Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Golden Cross Health Care of Fresno
(CCN: 55-5426),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-09-568

Decision No. CR2186

Date: July 19, 2010

DECISION

Petitioner, Golden Cross Health Care of Fresno (Petitioner or facility), is a long-term care facility located in Fresno, California, that participates in the Medicare program. The Centers for Medicare and Medicaid Services (CMS) determined that, among other deficiencies, the facility was not in substantial compliance with Medicare requirements for preventing accidents and that its deficiencies posed immediate jeopardy to resident health and safety. CMS has imposed a $7,000 per instance civil money penalty (CMP).

Petitioner appealed, and CMS now moves for summary judgment.

For the reasons set forth below, I find that CMS is entitled to summary judgment. CMS has come forward with evidence establishing that the facility was not in substantial compliance with Medicare program requirements and that the penalty imposed is reasonable. Petitioner has tendered no evidence suggesting a dispute over any material fact, and only one reasonable conclusion can be drawn from the undisputed facts.

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 surveying each facility 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); 488.308.

Here, following an abbreviated standard survey, completed April 22, 2009, CMS determined that the facility was not in substantial compliance with Medicare participation requirements and that its deficiencies posed immediate jeopardy to resident health and safety. Specifically, CMS found that the facility was not in substantial compliance with 42 C.F.R. § 483.25(h) (Tag F323) (accident prevention and supervision), as well as 42 C.F.R. § 483.15(a) (Tag F241) (resident dignity), and 43 C.F.R. § 483.20(k)(3)(i) (Tag F281) (comprehensive care plans). CMS also determined that the facility's failure to meet the requirements of 42 C.F.R. § 483.25(h) posed immediate jeopardy to resident health and safety. CMS Exhibit (Ex.) 1; CMS Ex. 2. Based on the facility's substantial noncompliance, CMS denied payment for new admissions, effective May 21, 2009. Based solely on the deficiency cited under § 483.25(h), CMS imposed a $7,000 per instance CMP. CMS Ex. 2.

Petitioner timely requested a hearing. The parties filed their initial briefs (CMS Br.; P. Br.). CMS filed a motion for summary judgment (CMS MSJ) to which Petitioner filed a response (P. Resp.). CMS submitted 27 exhibits (CMS Exs. 1-27). Petitioner submitted 42 exhibits (P. Exs. 1-42).

II. Issues

I consider whether summary judgment is appropriate.

On the merits, I consider:

1) whether, at the time of the April 22, 2009 survey, the facility was in substantial compliance with 42 C.F.R. § 483. 25(h); and

2) if the facility was not in substantial compliance, is the penalty imposed – $7,000 per instance – reasonable?

Because CMS bases the denial of payments for new admissions (DPNA) on all of the cited deficiencies, I have the authority to review them all. *See Schowalter Villa*, DAB No. 1688 (1999). Nevertheless, in the interests of administrative economy, I do not consider the facility's compliance with 42 C.F.R. §§ 483.15(a) and 483.20(k)(3)(i). Because I find that the facility was not in substantial compliance with 42 C.F.R. § 483.25(h), CMS has the authority to impose any of the penalties listed in 42 C.F.R. § 488.406, which include imposing a DPNA. Act § 1819(h); 42 C.F.R. § 488.402; *see Claiborne-Hughes Health Ctr.*, No. 09-3239 at 11 (6th Cir. 2010).

Nor will I review CMS's finding of immediate jeopardy. An Administrative Law Judge (ALJ) may review CMS's scope and severity findings (which include a finding of immediate jeopardy) only if: (1) a successful challenge would affect the range of the CMP; or (2) 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. Where, as here, the facility has been assessed a CMP of $5,000 or more, the state agency may not approve its nurse aide training program. Act § 1819(f)(2)(B); 42 C.F.R. § 483.151(b)(2)(iv).

III. Discussion

Summary Judgment. Summary judgment is appropriate if a case presents no genuine issue of material fact, and the moving party is entitled to judgment as a matter of law. *Illinois Knights Templar Home*, DAB No. 2274 at 3-4 (2009), and cases cited therein.

The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law, or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to [that party's] case, and on which [that party] will bear the burden of proof at trial." *Livingston Care Ctr. v. Dep't of Health & Human Servs.*, 388 F.3d 168, 173 (6th Cir. 2004) (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986)). To avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986); *see also Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing and Rehab. Ctr.*, DAB No. 1918 (2004).

> To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact . . . .

Illinois Knights Templar, DAB No. 2274 at 4; *Livingston Care Ctr.*, DAB No. 1871 at 5 (2003).

