliance when the facility itself has determined that type of care is necessary.” *Id.* (citing *Azalea Court*, DAB No. 2352 at 9 (2010)). Given the failure to follow the care plan requirement of a two-person assist with transfer to the commode, CMS has established a *prima facie* case that Petitioner was noncompliant with 42 C.F.R. § 483.25(d).

The question then becomes whether Petitioner has proven substantial compliance with federal requirements by a preponderance of the evidence. Petitioner makes several arguments to establish compliance. It initially asserts that, in essence, there was nothing the CNA could have done differently on October 21, 2018. It alleges that:

[i]n this case, CNA one was forced to make a choice . . . A balancing of the interest at the moment. She attempted to provide the care in accordance with the two-person assist care plan and requested resident 43 to wait. It is undisputed resident 43 refused to wait and got up to grab at her walker. At this point in time, at this moment, it was too late for CNA one to provide a two person assist because resident 43 was already in motion and would not wait. Resident 43 exercised

her right to refuse the two-person assistance. CNA one exercise [sic] her discretion to try to achieve the best possible outcome to the highest practicable degree by balancing the options and interest in place at the moment in time. It was a matter of seconds.

P. Br. at 5. Similarly, Petitioner argued that “[t]here was no other staff immediately available to tend to the sudden actions of Resident 43. It was a matter of seconds with no opportunity to do otherwise.” P. PH Br. at 10.

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The Director of Nursing (DON) and the Administrator provided similar descriptions of the incident. In identical statements, they indicated that when:

CNA 1 answered the call light for Resident 43 on October 21, 2018, Resident 43 immediately advised CNA 1 that Resident 1⁸ needed to use the restroom immediately. CNA 1 explained to Resident 43 that Resident 43 needed to wait for another person to arrive and assist with the transfer. Resident 43 became angry, refused to wait, and uncharacteristically began to stand up. The CNA was aware of the intervention of two-person assist, and when she answered the call light to ask the resident what assistance was needed, the resident informed her she wanted to go to the bathroom. The CNA informed resident she would need to get a second person for

this, at which time the resident became angry and refused to wait and began grabbing the walker and started to stand up. The CNA had to decide what was best at that moment, to stop and help the resident or to leave the resident to proceed to get a second person, and decided to help the resident, and eased the resident to the floor.

P. Ex. 45 at 11; P. Ex. 46 at 10.

The problem with the “she did everything she could under the circumstances” argument is that there is no evidence to corroborate many of these statements. Petitioner’s briefs and witnesses both indicate the incident occurred in a “matter of seconds.” P. Ex. 45 at 12; P. Ex. 46 at 11. Petitioner cited as an undisputed fact that “in the few seconds it took for the accident to happen” the CNA was forced to make a choice. P. PH Br. at 15. However, CNA 1 did not use this phrase or give a specific indication of timing in her statements. P. Ex. 5 at 1; CMS Ex. 1 at 14; P. Ex. 7. The statements from the DON and Administrator that there “was no other staff immediately available to tend to the sudden actions of Resident 43” in P. Ex. 45 at 12 and P. Ex. 46 at 11 are merely that - statements without any accompanying evidence of what staff members were present at that time and where they were. There is also no corroboration of the statements that there were only two options: helping the resident or leaving the resident. There were only two people who knew exactly what transpired in that room on October 21, 2018 - the resident, who was described as an inaccurate or poor historian, and CNA 1. P. Ex. 21 at 1; P. Ex. 46 at 15; P. Ex. 45 at 16. Petitioner elected not to produce

CNA 1 as a witness. As a result, I am unable to determine how long the interaction with R43 took place, what exactly was said to R43 regarding the benefits of a two-person transfer, as was done on October 19,

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2018, why CNA 1 could not have immediately called for assistance with the emergency call button as she did after the fall, or why the call button was not answered by two members of the staff. The unanswered questions do not constitute a preponderance of the evidence.

