Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Cascade-Abilene Health Services, d/b/a Silver Spring
(CCN: 67-6376),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-17-73

Decision No. CR4826

Date: April 14, 2017

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose remedies against Petitioner, Cascade-Abilene Health Services d/b/a Silver Spring, a skilled nursing facility operating in the State of Texas, consisting of civil money penalties of:

- $5,650 per day for each day of the period running from June 29, 2016 through July 1, 2016;

- $650 per day for each day of the period running from July 2, 2016 through August 4, 2016; and

- $150 per day for each day of the period running from August 5, 2016 through August 30, 2016.

Additionally, I sustain CMS's imposition of the remedy of denial of payment for new Medicare admissions for a period running from August 2, 2016 through August 30, 2016.

I. Background

Petitioner requested a hearing in order to challenge CMS's determinations that Petitioner had failed to comply with Medicare participation requirements and to impose the remedies that I describe above. CMS filed a brief in support of its determinations and 20 proposed exhibits, identified as CMS Ex. 1-CMS Ex. 20. Petitioner filed a brief and five proposed exhibits, identified as P. Ex. 1-P. Ex. 5.

CMS filed, as part of its exhibits, the written direct testimony of three individuals: Jessica Austin, Melissa Schwarz, and Mindy Kohlbrecher. Petitioner filed the written direct testimony of Marjorie Dorrow. Neither party requested to cross-examine the other party's witness or witnesses. Neither party objected to my receiving any of the proposed exhibits into evidence. I find no need to conduct an in-person hearing in this case given that there are no requests to cross-examine any of the witnesses. I receive into evidence all of the parties' exhibits. I base my decision on these exhibits as well as the applicable law.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues are whether:

1. Petitioner failed to comply substantially with Medicare participation requirements;

2. CMS's finding of immediate jeopardy level noncompliance is clearly erroneous; and

3. CMS's remedy determinations are reasonable.

B. Findings of Fact and Conclusions of Law

CMS's allegations of noncompliance emanate from two surveys conducted at Petitioner's facility: a survey completed on July 7, 2016 (July survey); and, a survey completed on August 5, 2016 (August survey).

1. July survey

At the July survey the surveyors found three events of alleged noncompliance: failures to comply with the requirements of 42 C.F.R. §§ 483.10(b)(4), 438.15(e)(1), and 483.70(f).

Specifically, the allegations of noncompliance made at the July survey include charges that Petitioner failed to honor a "do not resuscitate" (DNR) request that the family of a resident identified as Resident 1 made on his behalf. Furthermore, according to the surveyors, Petitioner's staff displayed a lack of knowledge of Petitioner's own policies governing DNR requests. CMS contends that these failures violate a resident's right to refuse treatment as is provided at 42 C.F.R. § 483.10(b)(4). Moreover, according to CMS, Petitioner's noncompliance with this regulation was so egregious as to comprise immediate jeopardy for residents at Petitioner's facility.

CMS alleges additionally that as of July 7 Petitioner's call system was not accessible to three of Petitioner's residents. CMS asserts that this alleged noncompliance contravenes the requirements of 42 C.F.R. § 483.15(e)(1), which provides that a facility resident has the right to receive services with reasonable accommodation of his or her needs.

CMS's third allegation of noncompliance as of July addresses surveyors' findings that call lights throughout Petitioner's facility failed to signal Petitioner's nurses' station when they became unplugged. CMS asserts that this failure constitutes a violation of 42 C.F.R § 483.70, which requires that a facility's nurses' station must be equipped to receive residents' calls through a functioning call system.

Petitioner challenged the July survey findings of noncompliance with 42 C.F.R. § 483.10(b)(4). It did not offer evidence or argument to challenge the July survey findings of noncompliance with 42 C.F.R. §§ 483.15(e)(1) and 483.70. I find that the evidence amply supports CMS's determination of noncompliance with the requirements of 42 C.F.R. § 483.10(b)(4). I also find that Petitioner did not prove to be clearly erroneous CMS's findings of immediate jeopardy level noncompliance with the requirements of this regulation. I find also that CMS's remedy determinations, civil money penalties of $5650 and 650 per day, are reasonable.

