Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Legend Oaks Healthcare and Rehabilitation – North,
(CCN: 67-6251),

Petitioner,

v.

Centers for Medicare & Medicaid Services

Docket No. C-15-2884

Decision No. CR4581

Date: April 12, 2016

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose two per-instance civil money penalties, each in the amount of $1950, against Petitioner, Legend Oaks Healthcare and Rehabilitation – North, a skilled nursing facility.

I. Background

Petitioner requested a hearing to challenge CMS's remedy determination. CMS filed a brief and seven proposed exhibits that it identified as CMS Ex. 1 – CMS Ex. 7. Petitioner filed a brief and four proposed exhibits that it identified as P. Ex. 1 – P. Ex. 4. I receive the parties' exhibits into the record. Neither side requested a hearing for the purpose of cross-examining witnesses. Consequently, this case is ready for a decision based on the parties' written submissions.

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 whether CMS's remedy determination is reasonable.

B. Findings of Fact and Conclusions of Law

CMS asserts that Petitioner failed to comply substantially with two Medicare participation requirements. First, it contends that Petitioner failed to comply with 42 C.F.R. § 483.60(a). This section requires, among other things, that a skilled nursing facility provide pharmaceutical services, including the dispensing and administering of drugs, to meet the needs of each of its residents. Second, CMS asserts that Petitioner failed to comply with 42 C.F.R. § 483.25, which requires that a skilled nursing facility provide each of its residents with the care and services necessary to attain the highest practicable level of functioning consistent with the resident's plan of care.

CMS asserts that Petitioner failed to comply with these requirements in that it failed to provide medication to a resident that had been prescribed by that resident's treating physician. The resident whose care is at issue, Resident 19, suffers from multiple medical problems. Her complaints included severe and frequent episodes of pain. CMS Ex. 2 at 70, 79. The resident's treating physician prescribed multiple medications and these included a prescription for Norco, a controlled substance. *Id.* at 8. The physician directed that Norco be administered to Resident 19 every six hours for pain management. *Id.*

Because Norco is a Schedule II controlled substance, prescriptions for the medication may not be refilled by telephone, fax, or electronically. CMS Ex. 3 at 4. In order to refill Resident 19's prescription, Petitioner's staff was obligated to obtain a written prescription signed by the resident's physician. CMS asserts – and the evidence establishes – that Petitioner's staff failed timely to obtain a written refill prescription from the resident's physician. CMS Ex. 2 at 45-47, 50, 54. Petitioner ran out of its supply of Norco. Consequently, Resident 19 did not receive Norco pursuant to the physician's orders.

The resident's treatment record included an instruction that Norco be reordered after March 11, 2015. CMS Ex. 2 at 98. However, Petitioner did not attempt to contact Resident 19's physician in order to get the prescription refilled until March 14, 2015 and was unable to get a refill until March 19. *Id.* at 63. As a consequence, Resident 19 did not receive Norco as prescribed by her physician for a five-day period. During that period the resident expressed pain levels as high as "9" on a 10-point scale. *Id.*

These facts establish Petitioner's noncompliance with the requirements of 42 C.F.R.

§§ 483.25 and 483.60(a). Resident 19 had a physician's order for Norco and a directive that it be administered to the resident once every six hours. Petitioner failed to comply with the physician's order because it failed timely to have the resident's prescription refilled. That constituted both a failure to provide Resident 19 with prescription drugs prescribed to meet her needs and to provide the resident with care that was consistent with her plan of care.

Petitioner argues that Resident 19 is an individual with a long history of medication-seeking behavior and suggests that she was inventing pain symptoms in order to obtain controlled substances, including Norco. It contends that the resident and her physician had agreed to wean her off controlled substances but that neither the resident nor her physician told Petitioner about this agreement. *See* P. Ex. 2 at 2. It argues that the non-refill of the resident's prescription for Norco was consistent with the plan worked out between the resident and her physician. It avers that the only reason that the physician eventually reordered Norco for Resident 19 was that he capitulated to pressure from Petitioner's staff. *See Id.* It asserts that it should be held harmless for the alleged agreement not to continue administering Norco to the resident.

I find these assertions to be unpersuasive. Petitioner has produced no records of any communications between its staff and Resident 19's physician – either prior to or contemporaneous with the events that are at issue here – documenting an effort by the physician to wean Resident 19 from Norco or other controlled substances. There is nothing in the resident's plan of care to suggest such an effort nor are there nursing notes that show it. Nor is there any evidence to suggest that the physician told Petitioner's staff, when the staff finally asked him to refill the resident's prescription, that he was discontinuing his order for Norco. There is no physician's order to that effect nor is there anything in the record to show that there were telephone conversations between the physician and Petitioner's staff during which he communicated an intent to discontinue the prescription for Norco. Indeed, the record is devoid of *any* contemporaneous communication suggesting that the resident's physician wanted to discontinue administration of this medication.

Petitioner was obligated to follow Resident 19's physician's orders absent something from the physician that changed or modified them. Its records established that Resident 19 was supposed to be receiving Norco at six-hour intervals. Petitioner was required faithfully to follow that order and that meant doing what was necessary to assure that there was a supply of the medication on hand in order to administer it to the Resident. It is not excused from that duty by the possibility of a secret agreement – if one existed – between the physician and the resident to discontinue administration of the medication.

Furthermore, there is no evidence showing that Petitioner failed to administer the medication to Resident 19 because of an alleged secret agreement. The failure was due to

Petitioner's staff's not timely reordering the medication. The staff waited until its supply of Norco was exhausted before attempting to reorder it.

CMS imposed the two per-instance penalties of $1950 under the authority of 42 C.F.R. § 488.438(a)(2), which allows for the imposition of civil money penalties of between $1000 and $10,000 for each instance of substantial noncompliance. The penalties imposed by CMS were at the lower end of the permissible range for per-instance penalties.

There are regulatory criteria for deciding what is a reasonable penalty amount. 42 C.F.R. §§ 488.438(f)(1)-(4), incorporating 42 C.F.R. § 488.404 by reference at 42 C.F.R. § 488.438(f)(3). These factors include the seriousness of noncompliance, a facility's noncompliance history, its culpability, and its financial condition. Neither CMS nor Petitioner offered arguments relating to these factors. However, it is apparent from the evidence of record that Petitioner's noncompliance was relatively serious. Not only did it deprive Resident 19 of pain medication that the resident's doctor had ordered as necessary, but the failure of the staff timely to seek a refill of the resident's prescription demonstrates a lack of understanding by the staff of the need to execute physician's orders promptly and completely. I conclude that this lack of understanding put other residents besides Resident 19 at risk. Given that, the two per-instance penalties of $1950 are entirely reasonable.

/s/
Steven T. Kessel
Administrative Law Judge