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DEVELOPMENTS IN LONG-TERM CARE Q2 2015

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

Federal Court Cases

Federal Court Lacks Jurisdiction to Address Administrative Delay. In *Cplace Springhill SNF, LLC v. Burwell*, 2015 U.S. Dist. Lexis 53014 (W.D. Cal Apr. 21, 2015), the U.S. Department of Health and Human Services (HHS) suspended Medicaid payments to a skilled nursing facility (SNF), effective July 25, 2014, based "on reliable information that an overpayment exists or that payments to be made may not be correct." According to the SNF, the "reliable information" was the finding of HHS's zone program integrity contractor (ZPIC) that the SNF had billed therapy services at a level beyond what was medically necessary for the treatment of Medicare beneficiaries. HHS did not make an initial determination or give notice of an overpayment; as a result, as late as October 27, 2014, however, the SNF was unable to initiate the administrative appeal process. On October 30, 2014, the SNF filed a civil action, on due process grounds, seeking an injunction against HHS from continuing the payment suspension and prepayment review. The court dismissed the lawsuit for failure to exhaust its administrative remedies. While sympathetic to the SNF's circumstance, the current backlog in the administrative appeal process was "not so egregious as to warrant circumvention of the administrative appeals process," and the court was not in a position to provide a fix for the backlog, despite the financial hardship for the SNF.

Administrative Survey and Certification Cases

Departmental Appeals Board (DAB) Decisions

Lack of Good Cause to Excuse Late Filing. In *St. George Health Care Center*, DAB 2645 (June 30, 2015), the Departmental Appeals Board (DAB) affirmed the conclusion of the administrative law judge (ALJ) that an appeal was untimely and good cause to excuse the late filing did not exist. On July 31, 2014, the Centers for Medicare and Medicaid Services (CMS) notified the facility that it was not in substantial compliance with various participation requirements, including deficiencies at the immediate jeopardy level, and that it had 60 days to appeal. On

August 21, 2014, CMS notified the facility that an August 7, 2014, revisit survey had resulted in the removal of one deficiency, but the facility remained out of compliance with other requirements, which warranted additional remedies, with 60 days to appeal this determination. The facility, in its request for a hearing, dated October 20, 2014, appealed CMS's August 21 determination and requested an extension to appeal the July 31 determination, because it had "overlooked the timeframes given the number of letters and communications that were occurring at the time" and actions "to assure the safety of residents and implement swift and effective corrective action." The ALJ held this was not a satisfactory showing of good cause. Later, the DAB, the facility asserted it did not construe the July 31 determination as an appealable determination separate and distinct from the August 21 determination. The DAB, found this statement "entirely inconsistent" with the facility's statements to the ALJ and concluded there was no basis to disturb the ALJ's decision.

No Appeal to Challenge CMS's Choice of Remedies. In *Penobscot Nursing Home*, DAB 2642 (June 11, 2015), the owner of a Maine nursing facility requested review of an ALJ's ruling that it lacked authority to request a hearing on a CMS determination to terminate the facility's provider agreement and to impose a civil money penalty. The ALJ concluded that the owner's court-appointed receiver was the only entity with authority to make decisions on the facility's behalf under Maine receivership law. Since the receiver requested an extension of time to file a hearing request but never filed one, the ALJ closed the case without considering the owner's hearing request. The ALJ did not err in closing the case, the DAB concluded, but for a different reason—the owner's hearing request, even after amendment, challenged only CMS's choice of termination as a remedy, rather than any specific finding of noncompliance, and thus did not identify any issue on which the facility had a right to a hearing. Since the hearing request was subject to dismissal, the DAB did not decide whether the owner or the receiver had authority to make the request.

