Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Legacy Health and Rehabilitation (CCN: 04-5267),	)	Date: March 18, 2009
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-08-507
	)	Decision No. CR1927
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

Legacy Health and Rehabilitation Center (Petitioner or facility) is a nursing facility, located in Fort Smith, Arkansas, that participates in the Medicare program. Based on a survey completed March 12, 2008, the Centers for Medicare and Medicaid Services (CMS) determined that the facility was not in substantial compliance with program participation requirements and imposed a $5000 per instance civil money penalty (CMP). Petitioner here challenges that determination and CMS now moves for summary judgment.

For the reasons discussed below, I find that summary judgment is appropriate. Based on the undisputed evidence, I conclude that the facility was not in substantial compliance with Medicare requirements governing notification of changes, 42 C.F.R. § 483.10(b)(11), and I affirm, as reasonable, the imposition of a $5000 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 the 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 with program participation requirements. 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); 488.308.

In this case, surveyors from the Arkansas Department of Human Services' Office of Long-Term Care (State Agency) completed a complaint investigation survey on March 12, 2008. Based on the survey findings, CMS determined that the facility was not in substantial compliance with federal requirements for nursing homes participating in the Medicare and Medicaid programs, and that its deficiencies posed immediate jeopardy to resident health and safety. Specifically, they found that the facility did not meet federal requirements under: 42 C.F.R. § 483.10(b)(11) (Tag F157 – Resident Rights-Notification of Changes), and 42 C.F.R. § 483.25(h) (Tag F323 – Quality of Care). CMS Exs. 1, 2. CMS imposes a per instance CMP of $5000 for the deficiencies cited under 42 C.F.R. § 483.10(b)(11).

Petitioner timely requested a hearing. CMS has moved for summary judgment, which Petitioner opposes. With its motion and brief, CMS has submitted eleven exhibits (CMS Exs. 1-11). With its response (P. Br.), Petitioner has submitted 34 exhibits (P. Exs. 1-34).

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 42 C.F.R. § 483.10(b)(11) (notification of changes); and 2) if the facility was not in substantial compliance, is the penalty imposed, $5000 per instance, reasonable?

The parties agree that, because CMS imposed no penalties for the deficiencies cited under the quality of care regulation, 42 C.F.R. § 483.25(h), the facility's compliance with that issue is not before me. 42 C.F.R. § 498.3(d)(10)(ii); *Schowalter Villa*, DAB No. 1688 (1999) (The imposition of a remedy, not the citation of a deficiency, triggers the right to a hearing.).

Nor may I review CMS's immediate jeopardy determination since a successful challenge to that determination would not affect either 1) the range of CMP amounts, or 2) a finding of substandard quality of care that results in the loss of approval of the facility's nurse aide training program. 42 C.F.R. § 498.3(b)(14). The penalty imposed here is a

per instance CMP, for which the regulations provide only one range ($1000 to $10,000), so the level of noncompliance does not affect the range of the civil money penalty. 42 C.F.R. § 488.438(a)(2). Nor does it 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 because the facility has been assessed a $5000 CMP. Act § 1819(f)(2)(B).

III. Discussion

A. Because the undisputed facts establish that facility staff did not immediately consult an attending physician when its residents suffered an accident or change in condition, or needed a significant change in treatment, the facility was not in substantial compliance with 42 C.F.R. § 483.10(b)(11), and CMS is entitled to summary judgment.[1]

Summary judgment is appropriate if a case presents no genuine issue of material fact, and one party is entitled to judgment as a matter of law. 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 Center v. Dep't of Health & Human Services*, 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); s*ee also Vandalia Park,* DAB No. 1939 (2004); *Lebanon Nursing and Rehabilitation Center,* DAB No. 1918 (2004). 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. *Livingston Care Center,* 388 F.3d at 172; *Guardian Health Care Center,* DAB No. 1943, at 8 (2004). 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 Center,* 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.").

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

CMS's case centers around the care provided to two of the facility's residents, identified as Resident 8 and Resident 10.