Petitioner next asserts that “to evaluate Petitioner’s compliance, it is necessary to examine whether the facility provided adequate supervision designed to meet the resident’s assessed needs **and to mitigate foreseeable risks** of harm to them.” P. Br. at 5 (citing *Northeastern Ohio Alzheimer’s Research Ctr.*, DAB No. 1935 (2004) and *Tri-County Extended Care Ctr.*, DAB No. 1936 (2004)) (emphasis in original). It is clear that a facility is not expected to protect residents against all possible risks. Rather, as the Board stated in *The Bridge at Rockwood*, the correct question is whether the facility did what it reasonably could to ensure that all residents received supervision needed to “mitigate foreseeable risks of harm” based on what it knew about the residents, their care needs, and the conditions in the facility. DAB No. 2954 at 10 (2019); see also *Owensboro Place & Rehab. Ctr.*, DAB No. 2397 at 8 (2011); 42 C.F.R § 483.25(h).

Petitioner argues that R43's behavior on October 21, 2018 was unforeseeable and "there was no history of resident 43 getting up on her own after she was asked to wait." P. Br. at 6 (citing P. Ex. 45 and P. Ex. 46). Both the DON and the Administrator stated that there was "no history of Resident 43 acting like that before." P. Ex. 45 at 11; P. Ex. 46 at 11. Instead, it alleges that R43 "refused to wait, . . . exercised her right to refuse the two-person assistance" and that the CNA "exercised her discretion to try to achieve the best possible outcome to the highest practicable degree by balancing the options." P. Br at 5. Petitioner similarly argued that R43 "is alert and oriented, and the resident chose to attend to her needs independently despite education provided by the CNA of the risk and to to [sic] wait for assistance. The resident has the right to refuse assistance from staff." P. Br. at 13.

Petitioner is correct that, under the provisions of 42 C.F.R. § 483.10(c)(6), a resident has "the right to request, refuse, and/or discontinue treatment." P. Br. at 9. However, the Board has repeatedly stated that this right does not absolve a facility of all responsibility to provide supervision. That duty exists even if a resident exercises her free will and decides to decline that which a facility offers. As the Board stated in *Koester Pavilion*, "while there is no dispute that the resident had a right to refuse treatment, the facility had a countervailing duty to protect the dependent individual under its care against accidents." DAB No. 1750 at 28 (2000). Thus, a refusal of treatment by a resident is not a free pass for the facility to avoid providing the care specified in the care

plan. Petitioner essentially concedes that some degree of supervision is required in the face of refusal of care. It asserts that the relevant inquiry is whether the supervision the facility provided was adequate “under the circumstances” and argues that the supervision provided in this case was adequate or reasonable under the circumstances at the time. P. Br. at 6-7; P. PH Br. at 16 (citing *Burton Health Care Ctr.*, DAB No. 2051 (2006)).

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However, *Burton* must be distinguished from the present case on its facts, and a complete reading of *Burton* does not lend great support for Petitioner’s position. In *Burton*, the Board upheld the first deficiency, finding that the facility “did not comply with its own care plan for Resident 36 on January 5, 2002 and failed to act reasonably to prevent him from falling.” *Burton*, DAB No. 2051 at 10. In the second instance, the Board upheld the ALJ’s finding that the facility was in substantial compliance with § 483.25(h)(2) ⁹ and indicated that, in determining whether the supervision was adequate under the circumstances, “we look first to whether *Burton* provided supervision ***in accordance with the resident’s assessment and plan of care.*** *Id.* at 14. If *Burton* failed to provide the type of supervision that it had determined was required to meet the resident’s needs, this would support a conclusion that this incident violated section 483.25(h)(2).” *Id.* (emphasis added). In that instance, the Board agreed that the facility had provided that level of care. *Id.*

Unlike the finding in *Burton*, in the instant case there is no argument that Petitioner provided the level of care identified in the care plan. Under the holding in *Burton*, this would support a conclusion that this incident violated § 483.25(d). Instead, Petitioner argues that the Administrative Law Judge (ALJ) should consider documentation and evidence relevant to the resident's exercise of her rights beyond the care plan and, where there is such evidence of a resident exercising those rights, the ALJ "must adequately consider a facility's need to balance its responsibilities in regard to providing care in accordance with the care plan with resident rights." P. Br. at 9-10 (citing *Venetian Gardens*, DAB No. 1956 at 18-19 (2009)).¹⁰ However, the decision cited by Petitioner for this argument again does not lend great support.

