DEVELOPMENTS IN LONG-TERM CARE – Q1 2015

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The following summary highlights key federal court cases and administrative decisions involving skilled nursing facility survey issues during the first quarter of 2015.

FEDERAL COURT CASES

Fifth Circuit Upholds Medication-Related Survey Deficiencies

In *Perry County Nursing Ctr v. HHS*, No. 14-60158 (5th Cir. Mar. 11, 2015), after a Perry staff member stole 2,446 Lortabs, a January 2010 survey resulted in deficiencies under Tag F224 (policies and procedures to prevent misappropriation) and Tag F425 (policies to manage the ordering and inventorying of medications). In a follow-up survey in August 2011, the state agency asserted three deficiencies at the IJ level, Tag F281 (medication administration); Tag F425 (acquiring, receiving, storing, controlling, and reconciling medications); and Tag F520 (quality assurance), and two non-IJ deficiencies, Tag F225 (timely notification to police about the missing Lortabs in 2009), and Tag F514 (clinical recordkeeping). After a hearing before an administrative law judge (ALJ) and an appeal before the DAB, the Fifth Circuit agreed that the facility was not in substantial compliance.

The court rejected Perry's argument that when the deficiency pertains to medications, the applicable standard is 42 C.F.R. § 483.25(m), which requires a SNF to ensure that 1) it is free of medication error rates of five percent or greater; and 2) residents are free of any significant medication errors. This interpretation, it held, would "render superfluous any regulation affecting SNFs' drug distribution mechanisms." The court interpreted a prior case, *Caretel Inns of Brighton* (2012), as standing for the proposition that 42 C.F.R. § 483.25(m) establishes a floor for 42 C.F. R. § 483.20(k)(3)(i), not a ceiling. It also rejected the argument that Perry should be able to challenge Tag F520, even though Tags F281 and F425 "more than justify the penalties imposed," because the deficiencies would remain in its public record. Finally, the court rejected the argument that CMS violated its regulations by "reopening" an earlier survey more than 12 months after the initial determination. Although the second survey found a deficiency related to the earlier Lortab theft,

this did not justify setting aside all the tags because: 1) the civil money penalty (CMP) imposed may be justified without Tag F225; 2) as of April 30, 2011, Perry still had not reported the Lortab theft to the police; and 3) the Tag F225 was a new deficiency, not a reopening of an old one. This issue did not "taint" the survey itself, because the 12-month reopening rule relates to the determination imposing a remedy, not the survey itself.

Ninth Circuit Holds that Nursing Home is Entitled to Administrative Review of All Cited Deficiencies

Plott Nursing Home v. Burwell, 2015 U.S. App. LEXIS 3379 (9th Cir. Mar. 3, 2015) is significant because it holds that an ALJ must review all the survey deficiencies upon which CMS relies in imposing penalties. In two surveys, surveyors cited Plott for 34 deficiencies, all below the IJ level, and imposed CMPs. Plott requested a hearing on both surveys, and the ALJ, after consolidating the proceedings, upheld the entire penalty based on three deficiencies for three different residents. Although CMS imposed the CMPs based on all the deficiencies, the ALJ had concluded that it was not necessary to address all the other alleged deficiencies from the earlier survey, because two of them provided "a sufficient basis for the enforcement remedies that CMS proposes." Upon review, the DAB had reversed one of the deficiencies, but held that the ALJ was not required to review other contested deficiencies.

The Ninth Circuit disagreed with the DAB's reasoning that it was not necessary to review the remaining deficiencies because they were "immaterial" to the penalty. "Unreviewed allegations of deficiency do indeed affect penalties," and the DAB's decision that, "so long as the penalty is within the maximum permitted, more deficiencies are immaterial, does not make sense," because unreviewed deficiencies can affect future penalties within an authorized range or in a subsequent survey. The court characterized the DAB's position as "analogous to claiming that we need not review a criminal conviction for five bank robberies, if the statutory maximum sentence on one of them exceeded the sentence imposed." It described the argument that the facility could contest an unreviewed deficiency in a subsequent survey appeal, if it had the effect of enhancing penalties as "verg[ing] on the ridiculous." The court concluded that if a provider appeals a deficiency in a survey, the deficiency must either be dismissed or reviewed. In addition, while CMS need not provide review prior to posting the survey to the Nursing Home Compare website, it "must allow review and correction" for deficiencies reversed on appeal.