Return to Substantial Compliance. In *Grace Living Center-Northwest OKC*, DAB2633 (Apr. 17, 2015), the issue was whether an Oklahoma skilled nursing facility returned to substantial compliance by November 12, 2013, the date alleged in the plan of correction (PoC), prior to a revisit survey that resulted in another deficiency. In the November 1 survey, surveyors alleged that the facility's staff left cleaning fluid and hand sanitizer unattended in unlocked carts to which residents had access. In the November 25 survey, surveyors asserted that the facility provided inadequate care for a resident who was totally incontinent of bowel and bladder function. The ALJ reasoned that the facility could not have completed daily audits for 30 days beginning on October 31, as the PoC for the first survey required, in only 12 days and then also report the findings to the facility's quality assurance committee (QA committee). The DAB reversed. Viewing the evidence in the light most favorable to the facility, it was possible to read the PoC, dated November 22, as alleging that the facility had already achieved compliance on November 12 based on the measures it had taken by that date (such as in-service training, some audits, and a meeting of the QA committee) and that ongoing monitoring through further audits and another QA committee meeting were planned to ensure the correction would remain effective in the longer term, rather than to achieve substantial compliance in the first instance. The DAB remanded the case to the ALJ for further factual development.

Civil Remedies Division: Administrative Law Judge (ALJ) Decisions

G-Tube and Trach Care/Facility Policies and Procedures/Administration. *Wingate at Beacon v. CMS*, CR 3979 (Jun. 22, 2015) (Hughes, ALJ), involved quality-of-care deficiencies relating to naso-gastric tubes and special needs, 42 C.F.R. § 483.25(g) (Tag F322) and 42 C.F.R. § 483.25(k) (Tag F328), and administration, governing body, and medical direction

(42 C.F.R. §§ 483.75 (Tag F490), 483.75(d)(1)-(2) (Tag F493), and 483.75(i) (Tag F501), all at the immediate jeopardy (K) level. Although the regulations do not specifically so require, the ALJ held that a facility must have written policies and procedures for changing G-tubes or providing trach care. A nursing manual, which staff were free to consult, was "no substitute for written policies and procedures," because it was "not institution-specific" and did not "assign responsibilities among the facility staff, indicate who is authorized to perform necessary procedures, nor specify the individuals within the facility to whom staff must report problems." The ALJ found that the facility had not provided its nursing staff with formal training in trach or G-tube care in more than one year and had no safeguards in place to assure that nursing staff were competent to provide G-tube and trach care. The ALJ concluded that a facility cannot assure that its staff are providing appropriate G-tube and trach care and services unless it: i) defines for them what that care entails (hence, the need for written policies and procedures), particularly with respect to the individual needs of each resident (hence, the need for individualized care plan instructions); ii) trains them to provide that level of care; and iii) monitors them to assure that they have, in fact, provided that appropriate treatment and care." The ALJ upheld the deficiencies relating to the facility's practices and frequency for changing G-tubes and providing oxygen, found they posed immediate jeopardy to resident health and safety, and concluded that the shortcomings were directly attributable to the facility's administration, including its governing body, administrator, and medical director. CMS imposed civil money penalties (CMPs) of $5,650 per day for six days of immediate jeopardy and $150 per day for 40 days of substantial noncompliance that was not immediate jeopardy.

Substantial Compliance; Notice of Medicare Non-Coverage; No Potential for More than Minimal Harm. In *Winterhaven Healthcare Ctr. v. CMS*, CR 3978 (Jun. 22, 2015) (Sickendick, ALJ), the ALJ held that although a Texas SNF "effectively conceded" a violation of Tag F156, 42 C.F.R. § 483.10(b)(1) and (6), "the regulatory violation did not constitute noncompliance because it did not have the potential to cause more than minimal harm." The regulation at issue requires the facility to give notice to the resident in terms the resident can understand, or to the resident's representative, of the resident's rights, including among others notice of the services available in the facility and the charges for those services. CMS alleged that the SNF had three cognitively impaired residents sign a "notice of Medicare non-coverage," which they could not understand, and there was no evidence that the facility gave the notice to the responsible parties. While the ALJ found this was "a regulatory violation," it is only when the facility is not in "substantial compliance" that a remedy is warranted. Here, the regulations prohibit a facility from charging the resident for any item or service for which it has not advised the resident or representative that there will be a charge and the amount of the charge. Tag F162, 42 C.F.R. § 483.10(c)(8). If the facility fails to inform residents in advance that Medicare will not covered a service, it cannot charge the resident or representative for the non-covered item or service. Consequently, the failure to give a valid notice of termination of Medicare coverage has no negative financial impact upon a resident, only upon the facility, which becomes liable for the costs of continued care and services. As the facility was in substantial compliance, notwithstanding the deficiency, there was no basis for the imposition of any enforcement remedy.

