Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Princeton Place,
(CCN: 32-5045),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-1003

Decision No. CR3146

Date: March 7, 2014

DECISION

Petitioner, Princeton Place, challenged the determination of the Centers for Medicare & Medicaid Services (CMS) to impose two per-instance civil money penalties of $6,000 and $4,500, plus a denial of payment for new admissions beginning March 7, 2013 and continuing through March 20, 2013. I sustain the imposition of the $4,500 civil money penalty as well as the denial of payment for new admissions. I find that the preponderance of the evidence does not support imposition of the $6,000 civil money penalty and I do not sustain it.

I. Background

Petitioner is a skilled nursing facility located in Albuquerque, New Mexico. It participates in the Medicare program and its participation is governed by regulations at 42 C.F.R. Parts 483 and 488. Petitioner was surveyed on behalf of CMS on December 19, 2012 and on March 20, 2013 (December and March surveys). Petitioner was found noncompliant with Medicare participation requirements at both of these surveys. CMS premised its remedy determinations on the surveys' noncompliance findings.

Petitioner requested a hearing. The case originally was assigned to another administrative law judge and then was transferred to me. The parties filed pre-hearing exchanges consisting of briefs and exhibits including the written direct testimony of proposed witnesses. Then, they informed me that they had agreed to waive an in-person hearing. I allowed the parties to file final briefs. CMS filed a final brief and Petitioner did not. CMS offered 24 proposed exhibits that are identified as CMS Ex. 1 – CMS Ex. 24. Petitioner offered 10 proposed exhibits that are identified as P. Ex. 1 – P. Ex. 10. I receive these exhibits into the record.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues in this case are whether Petitioner failed to comply substantially with Medicare participation requirements and whether CMS's remedy determinations are reasonable.

B. Findings of Fact and Conclusions of Law

CMS's determinations to impose per-instance civil money penalties against Petitioner are based on findings that Petitioner failed to comply substantially with two Medicare participation requirements. Specifically:

- CMS premises the $6,000 per-instance penalty on findings made at the December survey that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25. This regulation, sometimes referred to as the "quality of care" regulation is a lengthy regulation with numerous subparts. CMS, in alleging noncompliance, relies on the broadly worded introductory paragraph of the regulation, which states that a skilled nursing facility must provide each of its residents with the necessary care and services "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."

- CMS bases the $4,500 per-instance civil money penalty on findings made at the March survey that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h)(1) and (2). These subsections direct a skilled nursing facility to ensure that its resident environment remains as free of accident hazards as is possible and that each resident receive adequate supervision and assistance devices to prevent accidents.

There were additional findings made at the December survey that Petitioner failed to comply substantially with additional regulations governing infection control and quality

assurance (42 C.F.R. §§ 483.65 and 483.75(o)(1)). These noncompliance findings are not the basis for either of the per-instance civil money penalties that CMS determined to impose. Arguably, they might have some relevance to CMS's imposition of another remedy, a denial of payment for new admissions that began on March 7, 2013 and that ran until March 20, 2013. It is unclear, however, whether the denial of payment is in fact predicated on these findings or is based on noncompliance findings that were made at the March survey. However, and as I discuss below, the findings of noncompliance made at the March survey are ample bases for the remedy even if the noncompliance findings of the December survey had never been made.

The gravamen of CMS's allegations of noncompliance with 42 C.F.R. § 483.25 is that Petitioner failed to communicate with a resident's physician about significant changes in the resident's medical condition. The resident, identified in the report of the December survey as Resident # 1, suffered from a number of debilitating conditions. The resident was in a persistent vegetative state and was completely dependent on facility staff for all activities of daily living. CMS Ex. 6 at 6 – 34. CMS asserts, without challenge by Petitioner, that the resident had a care plan that directed facility staff to notify the resident's physician and family of any significant changes in the resident's condition. CMS contends primarily that Petitioner contravened the resident's plan of care because it failed to notify the resident's treating physician of a significant medical development that occurred over a period that began on December 1, 2012 and continued through December 2, 2012 when the resident was transferred to a hospital.[1] CMS contends that on December 1 the resident's power of attorney (POA) discovered that the resident's scrotum was swollen and demanded that the resident be transferred to a hospital. CMS Ex. 8 at 1 – 2. However, according to CMS, the resident was not transferred until the following day, December 2, 2012. *Id.* Upon transfer it was discovered that the resident suffered from a potentially deadly infection, Fournier's Gangrene. The resident was transferred from the hospital to hospice care and he expired a few days later.