Postscript: On April 17, 2015, the Department of Health and Human Services (HHS) petitioned the Ninth Circuit for rehearing or rehearing *en banc* in *Plott Nursing Home*. HHS argues that the decision conflicts with decisions of other courts of appeals and hinders CMS's ability to protect SNF residents through the imposition of timely CMPs for deficient care.

Fifth Circuit Upholds Survey Deficiencies Alleging Abuse

Honey Grove Nursing Center v. U.S. Dep't of Health & Human Svcs., 2015 U.S. App. LEXIS 3334 (5th Cir. Feb. 24, 2015), involved a 77-year-old male resident with Alzheimer's, psychosis and anxiety who was resistant to care, physically and verbally aggressive, and preferred female staff.

Under Tag F223, the court upheld the deficiency based upon 1) a statement of the resident's roommate, who said the CNA rendered care despite the resident's resistance and caused what he called a "fight"; and 2) the resident's care plan, which instructed that if the resident is upset during care, "stop and return later to allow resident to calm down," which the CNA did not follow; and 3) references in the resident's chart to his preference for female-only care and increasingly aggressive behavior. Under Tag F226, the court upheld the deficiency based on: 1) the statement of a staff member about what he heard the CNA say, in the presence of other staff, to the resident about needing to be changed; and 2) the report of another

staff member that in March, the CNA told the resident, "[y]ou can get changed the easy way or the hard way." According to the court, that multiple employees failed to report the CNA's comments shows that, while the facility "may have had policies in place, they were ineffective." Finally, under Tag F490, the facility argued that the resident was harassing female staff, and this placed it in the "untenable position" of either honoring the resident's rights or providing "a work place free from discrimination and harassment," thereby precluding it from honoring his preference for female staff. The court rejected this argument on several grounds including that the findings resulted not from failure to implement a "female only" plan, but from physical abuse and failure to follow the direction to delay care when the resident is agitated. If a policy to limit which aides provided care to the resident would be discriminatory, the court stated, then the facility was obligated to take other steps to address the resident's escalating behaviors.

Administrative Survey and Certification Cases

Departmental Appeals Board (DAB) Decisions

Significant Change in Condition. In *River City Care Ctr.*, DAB 2627 (Mar. 24, 2015), CMS asserted immediate jeopardy deficiencies for under 42 C.F.R. § 483.10(b)(11) (consultation with physician and notification of significant change in resident condition); 483.13(c) (development and implementation of policies to prohibit neglect); 483.20(k)(3)(i) (facility services meeting professional standards of quality); and 483.25 (quality of care).

The board found substantial evidence that the facility failed to consult the resident's physician immediately after a significant change in condition. Although there were discussions between staff and the resident's physician at various times during the relevant period, these discussions did not constitute the required "immediate consultation after significant changes" in the resident's condition. Even if there had been "frequent consultation" after the physician notification on April 23 at 11 a.m., which there was not, the ALJ concluded this did not excuse the failure to consult the physician for more than seven hours after the staff initiated continuous supplemental oxygen at 3:45 a.m. Moreover, the resident deteriorated after April 23 in ways that should have demanded immediate consultations, including needing to use accessory muscles to breathe and increasing oxygen flow, becoming lethargic, and losing appetite and urine output. Further, while the physician ordered the chest x-ray to be performed stat, the results were not immediately reported to the physician. While there were various physician orders for treatment changes on April 25 and 26, the ALJ did not consider those orders sufficient to show communication with the doctor about the resident's ongoing deterioration.

The facility argued on appeal that the resident had pre-existing respiratory problems for which she had a standing physician order for nebulizer treatments, so her need for respiratory treatment on April 23 was not a "significant change" in condition. The board disagreed and found that the facility's portrayal "misrepresents core facts." There was no prior history of abnormal oxygen saturation levels, no prior need for supplemental oxygen when the resident complained of breathing difficulty, and no evidence of any preexisting physician order prescribing oxygen administration under such circumstances. Emphasizing that "immediate" consultation means exactly that, the board concluded that the facility failed to consult a physician immediately after a significant change in condition which the staff treated as precipitating a need for continuous supplemental oxygen, and this failure violated the regulatory requirement at 42 C.F.R. § 483.10(b)(11).