In examining the evidence for purposes of determining the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *Brightview Care Ctr.*, DAB No. 2132 at 2, 9 (2007); *Livingston Care Ctr.*, 388 F.3d at 172; *Guardian Health Care Ctr.,* DAB No. 1943 at 8 (2004); *but see Brightview*, DAB No. 2132 at 10 ([E]ntry of summary judgment upheld where inferences and views of non-moving party are not reasonable.). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cf. Guardian Health Care Ctr.*, DAB No. 1943 at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.").

A. CMS is entitled to summary judgment. The undisputed evidence establishes that the facility was not in substantial compliance with 42 C.F.R.§ 483.20(h), because facility staff did not ensure that the resident environment remained as free of accident hazards as possible and did not take reasonable steps to ensure that one of its residents received supervision sufficient to mitigate foreseeable risks of harm from accidents.[1]

Regulatory Requirements. 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. The facility must "ensure" that the resident's environment remains as free of accident hazards as is possible. It must "take reasonable steps to ensure that a resident receives the supervision and assistance devices designed to meet his assessed needs and to mitigate foreseeable risks of harm from accidents." *Briarwood Nursing Ctr.*, DAB No. 2115 at 5 (2007); *Guardian Health Care*

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

Ctr., DAB No. 1943 at 18 (*citing* 42 C.F.R. § 483.25(h)(2)). The facility must anticipate what accidents might befall a resident and take steps to prevent them. A facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods must constitute an "adequate" level of supervision under all the circumstances. *Briarwood*, DAB No. 2115 at 5; *Windsor Health Care Ctr.*, DAB No. 1902 at 5 (2003).

Resident 1 (R1). This case centers around the facility's treatment of R1, a 63-year-old resident suffering from a serious mental illness – schizophrenia, bipolar type – as well as a number of physical ailments. CMS Ex. 7 at 8; CMS MSJ at 6; P. Ex. 1; P. Resp. at 6. Among his problem behaviors, he made inappropriate sexual advances toward women residents and staff. CMS Ex. 7 at 7, 8; CMS Ex. 9 at 7-8; P. Ex. 1. At one time, his physicians treated his schizophrenia with an anti-psychotic medication (Zyprexa). But, because R1 repeatedly refused to take it, his primary care physician, Dr. O'Key Sams, discontinued the medication orders on December 9, 2008. CMS Ex. 7 at 8; CMS Ex. 8 at 2; CMS Ex. 9 at 7; P. Ex. 1.[2]

Until February 2009, physician orders called for "behavior monitoring" every shift. Specifically, the physician directed staff to monitor the resident for "episodes of schizophrenia disorder" manifested by sexual advances toward female peers and female staff. Another order directed staff to monitor for side effects/adverse reaction to antipsychotic medications. CMS Ex. 7 at 7. At the facility's request, however, on February 10, 2009, Dr. Sams discontinued all behavior monitoring orders "because the resident is not on any psychotropic medications at this time." CMS Ex. 7 at 5-7; CMS Ex. 9 at 6.[3]

Thereafter, however, R1 engaged in sexually inappropriate behaviors. CMS Ex. 9 at 6.

On March 15, 2009, one of the facility's housekeepers observed R1 lying outside on the back patio, refusing to get up, his face bleeding. He had used a razor to cut his face. He told staff that he wanted to die. When they approached him, he swung the razor at them,

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[2] R1 "had been regularly refusing to take any antipsychotic medication for many years." P. Resp. at 16; P. Ex. 40. Yet, his care plan does not mention that the medications were not provided "due to [his] exercise of rights . . . to refuse treatment." *See* 42 C.F.R. § 483.20(k)(1)(ii).

[3] Obviously, staff need not monitor for adverse reactions to medication if the resident no longer takes medications. However, nothing in this record explains why the physician would also cancel his orders for behavior monitoring. Where the individual is no longer taking his anti-psychotic medications, it seems all the more important to monitor for acute episodes of schizophrenia. Although puzzling, I do not find the issue material, and, for summary judgment purposes, I infer validity to the physician's decision to discontinue these behavior-monitoring orders.

but they were able to take it away from him. Staff called an ambulance, and he was taken to the hospital, where he was held for a 72-hour psychiatric observation. CMS Ex. 9 at 6; CMS Ex. 13; CMS Ex. 14 at 1; P. Ex. 26 (Amesquida Decl. ¶3); P. Ex. 38 (Villa Decl. ¶¶ 4, 5, 6); P. Ex. 28 at 2 (Crawford-Hood Decl. ¶ 9).