CMS doesn't assert specifically that there was a failure by facility staff to diagnose properly the resident's gangrene. Rather, its focus is upon the alleged failure of the staff to consult with the resident's physician about the POA's allegations and the staff's own findings of swelling that indicated an underlying infection. Thus, according to CMS: "the facility failed to provide the care and services to protect Resident # 1 from significant harm by not recognizing the significance of the changes in his condition and

[1] CMS does not allege specifically that Petitioner contravened the requirements of 42 C.F.R. § 483.10(b)(11), which requires a facility to consult immediately with a resident's treating physician about any significant change in a resident's condition. The consultation requirement of this regulation is stronger than the care plan's injunction that a physician be notified of a significant change of condition. A facility may not adopt a plan that imposes on it a lesser duty than the regulatory standard. For that reason I evaluate CMS's allegations using the "consult" standard stated in the regulation.

communicating to his physician those signs and symptoms." CMS's closing brief at 3, citing CMS Ex. 23 at 2. CMS argues that this alleged failure by Petitioner must be considered against a background of other alleged failures to consult with the resident's treating physician. According to CMS, Petitioner failed to communicate with the resident's physician over a period extending from October until December 2012 about problems exhibited by the resident including a urinary tract infection and a respiratory infection. *Id.*

I find these allegations to be unsupported by the record. CMS's allegations notwithstanding, the record establishes a pattern of frequent communications between Petitioner's staff and Resident # 1's physician or the physician's assistant. That is true generally for the period between October and December 2012 but it is also true with respect to the resident's scrotal infection in early December 2012.

This resident was an extremely ill and debilitated individual who was plagued with numerous and chronic problems. The resident's problems included a chronic respiratory infection and recurring urinary tract infections. His baseline condition was extremely poor and, thus, he would have appeared extremely ill at all times. That said, there were numerous occasions where the staff brought changes in the resident's condition to the attention of the resident's physician or his assistant and it is obvious from the follow-up care that was ordered for the resident that the communications were more than mere notification.

For example, on November 7, 2012, the resident ran an elevated temperature and was reported to have lung sounds with crackles. The staff clearly discussed this development with the resident's physician because the staff received orders from the physician for a urinalysis as well as a prescription for an antibiotic to be administered to the resident. P. Ex. 1 at 61. Tests results were reported to the physician's assistant later that day and orders were issued concerning medication and insulin administration. *Id.* at 62. New physician's medication orders were issued on November 22, 2012 along with another order for urinalysis. P. Ex. 1 at 67. The results were reported to the physician's assistant on November 23, 2012. *Id.*at 68.

There is nothing in the record to suggest that the physician, through his assistant, was not being kept fully apprised of the resident's condition on December 1 and 2, 2012. To the contrary, the evidence supports the conclusion that there were frequent discussions between staff and the resident's physician or physician's assistant about the resident's deteriorating condition during this period. On December 1, 2012, Petitioner's staff observed Resident # 1's scrotum to be edematous. The staff notified the physician's assistant and discussed the resident's condition with her. P. Ex. 1 at 69. The POA requested that the resident be transferred to a hospital on that date. The physician's assistant declined the request, advising the POA and facility staff that she wanted to see the resident personally before ordering a transfer. *Id.* On the following day, December 2,

2012, the staff discussed the resident's condition with the physician's assistant five separate times. P. Ex. 1 at 69 – 71. Physician's orders were given for urinalysis, and use of a nebulizer, among other things.

It is clear that the physician's assistant and the resident's POA disagreed about whether the resident should be referred immediately to a hospital. But, whether the physician's assistant's judgment was correct is not at issue here. What is at issue is whether Petitioner's staff discharged its obligations by consulting with the resident's physician or the physician's assistant about what was obviously a significant change in the resident's condition, his scrotal edema. The record clearly supports the conclusion that the staff did what it was obligated to do.

