Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
King City Rehab, LLC d/b/a Avamere Rehabilitation of King City, (CCN: 38-5132),	)	Date: October 19, 2009
	)	
Petitioner,	)	Docket Nos. C-09-50
	)	C-09-170
	)	Decision No. CR2020
- v. -	)	
	)	
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

Petitioner, King City Rehab, LLC (Petitioner or facility), is a long term care facility located in Tigard, Oregon, that participates in the Medicare program. The Centers for Medicare and Medicaid Services (CMS) has determined that the facility was not in substantial compliance with Medicare requirements, and that one of its deficiencies posed immediate jeopardy to resident health and safety. Based on its findings of noncompliance, CMS has imposed a denial of payment for new admissions, and, for two of the cited deficiencies, per instance civil money penalties (CMPs) of $3,500 and $1,500.

Petitioner here challenges CMS's determinations.[1] The parties have filed cross motions for summary judgment.

For the reasons set forth below, I find that CMS is entitled to summary judgment; the facility was not in substantial compliance with Medicare requirements, and I sustain as reasonable the CMPs imposed.

[1] The parties requested and I granted consolidation of C-09-170 with C-09-50. Docket No. C-09-50 is Petitioner's appeal of the imposition of the denial of payment for new admissions; Docket No. C-09-170 is Petitioner's appeal of the two per instance civil money penalties (CMP).

I. Background

The Social Security Act (Act) sets forth requirements for nursing facility participation 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 nursing facility must maintain substantial compliance with program requirements. To be 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 skilled nursing facilities are in substantial compliance. Act, § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months, and more often, if necessary, to ensure that identified deficiencies are corrected. Act, § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 499.308.

Between July and November 2008, the Oregon Department of Human Services (state agency) surveyed the facility multiple times, citing multiple deficiencies. CMS Exs. 1, 3; P. Ex. 1.[2] Here, I consider two deficiencies, which were cited during two separate surveys, and for which CMPs were imposed:

- following a Life Safety Code survey, completed July 23, 2008, CMS determined that the facility was not in substantial compliance with the Life Safety Code (LSC) of the National Fire Protection Association because it failed to implement adequate smoking regulations; CMS also determined that this deficiency posed immediate jeopardy to resident health and safety.

CMS Ex. 1, at 6-7, CMS Exs. 4, 5; *See* 42 C.F.R. § 483.70(a)(1). For this deficiency, CMS has imposed a $3,500 CMP. CMS Ex. 5.

- following its annual recertification survey, completed August 4, 2008, CMS determined that the facility was not in substantial compliance with 42 C.F.R. § 483.25 (quality of care), and that this deficiency caused actual harm that was not immediate jeopardy (scope and severity level G).

CMS Ex. 2, at 1-10; CMS Exs. 4, 5. For this deficiency, CMS has imposed a $1,500 CMP. CMS Ex. 5. CMS also denied payments for new admissions to the facility from September 3 through October 14, 2008, and advised the facility that its Nurse Aide

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[2] Surveys were completed on July 23, 2008 (Life Safety Code), August 4, 2008 (annual recertification survey), September 25, 2008 (revisit), and October 22, 2008 (revisit).

Training and Competency Evaluation Program would have to be denied or withdrawn. CMS Ex. 5.[3]

Thereafter, Petitioner requested Informal Dispute Resolution to challenge the survey findings. *See*, 42 C.F.R. § 488.331. By letter dated September 29, 2008, the state agency advised Petitioner that the deficiency cited under 42 C.F.R. § 483.25 remained in effect at the same level of scope and severity (actual harm that is not immediate jeopardy), although some of the surveyor findings were modified. P. Ex. 2; CMS Exs. 2, 8. In a letter dated October 13, 2008, the Oregon Office of State Fire Marshall declined to alter the LSC findings. P. Ex. 3.

Petitioner timely requested a hearing. After the parties submitted their pre-hearing briefs (CMS Br.; P. Br.), Petitioner moved for summary judgment (P. MSJ Br.). CMS responded with a memorandum in opposition and a cross-motion for summary judgment. (CMS MSJ Br.). Petitioner replied to CMS's cross-motion (P. Reply). CMS has submitted 24 exhibits (CMS Exs. 1-24) and Petitioner has submitted 13 exhibits (P. Exs. 1-13).

II. Issues

I consider whether summary judgment is appropriate.