Petitioner is correct that the Board indicated in *Venetian Gardens* that the ALJ should consider evidence other than the care plan for the purpose of proving "that a competent resident *had elected to refuse care and services* on occasion, by leaving the facility. Thus, on remand, the ALJ may consider documentation and evidence *relevant to the resident's exercise of his rights other than the care plan.*" *Venetian Gardens*, DAB No. 2286 at 18 (emphasis added). In this case, there is no need to look too far outside the care plan for evidence that R43 had elected to refuse recommended care. Her many refusals of care are readily apparent from the record, as discussed below. Moreover,

Venetian Gardens does not provide persuasive support for Petitioner's position. As the Board noted in *The Good Shepherd Home for the Aged, Inc., d/b/a The Good Shepherd Home*:

While *Venetian Gardens* concerned a “competent resident who repeatedly chose to leave the facility in his motorized wheelchair,” as well as a claim by CMS that the SNF violated section 483.25(h)(2) by allowing the resident to leave without supervision, see DAB No. 2286, at 1, 5-6, the Board did not decide the case's merits but, rather, vacated a grant of summary judgment in favor of CMS and remanded for further proceedings because it concluded that *Venetian Gardens* had raised a dispute about the facts on which CMS had relied in its summary judgment motion and that the ALJ had not provided any analysis for his reading of section 483.25(h)(2). Furthermore, unlike this case, *Venetian Gardens* did not involve a failure by staff to implement a recommendation of supervision issued pursuant to an unambiguous written resident care policy.”

DAB No. 2858 at 20 (2018).

What then is the facility's responsibility to provide supervision when a resident elects to refuse care? To begin, 42 C.F.R. § 483.21(b)(1)(ii) provides that a care plan must describe “any services that would otherwise be required under § 483.24, § 483.25, or § 483.40 but are not provided due to the resident's exercise of rights under § 483.10, including the right to refuse treatment under § 483.10(c)(6).”

Moreover, the facility's responsibility in the face of refusal of treatment does not end merely with a notation of such in the care plan. In *Van Duyn Home & Hosp.*, the Board stated that CMS's State Operations Manual (SOM) "explains facilities' obligations to make sure that any such refusal is informed, that the basis for the refusal is addressed, and that alternatives are offered." DAB No. 2368 at 7-8 (2011) (*citing* SOM, Appendix PP, at F11); *see also* 54 Fed. Reg. 5316, 5321 (Feb. 2, 1989). According to the Board, "[t]his guidance implies a duty to assess what the potential consequences of refusal are and what alternatives could reasonably be offered that would not violate the resident's rights." *Van Duyn*, DAB No. 2368 at 8. Thus, it is not enough for a facility to merely say that it was honoring the resident's wishes. A resident's right to refuse treatment does not absolve a facility from a continuous effort to comply with the regulations by use of other means. To allow this would mean facilities could permit residents to refuse treatment to the point of injury or death. *See Koester*, DAB No. 1750 at 28 ("It is simply unacceptable to abdicate the duty to supervise or use assistive devices to prevent falls even when the resident, for whatever reason, is resistant, noncompliant, or difficult to deal with.").

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Petitioner essentially argues that while R43 had voiced refusal of care previously, her actual refusal to wait for help on October 21, 2018 was not foreseeable and, therefore, the care provided was reasonable under the circumstances and consistent with her right to refuse it. It argues that, while "there was a history of resident 43

refusing care, there was no history of resident 43 getting up on her own after she was asked to wait. (P. Ex. 45 and 46 at p.) [sic].” P. Br. at 6. Petitioner states that two days before the fall, “resident 23 [sic] tried to be insistent and not wait for the second assistant to help with the transfer. On that occasion, with encouragement the resident complied. It was reasonable to foresee that the resident would comply again in the same manner.” *Id.*