The parties dispute whether R1 had a prior history of cutting himself. *Compare* CMS MSJ at 7 *with* P. Response at 8, 13-14. For purposes of summary judgment, I accept that facility staff were not aware of any self-injurious behavior prior to March 15, 2009.

R1 was readmitted to the facility on March 18, 2009, "[status post] suicide attempt." CMS Ex. 7 at 4; P. Exs. 2, 3. At the time of his admission, his physician ordered staff to 1) monitor behaviors for suicidal ideations every shift; 2) monitor his environment every shift for sharp objects, and to remove them if found; and 3) monitor for isolation, sadness, or statements of doom. Staff were to keep a tally of their findings, placing hash marks on the monitoring sheets. CMS Ex. 7 at 3; P. Ex. 4 at 1; P. Ex. 5 at 2-4; P. Ex. 7 at 1, 4-5. His psychiatrist, Dr. Gill, ordered psychotropic medications (Zyprexa, Haldol, Ativan, and Lexapro), but, on March 24, 2009, Dr. Sams again discontinued those medications and instructed staff to consult Dr. Gill about the possibility of ordering the medications administered by intramuscular injection. CMS Ex. 7 at 2; P. Ex. 3 at 3; P. Ex. 6. [4]

At the same time that Dr. Sams discontinued the orders for psychotropic medications, he discontinued the behavior-monitoring orders. P. Ex. 7 at 5; P. Ex. 28 at 3 (Crawford-Hood Decl. ¶ 12). Although Petitioner asserts that "nurses are obliged to abide by these orders" (P. Resp. at 17), it does not seriously argue that staff were therefore precluded from monitoring R1's behaviors. In fact, Petitioner later acknowledges that nurses continued monitoring "as a nursing intervention." P. Resp. at 18. According to the facility's monitoring sheets, staff continued monitoring R1's mood and, beginning April 1, 2009, resumed monitoring his environment for sharp objects. P. Ex. 7 at 4, 7, 9.

On April 6, 2009, Surveyor Colleen Newby, R.N., found razors in two of the drawers of R1's bedside stand, tucked underneath his clothes. She also found a rimless mirror on his bed. CMS Ex. 22 at 4 (Newby Decl. ¶ 11); CMS Ex. 1 at 11-12. According to Surveyor Newby, staff admitted giving R1 a razor to use while he bathed. CMS Ex. 22 at 4 (Newby Decl. ¶ 12). Petitioner disputes the assertion, and, for purposes of summary judgment, I resolve the factual dispute in Petitioner's favor.

[4] R1's care plan was not updated to reflect his suicidal ideation until April 7, 2009. The facility's Director of Nursing (DON) Teary Searcy, by herself, added the diagnosis to his care plan, without input from an interdisciplinary team. No interventions were added to the plan. P. Ex. 36 at 2 (Searcy Decl. ¶ 20); *compare* P. Ex. 1 *with* P. Ex. 14.

Petitioner nevertheless concedes that staff were aware of the mirror and that R1 frequently pilfered items – including razors – off the nurse aide carts, hiding them in his wheelchair, his room, or a pouch around his neck. P. Resp. at 14; P. Ex. 36 at 1 (Searcy Decl. ¶ 3); P. Ex. 28 at 1 (Crawford-Hood Decl. ¶ 5). Petitioner justifies allowing R1 to keep the mirror, because he liked to use tweezers and the mirror to pull hair from his face. P. Ex. 28 at 1 (Crawford-Hood Decl. ¶ 3). [5] According to Licensed Vocational Nurse (LVN) Judy Crawford-Hood, "[p]rior to March 15, 2009, [R1] never used his small mirror or any items that he pilfered inappropriately, nor did he exhibit any self-abusive behaviors or suicidal ideations." P. Ex. 28 at 1 (Crawford-Hood Decl. ¶ 5).

I accept that, prior to March 15, R1 displayed neither self-abusive behavior nor suicidal ideation. But on March 15 that all changed. From that point, facility staff knew that R1, with his largely untreated schizophrenia, was capable of serious self-injurious behavior and could not safely be allowed sharp objects. Yet, no one even considered that an unframed mirror is a sharp object posing a significant risk.

