Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Emery County Care and Rehabilitation
(CCN: 465085),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-17-781

Decision No. CR4979

Date: December 1, 2017

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose civil money penalties against Petitioner, Emery County Care and Rehabilitation Center, a skilled nursing facility, in the amount of $1,703.00 per day for each day of a period that began on November 30, 2016 and that ran through May 1, 2017.

I. Background

I issued a pre-hearing order pursuant to which the parties completed pre-hearing exchanges consisting of briefs addressing the merits and proposed exhibits including the written direct testimony of their witnesses. CMS filed exhibits that are identified as CMS Ex. 1-CMS Ex. 24 with its exchange. Petitioner filed exhibits that are identified as P. Ex. 1-P. Ex. 7. With its exchange CMS moved for summary judgment. Petitioner opposed the motion.

I receive the parties' exhibits into the record and decide the case based on that record. It is unnecessary that I decide whether the traditional criteria for summary judgment are

met because neither party filed a request to cross examine its opponent's witnesses.[1] Consequently, an in-person hearing would serve no purpose.

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 several Medicare participation requirements. These requirements are set forth at 42 C.F.R. §§ 483.24, 483.25, 483.45(f)(2), and 438.50(a)(2)(ii). In this decision I address only Petitioner's noncompliance with 42 C.F.R. §§ 483.24 and 483.25. I find it unnecessary to address Petitioner's alleged noncompliance with the other two regulations. Petitioner's noncompliance with the requirements of 42 C.F.R. §§ 483.24 and 483.25 is sufficiently serious to justify the imposition of the civil money penalties that CMS determined to impose, without regard to considering whether Petitioner failed to comply substantially with the requirements of 42 C.F.R. §§ 483.45(f)(2) and 483.50(a)(2)(ii). I note, furthermore that CMS found Petitioner only minimally noncompliant with these last two sections.

The two regulations that I address in this decision govern the quality of life and care that residents in a skilled nursing facility are entitled to receive. 42 C.F.R. § 483.24 (effective November 28, 2016), mandates that a skilled nursing facility provide each of its residents with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with that resident's comprehensive assessment and plan of care. 42 C.F.R. § 483.25 requires a skilled nursing facility to provide each of its residents with treatment and care in accordance with professional standards of practice, the resident's plan of care, and the resident's choices.

CMS argues that Petitioner contravened these regulations with its treatment of a resident who is identified as Resident 1. CMS contends that Petitioner's staff failed to recognize that the resident sustained a potentially life-threatening injury when the resident fell and hit his head. Consequently, according to CMS, the staff failed, in contravention of its own policy, to consult with a physician about the resident's condition and delayed calling

[1] The initial pre-hearing order that I issued in this case instructed each party to inform me if it desired to cross examine its opponent's witnesses. Neither party filed notice of an intent to cross-examine.

for transport to a hospital emergency room despite signs indicating deterioration of the resident's condition.

The evidence amply supports CMS's contentions. It proves that Resident 1 manifested signs of a potentially life threatening injury almost immediately after falling, signs that were sufficient at the outset to require physician consultation and transport of the resident to an emergency room. These signs persisted and, in fact, the resident's condition deteriorated markedly over the ensuing two hours. Although the staff attempted to contact the resident's treating physician it failed to pursue alternatives, as is required by Petitioner's policy, when the physician could not be reached. Inexplicably, the staff delayed calling for emergency transport for nearly one-half hour after the staff determined that the resident needed such transport. By the time the resident finally arrived at a hospital emergency room he was beyond assistance and he expired.

The facts demonstrate that Resident 1 fell and struck the back of his head at about 9 p.m. on the evening of November 29, 2016. CMS Ex. 15 at 2; CMS Ex. 16 at 2. According to Petitioner's staff the resident felt fine before he fell. CMS Ex. 15 at 1. Immediately after the fall the resident evidenced confusion and displayed a blood oxygen saturation level of 64 percent. CMS Ex. 16 at 2.

The unrebutted evidence offered by CMS is that the resident's blood oxygen saturation level should have, in and of itself, alerted Petitioner's staff that Resident 1 was potentially in a dire condition necessitating emergency medical care. CMS Ex. 23 at 2. Moreover, Resident 1's normal blood oxygen saturation level usually was above 90 percent, so the level recorded immediately after the resident's fall was not only in and of itself a warning of a potentially grave medical development but was a sharp departure from the resident's normal state. *Id.*; CMS Ex. 16 at 2.

The staff administered oxygen to Resident 1 beginning at 9:30 on the night of November 29. That only succeeded in increasing the resident's blood oxygen saturation level to 78 percent, still well below the resident's baseline. At 10 p.m., after having administered oxygen to the resident for 30 minutes, staff measured his saturation level at 74 percent, a decrease. The staff also noted that the resident had developed a fever of 100.2 degrees, that he was confused, that he no longer opened his eyes spontaneously, and that his extremities were flaccid with no response to stimuli. CMS Ex. 14 at 1. Despite all of these signs the staff still made no attempt to transport the resident to a hospital.

By 10:30 p.m. Resident 1's condition had deteriorated even further. His blood pressure fell to 80/42, his blood oxygen saturation level decreased to 69 percent despite being administered oxygen, he remained confused, his limbs remained flaccid, and he continued to open his eyes only when spoken to. CMS Ex. 14 at 1. Staff still did not seek emergency care for the resident despite his obvious deterioration, until nearly another half hour had elapsed. At 10:56 p.m. the staff finally called for ambulance

transport of the resident to a hospital emergency room. CMS Ex. 22. Resident 1 had stopped breathing by the time that he arrived at the hospital. Shortly thereafter, he was pronounced dead. CMS Ex. 13 at 1-2.