Resident 10 (R10). First, with respect to R10, CMS has come forward with evidence – primarily the facility's own records – establishing that:

- R10 had diagnoses of respiratory distress, congestive heart failure, renal failure, anemia, and schizophrenia. (CMS Ex. 5, at 1, 11; *see also* P. Exs. 13, 14; P. Ex. 15, at 2);

- Because of her respiratory difficulties, R10 was not able to lie flat (CMS Ex. 5, at 8) and required oxygen therapy (CMS Ex. 5, at 9);

- Among her medication orders, R10's physician called for 3-5 liters of oxygen via nasal cannula, keeping her oxygen saturation (O^2) levels greater than 92%. He ordered an "updraft treatment" with a one-unit dose of Albuterol every six hours for shortness of breath.[2] Staff were to stay with her while administering the treatment and to document the time of the updraft in minutes. The orders also called for one mg Ativan every eight hours as needed for anxiety (CMS Ex. 5, at 11; *see also* P. Ex. 15, at 1, 2, 19, 21, 23; P. Ex. 16, at 5, 7);

- R10's care plan also identified her as at risk for dehydration and directed staff to observe and report to her physician "immediately" incidents of vomiting or diarrhea (CMS Ex. 5, at 15);

- At 4:00 in the afternoon on February 10, 2008, R10, who was returning from an outing with her family, vomited a large amount of undigested food; she was short of breath, and her O^2 level was 68% without oxygen. A facility nurse administered oxygen via nasal cannula, and her O^2 level increased to 89%. Assisted to bed, the resident "[continued] to holler and be very anxious." Staff administered Ativan. The resident complained of nausea (CMS Ex. 5, at 28);

- At 6:00 p.m., R10's anxiety was continuing; she pulled off her oxygen and complained of nausea. She was incontinent of urine and feces. According to the nurse, "This behavior [is] not normal for [her]." The nurse administered her Albuterol updraft treatment, after which her O^2 level was 78% (CMS Ex. 5, at 28-29);

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[2] Albuterol is a common bronchodilator, often administered by means of an inhaler. An "updraft nebulizer" is a specialized type of inhaler that helps the medication get deeper into the lungs.

- Nurses notes report that at 8:00 p.m. R10 was still very anxious, and intermittently pulled off her oxygen (CMS Ex. 5, at 29);

- At 10:00 p.m., nurses describe R10 as "hollering loudly – very anxious." Her O^2 level was 58%. Staff administered three liters then an additional five liters of oxygen, and her O^2 rose to 61%. Her heart rate was 126; she was "very limp – not supporting neck." Staff called her physician who ordered her transferred to the hospital (CMS Ex. 5, at 29);

- When R10 arrived at the emergency room, her shortness of breath was severe, and she was diagnosed with acute respiratory failure (CMS Ex. 5, at 31-32);[3]

- R10 was admitted to the hospital in the early morning hours of February 11, and she died there on February 26, 2008 (CMS Ex. 5, at 29, 33).[4]

In CMS's view, these undisputed facts put the facility out of substantial compliance with 42 C.F.R. § 483.10(b)(11), which requires that the facility *immediately* consult with a resident's physician whenever there is 1) an accident involving the resident that results in an injury that has the potential for requiring physician intervention; 2) a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); or 3) a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment).

Petitioner does not challenge any of CMS's facts, but asserts that, prior to 10:00 p.m. on February 10, R10's condition did not merit physician consultation because she regularly experienced such symptoms, and nurses were able to raise her O^2 levels and decrease her

[3] A surveyor note indicates that the surveyor contacted the Emergency Medical Services (EMS) who reported that the facility called EMS at 10:46 p.m. CMS Ex. 5, at 5. Petitioner has presented no evidence suggesting any dispute over this assertion, although it claims generally that R10 "was promptly transferred to a hospital." P. Br. at 4.