CMS's allegations of noncompliance with the requirements of 42 C.F.R. § 483.10(b)(4) rest in part on evidence of the care that Petitioner's staff provided to an individual identified as Resident 1. There are no disputed facts concerning Petitioner's treatment of this resident. Petitioner admitted the resident to its facility on May 27, 2016. P. Ex. 1. On that date his family requested that he not be resuscitated in the event of cardiopulmonary arrest. CMS Ex. 11 at 16.

Petitioner had a policy concerning residents who were in DNR status. It required a red sheet, along with the DNR request, to be placed in a plastic sleeve in those residents' charts. CMS Ex. 17 at 1.

On May 28, 2016, a day after his admission, Petitioner's staff discovered that he was not breathing or responsive. CMS Ex. 5 at 5. What ensued after that discovery demonstrated obvious confusion by the staff as to Resident 1's status and a clear violation of the

resident's DNR request. A certified nurse asked for the resident's status and a nursing assistant told her that the resident was a "full code," meaning that all reasonable efforts should be made to resuscitate him. *Id.* at 5. Based on that misstatement, Petitioner's staff proceeded to do all that it could to resuscitate Resident 1. These efforts included manual cardiopulmonary resuscitation (CPR) and use of an automatic external defibrillator device (AED) along with an oxygen facemask. *Id.* at 11. The staff's efforts successfully restored the resident's heartbeat. The resident was transferred to a hospital where he died several days later after the hospital discontinued use of a ventilator at the resident's family's request.

These undisputed facts plainly describe a violation of the resident's right not to be resuscitated. In and of themselves they establish substantial noncompliance with regulatory requirements. However, evidence of Petitioner's noncompliance goes beyond Petitioner's failure to recognize Resident 1's DNR status and to treat him in accordance with that request. CMS offered evidence to establish that some members of Petitioner's staff hadn't received any training about resident code status. CMS Ex. 8. Staff members also expressed uncertainty or unfamiliarity with Petitioner's DNR policies. *Id.* at 3-6.

The failure to treat Resident 1 in accordance with his family's wishes coupled with the lack of instruction given to Petitioner's staff is not only evidence of noncompliance with regulatory requirements but it supports a finding of immediate jeopardy. The problem wasn't just that Petitioner committed an error in providing care to Resident 1 but that its staff was insufficiently trained to deal with DNR requests. I find that the consequence of this inadequate training and staff confusion was to put in jeopardy all of the 45 residents of Petitioner's facility who had executed DNR requests or had such requests executed by their guardians or close relatives. *See* CMS Ex. 5 at 18.

I take notice that cardiopulmonary resuscitation is in many cases a procedure that can cause great pain and distress to an individual. Ribs are often broken when manual CPR is administered. The electrical shock administered by an AED can be quite painful. And, resuscitation, even if successful, can in many cases only prolong an individual's suffering. There is also the distress that may be caused to an individual's family by the efforts of resuscitation and their aftermath. For these reasons it is critical that a facility honor a resident's DNR request. Noncompliance with one of these requests is likely to cause substantial physical and psychological harm.

Petitioner argues that its staff's failure to treat Resident 1 in accord with his family's wishes was a one-time error that Petitioner rectified almost instantly and that would never happen again. Petitioner observes that CMS's findings of immediate jeopardy level noncompliance cover a period running from June 29 through July 1, 2016; a period of time more than a month after the failure to treat Resident 1 appropriately, and Petitioner contends that assessing immediate jeopardy for this period bears no relationship to the facts. Petitioner contends that whatever noncompliance may have occurred on May 28,

2016, Petitioner corrected it "immediately through education and discipline." Petitioner's Brief at 6. It asserts that it suspended, and then discharged, the employee who failed accurately to communicate Resident 1's status to the remainder of Petitioner's staff and it asserts also that it provided in-service training to its staff in the days immediately after May 28. Consequently, according to Petitioner, it had already regained compliance as of the July survey.

Petitioner argues also, and at considerable length, that its efforts to assure the Texas State survey agency's employees that it had, in fact, corrected its noncompliance were thwarted by one employee's failure to respond to Petitioner's entreaties. Petitioner hints darkly and without elaboration that it may have been the victim of retaliation for some unspecified events that had occurred previously.

