Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Napa Nursing Center, Inc.
(CCN: 05-5161),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-09-121

Decision No. CR2091

Date: March 15, 2010

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose remedies against Petitioner, Napa Nursing Center, Inc., consisting of a per-instance civil money penalty of $5,000 and denial of payment for new admissions for a nine day period that began on November 29, 2008.

I. Background

Petitioner is a skilled nursing facility in California. It participates in the Medicare program. Its participation in Medicare is governed by sections 1819 and 1866 of the Social Security Act and by implementing regulations at 42 C.F.R. Parts 483 and 488. Its right to a hearing in this case is governed by regulations at 42 C.F.R. Part 498.

CMS determined to impose the remedies that I describe in the opening paragraph of this decision based on findings of noncompliance with participation requirements that were made at a survey of Petitioner's facility that was completed on October 9, 2008 (October survey). The determination to impose a per-instance civil money penalty was based explicitly on Petitioner's alleged failure to comply with the requirements of 42 C.F.R.

§ 483.25(h). This regulation mandates a skilled nursing facility to ensure that: (1) its resident environment remains as free of accident hazards as is possible; and (2) each of its residents receives adequate supervision and assistance devices to prevent accidents.

Petitioner requested a hearing and the case was assigned to me for a hearing and a decision.[1] I held an in-person hearing by teleconference on December 2, 2009. At the hearing I received exhibits from CMS that I identified as: CMS Ex. 1 – CMS Ex. 10; CMS Ex. 17 – CMS Ex. 19; CMS Ex. 22 – CMS Ex. 23; and CMS Ex. 25 – CMS Ex. 29. I received exhibits from Petitioner that I identified as P. Ex. 1 – P. Ex. 15. I heard the cross-examination and redirect testimony of several witnesses.

II. Issues, findings of fact and conclusions of law

A. Issues

The issues in this case are whether:

1. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h);

2. CMS's remedy determinations are reasonable.

B. Findings of fact and conclusions of law

I make the following findings of fact and conclusions of law (Findings).

1. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h).

The regulation has been the subject of much litigation. As a general rule, it requires that a facility take every reasonable measure to protect its residents against sustaining accidents from factors that are known or foreseeable. *Woodstock Care Center*, DAB No. 1726, at 28 (2000), *aff'd Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). In order to comply with the regulation a facility must do several things. First, it must assess each resident in order to identify those hazards to which the resident is exposed, either environmentally, or as a result of physical and/or mental problems that

[1] The noncompliance findings made at the October survey include findings in addition to Petitioner's alleged noncompliance with the requirements of 42 C.F.R. § 483.25(h). These are findings that Petitioner failed to comply substantially with the requirements of: 42 C.F.R. §§ 483.20(k)(3)(i) (comprehensive care plans); and 483.35(h)(2) (sanitation). Petitioner no longer challenges these additional noncompliance findings and, so, they are administratively final.

are unique to that resident. Second, it must plan the resident's care to address all of the hazards to which the resident is assessed as being exposed. The care plan should identify all interventions that are reasonably necessary to protect the resident. Finally, the facility must implement all of the interventions which are planned for that resident.

CMS's allegations of noncompliance center around the care that Petitioner gave to a resident who is identified as Resident # 25. The resident is an inveterate cigarette smoker. CMS alleges that Petitioner failed to assess the risks that the resident was exposed to by virtue of his smoking, failed appropriately to plan the resident's care, and failed to implement interventions that were necessary to protect this resident.

More specifically, CMS alleges that:

- Petitioner's staff failed to assess the resident comprehensively for hazards that might be associated with his smoking despite their knowledge that the resident suffered from limitations that might render smoking dangerous to his personal safety. CMS asserts that, for a period of approximately 18 months, Petitioner's staff failed to assess the resident for risks related to his smoking even though they knew that serious risks existed.

- The staff failed to plan interventions that they knew or should have known were reasonably necessary to protect Resident # 25 in light of his limitations and his past risky behavior.

- Petitioner's staff failed to supervise the resident adequately when he smoked. CMS contends that the resident was allowed to smoke essentially unsupervised by Petitioner's staff.