Sprinkler Systems. In *BGI Retirement, LLC, d/b/a Crossbreeze Care Center*, DAB 2620 (Feb. 23, 2015), the board upheld the ALJ's conclusion that the facility was not in substantial compliance with 42 C.F.R. § 483.70(a)(1)(i), which generally requires a Medicare-participating nursing facility to meet the applicable provisions of the 2000 edition of the Life Safety Code (known as NFPA 101) of the National Fire Protection Association. NFPA 101 in turn, incorporates provisions of the 1999 edition of another NFPA publication, "Installation of Sprinkler Systems" (NFPA 13). At issue was the NFPA "maximum distance" standard requiring that, if the horizontal distance between a sprinkler and an obstruction is less than one foot, the sprinkler's deflector must be even with or below the bottom of the obstruction.

The facility made three arguments on appeal. First, it argued that CMS failed to identify the controlling legal standards prior to or during the evidentiary hearing and thus failed to meet its burden of proof. The board, viewing this as a notice issue, rejected the argument because the facility owner admitted he was aware of why the deficiency was cited, and the ALJ found no substantive difference in the maximum distance standard between different editions of the code. Second, the facility argued that the ALJ erroneously assigned evidentiary weight to CMS's photographic evidence, without complying with CMS Survey & Certification Letter 06-33 (Sept. 29, 2006), entitled "Some Basic Principles of Using Photography During the Survey." The board rejected this argument on the ground that the CMS manuals, instructions, or policy "guidance," while instructive, do not have the force of law, and assigning weight to evidence is "largely within the ALJ's sound discretion." Third, the facility argued that the $200 per-day CMP should accrue for only one day, because the Florida agency's inspectors did not give notice of their distance measurements until August 28, and the facility corrected the condition the next day. The board rejected this argument because the surveyors first found the facility to be out of compliance on June 25, and "[t]he per day civil money penalty may start accruing as early as the date that the facility was first out of compliance, as determined by CMS or the State."

Bruising. In *Brenham Nursing & Rehabilitation Ctr.*, Dkt. No. A-15-1, Dec. No. 2619 (DAB Feb. 20, 2015), the DAB upheld the ALJ's decision sustaining $84,400 in CMPs based upon alleged noncompliance, at the IJ level, with 42 C.F.R. § 483.13 (c) (preventing, investigating and reporting abuse and neglect) and 42 C.F.R. § 483.75 (efficient facility administration). The ALJ concluded that the facility's response did not comply substantially with the regulatory requirements, and the DAB affirmed the ALJ's decision.

The ALJ identified a number of actions the facility should have taken but did not, such as appointing an individual to coordinate an investigation, conducting more extensive staff interviews, and identifying all the personnel and residents who might have had access to the resident. There was no effort to find out if the resident might have been subjected to physical violence or if any individual posed an ongoing threat to the resident welfare, or to investigate the possibility that an accident hazard might have caused the resident's injuries. Additionally, the facility did not report to the Texas state agency about the possibility of resident injury due to abuse or neglect, and did not notify Texas authorities of the results of an investigation. Although the facility argued that it investigated and determined that the bruising was caused by a blood disorder or a Hoyer lift, the ALJ rejected these arguments because blood tests showed no hematological disorder, and the facility made no credible efforts to determine whether the transfer had caused the resident's condition.