[4] The hospital's death summary report contains inconsistent dates of death. The text says that R10 died on the evening of February 23, but sets her discharge date at February 26, 2008. CMS Ex. 5, at 33. The facility's nurses notes set the date of death at February 26. For purposes of resolving this motion, I accept the date offered by Petitioner, February 26. *See* P. Ex. 32, at 3 (Stewart Decl. ¶ 6); P. Ex. 34, at 2 (Ross Decl.).

anxiety without physician involvement. According to Licensed Practical Nurse (LPN) Kathy Stewart, R10 would remove her nasal cannula almost every day, and, when she did so, her O^2 levels dropped, and she became anxious. LPN Stewart did not contact R10's physician when this occurred because she "was always able to bring her saturation levels back up." P. Ex. 32, at 1-2 (Stewart Decl. ¶ 3).

With regard to the events of February 10, LPN Stewart confirms that the resident vomited, was short of breath, and her O^2 level was 68%. LPN Stewart administered oxygen via nasal cannula, and Ativan, a combination that, in the past, had eventually reduced R10's anxiety. P. Ex. 32, at 2 (Stewart Decl. ¶ 4).

LPN Stewart also confirms CMS's assertion that, when R10 awakened at 6:00 p.m., she was still anxious, was pulling off her oxygen, and complaining of nausea. R10 was also incontinent, however, "which [is] not normal behavior for her." LPN Stewart administered an updraft treatment, and R10's O^2 level rose to 78%. LPN Stewart does not comment on the physician order that R10's O^2 level be kept at or above 92%. *But see* note 7 *below*. LPN Stewart claims that a 78% level "was not low for this [r]esident, as her oxygen levels were consistently at or around this level." P. Ex. 32, at 2-3 (Stewart Decl. ¶ 4).

LPN Stewart says that she checked on R10 at 8:00 p.m., and, the resident "intermittently remove[d] her nasal cannula, causing her to become anxious." But again, according to LPN Stewart, such was "[c]onsistent with her normal, usual behavior." P. Ex. 32, at 3 (Stewart Decl. ¶ 4).

LPN Stewart concludes that, from 4:00 to 10:00 p.m., R10's O^2 levels and anxiety "were neither a change in her status nor did it warrant any need to alter treatment significantly, but rather were a daily occurrence" for her. P. Ex. 32, at 3 (Stewart Decl. ¶ 5). At 10:00 p.m., however, R10 was "hollering very loudly and continued to be anxious"; her O^2 level had dropped to 58% and LPN Stewart could not bring it up any higher than 61%. R10's heart rate was 126, and she was "limp." LPN Stewart then notified R10's physician, R.W. Ross, M.D., who ordered her transferred to the hospital. P. Ex. 32, at 3 (Stewart Decl. ¶ 6).

Dr. Ross, who is also the facility's medical director, echoes much of LPN Stewart's testimony. He declares that, based on his regularly reviewing records, R10's oxygen saturation levels dropped "nearly every day." He declares it "prudent" for her caregiver to replace immediately her nasal cannula before calling a physician. "I should have written that order but did not." Dr. Ross refers vaguely to "a couple of occasions" when

he was notified of additional complications regarding R10.[5] Consistent with assertions from LPN Stewart and CMS, he says that, when the facility notified him on February 10 of R10's vomiting, anxiety, and O^2 level of 58%, which staff could not bring above 61%, he ordered her transfer to the hospital. P. Ex. 34 (Ross Decl.). Dr. Ross says nothing about his order that R10's O^2 level be kept at or above 92%. *See* note 7 *below*.

Petitioner also offers the declaration of the facility's minimum data set (MDS) coordinator, Jennifer Garner, R.N., who confirms that R10's care plan required immediate physician notification "if the resident is observed for vomiting or diarrhea," and explains that she added that provision because R10 was susceptible to dehydration. P. Ex. 33, at 2 (Garner Decl. ¶ 6).[6]

Thus, Petitioner's witnesses confirm CMS's factual allegations, and add the additional factual assertion that R10's O^2 levels regularly fell below 92%.[7] For purposes of summary judgment, I accept this as true. From this, Petitioner argues that staff were not obliged to consult R10's physician because anxiety and low O^2 levels did not represent any significant change for her.