Petitioner had a policy designed to deal with traumatic injuries and similar acute changes in a resident's condition. CMS Ex. 10. That policy required the staff to contact a resident's physician in an urgent situation and to obtain a response from the physician within one half hour or less. *Id.* at 1. Petitioner's staff did attempt to call Resident 1's physician at about 9:00 p.m. P. Ex. 2 at 3. However, the physician's voicemail box was full and so, the staff sent him a fax. CMS Ex. 16 at 2.

That clearly was an inadequate attempt at communication and Petitioner's staff should have known that. Petitioner's policy prescribed an alternative to consulting with a resident's physician when the physician did not respond timely to a call in a situation of urgency. In that event, the policy directed Petitioner's staff to contact the facility's medical director. CMS Ex. 10 at 2. Nothing in the record suggests that Petitioner's staff attempted to do this when they were unable to reach the resident's physician.[2]

The failure by Petitioner's staff to respond immediately and effectively to what was clearly a situation that required urgent care violated both the requirements of 42 C.F.R. §§ 483.24 and 483.25. This failure violated section 483.24 because, in allowing the resident's condition to deteriorate without obtaining emergency medical treatment, Petitioner's staff deprived the resident of the quality of life he was entitled to receive. It violated section 483.25 because the care that Petitioner's staff gave to the resident after he fell was substandard. The staff should have recognized an urgent medical situation and responded appropriately and it did not.

I have considered Petitioner's arguments in opposition to CMS's contentions and I find them to be without merit. First, Petitioner contends that the resident's condition did not decline significantly before 10:30 p.m. on the night of November 29, 2016. That assertion is belied by the undisputed facts. Those facts show a sharp decrease in the resident's blood oxygen saturation level immediately after he fell. They also show that well before 10:30 the resident had become confused, that he'd stopped opening his eyes except when he was spoken to, that he had developed a fever, and that his limbs had become flaccid. All of these signs – not responded to by Petitioner's staff – were evident signs of a significant deterioration in the resident's condition.

[2] I take notice that in many cases a skilled nursing facility's medical director also serves as the primary care doctor for many of the facility's residents. The record does not disclose whether that was the case here. But, assuming that it was, Petitioner should have made arrangements for an alternate physician to be on call on those occasions when its medical director was unavailable.

Moreover, Petitioner has not disputed that its staff waited until almost 11 p.m. on November 29 before calling for an ambulance, nearly a half hour *after* Petitioner asserts that the resident's condition had declined.

Petitioner attempts to argue that the resident's sharp decline in blood oxygen saturation level beginning at 9 p.m. on the night of the 29th was not a significant change in the resident's condition. As I have concluded, the unrebutted testimony offered by CMS shows that the decline certainly was significant, when considered in isolation, but also when the drop in the resident's blood oxygen saturation level is compared with his baseline. CMS Ex. 16 at 2. Moreover, Petitioner's argument that the drop in the resident's blood oxygen saturation level was not significant is belied by the fact that Petitioner's staff evidently found it sufficiently alarming as to attempt (albeit unsuccessfully) to notify the resident's treating physician.

Petitioner contends that it satisfied its duty to Resident 1 because it provided ongoing assessments of the resident's condition after his fall. However, merely assessing a resident's condition in a medical emergency doesn't satisfy regulatory requirements. Petitioner was required to do something to address that condition. Moreover, recording vital signs, while certainly a necessary element of an assessment, isn't in and of itself an "assessment." Assessing something means to record pertinent information and then arrive at an informed conclusion as to what that information means. The evidence in this case shows that Petitioner's staff dutifully recorded Resident 1's vital signs and condition after he fell. It does not show that the staff made a realistic evaluation of what they found before about 10:30 p.m. on November 29, 2016, 90 minutes after the resident fell. And, for reasons that remain inexplicable, the evidence shows that the staff waited another half hour before acting on their assessment.

Petitioner also contends that its staff asked Resident 1 more than once after the resident fell whether the resident wanted to be transported to a hospital and the resident declined that offer. That does not justify Petitioner's failure to act. The staff observed the resident to be confused immediately after he fell and his confusion continued right up until the staff determined that he needed emergency care. Indeed, by 9:30 p.m. on the night of the 29th the staff observed that the resident no longer opened his eyes voluntarily. The degree of confusion exhibited by the resident after he fell, coupled with the resident's decreased oxygen saturation level and his flaccid extremities should have made it obvious to Petitioner's staff that the resident's opinion as to whether he needed to be taken to a hospital was invalid.

Petitioner offered no evidence to challenge either the duration of its noncompliance or the amount of the penalty – $1,703.00 for each day of Petitioner's noncompliance – that CMS determined to impose. However, I have considered the penalty amount and its duration, and I find that the evidence more than justifies these remedies. The penalty amount is only slightly more than one-fourth of the maximum amount that CMS is

authorized to impose for a non-immediate jeopardy level deficiency. It is justified by the seriousness of Petitioner's noncompliance. Petitioner's staff should have known immediately after Resident 1 sustained a fall that the resident was potentially very gravely injured and required immediate and urgent medical attention. Their failure to recognize the potential severity of the resident's condition is sufficient, by itself, to justify the penalty amount.

CMS based its determination of duration of the penalty on its conclusion that Petitioner did not cure its noncompliance until May 1, 2017. Petitioner did not offer evidence showing that it corrected its noncompliance at an earlier date. Consequently, I sustain CMS's determination.

_____/s/_____
Steven T. Kessel
Administrative Law Judge