Petitioner has a policy governing smoking by its residents. CMS Ex. 10, at 67. It allows residents to smoke subject to rules published by the facility and distributed to the residents and their families. *Id.* Petitioner assigns responsibility to its inter-disciplinary team (IDT) for ensuring that safety risks are evaluated and that smoking is conducted in a safe manner. *Id.* Petitioner charges its IDT with ensuring that: each resident is assessed for smoking safety and other relevant factors upon admission and with each significant change in the resident's condition; residents smoke only in designated safe areas; staff controls smoking materials; residents agree and adhere to facility smoking rules; and residents who smoke are evaluated and have appropriate interventions implemented to assure that they smoke safely. *Id.*

Petitioner developed and implemented a "Resident Smoking Assessment" form in order to assure that its smoking policies were implemented in individual cases and that each resident was protected adequately against the hazards of smoking. CMS Ex. 10, at 69. The form is designed to be completed by the facility IDT. It identifies three broad

categories of behavior related to smoking ("Resident is able to light cigarette, cigar, or pipe safely with a lighter," "Resident smokes safely," and "Resident is able to extinguish cigarette safely and completely when finished smoking"). *Id.* Each of these categories contains subcategories (e.g., under "Resident smokes safely" the first subcategory is "Does not allow ashes or lit material to fall on clothing while smoking"). The form prescribes that a resident is considered to be a safe smoker and may smoke independently only if all of the items – all of the subcategories – are assessed affirmatively. *Id.*

Resident # 25 was, as of the October survey, a long-term resident in Petitioner's facility. He has physical problems that include loss of mobility and balance even while sitting. CMS Ex. 10, at 50. He has mental problems that include short term memory loss and impaired decision making skills. *Id.* at 18, 38. Petitioner's staff assessed the resident as not being able to understand complicated subject matter and missing parts of messages. *Id.* at 38. He has also been note to be abusive frequently to members of Petitioner's staff. *Id.*

Resident # 25 is a heavy cigarette smoker. Smoking is, in fact, the resident's primary recreational activity. CMS Ex. 10, at 38. The resident spends much of his waking hours smoking, often on a patio that is part of Petitioner's premises.

The evidence in this case overwhelmingly establishes that Petitioner failed to discharge its duty to assess Resident # 25 for the safety risks associated with his almost continuous smoking. Petitioner's IDT failed to conduct a smoking assessment of this resident at any time after March 16, 2007. That is so notwithstanding that the IDT had previously identified several potentially serious risks associated with the resident's smoking and notwithstanding further that, after March 16, 2007, the resident was observed to engage in potentially highly dangerous conduct (smoking while in his room).

Petitioner's IDT conducted a resident smoking assessment of Resident # 25 on October 24, 2006. CMS Ex. 10, at 51. The staff found that there were numerous risk factors associated with his smoking. The IDT determined that the resident: did not store or handle a lighter securely or safely; light a lighter while holding it securely; prevent ashes or lighted material from falling on his clothing while he smoked; assure that lighted material fell in areas outside of an ashtray; and smoke only in a designated area. Under Petitioner's smoking policy the presence of even one of these risk factors meant that the resident could not smoke safely while unsupervised. CMS Ex. 10, at 67.

The IDT reevaluated Resident # 25 on March 16, 2007. CMS Ex. 10, at 51. CMS contends that the IDT concluded that the resident continued to manifest six problems associated with his smoking (those which I have enumerated above). That is not entirely clear. The evaluation form contains several checkmarks that are dated "3-16-07" which appear to indicate that the resident no longer manifested problems that were identified previously. *Id.* On the other hand the assessment contains no commentary or analysis

that states that the resident had overcome his previous problems nor does it explain how or why he would have done so. There was, for example, nothing added to the smoking assessment in March 2007 showing that the IDT had concluded that the resident's mental problems had improved to the extent that he could function at a level of cognition that made him a safe smoker. I conclude that the ambiguities in the assessment form are simply that and do not persuasively establish that the resident had improved between October 24, 2006 and March 16, 2007. *Id.*