Substantial Compliance; Accidents/Assistive Devices (Partial Bedrails); CMP Reversed. In *Pigeon Forge Care & Rehab Ctr. v. CMS*, CR 3909 (May 28, 2015) (Anderson, ALJ), CMS imposed upon a Tennessee SNF CMPs totaling $378,950 based upon alleged violations under Tag F157, 42 C.F.R. § 483.10(b)(11) (Physician Notification) (D Level); Fag F272, 42 C.F.R. § 483.20(b)(1) (Comprehensive Assessments) (J); Tag F323, 42 C.F.R. § 483.25(h) (J); Tag F490, 42 C.F.R. § 483.75 (Administration) (J); and Tag F520, 42 C.F.R. § 483.75(o)(1) (Quality Assurance) (J). The ALJ concluded that the SNF was in substantial compliance with participation requirements. For resident 2, after finding the resident on the edge of her bed with her flaccid left hand through an open area in the bed's partial bed rail, the facility staff: assisted resident 2 back

into her bed, determined she was unharmed; assessed and concluded that it was still appropriate and necessary for her to have partial bed rails on her bed; and immediately implemented additional interventions, including additional physical therapy related to the use of the bed rails, adding a bed pressure alarm, ensuring safety mats were on the floor by the bed, moving the bed to a lower position, and placing bed controls out of resident 2's reach. For resident 1, after finding the resident sitting on the floor in front of her wheelchair with the wheelchair's releasable seat belt around her chest, the facility staff: assisted resident 1 into her bed and determined she was unharmed; concluded that the resident slipped from the wheelchair when she tried to remove a blanket from underneath her; informed the resident's physician of the incident the next morning; assessed and concluded that resident 1 should not have a seat belt on her wheelchair any longer and that she needed a new cushion in the wheelchair; removed the seat belt from the wheelchair and added a new cushion to the wheelchair; and, at resident 1's request, added a new releasable seat belt to the wheelchair after resident 1 and her family protested the removal of the seat belt. The ALJ found that these actions were sufficient to meet the regulatory requirements relating to monitoring, supervision and assistive devices to prevent accidents under 42 C.F.R. § 483.25(h); assessing the safety of devices that residents required for mobility and positioning under 42 C.F.R. § 483.20(b)(1); maintaining an effective quality assessment and quality assurance committee under 42 C.F.R. § 483.75(o); administering the facility effectively under 42 C.F.R. § 483.75; and timely notifying resident 1's physician of a change in the resident's condition under 42 C.F.R. § 483.10(b)(11).

Life Safety Code. In *Crestview Health & Rehab. v. CMS*, CR 3886 (May 21, 2015) (Hughes, ALJ), the ALJ concluded that a Tennessee SNF was ***not*** in substantial compliance with two provisions of the Life Safety Code of the National Fire Protection Association (NFPA), at the immediate jeopardy level, and with seven other Life Safety Code provisions at the non-immediate jeopardy level, and that the imposition of a per-instance CMP in the amount of $8,000 was reasonable. The requirements at issue were related to corridor doors (K018, LSC § 19.3.6.3); smoke barriers (K025, LSC § 19.3.7), means of egress requirements (K038, LSC §§ 7.1 & 19.2.1); fire drills (K050, LSC § 19.7.1.2); fire extinguishers (K064, LSC § § 9.7.4.1 & 19.3.5.6); heating, ventilating, and air conditioning (K067, LSC §§ 9.2 & 19.5.2); smoke/fire barriers and penetrations and openings in those barriers (K130, LSC §§ 8.2.3.2.4.2 & 8.3.4.1); electrical wiring and equipment (K147, LSC § 9.1.2); and alcohol-based hand-rub solutions (K211, LSC §§ 8.4.3 and 19.3.2.7). In addition, the ALJ concluded that there was no authority to review the immediate jeopardy determinations because a successful appeal would not affect the range of a per-instance CMP or have any effect on the loss of approval of a nurse aide training program.

