Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Cedar Lake Nursing Home,
(CCN: 67-5898),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-09-434

Decision No. CR2137

Date: May 21, 2010

DECISION

Petitioner, Cedar Lake Nursing Home (Petitioner or facility), is a long-term care facility located in Malakoff, Texas that participates in the Medicare program. The Centers for Medicare and Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare requirements for respiratory care and that its deficiencies posed immediate jeopardy to resident health and safety. CMS has imposed a $6,000 per instance civil money penalty.

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 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.

Here, following a complaint investigation survey, completed February 8, 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(k) (Tag F328), which addresses the residents' special needs, and 42 C.F.R. § 483.75 (Tag F490), which governs administration. CMS cited both deficiencies at a K level of scope and severity, which means that CMS found a pattern of deficiencies that posed immediate jeopardy to resident health and safety. CMS Exs. 1, 5. [1] CMS initially imposed two per instance CMPs: $4,000 for the deficiency cited under section 483.75 (administration); and $6,000 for the deficiency cited under 42 C.F.R. § 483.25(k) (special needs). CMS Ex. 1. Thereafter, CMS determined that the facility returned to substantial compliance. For reasons it has not explained, CMS also rescinded the $4,000 penalty attributable to the administration tag. CMS Ex. 1 at 4-5; CMS Ex. 30.

Petitioner timely requested a hearing. The parties filed their initial briefs (CMS Br.; P. Br.). CMS has filed a motion for summary judgment (CMS MSJ) to which Petitioner filed a response (P. Response). CMS has submitted 30 exhibits (CMS Exs. 1-30). Petitioner has submitted 8 exhibits (P. Exs. 1-8).

II. Issues

Two issues are before me:

1) whether, at the time of the February 8, 2009 complaint investigation survey, the facility was in substantial compliance with 42 C.F.R. § 483.25(k); and

2) if the facility was not in substantial compliance, is the penalty imposed -- $6,000 per instance – reasonable?

[1] CMS re-numbered some of its initially submitted exhibits and attached them to its MSJ. To avoid confusion, I disregard that numbering and cite to the original exhibit numbers.

Petitioner is not entitled to review of CMS's determination that it was not in substantial compliance with 42 C.F.R. § 483.75. A provider dissatisfied with an initial determination is entitled to further review, but administrative actions that are not initial determinations are not subject to appeal. 42 C.F.R. § 498.3(a). A finding of noncompliance that results in the imposition of a remedy specified in 42 C.F.R. § 488.406 is an initial determination for which a facility may request an administrative law judge (ALJ) hearing. 42 C.F.R. § 498.3(b)(13). But a facility has no right to a hearing unless CMS imposes one of the specified remedies. *Lutheran Home -- Caledonia*, DAB No. 1753 (2000); *Schowalter Villa*, DAB No. 1688 (1999); *Arcadia Acres, Inc.*, DAB No. 1607 (1997). The remedy, not the citation of a deficiency, triggers the right to a hearing. *Schowalter Villa*, DAB No. 1688; *Arcadia Acres*, DAB No. 1607. Where CMS withdraws the remedies, or otherwise declines to impose one, Petitioner has no hearing right. *See Fountain Lake Health & Rehab., Inc.*, DAB No. 1985 (2005).

Nor will I review CMS's finding of immediate jeopardy. An ALJ may review CMS's scope and severity findings (which include a finding of immediate jeopardy) only if a successful challenge would affect the range of the CMP, or if 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), (d)(10); *see Evergreen Commons*, DAB No. 2175 (2008); *Aase Haugen Homes, Inc.*, 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. *Ill. 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., et al.*, 388 F.3d 168, 173 (6th Cir. 2004) (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (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 & 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 . . . .

Ill. Knights Templar, DAB No. 2274 at 4 (emphasis in original); *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 (entry 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*, 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 that the facility was not in substantial compliance with 42 C.F.R. § 483.25(k), because the undisputed evidence establishes that facility staff did not follow the physician's order, the resident's care plan instructions, nor its own policies and procedures when staff provided care to a resident in respiratory distress.[2]

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 residents with special needs receive "proper treatment and care" for certain special services, including respiratory care. 42 C.F.R. § 483.25(k).

Here, CMS has come forward with evidence (primarily the facility's own documents and statements from facility staff) establishing that, when Resident 1 experienced an episode of respiratory distress, staff did not follow her physician's order, the instructions in her care plan, nor its own policies and procedures. Petitioner has not come forward with evidence suggesting a dispute over these facts; indeed, Petitioner looks at precisely the

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

same set of documents as CMS and makes the same findings as to the staff's actions. However, Petitioner disputes whether those actions put it out of substantial compliance with Medicare requirements.