In any event, the March 16, 2007 reassessment of the resident was the last assessment of his smoking behavior by the IDT prior to the October survey. There are no documents in Petitioner's records other than the smoking assessment form completed in October 2006 and March 2007 which show that the IDT reevaluated comprehensively the resident's ability to smoke at any time between March 2007 and October 2008. A total of about 18 months elapsed after this assessment without Petitioner's staff reassessing the resident. For example, although Petitioner prepared several minimum data sets and RAP worksheets for Resident # 25 during his stay at the facility, none of them contain the detailed analysis of the risks of smoking that is directed by Petitioner's smoking policy and the resident smoking assessment. CMS Ex. 10, at 17-50. Nor do such assessments exist in nursing notes, interdisciplinary progress notes, or interdisciplinary team conference notes. *Id.* at 9-16.

Petitioner's staff also prepared care plans for the resident. CMS Ex. 10, at 52-57. But, the care plans that are in evidence do not show a comprehensive analysis of the risks encountered by Resident # 25 when he smoked. Furthermore, the care plans do not specify any interventions to protect the resident. There is no statement in the care plans that Resident # 25 could smoke safely while unsupervised. The care plans direct, however, as a standard intervention, that the resident should be assessed for safe smoking. CMS Ex. 10, at 52.

Indeed, there is no evidence that at any time prior to the October survey did Petitioner's staff consider that Resident # 25 needed to be supervised closely while he smoked. Throughout the period leading up to the survey the resident was allowed to sit for extended periods of time on an outdoor patio smoking while not closely supervised by anyone.

However, during this 18-month period the resident engaged in behavior that put Petitioner's staff on notice that his smoking could endanger himself or other residents of Petitioner's facility. On January 12, 2008, Resident # 25 was found to be smoking in his room. CMS Ex. 10, at 66. This violation of Petitioner's smoking policy did not trigger a new comprehensive assessment of the risks associated with the resident smoking. Petitioner's smoking privileges were restricted for a time but they were restored after a few months without any additional comprehensive assessment being performed of the risks associated with his smoking.

There was also good reason for the staff to question whether the resident was capable of understanding the instructions given to him about smoking. As I note above, the resident was assessed as having both short term memory loss and impaired decision making skills. Yet, the IDT did not, after March 16, 2007, consider whether these impairments might make it difficult or impossible for the resident to understand and remember facility policies concerning smoking. The resident was also noted to exhibit aggressive and combative behavior towards Petitioner's staff. CMS Ex. 10, at 18. No assessment was made to determine whether this behavior, coupled with other mental or psychological problems, might render the resident's smoking a hazard to himself or to others.

Moreover, credible observations of Resident # 25 made by surveyors confirm that this resident was not an individual who could be left unattended while he smoked. Ramona McSweeney, a registered nurse, observed Resident # 25 on October 9, 2008. CMS Ex. 27, at 6. She saw the resident sitting, completely unsupervised, on Petitioner's patio area, awake and smoking. *Id.* at 7. The resident had a red blanket in his lap. Ms. McSweeney counted 15 burn holes in the blanket, measuring from ¼ to ½ inch in diameter. *Id.* Another surveyor, Stephanie Barch, who is also a registered nurse, observed the resident on two occasions on October 7, 2008, sitting on Petitioner's patio, apparently nodding off to sleep while holding a lighted cigarette. CMS Ex. 28, at 4.

Petitioner disputes that the resident actually slept while smoking. However, it would be very difficult for any staff to determine whether the resident slept while he smoked without closely observing and assessing him and the record is devoid of evidence to show that the staff did that after March 16, 2007. Moreover, the risks to the resident should have been apparent even if the resident merely slumped over while he smoked.