Civil Remedies Division – Administrative Law Judge (ALJ) Decisions

Bruising. In *Tulsa Jewish Community Ret. & Health Care Ctr. v. CMS*, CR3712 (Mar. 31, 2015) (Sickendick, ALJ), the ALJ upheld deficiencies at the immediate jeopardy level under Tag F225, F226, and F490. For one resident, the evidence showed that during a five-month period, the facility's staff discovered and reported at least ten instances of bruising in multiple areas. The resident was on anticoagulant therapy, but the fact she was subject to easy bruising due to the anticoagulant therapy did not address the cause of the trauma that caused the multiple bruises she suffered. Even if there was no intentional bruising, that did not rule out the possibility that staff neglected to exercise necessary care in handling her or mistreated her by rough handling. Because the facility did not recognize the resident's repeated bruising as potential abuse, neglect, or mistreatment, it never complied with the requirements to protect the resident, investigate, report, and retain documents reflecting the investigation, protection, and reporting and therefore violated 42 C.F.R. § 483.13(c)(2), (3), and (4). For another resident, an alleged spanking incident also reflected a regulatory violation, because the CNA who allegedly witnessed the event did not immediately report it to the administrator, and this prevented a timely report to the state agency. The failure to report also prevented protecting the resident from further potential abuse, because the weekend sitter who did the alleged spanking was permitted to complete her shift that day. Moreover, according to the ALJ, although the facility had policies and procedures prohibiting abuse, neglect, mistreatment and the misappropriation of resident property, it failed to implement them. Further, the noncompliance under Tags F225 and F226 at the IJ level established that the facility failed to administer its facility effectively to ensure residents attained and maintained their highest practicable physical, mental, and psychosocial well-being.

Choking. In *Hanover Hill Health Care Ctr. v. CMS*, CR3745 (Mar. 31, 2015) (Hughes, ALJ), staff recognized that a resident with dementia tended to "shovel peanut butter" into his mouth and had recently exhibited difficulties swallowing, but staff left him alone and unsupervised with crackers covered in peanut butter. He choked to death, with "large amounts" of the peanut butter lodged in his throat. CMS imposed a $7,500 per-instance CMP based on deficiencies under Tags F224 and F309, both at the IJ level. The ALJ found that the facility was not in substantial compliance with the regulation prohibiting abuse and neglect, due to evidence of multiple examples of staff ignoring R17's serious medical problem, which the ALJ considered to be neglect. The ALJ also found that the facility was not in substantial compliance with 42 C.F.R. § 483.25, the quality-of-care regulation, because the resident needed to be supervised while eating, but he was not, and when mounting evidence established that his swallowing problems were more serious, he needed a professional assessment and treatment plan, which the facility did not provide.

No Right to a Hearing. *In Monterey Care Inc., d/b/a Scottsdale Nursing & Rehab. v. CMS*, ALJ Ruling 2015-11 (Mar. 18, 2015) (Grow, ALJ), the ALJ dismissed the facility's appeal on the ground that CMS did not impose an enforcement remedy, and therefore the facility had no right to a hearing. The facility pursued informal dispute resolution, after which the deficiencies remained the same other than the removal of one resident. The ALJ held that: 1) an "IDR result from the state agency is not a CMS administrative action that may be appealed to an ALJ"; 2) "it is the enforcement remedy, not the citation of a deficiency, that triggers the right to a hearing"; and 3) because "CMS has imposed no remedies, Petitioner does not have a right to a hearing."

The facility argued that it received disparate treatment from CMS, which acted in an arbitrary and capricious manner, amounting to unequal treatment under the law, and that it would suffer the "loss of property rights and a loss of due process" if it could not appeal the deficiency and scope and severity rating. The ALJ concluded, however, that he had no authority to review these constitutional arguments, because the DAB "has concluded that neither the Board nor ALJs can ignore

unambiguous statutes or regulations on the basis that they are unconstitutional."

No Right to a Hearing. In *Golden Living Ctr.-Trussville v. CMS*, ALJ Ruling No. 2015-9 (Feb. 20, 2015) (Hughes, ALJ), the ALJ dismissed the appeal on the ground that the facility had no right to a hearing. To "graduate" from special focus facility designation, a facility must have two consecutive surveys with no deficiencies cited at scope and severity level F or higher. In this case, the facility was designated a special focus facility in 2012. In 2013, CMS determined that the facility was not in substantial compliance with 42 C.F.R. § 483.35(i) (dietary services/sanitary conditions) at the F level. CMS did not impose a remedy (such as a CMP or denial of payment for new admissions), as specified in 42 C.F.R. § 488.406, for which a facility may request an ALJ hearing.