But even accepting the assertion that anxiety and extremely low O^2 levels were normal for R10, and did not represent a significant change in her status requiring physician consultation, the facility's treatment of R10 still violated 42 C.F.R. § 483.10(b)(11). Staff failed to consult immediately her physician when she exhibited other symptoms that unquestionably represented significant changes: at 4:00 p.m. she vomited a large amount; at 6:00 p.m. she was incontinent of urine and feces.

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[5] Dr. Ross is apparently referring to two earlier instances when nurses were unable to bring up R10's O^2 levels. On October 14, 2007, staff notified him that R10's O^2 level dropped to 87% and her pulse was 80. The following day (October 15), her O^2 level was 88% and she coughed up white colored sputum. P. Br. at 8-9; P. Ex. 18, at 5.

[6] The facility must develop for each resident an individualized, comprehensive care plan. Among other requirements, the plan must be prepared by an interdisciplinary team that includes the attending physician, a registered nurse, and other appropriate staff. 42 C.F.R. § 483.20(k).

[7] Petitioner claims that the physician order that staff maintain an O^2 level of 92% was discontinued, and presents a copy of R10's chart in which that order has been crossed out. P. Br. at 15; P. Ex. 15, at 19; *but see* CMS Ex. 5, at 11. Whether the order was in effect on February 10 is not material. I accept, for purposes of summary judgment, that the order had been discontinued.

The facility's own policies list examples of a change in condition necessitating physician involvement, and that list includes "nausea, vomiting, diarrhea" as well as "sudden incontinence." CMS Ex. 7, at 1. Further, R10's care plan required staff to report to her physician "immediately" incidents of vomiting. CMS Ex. 5, at 15. Staff either ignored or were unaware of these unambiguous directives.

Although vomiting and incontinence represented significant changes, staff did not consult R10's physician until hours after they occurred, by which time her condition had significantly deteriorated. Such delay violates the regulation. "Immediately" means "as soon as the change . . . is detected, without any intervening interval of time." *Magnolia Estates Skilled Care*, DAB No. 2228, at 8 (2009); *The Laurels at Forest Glenn*, DAB No. 2182, at 13 (2008).

Resident 8 (R8). The situation involving R8 is even more straight-forward. CMS has come forward with the following evidence, which Petitioner does not challenge:

- R8 was a bilateral amputee, with a history of stroke, who suffered from diabetes (CMS Ex. 4, at 4, 7);

- R8 was totally dependent on staff to move within her room, throughout her unit, and off her unit (CMS Ex. 4, at 7). She was at risk for falls, and had a history of falls (CMS Ex. 4, at 10-11);

- At 6:45 p.m. on March 6, 2008, R8 was found sitting on the sidewalk with abrasions around her left eye. Staff had rolled her wheelchair out of the facility so that she could smoke, but apparently failed to lock the chair's brakes. Another resident rolled through the doorway, his chair hit her chair, she rolled away, her chair hit the curb, and she fell out (CMS Ex. 4, at 12-15);

- Staff notified R8's daughter of the incident, and sent a fax to R8's physician (CMS Ex. 4, at 15);

- Following the accident, R8 complained of hip and shoulder pain, and staff administered Tylenol (CMS Ex. 4, at 15);

- At 7:45 p.m., R8 continued to complain of pain, and the nurse wrote that, if her complaints continued through the night shift (11p.m. to 7 a.m.), staff would follow-up with the day shift (7 a.m. to 3 p.m.) for x-rays (CMS Ex. 4, at 15);

- At midnight, R8 was awake, complaining of pain in her right leg. Staff gave her Tylenol (CMS Ex. 4, at 16);

- At 2:00 a.m., R8 was still complaining of right leg pain, and staff reported that the Tylenol was "ineffective" (CMS Ex. 4, at 16);

- The following afternoon (March 7 at 1:45 p.m.), R8's family asked that she be sent to the emergency room for evaluation and treatment. Because of her "severe pain," the facility called EMS, and R8 was transported to the hospital in an ambulance (CMS Ex. 4, at 16, 17);

- X-rays showed no fractures, although R8 had contusions to both her left shoulder and hip. She returned to the facility with a prescription for Lortab (Acetaminophen with the narcotic, Hydrocodone) and instructions to limit her activity (CMS Ex. 4, at 19, 20, 21).

