

Skilled Nursing: Multiple Violations Of Medicare Standards, Civil Monetary Penalties Upheld.

State survey inspectors came to a skilled nursing facility in response to complaints and found nine violations of Medicare standards. They revisited the facility six weeks later and found the facility in substantial compliance.

A month later, however, during the facility's annual inspection, \$77,100 in civil monetary penalties were levied for twenty-nine separate violations of Federal Medicare standards found in Title 42 of the US Code of Federal Regulations (42 CFR § 438.15 and § 438.25).

The facility's appeal was heard by the US Circuit Court of Appeals for the Sixth Circuit. The court upheld all twenty-nine penalties, but limited its discussion only to certain illustrative examples.

Social Services

Alcohol Problem Not Addressed

42 CFR § 438.15 (g)(1) requires a skilled nursing facility to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychological well-being of each resident.

The facility was found not to have conducted adequate interventions to stop a resident from leaving the facility on weekends to abuse alcohol and return to the facility intoxicated, creating an unacceptable risk of harm to him and others.

His physician recommended he not be allowed to leave, or that an alternative placement be found for him that could meet his needs, but the social work charting was inattentive to his alcohol problem.

Restraints in Use

Injury Permitted

42 CFR § 438.25 says in general terms that the facility must provide necessary care and services to attain or maintain the highest practicable level physical, mental and psychological well-being in accordance with the resident's comprehensive assessment and plan of care.

A resident in a geri chair was allowed to slide so far forward that her pelvic restraint wedged into her body folds. The inspectors believed it had to have been happening repeatedly to cause the injuries to her perineum and upper thighs they observed.

The skilled nursing facility argued in its defense that some of the residents were not actually harmed by the violations the state survey inspectors observed.

The facility's argument fails to recognize that actual harm is not required for survey inspectors to impose a civil monetary penalty.

A threat of more than minimal harm to a resident due to substandard compliance with Medicare-participation requirements is all that is necessary to justify imposing a penalty.

The amount of the daily penalty – from the time a deficiency is found until it is corrected – will vary depending on the severity of the specific harm which could potentially happen to a resident.

If actual harm does occur, the fact of actual harm and its severity are additional factors going to the amount of the civil monetary penalty commensurate with the violations in question.

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT
August 1, 2006

The facility was faulted for not getting a specially-fitted wheelchair or at least ordering a supply of the pommel cushions which could have been used to keep her positioned properly.

The facility's argument was that she was small of stature, demented, agitated and would not sit still. In the court's judgment that did not excuse what happened, but instead made it all the more necessary for staff to be attentive to her needs.

Pressure Sores

Positioning, Incontinence Care Faulted

42 CFR § 438.25 (c) says that a facility must ensure that -

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable, and

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

The inspectors found a resident with an advanced pressure sore on her coccyx. The resident was wearing a foul-smelling, urine-saturated incontinence brief with "5:25 a.m." and the initials of a previous-shift staff member jotted on it. That is, she had been ignored for a 3 1/2 hour period.

The court also said there was no pressure-relief device on the chair in her room.

The facility argued that this resident was at high risk for pressure sores. Just saying that, in and of itself, does not show that the resident was receiving necessary care and services to promote healing and prevent new pressure sores, the court pointed out.

Incontinence Care

Unsanitary Cleansing Technique

42 CFR § 438.25 (d)(2) says that a resident who is incontinent of bladder must receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

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Skilled Nursing, Medicare Standards (Continued.)

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An inspector observed an aide wiping stool from a resident's perineal area forward toward the area of her urinary tract without turning the cloth to a clean side or getting another clean cloth.

The resident did not then have or later develop a urinary tract infection. Only on one occasion did the inspector see her receive incontinence care.

However, actual harm to a resident is not necessary for a violation of Medicare standards to occur. The court sided with the inspectors on this issue. All that is necessary for a violation is inappropriate care that creates a risk of more-than-minimal harm to a resident.

Range of Motion

No Knee Splints

42 CFR § 438.25 (e)(1) says that a facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.

One resident, who entered with no range-of-motion deficits in his lower extremities, developed limitations in both knees despite orders from his physician for knee splints on an alternating four-hours-on, four-hours-off cycle. The physician's orders were implemented nine days late, after the inspection.

The facility argued that he was bedridden and was not going anywhere. Furthermore, he was easily agitated and often refused to take his pills. The court pointed out, however, that Medicare standards contain no "difficult to work with" exemption. A physician's orders must be followed or at least there must be competent documentation why not, the court said.

Janitor's Closet Not Locked

Created Accident Hazard

42 CFR § 438.25 (h)(1) requires a facility to ensure that the residents' environment remains as free of accident hazards as is possible.

The court accepted the state inspectors' observation that the janitor's closet was not locked and validated their judgment that an unlocked janitor's closet poses an unacceptable risk of harm due to the presence of dangerous substances that dementia patients could get into.

The court rejected the facility's argument that it could not be penalized with no actual harm happening to a resident. The court reiterated again that the potential for more than minimal harm to a resident is all that is required to impose a civil monetary penalty on a nursing facility.

Two Persons To Assist In Transfer

Only One Aide Involved – Fall

42 CFR § 438.25 (h)(2) requires a facility to ensure that each resident receives adequate supervision and assistance devices to prevent accidents.

One resident's nursing and occupational-therapy assessments pointed to the need and her care plan stated that she was to have two staff members for bed mobility, toileting, transfers and bathing.

In reading her chart the state inspectors found a past incident where she slid out of her geri chair, fell to the floor and injured her forehead and nose, while in the bathroom with only one aide.

When the surveyors questioned the aide about the incident the aide said she had put a gait belt on the resident's waist, then stood in front of her and tried to raise her to a standing position.

If another staff member had been present, per the resident's care plan, the other person could have grasped the gait belt correctly from behind the patient and prevented her fall, the court concluded.

The court was not swayed by an occupational-therapy assessment two weeks later to the effect the resident was mentally alert and physically strong enough for one-person assists in transfer. It was not relevant to the time frame in question; at that time she was still a two-person-assist patient. **Harmony Court v. Leavitt, 2006 WL 2188705 (6th Cir., August 1, 2006).**