In considering the question of whether the refusal of care on October 21, 2018 was a foreseeable risk, I initially note that, consistent with the statements from Petitioner, the record clearly demonstrates a history of refusal of care by R43. Following a fall on June 17, 2018 due to her knees giving out during a transfer from a power chair to commode, R43’s care plan was amended to add “2 person assist to transfer to commode.” CMS Ex. 4 at 34. In addition, following a rehabilitation assessment on June 17, 2018, sit-to-stand exercises after transfer back to bed were recommended. CMS Ex. 5 at 1. The care plan was amended on June 20, 2018 to provide for “RNA provide Sit to Stand Exercise daily.” CMS Ex. 4 at 34. However, facility records reflected numerous refusals to perform the sit-to-stand exercises.¹¹ R43 declined sit-to-stand exercises because she was weak, said she was watching a movie and then going out to dinner, said she had a friend over and wanted to talk to her, and because of pain. CMS Ex. 6 at 12, 14, 16, 18, 22, 26. Because of the multiple refusals, the facility contacted the treating physician, who declined to discontinue the RNA exercises. CMS Ex. 5 at 24.

According to Resident Progress Notes, a nurse then spoke to R43

about the risk versus benefits of the RNA exercises and staff was notified to continue to encourage her to participate in the exercises. *Id.*

Refusals of treatment were also detailed in the statements from the DON and the Administrator. In identical statements, they indicated that a

[s]tatement from resident's primary care physician also indicates resident is non-compliant and it is expected that with her continued refusals of RNA (Restorative Nursing Assistance), Resident 43 is at high risk for developing

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pressure ulcers, DVT's and becoming progressively deconditioned (P. Ex. 3) Attachment 16). [sic] The resident has a history of refusals including refusal of repositioning, turning, off-loading heels and RNA as documented in her care plan.

P. Ex. 45 at 14-15; P. Ex. 46 at 14; CMS Ex. 4 at 32. The care plan beginning on October 12, 2017 contained provisions to explain risks versus benefits of calling for assistance to address falls, because Resident 43 was described as “non compliant with asking for assistance and asking/allowing friends to help instead of staff.” CMS Ex. 4 at 34. Resident 43 was also reported to have been refusing to have her bed in the lowest position. P. Ex. 21 at 1.

There was also evidence of earlier refusals to comply with transfer assistance. During an interview with the surveyor, CNA 2, the CNA who regularly cared for R43, indicated she was often non-compliant with care. CMS Ex. 1 at 12. She stated that she began working with a lift for transfers about two months before the fall because R43 was having difficulties with transfers. *Id.* CNA 2 stated she never did transfers by herself because the pivot turn was hard and required two persons. *Id.* She indicated that R43's care was different every day and she did not want to use the lift with some staff. *Id.* Similarly, the DON indicated in an interview with the surveyor that R43 "picks and chooses what staff she prefers to use the gait belt."¹² *Id.*

A Resident Progress Note dated October 19, 2018, two days prior to the fall at issue, indicated R43 was declining transfer assistance. CMS Ex. 5 at 26. According to the note, a nurse was summoned to R43's room to assist with a transfer. *Id.* The resident reportedly told the CNA that she could do it by herself and she declined the gait belt. *Id.* The nurse reported that she spoke with the resident regarding the risks and benefits of the gait belt and two-person assist for transfers. *Id.* The resident stated she was aware of the risks and benefits, but didn't feel there was a need for it. *Id.* The nurse then assisted the CNA to transfer R43 to the commode. *Id.* The note indicated that staff would continue to encourage transfer assistance of two and gait belt. *Id.*

Despite the above history of noncompliance, Petitioner argues that R43's refusal to wait for a second person to assist with the transfer on October 21, 2018 was not foreseeable because she had responded to encouragement in the past. The Administrator and the DON provided identical statements that the incident on October 21, 2018 "was an unpredictable and unforeseeable occurrence that could not reasonably have been anticipated or prevented." P. Ex. 45 at 3; P. Ex. 46 at 2. I would certainly agree that

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there is no evidence that R43 had actually attempted to self-transfer or get up on her own prior to the subject fall. However, I see no basis for requiring an *actual* attempt to self-transfer before it is foreseeable that it *could* happen.