I find that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h)(1) and (2). The evidence establishes that Petitioner failed to assure that one of its fire exit doors was locked and properly secured with an alarm system. Surveyors inspecting the door and the corridor found that they were able to open it freely without an alarm sounding. They found that the corridor leading to the building's exit was blocked by medical equipment and furniture.

The door in question and the corridor were a principal means of emergency egress from the facility for more than 60 residents and more than 20 of these residents were cognitively impaired. Petitioner's failure adequately to maintain the door and the corridor on which it opened put these residents at risk in the event of a fire or other emergency that would have required them to leave the premises. Petitioner's failures also heightened the risk that a resident could wander into the corridor on the other side of the fire exit door undetected and encounter potentially hazardous circumstances. It is undisputed that the corridor outside of the fire door led to two flights of descending stairs as well as to the obstructed corridor that led to the building's exit. CMS Ex. 17 at 1 – 4; CMS Ex. 18 at 1 – 4; CMS Ex. 19 at 1 – 6; CMS Ex. 21, at 2 – 3. Surveyors inspecting the door and the corridor found that they were able to open it freely without an alarm sounding. They found that the corridor leading to the building's exit was blocked by medical equipment and furniture.

Petitioner attempts to explain these facts but it does not deny them. It admits that the fire exit door was defective. Petitioner's pre-hearing brief at 28; Petitioner's revised pre-hearing brief at 23. It asserts that the problem was mitigated in some way by the fact that the surveyors failed immediately to report the problem to facility management. According to Petitioner: "The fact that the survey team did not inform the facility for approximately four hours of the potential situation with the door, raises the question of how much of an immediate problem the door presented." Petitioner's pre-hearing brief at 29; Petitioner's revised pre-hearing brief at 23-24. This is no defense. The burden did not fall on the surveyors to identify the problem and bring it to the facility's attention. And, if the surveyors delayed in raising the issue with facility management that does not

derogate one iota from the risk that it presented. The risk stands apart from the surveyors' actions after they identified the risk.

Petitioner argues that the objects in the exit corridor left the exit doorway only "slightly obstructed." Petitioner's pre-hearing brief at 29; Petitioner's revised pre-hearing brief at 24. Additionally, it contends that the equipment could be moved easily. *Id.* But, what might be a "slight" obstruction for an able bodied individual looms as a potentially insurmountable hazard for someone who is debilitated and/or demented. I find Petitioner's argument here to be without merit.

Petitioner has not specifically challenged the dollar amount of the per-instance civil money penalty, $4,500, except to assert that it was unjustified because there was allegedly no immediate jeopardy caused by the deficiency on which the penalty is based. However, a finding of immediate jeopardy is not a prerequisite to a per-instance civil money penalty such as the one that CMS determined to impose against Petitioner. 42 C.F.R. § 488.408(e)(1)(iv). The penalty that CMS determined to impose against Petitioner is, in fact, extremely reasonable given the hazards presented by the defective exit door and the blocked corridor. As I have stated, a demented and debilitated resident could have wandered through that door and gotten lost, without facility management being aware of the resident's whereabouts, in a corridor that contained hazardous and dangerous objects.

The additional remedy that is at issue in this case is a denial of payment for new admissions. CMS elected to begin implementation of the denial of payment on March 7, 2013 and to end it on March 20, 2013. CMS does not specify exactly which deficiencies, those identified at the December survey or those identified at the March survey, are the basis for the remedy. However, the deficiencies that were identified at the March survey – the failure to protect the facility's residents against the hazards caused by a defective exit door and a partially blocked exit corridor – are certainly sufficient grounds to justify the remedy. For that reason, I find it unnecessary to rule on the findings of noncompliance that were made at the December survey that are in addition to CMS's allegations concerning the care that was given to Resident # 1.

It is reasonable to infer that the problems with the exit door and the blocked corridor began prior to March 20, 2013. There was, for example, an accretion of broken equipment and furniture in the exit corridor that clearly was not put there overnight but that had been there for some time. For this reason, it is reasonable to conclude that the hazards identified by the surveyors had been there for days or weeks at the least. A denial of payment for new admissions based solely on the presence of these hazards and commencing on March 7, 2013 is therefore reasonable.

/s/
Steven T. Kessel
Administrative Law Judge