It is evident that, to the extent that Petitioner's staff considered any of the risks associated with the resident's smoking, their concern was limited to and focused on the resident's proclivity to smoke in his room. Thus, on May 1, 2008 Petitioner's staff assessed the resident only to determine whether they could restore the privileges that they had removed after he was found smoking in his room in January. CMS Ex. 10, at 11; Tr. at 134-35; 141-42. The staff's finding that it was safe to restore the resident's smoking privileges apparently was based on discussions with the resident concerning Petitioner's policy and the resident's assertion that he knew that smoking was not permitted inside the facility. CMS Ex. 10, at 11. But, there is no indication that the staff actually comprehensively assessed the resident on or before May 1. No consideration was given at that time to the overall issue of whether it was safe for Resident # 25 to continue smoking without close supervision or without other interventions that might be needed to protect him. There is no evidence that the staff observed the resident while he smoked in order to determine whether any of the problems that had been identified previously by the IDT – such as the resident's inability to handle a lighter safely – persisted or had become worse.

The evidence also overwhelmingly supports my conclusion that Petitioner's staff failed to take effective measures to supervise Resident # 25 when he smoked. The failure by Petitioner's staff was not just a failure to assess the resident or to plan his care, but to take affirmative actions in order to protect him against the risks associated with his smoking.

Essentially, Petitioner's staff allowed Resident # 25 to smoke independently – notwithstanding identified risk factors – and without meaningful supervision. None of the care plans that were prepared for the resident directed the staff to supervise him. CMS Ex. 10, at 52-57. During the October survey, surveyors observed the resident on several occasions smoking on Petitioner's exterior patio. On none of these occasions was the resident being directly supervised or even watched by Petitioner's staff. CMS Ex. 1, at 5-9; CMS Ex. 17, at 12; CMS Ex. 18, at 1; CMS Ex. 19, at 12.

Petitioner's staff had no way of knowing how much supervision the resident required when he smoked because they had failed to assess those risks for a period of 18 months. They knew, however, that previous assessments had identified problems that suggested strongly that the resident was *not* a safe smoker. That information should have triggered a plan to ensure that the resident did not smoke while unsupervised. Just the fact that the resident had been assessed in the past as not being able to handle a cigarette lighter safely was a reason for the staff to impose some reasonable supervision of the resident while he smoked. There were other reasons that compelled the staff to consider supervising the resident. These included his proclivity to smoke in prohibited areas and the fact that the resident was observed to slump forward while sitting in his wheelchair.

Petitioner makes several assertions and contentions in an attempt to counter the evidence that I have discussed. I have considered these and I find them to be unpersuasive.

It argues first that the manner in which it cared for Resident # 25 struck a balance between protecting the resident and allowing him to maintain his sense of dignity and to control his daily life. Petitioner's Post-Hearing brief at 2-3. From this Petitioner suggests that allowing the resident to smoke essentially unsupervised is a product of the balance that the staff struck in his case. The problem with this analysis is that there is nothing in the record of the resident's care that supports any conclusion that Petitioner's staff – and its IDT in particular – made the kind of reasoned determination to factor risks against benefits that Petitioner asserts occurred. The record in this case is devoid of *any* comprehensive assessment of Resident # 25's smoking after March 2007. Similarly, the record is devoid of any analysis showing that the staff strove to balance the resident's rights against the need to protect him.

Petitioner next asserts that Resident # 25 was subject to continual assessments and reviews by the staff to determine whether he was able to make decisions, particularly as to his ability to smoke, and whether the staff should implement safety measures in order to protect him. Petitioner's Post-Hearing brief at 3-6. I find this assertion to be unsupported.

Petitioner points to the smoking assessments that it conducted of Resident # 25 in October 2006 and March 2007 as evidence of its staff's focus on the potential hazards related to the resident's smoking. The problem with this, of course, is that Petitioner's staff did nothing *after* March 2007 to assess comprehensively the risks related to the resident's smoking. CMS's case is based on what happened after the March 2007 assessment was performed. The fact that Petitioner's IDT performed assessments up to that date is no evidence that they continued to do so. However, that evidence shows that the IDT knew or should have known that continued reassessments of the resident needed to be performed.

