Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Apollo Health & Rehabilitation Center,	)	Date: June 20, 2007
(CCN: 10-5202)	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-06-508
	)	Decision No. CR1611
Centers for Medicare & Medicaid	)	
Services.	)	
	)	

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose two $5,000 per-instance civil money penalties against Petitioner, Apollo Health & Rehabilitation Center.

I. Background

Petitioner is a skilled nursing facility in St. Petersburg, Florida. It participates in Medicare. Its participation in that program is governed by sections 1866 and 1819 of the Social Security Act and by implementing regulations at 42 C.F.R. Parts 483 and 488.

On March 30, 2006, Petitioner was surveyed for compliance with Medicare participation requirements. The surveyors found several distinct failures by Petitioner to comply. On April 12, 2006, CMS notified Petitioner that it concurred with the surveyors' findings and that it had determined to impose remedies against Petitioner. Petitioner requested a hearing and the case was assigned to me for a hearing and a decision. I scheduled an in-person hearing in the case. Prior to the hearing the parties agreed that the case could be decided based on their written submissions. Each party submitted a brief and a reply

brief. CMS filed exhibits which it designated as CMS Ex. 1 - CMS Ex. 33. Petitioner filed exhibits which it designated as P. Ex. 1 - P. Ex. 12. I receive the parties' exhibits into evidence.

II. Issues, findings of fact and conclusions of law

A. Issues

CMS determined to impose remedies against Petitioner, consisting of two per-instance civil money penalties of $5,000, for two of the alleged deficiencies that are specified in the survey report. These consist of Petitioner's alleged failures to comply with the requirements of 42 C.F.R. §§ 483.13(c) and 483.20(k)(3)(i). CMS Ex. 3, at 15 - 19; 19 - 23. The first of these two regulations requires that a facility develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. The second requires a facility to provide services to its residents that meet professional standards of quality.

In this decision I address each of these two allegations of noncompliance. The issues that I hear and decide are whether:

> 1. Petitioner failed to comply substantially with the requirements of 42 C.F.R. §§ 483.13(c) and 483.20(k)(3)(i); and
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> 2. A per-instance civil money penalty of $5,000 for each instance of noncompliance is reasonable.

I do not address other allegations of noncompliance because they are irrelevant to my decision. In its April 12, 2006 notice to Petitioner, CMS made it clear that it based its civil money penalty determinations *only* on Petitioner's alleged noncompliance with the two regulations that I cite above. Furthermore, on May 10, 2007, the parties entered into a stipulation in which they agreed that other allegations of noncompliance are not relevant to the issues of whether per-instance civil money penalties should be imposed or the reasonableness of penalty amounts.[1]

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[1] The April 12 notice also makes reference to a denial of payment for new admissions which, arguably, could be based on Petitioner's noncompliance with other regulations than those which I address in this decision. However, neither CMS nor Petitioner offered any argument concerning this possible additional remedy.

Nor do I address CMS's determinations that Petitioner's noncompliance was so egregious as to constitute immediate jeopardy for the residents of the facility. Such determinations are unnecessary to deciding whether per-instance – as opposed to per-diem – civil money penalties are reasonable. 42 C.F.R. § 488.438(a)(1), (2).

B. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below as a separate heading. I discuss each Finding in detail.

1. Petitioner neglected the needs of one of its residents.

The term "neglect" is defined at 42 C.F.R. § 488.301 to mean a failure by a facility to provide goods and services to a resident that are necessary to avoid physical harm, mental anguish, or mental illness. CMS asserts that Petitioner neglected the needs of one of its residents, identified in the survey report as Resident # 3, by failing to report significant changes in the resident's condition to her treating physician, and by failing to provide the resident with cardiopulmonary resuscitation (CPR). CMS Ex. 3, at 15 - 19. CMS presented a strong prima facie case to support this allegation which Petitioner failed to rebut.

Resident # 3 was admitted to Petitioner's facility on March 13, 2006. CMS Ex. 3, at 15. On admission the resident was observed to be alert and oriented. *Id.* The resident's record did not contain an advanced directive (instructions concerning providing or withholding care in the event of a medical crisis) nor did it contain a do not resuscitate (DNR) order (an order directing that CPR not be attempted in the event that the resident ceased breathing or went into cardiopulmonary arrest). *Id.* at 16.