The facility argued that the prospect of it remaining a special focus facility is sufficient to create a hearing right, but the ALJ disagreed. Citing the general rules that 1) the remedy, not the citation of a deficiency, triggers the hearing right, and 2) the facility has no right to a hearing where CMS declines to impose one of the specified remedies, the ALJ held that "CMS has not made an initial determination," and the facility had no right to a hearing. The ALJ declined to follow a Nebraska federal case, *Golden Living Ctr. – Grand Island Lakeview v. Sebelius*, 2011 WL 6303243 (D. Neb. Dec. 16, 2011), which required the secretary to allow an ALJ to develop the record on the merits after CMS withdrew the appealable remedy.

Defective Notice. In *Corpus Christi Nursing & Rehab. Ctr. v. CMS*, CR3640 (Feb. 11, 2015) (Sickendick, ALJ), CMS sent the facility a notice letter dated November 25, 2013, by facsimile, imposing enforcement remedies. By letter dated August 31, 2014, the facility requested a hearing before an ALJ. CMS moved to dismiss the case on grounds that the request for hearing was not timely, with no good cause to extend the period for filing. Petitioner responded that it did not receive notice of CMS's final determination by mail, as 42 C.F.R. § 498.20(a)(1) requires. The ALJ remanded the appeal to permit CMS to provide Petitioner proper notice of its initial determination by mail as required by 42 C.F.R. § 498.20(a)(1), or to take such other action CMS as deems appropriate.

Untimely Hearing Request. In *Orchard Park Health Care Ctr. v. CMS*, ALJ Ruling 2015-8 (Mar. 3, 2015) (Hughes, ALJ), the facility received the determination notice letter on May 16, and its hearing request was due no later than July 15, 2013. The facility did not file its hearing request until July 29, 2013. The ALJ dismissed the request pursuant to 42 C.F.R. § 498.70 (c) as untimely, with no good cause justifying an extension to the time for filing.

Resident Fall. In *Bear Hill Nursing Ctr, Inc*., No. CR3564 (Jan. 9, 2015), ALJ Kessel granted summary judgment in favor of CMS and against a Massachusetts SNF and sustained a $2500 per-instance CMP for alleged violations of 42 C.F.R. § 483.20 (k)(3)(ii) (provision of services by qualified persons in accordance with the plan of care); 42 C.F.R. § 483.25 (necessary care and services for highest practicable well-being); and 42 C.F.R. § 483.25(h) (accident prevention). The resident's care plan provided for transfer with the assistance of two staff and by means of a mechanical lift. While attempting to reposition the resident without assistance, a CNA diverted her attention momentarily, and the resident fell to the floor. The CNA picked the resident up without assistance or the use of a mechanical lift (both of which were required), placed the resident in a shower chair, and attempted to cover up what had occurred. The CNA did not report the fall immediately to a nurse, but instead told another CNA, who did not report it to a nurse. Eventually, the first CNA told a nurse and a nurse supervisor that the resident had fallen when both CNAs attempted to transfer the resident via a mechanical lift. The resident's family member noticed a bump on the resident's head and reported it to the nursing staff. X-rays revealed a fractured right clavicle due to the fall. The ALJ rejected the argument that the accident was an aberration – a one-time occurrence – for which it

should not be held liable and instead concluded that the facility is "liable for its employee's actions when an employee such as CNA # 1 willfully violates the directions in a resident's plan of care."

Emergency Power: CMS Did Not Establish Noncompliance. In *Peaks Care Ctr.*, *CR3551* (Jan. 6, 2015), ALJ Sickendick rejected CMS's allegation that the facility was noncompliant, at the IJ level, with Tag F517 (disaster/emergency preparedness). According to the surveyors, the facility had no emergency power source to power suction devices in the event of a power outage and did not develop a plan to address how residents requiring suctioning could be suctioned in the event of a power outage. In a lengthy opinion, ALJ Sickendick found that CMS did not establish noncompliance, because: 1) CMS did not identify any statute, regulation, or policy requiring the facility to have a backup generator to power suction machines or air mattresses; 2) the facility's electrical outage plan specified that a backup generator would be used, and the facility had a backup generator; 3) staff responses about what to do in case of an electrical outage were consistent with the electrical outage policy; and 4) CMS presented no competent evidence that there was a risk for more than minimal harm to any resident.