Next, Petitioner cites to the resident's care plan as evidence that the staff was reassessing the resident and planning for anticipated risks. CMS Ex. 10, at 52. However, and as I discuss above, this care plan is no evidence that Petitioner's IDT reassessed the resident after March 2007. Nor does it show that anyone else on the staff reassessed the resident comprehensively after March 2007 for the risks related to his smoking. The plan contains printed instructions which are not particularized to the resident and which state no specific interventions that were designed to protect him ("assess for safe smoking," "reinforce risks smoking behavior," "inform appropriate smoking areas," "offer smoking cessation encouragement"). *Id.* Indeed, not only does the plan fail to describe specific interventions but it is apparent that the plan's directive that the resident be assessed for safe smoking was not carried out after March 2007. The plan also contains some specific discussion of episodes in October 2006 and January 2008 in which the resident was found to be smoking in his room. *Id.* These episodes were treated in the plan as isolated incidents and no comprehensive assessment is shown as having been performed after the 2008 episode. *Id.*

Petitioner then asserts that its nursing staff and its social services personnel "regularly assessed Resident 25 and his smoking habits." Petitioner's Post-Hearing brief at 4 (citing to various CMS exhibits). I do not find that the exhibits cited to by Petitioner support this assertion. There are references in Petitioner's nursing notes to the resident's smoking and to specific episodes related to his smoking. CMS Ex. 10, at 9, 11. However, these references do not comprise comprehensive assessments of the resident's smoking behavior and the risks that he might encounter when he smoked. For example, a nursing note of May 1, 2008 recites that the resident's smoking privileges were resumed after the

resident promised not to smoke again inside Petitioner's facility. CMS Ex. 10, at 11. This note contains no analysis of the resident's cognitive state and whether he was capable of intelligently making the promises recited in the note. Nor does it address how safely the resident would smoke once his privileges were resumed.

Petitioner then contends that the facility's awareness and assessments of the resident's smoking are contained in IDT progress notes. However, there are only two notes cited to by Petitioner that refer to the resident's smoking. One of these is dated February 5, 2005, years before the relevant time period of this case. CMS Ex. 10, at 13. The other is an IDT conference note of May 31, 2007. CMS Ex. 10, at 15. This note recites that the resident "smokes outside daily." *Id.* That laconic comment aside, there is no discussion whatsoever of the resident's smoking behavior.

Activity progress notes are also cited by Petitioner as evidence of the alleged continual assessments that its staff made of Resident # 25's smoking. CMS Ex. 10, at 62-66. These notes contain occasional references to the resident's smoking. But, they contain absolutely no assessment of his ability to smoke safely.[2]

Petitioner argues also that the resident's care plan was reviewed periodically, citing review dates of March, June, September, and December 2007, and March, June, and September 2008. Petitioner's Post-Hearing brief at 5. From this Petitioner would have me infer that these reviews included a comprehensive reassessment of the risks associated with Resident # 25's smoking. I am not persuaded that these reviews indicate any such thing. That is because, aside from March 2007, there were no assessments done by the IDT for the care plan reviewers to consider. A care plan is a document that is supposed to be constructed from the comprehensive assessments made of a resident by a facility's staff. 42 C.F.R. § 483.20(k). In reviewing the resident's care plan after March 2007 Petitioner's staff had no updated written assessments on which they could rely. Petitioner has given me no reason to conclude that, in reviewing the resident's care plan, Petitioner's staff somehow performed the assessment duties that were delegated to the IDT and which were not performed by that entity.

Additionally, Petitioner contends that the resident's smoking behavior was assessed in a document which it refers to as a "multi-discipline care plan." Petitioner's Post-Hearing brief at 5. It asserts also that this document was periodically reviewed, thereby proving that its staff periodically reassessed the risks related to Resident # 25's smoking. But, the document relied on by Petitioner says no such thing. CMS Ex. 10, at 57. It merely lists

[2] Petitioner also cites to P. Ex. 2, at 4, 5, 20, 21, and 23-39 as evidence of its staff's alleged continual reassessment of the resident's smoking behavior. This exhibit appears largely to duplicate the CMS exhibits which I have discussed. In any event, there is nothing in the pages cited to by Petitioner that shows any comprehensive assessment of the resident's smoking after March 2007.

activities that were offered to the resident or in which the resident participated. It recites that the resident socializes and enjoys smoking with friends on the facility's patio throughout the day and it contains a notation that unspecified individuals would "observe safety [in connection with the resident's] smoking." *Id.* That is hardly a comprehensive assessment of the resident's smoking behavior nor is it a comprehensive description of interventions intended to protect the resident.

