Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

The Meadows of Central Massachusetts,
(CCN: 22-5668),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-17-799

Decision No. CR4975

Date: November 22, 2017

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose a per-instance civil money penalty of $5,807.00 against Petitioner, Meadows of Central Massachusetts, a skilled nursing facility doing business in the State of Massachusetts.

I. Background

CMS moved for summary judgment, contending that there are no disputed issues of material fact. With its motion CMS filed 17 proposed exhibits that it identified as CMS Ex. 1 – CMS Ex. 17. Petitioner opposed the motion, filing no exhibits of its own.

There is no reason to convene an in-person hearing. Petitioner waived its right to cross-examine CMS's sole witness, Ms. Carolyn Correia. *See* CMS Ex. 17.[1] Nor did Petitioner file objections to my receiving any of CMS's proposed exhibits into the record. In light

[1] My Acknowledgment and Pre-hearing Order of June 26, 2017 directed Petitioner to advise CMS and me in writing if it wished to cross-examine any of CMS's witnesses. Petitioner did not file a request.

of that, an in-person hearing would be pointless. I receive CMS Ex. 1 – CMS Ex. 17 into evidence and I decide this case based on the written record. And, because an in-person hearing is unnecessary it is likewise unnecessary that I decide whether the criteria for summary judgment are met.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues are whether Petitioner failed to comply substantially with Medicare participation requirements and whether a per-instance civil money penalty of $5,807.00 is reasonable.

B. Findings of Fact and Conclusions of Law

CMS alleges that Petitioner did not comply substantially with three regulations governing participation of skilled nursing facilities in the Medicare program. These regulations are 42 C.F.R. § 483.21(b)(3)(i), which in relevant part, requires a facility to provide its residents with care that satisfies professionally recognized standards of care; and 42 C.F.R. §§ 483.24 and 483.25(k)(1) which: mandate a facility to provide each of its residents with the care necessary to enable the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with that resident's comprehensive plan of care; and, ensure that pain management is provided to each resident requiring such services consistent with professional standards of practice, the resident's comprehensive plan of care, and the resident's goals and preferences.

CMS contends that Petitioner contravened 42 C.F.R. § 483.21(b)(3)(i) because it failed to develop adequate policies and procedures to treat residents with substance abuse disorders and to train its staff accordingly, as is required by professional standards of quality. To support this assertion, CMS cites to federal and Massachusetts guidelines that establish standards for skilled nursing facilities such as Petitioner for dealing with residents who have substance abuse disorders. Most pertinently, the Massachusetts Department of Public Health advised facilities to include an antidote for opioid overdoses – naloxone (a/k/a Narcan) – in their emergency kits and to incorporate standing orders on the use of naloxone into their emergency kits. Circular Letter DHCQ 16-11-662 from Eric Sheehan, Dir. Bureau of Health Care Safety & Quality, to Long-Term Care Facility Admin. (Nov. 15, 2016) (Circular Letter).

CMS offered uncontroverted proof to show that Petitioner did not develop a comprehensive policy advising its staff on how to treat residents with substance abuse issues until March 7, 2017, months after the publication of the Circular Letter. Furthermore, Petitioner did not train its staff in the administration of naloxone. CMS Ex.

17 at 4-6. Consequently, residents of Petitioner's facility who potentially had substance abuse issues were left unprotected.

The evidence offered by CMS, coupled with proof as to the prevailing professionally recognized standards of care compellingly establishes that Petitioner failed to comply with the requirements of 42 C.F.R. § 483.21(b)(3)(i). Furthermore, Petitioner's noncompliance was not academic or hypothetical because on February 15, 2017, one of its residents, an individual identified as Resident 1, suffered from an overdose of a self-administered controlled substance. CMS Ex. 7 at 9. The resident became unconscious. *Id.* EMS personnel were called to the facility and, when they arrived, they found Resident 1 to be unresponsive, with a rolled up dollar bill with a white substance in it and possible heroin near his bed. CMS Ex. 10 at 1. EMS personnel administered naloxone to the resident and revived him. *Id.* Petitioner's staff was unable to administer naloxone because they lacked the prerequisite training. Petitioner's medical director was, in fact, unaware that the staff was not trained in the use and administration of naloxone. CMS Ex. 17 at 4.

The case presented by CMS also establishes that Petitioner contravened the requirements of 42 C.F.R. §§ 483.24 and 483.25(k)(1). These regulations require a facility to assess each resident for any issue or medical condition that the staff needs to address and to develop and implement a plan to address those conditions and issues. They require also that the facility manage a resident's complaints of pain – administering appropriate medication as needed – but also that it monitor the administration of that medication.

Petitioner failed to comply with these requirements, first, because it failed to develop and implement a plan of care for Resident 1 that addressed his substance abuse disorder. Petitioner's staff knew upon admission of Resident 1 into Petitioner's facility that the resident had a substance abuse disorder, but the plan of care that they developed for the resident was silent as to that issue. The staff also failed to develop interventions to address the resident's substance abuse until it became apparent that he had overdosed on controlled substances during his stay at Petitioner's facility. Furthermore, the staff did not monitor the resident for possible substance abuse.