Even more disturbing, R1 possessed razors, which shows that the facility ineffectively monitored his environment for sharp objects. The razors Surveyor Newby found were not particularly well-concealed. They were in two of his bed-side drawers underneath his clothing. Any cursory search would have produced them. Moreover, staff admit that they were well-aware of R1's pilfering from the nurse aide carts, but Petitioner offers no evidence that the facility made any particular effort to keep razors off those carts and away from R1 until April 7, 2009, the day after Surveyor Newby found the razors in R1's bed-side stand. P. Ex. 22 at 5.

Petitioner suggests a factual dispute as to *when* R1 "secreted" the razors in his bedside stand. According to Petitioner, he could have done so "immediately prior to the inspection." P. Resp. at 22. Petitioner comes forward with no evidence to establish this factual dispute – no staff member claims to have searched R1's bedside stand at any point prior to the discovery. But the issue is not material. The facility was deficient, because

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[5] R1's care plan identifies *as a problem* his proclivity for tweezing his whiskers and in no way suggests that the behavior should be encouraged. P. Ex. 1. According to Carolyn Norcross, the facility administrator, he also "liked to keep his face, chest, and arms free of hair." P. Ex. 34 at 1 (Norcross Decl. ¶ 3). Further, according to the declarations of staff, R1 displayed other significant behaviors that do not appear to have been addressed in his care plan, nor discussed much in his treatment records. He liked to sun himself naked in the back of the facility, which seems problematic for someone who has a history of disrobing in public. P. Ex. 34 at 1 (Norcross Decl. ¶ 3); P. Ex. 41 at 4. He also regularly purged, which seems a problematic behavior for anyone, but especially for someone with a history of anemia and GI bleeding. P. Ex. 34 at 1 (Norcross Decl. ¶ 3); P. Ex. 37 at 1 (Taylor Decl. ¶ 3). The appropriateness of the facility's response (or lack of response) to these behaviors is not before me, however.

R1 had access to these dangerous objects, which shows that it was not taking the steps necessary to keep the resident safe.

Thus, after March 15, 2009, the facility knew that allowing R1 access to sharp objects could endanger his safety. Yet, it did not ensure that his environment was as free of accident hazards as possible, nor did it take reasonable steps to provide the supervision he needed to mitigate foreseeable risks of harm from accidents. The facility was therefore not in substantial compliance with 42 C.F.R. § 483.25(h).

B. The penalty imposed is reasonable.

I next consider whether the CMP is 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 Ctr.*, 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 just one $7,000 per instance CMP, which is in the mid-to-high end of the penalty range ($1,000-$10,000). 42 C.F.R. §§ 488.408(d)(iv), 488.438(a)(2). On the other hand, the penalty is modest considering what CMS might have imposed. *See Plum City Care Ctr.*, 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.").

CMS does not cite facility history as a factor that justifies a higher CMP.

With respect to its financial condition, Petitioner has submitted no financial documents, such as tax returns, financial statements, or audits to establish its financial condition. However, in a supplemental declaration, the facility administrator points out that, from 2007 to 2009, the State of California was delinquent in paying its Medi-Cal providers and argues that a $7,000 CMP places an additional "financial burden on the facility." Decl. of

Carolyn Norcross (Feb. 12, 2010); P. Resp. at 21. I accept her assertion as true; however, that a CMP imposes "financial burden" does not make it unreasonable. In fact, a CMP is supposed to impose a financial burden significant enough to compel corrective action. In any event, Petitioner misstates the standard for determining whether a CMP is reasonable based on the facility's financial condition. The facility must show that it lacks "adequate assets to pay the CMP without having to go out of business or compromise resident health and safety." *Sanctuary at Whispering Meadows*, DAB No. 1925 at 19 (2004); *Guardian Care Nursing and Rehab. Ctr*., DAB No. 2260 at 9-10 (2009). Since Petitioner does not claim this degree of financial insolvency, its financial condition does not render the CMP unreasonable.

With respect to the remaining factors, I consider the severity of the deficiencies significant enough to warrant at least this relatively modest penalty. Facility staff knew that this seriously mentally ill resident was capable of significant self-injurious behavior, as he had taken a razor blade to his face. Allowing him unsupervised access to sharp objects was likely to cause him serious injury or even death. Yet, no one reconsidered the wisdom of allowing him an unframed mirror, and R1 continued to have access to razors. These failures evidence significant disregard for the resident's safety, for which the facility is culpable.

I therefore find reasonable the $7,000 per instance CMP.

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 governing residents' special needs, 42 C.F.R. § 483.25(h). The $7,000 per instance penalty imposed is reasonable. I therefore grant CMS's motion for summary judgment.

/s/
Carolyn Cozad Hughes
Administrative Law Judge