Also, Petitioner argues that there is no objective evidence showing that the resident posed a hazard to himself or to others when he smoked. As support for this it avers that:

> There is not a single notation or observation that Resident 25 ever fell asleep outside while smoking, nor was he observed in the smoking patio "with eyes closed, head dropped forward and a lit cigarette in his hand."

Petitioner's Post-Hearing brief at 10 (citing P. Ex. 8).

It may be true that Petitioner's staff never observed the resident asleep while smoking. But, in fact, he was seen apparently nodding off by a surveyor. And, even if he didn't sleep while smoking, the many burns on the resident's blanket certainly indicated ongoing careless handling of lighted smoking products by the resident.

Finally, Petitioner asserts that that it adequately supervised Resident # 25. As support, Petitioner cites to the March 16, 2007 smoking assessment of Resident # 25. Petitioner contends that this is evidence that the resident could smoke safely, essentially unsupervised. Petitioner's Post-Hearing brief at 11.

Above, I explain why I conclude that the March 16, 2007 smoking assessment is not persuasive evidence that the staff had actually determined that the resident's cognitive and physical functioning had improved so much that the resident could smoke safely and unsupervised. But, even if Petitioner's characterization of the March 16, 2007 assessment is correct, that begs the question of why the staff didn't reassess the resident subsequently, especially after the resident displayed behavior (smoking in his room) that was clearly dangerous. Moreover, it should have been obvious to staff just from observing the resident that he manifested behaviors that showed that he was dangerous to himself and to others if he smoked unsupervised. The many burned areas on the resident's blanket are proof of the hazards that the resident encountered. So also is the resident's distinctive slouching while he sat in his wheelchair and smoked.

2. A per-instance civil money penalty of $5,000 is reasonable.

CMS is authorized to impose a per-instance civil money penalty of between $1,000 and $10,000 as a remedy for a single deficiency. 42 C.F.R. § 488.438(a)(1)(iii). There exist regulatory factors for deciding where within this range a specific penalty should lie.

These factors are set forth at 42 C.F.R. §§ 488.438(f)(1) – (4) and 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)). Factors which may be considered include the seriousness of a facility's noncompliance, its performance history, and its financial condition.

The penalty of $5,000 determined by CMS is at the midpoint of the permissible range for per-instance civil money penalties. I find it to be reasonable because the penalty amount is very modest when measured against the seriousness of Petitioner's noncompliance. Here, and for a protracted period of more than 18 months, Petitioner failed to safeguard a resident who clearly was at risk when he smoked. It failed utterly to keep current its assessment of the resident's smoking abilities and risks. This meant that the staff was in no position to know whether the resident's capabilities were deteriorating. The staff also allowed the resident to smoke more or less constantly without imposing even minimal supervision on him. They did so despite the presence of warning signs that the resident was not trustworthy to smoke unsupervised.

I note also that the civil money penalty that CMS determined to impose against Petitioner is miniscule when compared against that which CMS could have imposed. Petitioner's failures to assess and protect Resident # 25 extended over a period of 18 months. Penalties of even a few hundred dollars a day – a very low amount for a daily civil money penalty in a case such as this one – extended over a period of just a few months would amount to total civil money penalties that are vastly greater than that which CMS determined to impose and which I sustain.[3]

/s/
Steven T. Kessel
Administrative Law Judge

[3] As I discuss at the beginning of this decision CMS also determined to impose a denial of payment for new admissions against Petitioner for a period of nine days. Petitioner has not specifically challenged the imposition of this remedy. I find it to be authorized, both by virtue of Petitioner's noncompliance with the requirements of 42 C.F.R. § 483.25(h), but also because of the other noncompliance findings made at the October survey that Petitioner did not challenge. The presence of even a single deficiency is sufficient authority for CMS to impose a denial of payment for new admissions. 42 C.F.R. § 488.417(a).