To the contrary, the Board has indicated in *Josephine Sunset Home* that, "[f]or a risk to be foreseeable, it need not have been made obvious by having already materialized." The Board continued by noting that

Sunset appears to have understood the Board's rejection of strict liability to mean that an accident must have previously occurred to the same person in the precise manner in order to attribute foreseeability to its repetition. A professional care facility can reasonably be expected to exercise more foresight than this. The Woodstock decision expressly rejected that facility's position that "it must somehow be

provided advance warning of each adverse event in order to be responsible for taking reasonable measures to prevent injurious occurrences which it knows to be likely to take place at some point, if not at a particular time or place."

DAB No. 1908 at 14-15 (2004) (citing *Woodstock Care Ctr.*, DAB No. 1726 (2000), *aff'd*, *Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003).

The appropriate question then is not whether R43 had attempted to self-transfer previously, but rather whether it was foreseeable that she would attempt to self-transfer. Under the facts of this case, I find such an occurrence was foreseeable. R43 had made known her feelings about transfer assistance and the use of a gait belt. As discussed above, two days before the October 21, 2018 fall, R43 reportedly told a CNA that she could do the transfer by herself and indicated she did not believe there was a need for a gait belt, even after being advised of the benefit by the nurse. CMS Ex. 5 at 26. She clearly had refused other care after being advised of the benefit of the care and receiving encouragement to accept the care. Her refusals even included care or treatment recommended by her physician. On September 19, 2018, R43 refused to go to an appointment for a CT scan ordered by her physician to evaluate her complaints of neck pain, stating she did not need it, even after a nurse explained the need for and benefit of the test. CMS Ex. 5 at 23. While it was certainly her right to refuse such care, these actions demonstrate that R43 would not necessarily accept prescribed care,

even with encouragement, education, or cajoling. Thus, an outright refusal of care, even in the face of explanation or encouragement, was not unforeseeable.

Moreover, what the record does not show is an acknowledgment of the refusal of care related to the fall risk documented in the care plan and an indication of what alternatives

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were developed in response to her repeated refusals of care.¹³ While there is a reference to being noncompliant with asking for assistance, there is no specific discussion of the voiced refusal of care related to transfer assistance. CMS Ex. 4 at 34. Given this awareness of R43's voiced resistance to assistance in the face of the care plan's requirement for a two-person assist with transfers, the facility would be expected to "assess what the potential consequences of refusal are and what alternative could reasonably be offered that would not violate the resident's rights." *Van Duyn*, DAB No. 2368 at 8. Unfortunately, this did not occur before R43 was injured due to her refusal of care. Two days later, on October 21, 2018, R43 refused to wait for a second person to assist in a transfer to the bathroom and fell. P. Exs. 5, 20. The failure to follow the provisions in the care plan, coupled with the lack of alternatives offered, resulted in a significant injury to R43. It was not until after the fall on October 21, 2018 that the care plan was amended in response to her refusals of care and to include revised approaches to accommodate her refusals. P. Ex. 21 at 1.

Petitioner finally argues that “[t]he Department makes no argument or suggestion of what should have been done at moment’s notice by the CNA.”¹⁴ P. Br. at 13; P. PH Br. at 18. However, it is not for CMS, or the ALJ for that matter, to suggest alternative medical treatments or approaches. It remains within the province of the facility to provide care consistent with the plan of care or, if refused, to identify alternative care. In short, while there is no dispute that the resident had a right to refuse treatment, the facility had a countervailing duty to protect the dependent individual under its care against accidents. Under the facts of this case, I find that Petitioner was not in substantial compliance with the provisions of 42 C.F.R. § 483.25(d) because R43 did not receive adequate supervision and assistive devices to prevent accidents.

2. The evidence establishes that the penalty imposed is reasonable.

In deciding whether the CMP amount is reasonable, I may consider only the factors specified in 42 C.F.R. § 488.438(f). 42 C.F.R. § 488.438(e)(3); *Southpark Meadows Nursing & Rehab. Ctr.*, DAB No. 2703 at 12 (2016). Those factors are: (1) The

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facility’s history of noncompliance; (2) the facility’s financial condition; (3) the 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. 42 C.F.R. § 488.438(f). The factors in 42 C.F.R. § 488.404, in turn, 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.