On the merits, the issues before me are: 1) whether the facility was in substantial compliance with the Life Safety Code of the National Fire Protection Association and 42 C.F.R. § 483.70(a)(1), because it failed to "implement adequate smoking regulations"; 2) if the facility was not in substantial compliance with the Life Safety Code, is imposing a $3,500 per instance CMP for that deficiency reasonable; 3) whether the facility was in substantial compliance with 42 C.F.R. § 483.25 (quality of care); and 4) if the facility was not in substantial compliance with 42 C.F.R. § 483.25, is imposing a $1,500 per instance CMP for that deficiency reasonable?

As discussed below, I have no authority to review CMS's immediate jeopardy determination in this case. *See*, 42 C.F.R. § 498.3(b)(14).

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[3] The denial of payment for new admissions is not specifically tied to either of the deficiencies for which CMPs were imposed, but is based on the finding of substantial noncompliance, generally. *See*, 42 C.F.R. § 488.408(d)(3)(i). The denial of nurse aide training program approval stems from the denial of payment for new admissions. CMS Ex. 5, at 1; Act, §§ 1819(f)(2)(B); 1919(f)(2)(B).

III. Discussion

A. CMS is entitled to summary judgment because the undisputed facts establish that the facility failed to enforce its written smoking policies and was therefore not in substantial compliance with the LSC and 42 C.F.R. § 483.70(a)(1). [4]

With respect to the LSC issues, summary judgment is appropriate because the parties agree on all the material facts, and the case turns on questions of law. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986); *Livingston Care Center v. United States Department of Health and Human Services*, 388 F. 3d 168, 173 (6th Cir. 2004). *See also, Illinois Knights Templar Home*, DAB No. 2274, at 3-4 (2009), *citing Kingsville Nursing Center*, DAB No. 2234, at 3-4 (2009).

A facility must be designed, constructed, equipped, and maintained to protect the health and safety of its personnel and the public. 42 C.F.R. § 483.70. With respect to fire safety, facilities must meet the applicable provisions of the LSC, which is a set of fire protection requirements designed to provide a reasonable degree of safety from fires. 42 C.F.R. § 483.70(a)(1). Among other requirements, the LSC mandates that facilities adopt smoking regulations and that patients classified as "not responsible" be allowed to smoke only under direct supervision. CMS Ex. 1, at 6.

Here, the parties agree that the facility had in place a written policy governing resident smoking. The policy mandated that residents with smoking histories be "reviewed to determine safe smoking capability." Any "capable resident" would be allowed to smoke in designated, outdoor smoking areas. CMS Ex. 13, at 3. Among the policy's provisions were the following:

- Residents with a history of smoking would be reviewed for safe, independent smoking skills;

- The smoking safety review would include the risks of smoking;

- Resident smoking articles (cigarettes, lighters, matches) could be stored in a resident's room *in a locked drawer.*

CMS Ex. 13, at 3; CMS Br. at 9.

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

The surveyors focused on three residents deemed capable of smoking without supervision. For these three people, the facility has produced individual smoking safety assessments, establishing their capabilities. However, none were allowed to store smoking materials in his/her room. Each assessment mandates that the resident's cigarettes and lighters be kept in the medication cart at the nurse's station. P. Ex. 9, at 8; P. Ex. 10, at 3; P. Ex. 11, at 1.

The parties agree that the facility did not follow its smoking policy. As Petitioner concedes, the resident rooms did not even contain boxes or drawers in which smoking materials could be locked. P. Br. at 6. Nor did the facility follow the assessment instructions for the three residents deemed capable of independent smoking. All three were allowed to keep "unsecured smoking materials" (i.e., cigarettes and lighters) in their unlocked rooms or on their persons. In fact, each of these residents pulled out a cigarette lighter and showed it to the fire inspector. P. Br. at 7; P. MSJ at 4, 6; CMS Br. at 10; CMS Ex. 21, at 2-3 (Jones Decl. ¶¶ 11, 12, 13).

The facility was thus not in substantial compliance with the LSC or the federal regulation requiring compliance with the LSC, 42 C.F.R. § 483.70(a)(1). The facility's admitted failure to enforce its written smoking policy violates the LSC. To hold otherwise would render meaningless the requirement that the facility adopt smoking regulations. Moreover, as the Departmental Appeals Board recognized in *Oxford Manor*, DAB No. 2167 (2008), a facility's smoking policy "function[s] as evidence that the facility [understands] the dangers if residents are allowed to keep lighters in their rooms" and evidences "the standard of care the facility expect[s] its staff to provide."[5] In *Oxford Manor*, the Board recognized that facility staff might legitimately make a policy exception for a particular resident, but emphasized that the staff would then have to document that exception and explain why it was appropriate. *Oxford Manor* at 5. Here, staff documented a more restrictive "exception" to its written policy, by drafting care plans that required the facility to keep the residents' lighters and cigarettes in the medication cart at the nurse's station. But it failed to implement those plans, putting at risk the health and safety of all residents and staff.