The undisputed evidence establishes that the resident lived at Petitioner's facility for almost nine months before Petitioner's staff addressed a substance abuse disorder that they knew about upon the resident's admission. Petitioner admitted Resident 1 to its facility on May 31, 2016. At the time of his admission the resident suffered from paralysis, the consequence of a fall that he had sustained about six weeks previously. CMS Ex. 2 at 1. On admission Petitioner's medical director and staff noted that the resident had a history of substance abuse. *Id.*; CMS Ex. 3. The staff developed a care plan for the resident. CMS Ex. 11. The care plan listed a variety of goals and

interventions but it said nothing about Petitioner's history of substance abuse, nor did it provide any interventions that might have addressed the resident's substance abuse disorder. *Id.* at 1-7.

As I discuss above, Resident 1 self-administered a controlled substance, possibly heroin, on February 15, 2017. The resident was discovered by Petitioner's staff to be unconscious and EMS personnel found him to be unresponsive. The EMS personnel revived the resident by administering naloxone. The EMS transported the resident to a local hospital emergency room, where the attending physician concluded that the resident had been "cheeking meds and using heroin." CMS Ex. 10 at 7. I take notice that "cheeking" means that the resident had been pretending to swallow prescribed pills containing OxyContin (the resident had been prescribed OxyContin, an opioid, for pain) and hoarding them for recreational use. The physician concluded that the resident had recreationally overdosed on OxyContin. *Id.*[2]

It was only after this episode that Petitioner's staff amended Resident 1's care plan to include interventions for substance abuse. CMS Ex. 11 at 2.

The evidence establishes, furthermore, that Petitioner contravened regulatory requirements because its staff failed to plan for and monitor the administration of prescribed opioid controlled substances to Resident 1. On admission to Petitioner's facility the resident was prescribed methadone and oxycodone. I take notice that both of these medications are controlled substances and are opioids. CMS Ex. 2; CMS Ex. 3. At some point thereafter Petitioner's medical director ordered that the resident stop receiving methadone and replaced that medication with OxyContin, another opioid. But, notwithstanding this change – a substitution of one opioid for another – Petitioner's staff failed to amend Resident 1's care plan and failed to develop any intervention to monitor the possible adverse consequences of a new controlled substance regime. CMS Ex. 11.

Petitioner's staff also failed to amend Resident 1's care plan to address the resident's increasingly aggressive and defiant behavior. Beginning in January 2017 the resident displayed anger and hostility stemming from the staff's decision to limit the resident's use of an electric wheelchair. CMS Ex. 7; CMS Ex. 8. The resident regularly yelled at the staff, insulted them, uttered racist slurs, and cursed. His behavior became so abusive that on January 20, 2017 staff called police to intervene. CMS Ex. 7 at 3.

---

[2] Petitioner disputes that Resident 1 overdosed on a controlled substance. The evidence is equivocal as to whether the Resident overdosed on an illicit controlled substance such as heroin, but the preponderance of the evidence establishes that, if he did not, he overdosed on some sort of opioid, mostly likely OxyContin. That is evident from the fact that EMS personnel revived the resident with naloxone, an antidote for opioid overdosing, and from the conclusion of the emergency room physician that the resident had most likely overdosed on OxyContin or heroin.

Notwithstanding, Petitioner's staff neither amended the resident's care plan to address these outbursts nor did they consult with the resident's physician (Petitioner's medical director) about them.

The remedy that CMS determined to impose, a per-instance civil money penalty of $5,807.00, is reasonable. It is relatively modest, comprising only about one-half of the maximum allowable amount for a per-instance penalty. It is also modest in light of the seriousness of Petitioner's noncompliance. Opioid overdoses can be, and often are, fatal. In a facility where even a single resident has a known substance abuse disorder it is imperative that the staff plan for possible abuse and know how to treat it. Petitioner failed to do so and thus, potentially endangered Resident 1 and any other resident that might suffer from a similar disorder.

Petitioner does not contest any of the facts offered by CMS nor does it deny that it contravened applicable regulations. Furthermore, it expressly does not challenge CMS's authority to impose a per-instance civil money penalty against it and it does not challenge the penalty amount. Petitioner's entire defense is that CMS overstates the severity of its noncompliance. In particular, Petitioner challenges the scope and severity of CMS's noncompliance finding, contending that there was no actual harm to Resident 1.

Although CMS concluded that Petitioner's noncompliance caused harm to Resident 1, it did not determine the noncompliance to be so egregious as to comprise immediate jeopardy for this resident or for other residents. The deficiencies in this case are non-immediate jeopardy level deficiencies.

Petitioner has no right to challenge the scope and severity of CMS's noncompliance findings and I have no authority to hear and decide Petitioner's argument that CMS overstates the scope and severity level of its noncompliance. 42 C.F.R. § 498.3(b)(14).[3] A skilled nursing facility may challenge a determination as to the scope and severity of its noncompliance only in the circumstance where the scope and severity determination affects the civil money penalty range (immediate jeopardy versus non-immediate jeopardy) or where a finding of substandard quality of care causes a facility to lose its authority to conduct nurse aide training. *Id.* Neither of those circumstances are present here.

_____/s/_____
Steven T. Kessel
Administrative Law Judge

[3] I would have dismissed this case on the ground that I lack authority to hear and decide it had CMS moved for dismissal.