Resident 1 (R1). R1 was a 72-year-old woman suffering from a long list of ailments, including sepsis, moderate malnutrition, depression, history of stroke, and dementia. CMS Ex. 11 at 1. She had a feeding tube. CMS Ex. 9 at 18; CMS Ex. 15. She also suffered from pulmonary disease and was at risk for respiratory distress/failure. To prevent respiratory distress, her care plan directed staff to monitor her for signs and symptoms of respiratory infection, "to apply oxygen per order," and to "provide respiratory treatments per order." CMS Ex. 9 at 23; CMS Ex. 12.

R1's physician ordered oxygen, as needed, at two liters per minute *via nasal cannula*. CMS Ex. 8 at 8; CMS Ex. 11 at 3.

Facility policies. The facility's policies and procedures for oxygen administration direct staff to obtain a physician's order for the "rate of flow and *route of administration* of oxygen (i.e., by tank, concentrator, nasal cannula, mask, etc.)." P. Ex. 2 at 18; CMS Ex. 19 at 1 (emphasis added). The appropriate staff (registered nurse or licensed respiratory care practitioner) is then directed to obtain "appropriate oxygen delivery system (a nasal cannula, simple mask, or transtracheal oxygen)." P. Ex. 2 at 19.

Facility policy also confirms CMS's position that the appropriate oxygen flow rate varies depending on the route of administration. According to the written policy, oxygen administered via nasal cannula should flow at a rate of 1-5 liters per minute. Oxygen delivered via a simple mask, as done here, requires a greater flow rate, of 6-10 liters per minute. P. Ex. 2 at 15, 17; CMS Ex. 19 at 4 ("Use of oxygen mask NOT recommended if flow is less than five liters."); CMS Exs. 20, 21; *see* CMS Ex. 24; CMS Ex. 27 at 3 (Hunter Decl.); CMS Ex. 28 at 3 (Jensen Decl.) ([W]hen using a mask, providing fewer than 5 liters of oxygen per minute places the resident at risk of suffocation.).

The events of February 4-5, 2009. According to the nurses' notes, R1 had an episode of vomiting at 10:10 p.m. on February 4, 2009. CMS Ex. 14 at 2. At 2:40 a.m. the following morning, she had a second episode of vomiting. She was "pale" and "unresponsive." She made "'gurgling'- wet sounds." The nurse turned off her parenteral feeding tube. Staff were not able to obtain an oxygen level. CMS Ex. 14 at 3; CMS Ex. 23 at 3; P. Ex. 5 at 3 (Morgan Decl.); P. Ex. 7 at 2 (Sparks Decl.). The nurse called R1's physician who instructed her to administer oxygen and send R1 to the hospital. CMS Ex. 14 at 3. According to Petitioner, staff did not ask the physician for an order, because a prn (as needed) order for oxygen was already in place. P. Response at 5-6.

Despite the physician's order and the facility's policies, the nurse administered oxygen "per mask" rather than per cannula (as called for in the physician's order) and at the rate of 2 liters per minute (even though facility policy required a rate of 6-10 liters per minute when administering by means of a simple mask). CMS Ex. 14 at 3.

When the emergency medical technicians arrived at 2:55 a.m., they found R1 in respiratory distress, her respirations rapid and labored. They took her to the emergency room. CMS Ex. 13 at 2; CMS Ex. 14 at 3.

These facts are undisputed. Petitioner nevertheless points to its witnesses' assertions that staff "carried out the physician's orders" and argues that these assertions create material facts in dispute. P. Response at 6; P. Ex. 5 at 3, 4 (Morgan Decl.); P. Ex. 7 at 2 (Sparks Decl.). But the parties do not dispute what the order said, nor do they dispute what staff did. Petitioner asks me to infer from these undisputed facts that staff carried out the physician's order. For summary judgment purposes, I am required to draw all reasonable inferences in the light most favorable to the non-moving party, but the inference Petitioner asks me to draw is not reasonable. It is plainly erroneous. The physician order (and every order for the administration of oxygen) consists of two parts: rate of flow; and route of administration. Because staff used the wrong route of administration, they did not follow the physician's order.