The resident's physician saw the resident on the morning of March 19, 2006, and ordered lab work. At around 2:00 p.m. on the 19th, the resident ceased to drink and began to complain of abdominal pain. CMS Ex. 16, at 34. The physician was notified of this change in the resident's condition, and the physician advised the nurse that the lab work could be done the following morning. *Id.* At about 2:45 p.m. the resident's vital signs were noted as stable and the resident was observed to be resting without distress. *Id.*

However, at about 3:30 p.m. on March 19, a nursing assistant observed that the resident's condition had changed. The resident was disoriented, calling out "mother, mother." The nursing assistant notified an attending nurse of the change in the resident's condition. CMS Ex. 16, at 34. The nurse observed the resident and concluded that she did not look well. *Id.* The resident's vital signs were checked between 4:00 and 5:00 p.m. and were recorded to be within normal limits. *Id.* At about 5:00 p.m. the resident was administered two Percocet tablets for pain. *Id.* But, at 6:00 p.m. the resident was observed to be moaning in apparent pain. No additional vital signs were taken.

At 7:15 p.m. the nurse was summoned to Resident # 3's room by the nursing assistant. The resident was observed to be "taking last breaths." CMS Ex. 3, at 17. No attempt was made to resuscitate the resident. At 7:25 p.m. the resident was observed to be without pulse or respiration or blood pressure. *Id.* It was only then that the staff notified the resident's physician and family.

The foregoing evidence is classic evidence of neglect. It establishes that, at no time between 3:00 p.m. and the resident's death at 7:25 p.m. on the 19th of March did Petitioner's staff notify Resident # 3's physician of changes in the resident's status. Yet, there obviously were significant changes that demanded notification. One obvious change was the resident's sudden disorientation at 3:30 p.m., less than an hour after the staff had observed the resident to be resting without distress. No less obvious was the staff's failure to call the physician at 7:15 p.m. when they observed the resident dying. Moreover, the staff failed even to attempt to resuscitate the resident despite the fact that nothing in the resident's record – neither an advanced directive nor a DNR order – told the staff not to attempt to resuscitate Resident # 3 in the event of a crisis.

For the most part, Petitioner does not dispute the evidence that I describe above. It argues, however, that the failure to provide care to Resident # 3 must be attributed to simple human error, and it asserts that its overall compliance with participation requirements should not be measured by this allegedly isolated mistake.[2] According to

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[2] Petitioner argues also that its staff's administration of Percocet to Resident # 3 was consistent with the resident's physician's orders and that it was consistent with appropriate medical practice for the staff to wait to determine whether the Percocet was producing beneficial results. Petitioner's initial brief in lieu of hearing at 6 - 7. However, CMS does not base its case against Petitioner on whether the staff administered pain medication appropriately and I make no findings as to that issue. I base my decision that Petitioner's staff neglected the resident entirely on the staff's failure to notify the physician of the significant changes that I identify above and its failure to attempt

(continued...)

Petitioner, the failure to attempt to resuscitate Resident # 3 was caused by a misreading of the resident's chart by a nurse. "[I]t was not foreseeable", Petitioner contends, that the nurse would misread that chart, and consequently, that error was an event that was beyond Petitioner's ability to control. Petitioner's initial brief in lieu of hearing at 9. Moreover, according to Petitioner, this error – if it was neglect at all – was an isolated error for which Petitioner is not accountable. *Id.* at 9 - 10.

This argument is unpersuasive. I have no doubt that human error accounted for the failure by Petitioner's staff to attempt to resuscitate Resident # 3. But, Petitioner's arguments notwithstanding, the staff was under Petitioner's *direct control.* The nursing staff are not independent contractors. Petitioner may not deflect its responsibility by attributing the neglect of the resident's needs to staff error because, in the final analysis, the regulations make Petitioner responsible for the care that its staff provides.

Petitioner's argument, if taken to its logical conclusion, would render the nursing home regulations essentially meaningless. Virtually all deficiencies in nursing home care are the consequence of human error. The regulations take that into account by making a nursing facility ultimately responsible for the performance of its staff.

Additionally, I do not accept Petitioner's assertion that the staff errors in this case were confined only to an apparent misreading of Resident # 3's medical record. Misreading the record might account for the failure to attempt resuscitation. But, it does not explain the failure of the staff to notify the resident's physician of the resident's disorientation or of its failure to tell the physician that the resident was in her death throes.

Petitioner also argues that the resident's physician was, in fact, notified about changes in the resident's condition on the afternoon of March 19, 2006. Petitioner's reply brief at 3. However, that notification occurred *prior* to the changes in the resident's condition that I address in this decision. The fact that the staff notified the physician at about 2:00 on the afternoon of the 19th of the resident's abdominal pain and refusal to drink does not justify the staff's failure to notify the physician subsequently about the resident's disorientation or her death throes.

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[2](...continued)
resuscitation.

Finally, and amazingly, Petitioner contends that there were in fact *no* significant changes in Resident # 3's condition after 2:00 on the afternoon of March 19. Petitioner's reply brief at 2. That assertion flies in the face of reality. Prior to March 19, 2006, the resident was described by Petitioner's staff as being alert and oriented and able to make her needs known. CMS Ex. 3, at 16. But, beginning at about 3:30 on the afternoon of the 19th, the resident became disoriented and ultimately, died. By any measure or standard the resident's disorientation and death throes were significant changes that demanded physician notification.