Based on these undisputed facts, I find that the facility did not immediately consult R8's physician following her accident, nor when she subsequently complained of significant pain.

Sending a fax to the physician's office – particularly after regular business hours – does not satisfy the requirement to "consult." As the Departmental Appeals Board recently ruled in *Magnolia Estates*, consultation requires more than just informing or notifying the physician.

> Consultation . . . requires a dialogue with and a responsive directive from the resident's physician as to what actions are needed; it is not enough to merely notify the physician of the resident's change in condition. Nor is it enough to leave just a message for the physician.

DAB No. 2228, at 9. The facility then compounded its error when it failed to consult the physician about R8's escalating complaints of pain, for which Tylenol proved "ineffective."

Petitioner justifies its inaction by pointing out that R8 ultimately suffered no broken bones, and asserting (without any support) that the narcotic pain medication Lortab is "not much more potent than the [Tylenol]." P. Br at 13.

I reject Petitioner's arguments. First, "significant" does not mean "life-threatening." Nor does the regulation require a medical emergency. Drafters of the regulation emphasized that "in all cases, whether or not there is a medical emergency," the facility must immediately consult the attending physician. 56 Fed. Reg. 48826, 48833 (September 26, 1991). As the drafters explained, a "significant change" could be life-threatening, but it could also involve clinical complications, such as the development of a stage II pressure sore or onset of delirium. *The Laurels at Forest Glen*, DAB No. 2182, at 11-12.

Here, an elderly and infirm woman fell out of her wheel chair, suffering abrasions around her left eye, and, as discovered a day later in the emergency room, contusions to both her left shoulder and hip. She complained of significant pain throughout the night and the following morning. When, at the insistence of her family, the facility sent her to the emergency room, she had to be transported by ambulance because of her "severe pain." CMS Ex. 4, at 12-17. Fortuitously, she was not more seriously injured. However, she was undeniably involved in an accident resulting in an injury "that had the potential for requiring physician intervention"; she underwent a significant change in her status – experiencing severe pain; and ultimately required a significant treatment change – x-rays to rule out fracture, and a prescription narcotic to treat her pain.

Thus, the undisputed facts lead to the inescapable conclusion that the facility did not immediately consult with either resident's physician following an accident/change in condition/need to alter treatment. The facility was therefore not in substantial compliance with 42 C.F.R. § 483.10(b)(11).

B. The CMP imposed – $5000 per instance – is reasonable.

Having found a basis for imposing a CMP, I now consider whether the amount imposed is reasonable, 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. 42 C.F.R. § 488.438(f). 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; 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

It is well-settled that, in reaching a decision on the reasonableness of the CMP, I may not look into CMS's internal decision-making processes. Instead, I consider whether the evidence presented on the record concerning the relevant regulatory factors 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 other factors involved (financial condition, facility history, culpability). 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. 1683, at 8 (1999).

CMS does not claim that facility history warrants any increase in penalty. Petitioner has not suggested that its financial condition affects its ability to pay the penalty. However, with respect to the other factors, I note that this was not a single isolated incident. The facility's repeated failure to consult the attending physician put each of these residents at significant risk, threatening her comfort, health and safety, for which the facility is culpable. Moreover, although toward the mid-range for per instance situations (per 42 C.F.R. § 488.438(a)(2), the range is $1000 – $10,000), $5000 seems a minimal penalty for inducing any corrective action.

Because the undisputed facts establish deficiencies that are sufficient to sustain the penalties imposed, CMS is entitled to summary judgment.

IV. Conclusion

For all of the reasons discussed above, I find that the facility was not in substantial compliance with 42 C.F.R. § 483.10(b)(11) (notification of changes). I also sustain the $5000 per instance CMP.

/s/
Carolyn Cozad Hughes
Administrative Law Judge