Next, Petitioner disingenuously asserts that administering the oxygen at a rate of 2 liters per minute comports with facility policy, "which states that oxygen should be administered at 1 to 5 liters per minute." P. Response at 6. In fact, the policy states 1-5 liters per minute *with the nasal cannula*. If the device used is a simple mask, the flow rate should be 6-10 liters per minute. P. Ex. 2 at 15, 17. The policy emphasizes that "[u]se of oxygen mask NOT recommended if flow is less than five liters." CMS Ex. 19 at 4.

Alluding vaguely to the declarations of its three witnesses, Petitioner deems it "of no significance whether oxygen was administered via nasal cannula or via rebreather mask." P. Response at 6. Petitioner does not specify where its witnesses made such statements, and, in fact, they said no such thing. All of the evidence in the record addressing this specific question says exactly the opposite: the rate of flow depends on the means by which oxygen is administered. P. Ex. 2 at 15, 17; CMS Exs. 20, 21, 24; CMS Ex. 27 at 3 (Hunter Decl.); CMS Ex. 28 at 3 (Jensen Decl.).

Finally, Petitioner concedes that it could not follow the physician's order, because the facility had no available nasal cannulae. R1 had no oxygen in her room, so staff retrieved it from the crash cart. But the crash cart had only a mask. P. Response at 7. According to Petitioner, crash carts typically do not have nasal cannulae on them and are not required to have nasal cannulae on them, so the facility should not be faulted for failing to use one. P. Response at 7; P Ex. 5 at 3-4 (Morgan Decl.); P. Ex. 7 at 2 (Sparks Decl.). Thus, by its own admission, the facility was not equipped to follow the physician's order. This creates a disturbing situation. Respiratory distress is a serious, potentially fatal,

event. A facility must be prepared to respond quickly and appropriately and must follow the physician's order. Facility staff are simply not free to disregard any portion of that order. Here, the facility's inadequate preparation put R1 at risk of serious harm.

Moreover, R1 was not the only facility resident who had a prn order for oxygen to be delivered via nasal cannula. Forty-five residents had virtually identical orders. CMS Ex. 8. Every one of these residents was at risk for an acute respiratory episode. The facility was obligated to equip itself so that it could follow the physician orders, or, if that was not possible, to advise the physician that it was not equipped to administer oxygen as ordered, which would allow the physician to adjust his orders. Because it failed to do so here, the facility was not in substantial compliance with 42 C.F.R. § 483.25(k).

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, 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); *Cmty. 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 has imposed just one $6,000 per instance CMP, which is in the middle of the penalty range ($1,000-$10,000). 42 C.F.R. §§ 488.408(d)(1)(iv), 488.438(a)(2). On the other hand, the penalty is modest considering what CMS might have imposed.[3] *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.").

[3] That the facility had physician orders with which it could not comply presented the potential for more than minimal harm. CMS could have imposed a CMP for every day in which this situation existed at the facility. 42 C.F.R. § 488.438(a)(1).

CMS does not cite facility history as a factor that justifies a higher CMP.[4] Petitioner has not argued that its financial condition affects its ability to pay the penalty.

With respect to the remaining factors, I consider the severity of the deficiencies significant enough to warrant this relatively modest penalty. This facility had multiple residents at significant risk for acute respiratory incidents. Physician orders were in place to address those risks. Facility staff must have known that they were not capable of following the physician orders, because they had no available nasal cannulae. Yet, staff neither asked for alternative orders nor obtained the necessary equipment. When R1 experienced her plainly foreseeable acute episode, and staff lacked the equipment called for in the physician order, they did not ask the physician for an alternative order. They also ignored the facility's policies and procedures for administering oxygen by means of a mask and, in doing so, seriously jeopardized the resident's health and safety. These actions demonstrate staff indifference or disregard for the safety of all its residents with orders for oxygen prn, to be delivered via nasal cannula. Thus, the facility bears a significant degree of culpability.

I therefore find reasonable the $6,000 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(k). The $6,000 per instance penalty imposed is reasonable. I therefore grant CMS's motion for summary judgment.

/s/
Carolyn Cozad Hughes
Administrative Law Judge

[4] On the other hand, Petitioner seems to concede a less than perfect history but asserts that it "does not have a history of uncorrected F328 violations or enforcement action prior to this survey." P. Response at 12. *See Cedar Lake Nursing Home*, DAB No. 2288 (2009) (Based on a 2008 survey, this facility was not in substantial compliance with 42 C.F.R. § 483.25(h) (accident prevention), and a $5,000 per instance CMP was reasonable.).