Petitioner initially argues that “[e]vidence has not been presented by CMS to support 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 considering the section 488.438(f) factors.” P. Br. at 19. In response to this argument, it must be noted that the Board has held that “there is a presumption that CMS has considered the regulatory factors in setting the amount of the CMP and that those factors support the CMP amount imposed by CMS.” *Coquina Ctr.*, DAB No. 1860 at 32 (2002); *Brenham Nursing & Rehab. Ctr.*, DAB No. 2619 at 18 (2015), *aff'd*, *Brenham Nursing & Rehab. Ctr. v. U.S. Dep’t. of Health & Human Servs.*, 637 F. App’x 820 (5th Cir. 2016). “Accordingly, the burden is not on CMS to present evidence bearing on each regulatory factor, but on the SNF to demonstrate, through argument and the submission of evidence addressing the regulatory factors, that a reduction is necessary to make the CMP amount reasonable.” *Oaks of Mid City Nursing & Rehab. Ctr.*, DAB No. 2375 at 26 (2011).

In response to this burden, Petitioner does not bring forth evidence on these factors and, instead, states that there is “no evidence in this case showing that Petitioner has a poor compliance history.

Nor is there evidence pertaining to its financial condition.” P. Br. at 19. Petitioner then argues that the evidence does not support a high degree of culpability and, instead, reflects an error of judgment, rather than a deliberate decision to compromise the care provided to R43 under the circumstances. *Id.*

In considering the regulatory factors, I do not find that Petitioner has met its burden of introducing evidence to demonstrate that a reduction in the penalty amount is necessary to make the CMP reasonable. *Crawford Healthcare & Rehab.*, DAB No. 2738 at 19 (2016).

CMS has imposed a per-instance penalty of \$10,205.00, which is in the middle of the range of possible per-instance penalties (\$2,140 to \$21,393). 42 C.F.R. §§ 488.408(d)(1)(iv), 488.438(a)(2); 45 C.F.R. § 102.3 (2017); 82 Fed. Reg. 9174, 9182-83 (Feb. 3, 2017).

Petitioner does not claim that its financial condition affects its ability to pay this fairly modest amount, nor has it tendered any evidence relating to its history of compliance prior to the survey-cycle presently at issue.

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Petitioner’s culpability in this matter is quite high. The failure to follow the provisions in the care plan, coupled with the lack of alternatives offered when that care was refused, resulted in a broken leg, which was a significant injury to R43. For this, the

facility is culpable, and the penalty imposed is appropriate considering the seriousness of the deficiency. For these reasons, I find the imposed per-instance CMP of \$10,205.00 to be reasonable.

IV. Conclusion

For all of these reasons, I find that the facility did not ensure that R43 received adequate supervision and assistance devices to prevent accidents. The facility was, therefore, not in substantial compliance with 42 C.F.R. § 483.25(d). The imposed per instance penalty of \$10,205.00 is reasonable.

Endnotes

¹ This case was reassigned to me on December 3, 2021.

² See 42 C.F.R. §§ 488.438(f) and 488.404, as discussed below.

³ My findings of fact/conclusions of law are set forth, in italics and bold, in the discussion captions of this decision.

⁴ In their written statements, both of Petitioner's witnesses indicated R43 was 71 years old. P. Ex. 45 at 4; P. Ex. 46 at 3. These are presumed to be typos since R43's date of birth is consistently reported to be August 20, 1927. CMS Ex. 2 at 1; CMS Ex. 3 at 5. However, even if facility records incorrectly recorded her date of birth, R43's actual age is not a relevant fact in this adjudication.

⁵ There are a number of inconsistencies in the record regarding the fall on October 21, 2018, primarily in the statements from R43. R43 initially provided a statement in which she indicated that, during the transfer from the chair to the shower chair, her knees gave out and she was eased to the floor. P. Ex. 20. However, during an interview with the surveyor on January 29, 2019, R43 stated she “sustained the fracture because she was *dropped* by an inexperienced staff person who helped her during a transfer.” CMS Ex. 1 at 11 (emphasis added). During the same interview, R43 stated she had lost three months of her life because she had a wound to her right heel as a result of the fracture. *Id.* Yet, her treating physician did not attribute the pressure ulcer to the fracture. P. Ex. 3. Moreover, in December 2018, she reported she had been playing bridge during the week, going with friends “as much as she has ever been” and had “been busy” - activities that would be inconsistent with loss of quality of life. P. Ex. 15 at 3-4. There was also a dispute as to whether the CNA’s movement of the leg after the fall resulted in additional injury, but Dr. Takhar provided a credible opinion that it had not. P. Ex. 43. I do not find these disputed facts to be “material” to the issue before me because they do not directly relate to the issue of whether the facility provided “adequate supervision and assistance devices” to prevent the accident in question.