2. Petitioner failed to provide care that met professional standards of quality.

CMS bases its allegation that Petitioner failed to provide care that met professional standards of quality on the same facts as are the basis for its neglect allegation. And, Petitioner's defense to this second allegation of noncompliance is identical to that which it makes in response to the neglect allegation.

I find CMS's allegation to be well-founded and I do not find Petitioner's defenses to be persuasive. First, the requirement that a nursing staff notify a resident's physician of a significant change in that resident's condition is axiomatic and is made explicit in regulations governing nursing facilities. A facility must immediately consult with a resident's physician of a significant change in that resident's condition. 42 C.F.R. § 483.10(b)(11).[3] Indeed, a nursing facility operates no more independently from a physician than does a nurse in a hospital or in a physician's office. In all three instances the ultimate authority and responsibility for determining the care that is given to a patient is vested in the patient's physician. A failure by a nurse in any of those settings to consult immediately with a physician about significant changes in a patient's condition that he or she observes would impede the physician's ability to make the necessary judgments about care that he or she is uniquely responsible for making.

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[3] CMS did not base its determination to impose civil money penalties against Petitioner on Petitioner's failure to comply with this regulation. However, the standard of quality that the regulation embodies – the requirement that a staff consult immediately with a physician about a significant change in a resident's condition – is subsumed within both 42 C.F.R. §§ 483.13(c) and 483.20(k)(3)(i).

Second, the failure by Petitioner's staff to provide resuscitation to Resident # 3 was a clear failure by it to meet professional standards of quality. Providing resuscitation when needed is an integral part of a nurse's duty to a patient. A patient, or a nursing facility resident, has the right to decline such care. But, a staff may not withhold it absent a request that it not provide resuscitation.

3. Per-instance civil money penalties of $5,000 are reasonable.

Regulations provide that CMS may impose either per-diem or per-instance civil money penalties to remedy a nursing facility's deficiencies. 42 C.F.R. § 488.438(a)(1), (2). In this case CMS determined to impose two per-instance civil money penalties of $5,000 to remedy the two deficiencies that I discuss at Findings 1 and 2.

A per-instance civil money penalty may fall within a range of from $1,000 to $10,000. 42 C.F.R. § 488.438(a)(2). Regulations prescribe criteria for deciding where within that range a per-instance civil money penalty should fall. 42 C.F.R. §§ 488.438(f)(1) - (4), 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)). Factors which are relevant to determining penalty amount include: the seriousness of a facility's non-compliance; a facility's compliance history; a facility's culpability; and, its financial condition. *Id.*

I decide that the two per-instance penalties, which are at fifty percent of the maximum that CMS is authorized to impose, are reasonable because they take into account the seriousness of Petitioner's deficiencies. Neither party offered evidence concerning the other regulatory factors which bear on penalty amount. Thus, I base my decision to uphold the penalty determination on the seriousness, and only the seriousness, of Petitioner's noncompliance.[4]

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[4] CMS makes two arguments which I find to be essentially irrelevant. First, CMS contends that I should sustain the penalty determinations because it applied the regulatory criteria to determine the penalty amounts. That argument is irrelevant because my review authority in this case is de novo and not appellate. I must weigh the evidence that relates to penalty amount independently and without regard to whether CMS did a good job or a poor job in evaluating the same evidence. Second, CMS contends that the penalties are justified in part because it found that Petitioner's deficiencies were so serious as to comprise immediate jeopardy for residents of the facility. That argument is not relevant here because the range in which a per-instance penalty may fall – as opposed to that of a per-diem penalty – does not depend on a finding of immediate jeopardy.

The deficiencies in this case were extremely serious. Emergency resuscitation is a service that is utilized only where a resident's life is at stake. Withholding resuscitation – as happened here – from a patient who is in cardiac or pulmonary arrest can have catastrophic consequences. I do not conclude that Resident # 3 would have survived had Petitioner's staff performed CPR on her. There is no way of deciding whether withholding CPR caused the resident to die. But, that does not mitigate the seriousness of Petitioner's noncompliance. In this case withholding CPR from the resident deprived her of the *possibility* of life.

Equally serious was Petitioner's staff's failure to notify the resident's physician of significant changes in the resident's condition. The fact that this resident, previously diagnosed as alert, became disoriented should have triggered an immediate call by the staff to the resident's physician. But, it did not. Nor did the resident's apparent cardio-pulmonary arrest. In both instances the physician was deprived of information that might have enabled him to make potentially life-saving decisions on behalf of Resident # 3. The potential for very serious harm to the resident resulting from these failures to notify is manifest.

/s/

Steven T. Kessel
Administrative Law Judge