I find these arguments to be without merit. The evidence doesn't support Petitioner's assertion that the failure to treat Resident 1 appropriately was a one-time event. As CMS contends, at least two of Petitioner's staff averred that as of the July survey, Petitioner had not provided them with training as to how to ascertain whether residents in cardiopulmonary arrest were in DNR status. CMS Ex. 8 at 3-6. As of the July survey, Petitioner's staff had not been fully trained concerning their duties and responsibilities. The fact that as late as July 2016 not all of Petitioner's employees understood the facility's policies concerning directives posed two distinct risks for residents: first, that staff would attempt to resuscitate a resident notwithstanding that resident's DNR directive; and, just as important, the staff might *not* attempt to resuscitate a resident who was in "full code" status. The problem, obviously, is that if the staff didn't understand the facility's policies and wasn't fully versed in the care wishes of each of its residents, they would not know what to do for any individual resident in an episode of cardiopulmonary arrest.

I also find Petitioner's arguments concerning the asserted non-cooperation of a Texas State agency's employee to be irrelevant. I rest my findings of noncompliance on the evidence of what conditions prevailed at Petitioner's facility as of the July survey and not on discussions between Petitioner's staff and State agency employees.

CMS imposed civil money penalties of $5,650 per day for a three-day period (June 29-July 1, 2016) to remedy Petitioner's immediate jeopardy level noncompliance. I find these penalties to be reasonable. First, they accurately reflect the seriousness of Petitioner's noncompliance. 42 C.F.R. §§ 488.438(f)(3); 488.404. As I have discussed, failure to respect a resident's wishes about resuscitation is likely to cause serious harm both to a resident and his or her family. These penalties, at the lower end of what may be imposed for immediate jeopardy level noncompliance, are not only appropriate, but also modest.

Moreover, Petitioner has a history of noncompliance that supports the penalty amount. Indeed, the immediate jeopardy level deficiency found at the July survey is part of a long continuum of deficiencies found in Petitioner's facility. In 2015 there were two substantiated complaints about the care that Petitioner gave. In 2016 there were nine such substantiated complaints. CMS Ex. 20 at 1. In 2015 the Texas State agency cited Petitioner for 26 violations of nursing home or Life Safety Code regulations. *Id.* at 3-5. The agency found that three of these deficiencies caused residents to experience actual harm. *Id.*

I sustain CMS's determination to impose civil money penalties against Petitioner of $650 per day for the period beginning July 2 and continuing through August 4, 2016. These penalties largely are predicated on findings made at the July survey that Petitioner did not challenge. Petitioner neither argued that it was in fact compliant with the regulations that CMS contends it contravened nor did it contend that it corrected these deficiencies on dates earlier than the compliance dates found by the Texas State agency.

2. August survey

CMS alleges three failures by Petitioner to comply substantially with participation requirements emanating from the August survey of the facility. These are alleged failures to comply with the requirements of 42 C.F.R. §§ 483.15(a), 483.25(a)(3), and 483.15(c)(6).

Specifically, CMS contends that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.15(a) – a regulation that requires a facility to maintain and enhance each of its residents' dignity – because its staff failed timely to answer residents' requests for assistance communicated via a call light system. CMS contends that some residents who needed assistance with toileting weren't provided with necessary assistance, leaving them soiled and humiliated.

CMS also contends that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(a)(3) because it failed to assure that residents were toileted timely. This regulation requires a facility to assure that residents who need assistance with the activities of daily living, such as personal hygiene, receive such assistance.

Finally, CMS argues that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.15(c), a regulation that requires a facility to listen to and act on the grievances and complaints of its residents and their families. CMS alleges that Petitioner failed to comply with this regulation in that it disregarded complaints voiced by its residents' Residence Council, an organization of residents formed specifically to address residents' concerns to Petitioner's management.

I find that the evidence supports these allegations of noncompliance, and it also supports CMS's determination to impose as remedies civil money penalties of $150 per day and a denial of payments for new admissions.

Petitioner contests CMS's findings of noncompliance with 42 C.F.R. §§ 483.15(a) and 483.25(c) by asserting that these findings are premised on the unreliable hearsay assertions of two residents, Residents 4 and 8. It contends that both of these residents have long histories of behavioral issues, that they are uncooperative with Petitioner's staff, and that they often resist care. Petitioner characterizes these residents' assertions that the staff failed to answer their call lights when the residents needed to be toileted as insufficient evidence of noncompliance.

