

## **SURVEY & ENFORCEMENT ALERT:**

### **NF Not Held Liable When Nursing Assistant Did Not Follow Policy**

Unfortunately, most nursing facilities (NFs) are aware of the "strict liability" interpretation of the law that the Centers for Medicare & Medicaid Services (CMS) has taken in many areas of survey and enforcement. Under that approach, it does not matter how good a NF's systems, policies and training are – if an employee ignores all of that guidance and a negative incident occurs, then the NF is to be cited. For those of you who were beginning to become a bit cynical about the whole process, Administrative Law Judge (ALJ) Steven T. Kessel has given facilities a reason to hope in *JFK Hartwick at Edison Estates v. CMS* (2001). He has also given NFs another reason to consider a formal appeal of unjustified citations – even if they have lost an informal dispute resolution.

In the *Hartwick* case, ALJ Kessel determined that a NF should not have been cited under F324 (adequate supervision and assistive devices) when a nursing assistant transferred a resident by herself when the facility's policy was clear that the transfer was to be done only with a two-person assist.

We enjoyed ALJ Kessel's common sense reasoning, and we thought that many of you would as well. Thus, we have reproduced most of the section of his opinion relating to the nursing assistant's transfer below. (We have redacted the references to the facility's and CMS' exhibits). Please note that this case can be appealed.

"On February 29, 2000, Resident # 2 was injured while being transferred from bed via a Hoyer lift. A nursing assistant was getting the resident out of bed with the aid of the lift when the lift slipped, and the resident became frightened, slipping to the floor. The resident sustained a fracture of the right leg.

A Hoyer lift is a device that is used for transferring individuals who are unable to move without assistance. One nursing assistant was operating the lift at the time of the accident. Petitioner's internal policy was to require two nursing assistants to operate the lift. However, the manufacturer of the Hoyer lift does not suggest that more than one person is necessary to operate the lift.

I do not find that CMS established a prima facie case that Petitioner failed to comply with the requirements of 42 C.F.R. § 483.25 in providing care to Resident # 2. There is no question that the resident sustained an accident. It may also be concluded from the fact that only one nursing assistant was operating the Hoyer lift at the time that the accident occurred that the lift was being operated in

violation of Petitioner's internal policy at the time of the accident. But, this evidence does not show that Petitioner provided insufficient training to the nursing assistant or supervised either the nursing assistant or the resident inadequately.

It is not unreasonable to infer that Petitioner wanted two staff members to operate the Hoyer lift because it was concerned for the safety of its residents. Given that, a failure by Petitioner to train its staff, disseminate its policy, or correct a known noncompliance of its policy would be a basis for me to conclude that Petitioner was not providing adequate supervision. But, there is no basis to find Petitioner liable if the evidence only establishes an isolated error by a member of Petitioner's staff which occurred despite – and not because of – the way that Petitioner instructed and supervised its staff.

In other cases I have found that a facility is liable under 42 C.F.R. § 483.25(h)(2) for failing to address accident hazards of which it was aware. For example, in *Woodstock*, I found that the facility did not provide adequate supervision to its residents based on evidence which showed that the facility failed to take remedial measures despite repeated episodes of elopements and resident-against-resident assaults. The facility knew that there were problems with assaults and elopements but did not address those problems. In another case, *Sonogee Rehabilitation and Living Center*, (2001), I held that a facility failed to provide supervision to its residents in order to prevent accidents where the facility knew that a resident was prone to elope the facility through a window but where it failed to secure the window in order to prevent further elopements. Again, the facility knew that a problem existed but did not address that problem.

By contrast, the evidence presented by CMS in this case does not show that Petitioner knew or should have known that its staff was not complying with its directive concerning use of the Hoyer lift. CMS did not produce anything to show that the episode involving Resident # 2 was more than an isolated failure by one employee on Petitioner's staff to comply with facility policy.

Furthermore, there is no evidence that the staff's failure to follow the policy concerning use of the Hoyer lift was the proximate cause or even an indirect cause of the accidental injury to Resident # 2. CMS has not made any showing that the resident fell from the Hoyer lift as a consequence of only one staff person operating the lift."

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