Although Petitioner admits that three of its smoking residents had unsecured smoking materials in their rooms, contrary to facility policy and "contrary to their smoking assessment documentation," it points out that facility staff "responded by immediately stowing the material under lock in the med-carts and revising its policy to completely

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[5] *Oxford Manor* did not involve a LSC survey, but a health survey. The facility's failure to follow its own smoking policy was cited under 42 C.F.R. § 483.25(h) – which requires that the facility take reasonable steps "to mitigate foreseeable risks of harm from accidents." I note, however, that, when applied to facility smoking policies, section 483.25(h) and the LSC are similar in purpose – to keep people safe from injury due to foreseeable risks. Both recognize potential dangers unless smoking policies are carefully thought-out and followed.

forbid the presence of any [m]aterials in resident rooms." P. Br. at 6. That the facility may have corrected the deficiency does not preclude CMS from imposing penalties. *Price Hill*, DAB No. 1781 (2001). *See also*, *Asbury Center at Johnson City*, DAB No. 1815, at 19-20 (2002) (Substantial compliance means that the cited deficiencies were corrected, that no other instances have occurred, *and* that the facility has implemented a plan of correction designed to assure that no such incidents occur in the future).

Ultimately, Petitioner recognizes that its failure to secure lighters and other smoking materials may have presented the potential for serious injury, harm, impairment or death, but argues that the harm was "not likely" so the deficiency should not have been cited at the immediate jeopardy level. P. MSJ Br. at 7. I have no authority to review that issue.

An ALJ may review CMS's scope and severity findings (which include a finding of immediate jeopardy) only if a successful challenge would affect the range of the CMP, or if CMS has made a finding of substandard quality of care that results in the loss of approval of a facility's nurse aide training program. 42 C.F.R. § 498.3(b)(14); 42 C.F.R. § 498.3(d)(10); *See*, *Evergreen Commons*, DAB No. 2175 (2008); *Aase Haugen Homes*, DAB No. 2013 (2006). Here, the penalty imposed is a per instance CMP, for which the regulations provide only one range ($1,000 to $10,000), so the level of noncompliance does not affect the range of the CMP. 42 C.F.R. § 488.438(a)(2). Nor does CMS's scope and severity finding affect approval of the facility's nurse aide training program. Even without the immediate jeopardy finding, the facility's nurse aide training program could not be approved. A state may not approve a facility's nurse aide training program if, within the last two years, the facility has been assessed a CMP of $5,000 or more, or has been subject to one of the remedies specified in the statute – denial of payment for new admissions, appointment of temporary management. Act, § 1819(f)(2)(B); 42 C.F.R. § 483.151(b)(2)(iv). Here, CMS has imposed a denial of payment for new admissions as well as CMPs totalling $5,000.[6]

B. CMS is entitled to summary judgment because the undisputed evidence establishes that the facility failed to provide necessary care and services (42 C.F.R. § 483.25).

Under the statute and the "quality of care" regulation, each resident must receive, and the facility must provide, the necessary care and services to allow a resident 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. Act, § 1819(b); 42 C.F.R. § 483.25.

Here, CMS cites multiple instances in which facility staff failed to follow physician orders.

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[6] Because I find that CMS had a basis for imposing a CMP, I may not review its choice of remedies. 42 C.F.R. § 488.408(g)(2).

First, CMS alleges that the facility failed to provide necessary assessments and treatment to Resident 11, an acutely ill man, suffering from hepatic encephalopathy, ascites, chronic liver disease, acute renal failure, and cirrhosis of the liver. Petitioner, however, comes forward with evidence suggesting a dispute regarding its treatment of Resident 11. P. Br. at 12-17.

CMS also alleges that the facility did not accurately track the size of Resident 7's amputation incision. Resident 7's leg had been amputated, and, according to CMS, facility staff did not properly measure and describe the wound, which meant that they could not properly assess the effectiveness of their wound care. Petitioner concedes an "apparent misunderstanding between two staff members," but points out that the wound "was healing well," and the resident suffered no actual harm. P. Br. at 17.