These residents' assertions are hearsay evidence. I generally consider such evidence to be of dubious probative value, especially when offered without corroboration. I would not find noncompliance if CMS's case rested solely on the residents' uncorroborated assertions.

However, there is corroborating evidence of noncompliance and this corroborating evidence renders credible the complaints of Residents 4 and 8. The surveyors interviewed a registered nurse whose responsibilities included the halls on which Residents 4 and 8 reside. The nurse admitted residents' call lights weren't always answered promptly and that Residents 4 and 8 sometimes had episodes of incontinence when their toileting needs were not attended to timely. CMS Ex. 6 at 6.

Petitioner also admitted that at times equipment necessary to assist residents to bathrooms wasn't available. Resident 8 needs a mechanical lift to help him get out of bed and into a bathroom. He complained that at times the lift was unavailable and that, as a consequence, he had episodes of incontinence. A nursing assistant corroborated Resident 8's complaint, advising the surveyors that it would sometimes be 30 minutes or longer before a lift became available to assist the resident. CMS Ex. 6 at 30.

Finally, Petitioner's administrator tacitly acknowledged that there were times – especially at mealtimes when Petitioner's staff was busy feeding residents – that there might be inadequate staff on hand to attend to all of the residents' toileting needs. He asserted that, on such occasions, residents and their families would just have to understand the demands on Petitioner's staff. CMS Ex. 6 at 32.

In sum, the weight of the evidence is that Petitioner lacked personnel to always answer residents' call lights timely and that as a result, residents were allowed to become incontinent at times. This evidence amply supports CMS's assertions of noncompliance with the requirements of 42 C.F.R. §§ 483.15(a) and 483.25(c).

There also is ample support for CMS's allegations of Petitioner's noncompliance with the requirements of 42 C.F.R. § 483.15(c). On multiple occasions Petitioner's Residence Council recorded grievances and informed Petitioner's management of its concerns. CMS Ex. 6 at 7-11.

There is no record showing that management even acknowledged, much less addressed, these grievances. Petitioner's administrator acknowledged to surveyors that there were unaddressed resident grievances. *Id.* at 13.

Petitioner asserts that it took steps to address the concerns of its Residence Council. But, this assertion notwithstanding, Petitioner offered no evidence to show that it actually had done so aside from offering records of in-service training of its staff that addressed residents' concerns about call lights and availability of ice water. This training, assuming it was accomplished as Petitioner contends, doesn't address the myriad of grievances asserted by the Residence Council. These grievances included: failure to turn and reposition bedridden residents timely; disorganized nighttime administration of medication; not replacing trash bags in residents' rooms; failure to answer call lights timely; and not providing snacks when requested. CMS Ex. 6 at 7-11.

CMS determined to impose civil money penalties of $150 per day for the period running from August 5 through August 30, 2016 as a remedy for the noncompliance found at the August survey. This is a minimal civil money penalty. I would find it to be justified based on any of the three deficiencies that the surveyors found in August. Petitioner has offered no evidence to suggest that the penalty amount is excessive. Nor did Petitioner prove affirmatively that it attained compliance at a date that is earlier than August 30.

CMS also imposed the remedy of denial of payment for new Medicare admissions for each day of the period running from August 2 through August 30, 2016. This remedy is premised on the deficiencies that were found at the August survey. Regulations authorize CMS to impose the remedy. It may impose denial of payment for new admissions whenever a facility is not in substantial compliance with participation requirements. 42 C.F.R. § 488.417(a).

Petitioner argues that denial of payment for new admissions is an unauthorized remedy because its noncompliance – if it existed – did not "rise to the level" of noncompliance that merits the remedy. Petitioner's brief at 14. The regulations do not support this argument. As I have stated, CMS may impose a denial of payment for new admissions

whenever there is failure by a facility to comply substantially with Medicare participation requirements. Such noncompliance existed at Petitioner's facility between August 2 and 30, 2016.

/s/
Steven T. Kessel
Administrative Law Judge