⁶ Petitioner, at one point, argues that there was a factual dispute as to what “two person assistance” entailed and CMS had offered no evidence of when the two-person assistance was required to begin and end. P. Br. at 18; P. PH Br. at 18. A review of R43’s care plan

clearly indicates that a “2 person assist to transfer to commode” was to start on June 17, 2018. CMS Ex. 4 at 34. There is no indication in the care plan that this requirement had ended; at least through the relevant time period here. Moreover, Petitioner argues at another point that the CNA “attempted to provide the care in accordance with the two-person assist care plan.” P. Br. at 5. It is clear through these logically and factually inconsistent arguments that neither have merit.

⁷ Petitioner has suggested that the two-person assist was not required by the plan of care. It argued that “CNA 1 was aware that Resident 43’s care plan indicated Resident 43 *may* need two person assist for transfers”. P. PH Br. at 1 (emphasis added). It further argued that “[a]lthough the care plan identified two-person assistance, and the practice had been to provide two-person assistance, one person could reasonably safely assist her with all her needs,” citing the results of the Physical Therapy assessment that Resident 43 “[m]ay at times need a 2-person assist.” P. PH Br. at 8 (citing CMS Ex. 5 at 1). The care plan, however, was not equivocal on the two-person assist requirement.

⁸ The reference to Resident 1 is presumed to be a typo since Resident 43 was the only resident involved in this incident.

⁹ The regulations governing long-term care facilities have been revised since *Burton* was decided; the requirement that facilities minimize the risk of accidents is now found at § 483.25(d). 81 Fed. Reg. 68,688 (Oct. 4, 2016); 82 Fed. Reg. 32,256 (Jul. 13, 2017).

However, the substance of the “quality of care” requirements, which are also statutory, has not changed, so decisions that pre-date the regulatory changes remain valid.

¹⁰ Although Petitioner cited the ALJ decision in *Venetian Gardens* in its brief, the pagination cited and the language referenced appear to be from the Board’s remand of that decision. P. Br. at 4, 9-10. See *Venetian Gardens*, DAB No. 2286 (2009).

¹¹ I concur with Petitioner’s argument that the statements by the surveyor in CMS Ex. 9 at 5, paragraphs 17 and 18, that R43 refused to participate in RNA exercises for three consecutive weeks, there was no physician follow up, and that the physician was not notified until October 20, 2018, are not supported by the written record. P. PH Br. at 6; CMS Ex. 6 at 14; CMS Ex. 5 at 12, 24. I have also not given any weight to her opinion in CMS Ex. 9 at 5 that there was a violation of F-Tag 689 because that is a legal conclusion reserved to the decisionmaker.

¹² While these statements are obviously hearsay, Petitioner has not submitted any evidence to dispute their accuracy.

¹³ Interestingly, the care plan did contain statements reflecting noncompliance with treatment for avoidance of skin ulcers, which were added on October 4, 2018. CMS Ex. 4 at 32.

¹⁴ Petitioner’s witnesses, again in identical statements, cite only two alternatives for the involved CNA; either assist the resident alone or leave her and go for help. P. Ex. 45 at 11; P. Ex. 46 at 10.

This ignores a third option, which was apparently utilized by the CNA on October 21, 2018; that of using the emergency alarm to summon help. CMS Ex. 1 at 14; CMS Ex. 5. Unfortunately, this was not done until after the fall. *Id.* The CNA, on October 19, 2018, was also apparently able to summon assistance without reportedly leaving the resident. CMS Ex. 5 at 26.

/s/

Mary M. Kunz
Administrative Law Judge