Although I need not find actual harm in order to find that the facility was not in substantial compliance, I decline to issue summary judgment based on the circumstances of Residents 11 and 7. In assessing the appropriateness of granting summary judgment to CMS, I must view Petitioner's evidence in the light most favorable to it, and draw all reasonable inferences in its favor. *Illinois Knights Templar Home*, DAB No. 2274, at 4 (and cases cited therein). Under this standard, Petitioner avoids summary judgment with respect to these two residents.

Nevertheless, I need not resolve the contested issues surrounding Residents 11 and 7, because the surveyors found multiple additional instances of staff's failing to follow physician orders in providing care to residents. Petitioner does not contest the following:

- Resident 8 suffered from pancreatic cancer. Her physician ordered insulin every six hours, the dosage based on a sliding scale tied to her blood glucose levels. If her blood glucose level fell between 201 and 250, staff were to administer 5 units of insulin. CMS Ex. 16, at 2; CMS Ex. 23, at 2 (Townsend Decl. ¶ 5). At midnight on July 18, 2008, staff failed to test her blood glucose as required. When they tested it at 6:00 a.m., her glucose level was 247. But staff gave her no insulin. CMS Ex. 16, at 4; CMS Ex. 23, at 2 (Townsend Decl. ¶ 6). Four days later, on July 22, 2008, at 6:00 p.m., her glucose level was 240. Staff administered two units of insulin, rather than the 5 units that were ordered. CMS Ex. 16, at 4; CMS Ex. 23, at 2 (Townsend Decl. ¶ 5).

- Resident 9 suffered from hypertension. His physician ordered that his blood pressure be monitored twice daily. For systolic readings over 200, staff were to administer Cloinidine. CMS Ex. 16, at 8, 9; CMS Ex. 23, at 2 (Townsend Decl. ¶ 8). On July 2, 2008, his systolic pressure was 207, yet staff failed to administer the medication. CMS Ex. 16, at 9, 10; CMS Ex. 23, at 2 (Townsend Decl. ¶ 8). On July 23, 2008, his systolic pressure measured 204, yet staff again failed to administer the prescribed medication. CMS Ex. 16, at 9, 10; CMS Ex. 23, at 2 (Townsend Decl. ¶ 8).

- Resident 1 had diabetes, and his physician ordered blood glucose monitoring, and administration of insulin on a sliding scale. Six units of insulin were required for blood levels between 241 and 300. On July 6, 2008, Resident 1's blood sugar level was 288, but staff administered only four units of insulin. CMS Ex. 2, at 8; CMS Ex. 11, at 95, 96, 98.

- Resident 3 suffered from hypertension. Her physician ordered four separate blood pressure medications, to be administered based upon her blood pressure readings. Staff were therefore required to measure her blood pressure every morning and every evening. CMS Ex. 15, at 6; CMS Ex. 22, at 2 (Stamas-Bacon Decl. ¶ 7). During the week of June 6, her physician ordered staff to measure her blood pressure twice a day for one week, after administering hypertensive medications, in order to assess her response to medication. CMS Ex. 15, at 16; CMS Ex. 22, at 2 (Stamas-Bacon Decl. ¶ 7). Staff repeatedly failed to take her blood pressure as ordered: on June 9 and June 14 (which was when they were supposed to assessing her response to antihypertensive medication) no readings were recorded for the afternoons. Staff again failed to take her blood pressure on the morning of June 29. CMS Ex. 15, at 9; CMS Ex. 22, at 3 (Stamas-Bacon Decl. ¶ 10).

- Resident 2 suffered from hypertension, and his physician ordered the anti-hypertensive medication, Metoprolol, 25 mg. twice per day. The physician also ordered staff to check his blood pressure before they administered the Metoprolol. CMS Ex. 14, at 18; CMS Ex. 20, at 2 (Martin Decl. ¶ 5). Staff were supposed to administer the medication at 8:00 a.m. and 8:00 p.m. But even though the medication was administered 45 times between July 1 and July 22, 2008, Resident 2's blood pressure was checked only 15 times. CMS Ex. 14, at 19-21; CMS Ex. 20, at 2 (Martin Decl. ¶ 6). Further, the facility could not demonstrate when the blood pressure was checked; nothing indicated that staff checked it prior to administering the medication, as his attending physician had ordered. CMS Ex. 14, at 20; CMS Ex. 20, at 2 (Martin Decl. ¶ 7). Even more troubling, although the physician directed staff to check blood pressure prior to administering the medication, no parameters instructed them when to notify the physician of a blood pressure reading, and when to withhold the medication based on that reading. CMS Ex. 20, at 2 (Martin Decl. ¶ 8). Registered Nurse, Jane Martin, who was one of the surveyors, noted that on July 9, 2008, Resident 2's blood pressure registered 99/63. Had staff administered the Metoprolol after this reading, it could have caused his pressure to drop, creating a medical emergency. But no instructions warned staff of that danger. CMS Ex. 20, at 2 (Martin Decl. ¶ 8, 9).

Petitioner admits these errors but characterizes them as "isolated" and argues that they should be disregarded because they caused no actual harm. P. Br. at 17-18. Again, I have no authority to review the scope and severity cited here, but may only determine whether the surveyor findings constituted substantial noncompliance, i.e., did the deficiencies pose "the potential for causing more than minimal harm?" 42 C.F.R.

§ 498.3(b)(14); 42 C.F.R. § 488.301. I find that these instances of staff's failing to follow physician orders posed the potential for more than minimal harm. The importance of monitoring blood sugars and following the physician's order for insulin is well-documented. *See, e.g., The Laurels at Forest Glen*, DAB No. 2182, at 14 *et seq.* (2008). Moreover, as surveyor Martin opined (and Petitioner has not challenged), the deficiencies surrounding Resident 2, alone, posed the potential for creating a medical emergency.

Because its staff did not follow physician orders, it was not providing the necessary care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The facility was therefore not in substantial compliance with 42 C.F.R. § 483.25.

C. Because the facility was not in substantial compliance, CMS may deny payment for new admissions.

Petitioner complains that CMS had no authority to impose a denial of payment for new admissions. Citing 42 C.F.R. § 488.408(d)(2), Petitioner suggests that CMS may deny payments for new admissions only when it finds either widespread deficiencies with the potential for more than minimal harm, or when it finds actual harm. P. Br. at 3. In fact, the regulation *mandates* that, when it makes such findings, CMS deny payment for new admissions, or impose some other "Category 2" remedy. It does not follow that CMS is therefore precluded from imposing such a remedy unless it finds actual harm. Moreover, section 488.408(d)(3) authorizes CMS to apply any "Category 2" remedy *except when the facility is in substantial compliance* or the deficiencies pose immediate jeopardy (in which case the CMP must be in the higher "Category 3" range). Thus, so long as the facility is not in substantial compliance, CMS may deny payment for new admissions.

D. I sustain, as reasonable, the CMPs imposed.

I next consider whether the CMPs are reasonable by applying the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) 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. The factors in 42 C.F.R. § 488.404 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.

In reaching a decision on the reasonableness of the CMP, I consider whether the evidence supports 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 in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's

discretion. *Barn Hill Care Center*, DAB No. 1848, at 21 (2002); *Community Nursing Home*, DAB No. 1807, at 22 *et seq.* (2002); *Emerald Oaks*, DAB No. 1800, at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638, at 8 (1999).

CMS has imposed two per-instance penalties: $3,500 for the LSC deficiencies and $1,500 for the quality of care deficiencies. These are at the low end of the penalty range for per-instance penalties ($1,000 to $10,000), and, under any rationale, are quite modest. 42 C.F.R. § 488.408(d)(iv). *See Plum City Care Center*, DAB No. 2272, at 18-19 (2009). (Even a $10,000 per instance CMP can be "a modest penalty when compared to what CMS might have imposed.").

With respect to facility history, CMS documentation establishes that the facility has not been found in substantial compliance during any survey as far back as July 2005, and it has been cited multiple times for deficiencies that were widespread, or that caused actual harm. In March 2008, it was not in substantial compliance with the quality of care regulation. CMS Ex. 7. I find the facility history, by itself, sufficient to sustain these minimal penalties.

Petitioner has not argued that its financial condition affects its ability to pay the penalty.

With respect to the remaining factors, I find that any lesser amounts would be highly unlikely to induce corrective action, and I agree with CMS that the deficiencies cited were the results of multiple staff errors for which the facility is culpable.

The CMPs are therefore reasonable.

IV. Conclusion

Accepting as true all of Petitioner's factual assertions, I find that the facility was not in substantial compliance with the Medicare requirements for LSC and quality of care. CMS may therefore impose a remedy and I find the CMPs imposed ($3,500 and $1,500) are reasonable.

/s/ Carolyn Cozad Hughes
Administrative Law Judge