Abuse and Accident Prevention. *Lifehouse of Riverside Healthcare Ctr. v. CMS*, CR 3845 (May 8, 2015) (Kessel, ALJ), involved two surveys. In the first survey, CMS alleged substantial noncompliance with 42 C.F.R. §§ 483.13(b) and 483.13 (c)(1)(i), which grants residents the right to be free from abuse and prohibits a facility's staff from using mental, sexual, or physical abuse or corporal punishment. CMS alleged that a nursing assistant verbally and physically abused a resident by telling her to relieve herself in her incontinence brief; by pulling her out of her bed using her left arm, which caused her to cry out in pain; and by grabbing her arm and pulling it downward when returning the resident to bed, again causing pain. The facility countered that the resident's allegations were not credible, but the ALJ disagreed, because: i) the resident consistently reported the same story; ii) her roommate, a former nursing assistant, corroborated it; and iii) physical evidence consisting of bruises were consistent with the allegations. Accordingly, the ALJ upheld the imposition of a $2,500 per-instance CMP.

In the second survey, CMS alleged substantial noncompliance with 42 C.F.R. § 483.25(h), which requires a facility to maintain a resident environment that is as free of accident hazards as possible and to provide adequate supervision and assistance devices to prevent accidents. The facility had assigned a resident, at high risk for falls, to a bed that could be lowered to within six inches of the floor. When a CNA raised the bed to waist level to provide care, then briefly left her unattended, the resident fell from the bed and sustained facial fractures. The ALJ rejected the facility's argument that the CNA's actions did not constitute noncompliance because it was necessary to lower the bed to provide the resident care. If so, the ALJ reasoned, then staff should not have walked out of the room and left the resident unattended in a raised bed. The ALJ upheld a $850 per day CMP for a period of approximately two weeks, a duration the facility did not challenge.

Life Safety Code. In *Royal Care of Avon Park v. CMS*, CR 3835 (May 6, 2015) (Grow, ALJ), the ALJ upheld CMS's allegation that a Florida SNF was not in substantial compliance with the NFPA Life Safety Code, 42 C.F.R. § 483.70, after it constructed a new 4' by 15' closet, allegedly without permits or regulatory approval. According to the SOD, a fire alarm strobe light, which should alert staff and residents to fire, was located in the closet where its staff and residents could not see it and that the closet did not have any fire suppression devices such as sprinkler heads. In addition, the facility was using power (surge protector) strips, rather than fixed wiring, to power medical equipment in the new therapy department. After the survey, CMS asserted that the closet lacked a door, which created an accident hazard for ambulatory, cognitively impaired residents, in violation of 42 C.F.R. § 483.25(h)(1). Although CMS did not assert an immediate jeopardy, the ALJ agreed with CMS that the facility was not in substantial compliance with the Life Safety Code requirements from December 6, 2013 through January 29, 2014, and that the $100 per day CMP, "which is only $50 more than the minimum," was reasonable. In view of the determination with respect to the Life Safety Code violations, the ALJ declined to address whether the petitioner was also noncompliant with 42 C.F.R. § 483.25(h)(1).

Resident to Resident Verbal and Mental Abuse and Facility Administration. In *Brookewood Nursing & Rehab. Ctr. v. CMS*, CR 3824 (Apr. 30, 2015) (Hughes, ALJ), the evidence established that a resident in an Arkansas skilled nursing facility swore at her roommates, ridiculed them, falsely accused them of stealing, forced them out of their room, would not allow them visitors, denied them access to the bathroom, and physically attacked one of them several times. The facility denied that the resident abused either of her roommates, characterizing their interactions as "daily disagreements" and "a roommate dispute." The ALJ disagreed and stated that these actions constituted abuse. The facility's practices were deficient, the ALJ held, because among other problems, staff were unaware of the facility's policies for preventing abuse. They did not recognize abuse (or chose to overlook it) and did not understand their obligations to investigate and report. The failures were attributable to administrative, as well as staff, failures, because the administration disregarded facility policies in failing to investigate thoroughly and report resident abuse, fell short in protecting other residents from the resident's abusive behavior and failed to maintain a list of residents with behavior issues, as the facility policies required. The ALJ further held that the penalty, consisting of $4,050 per day for the immediate jeopardy and $600 per day thereafter, was not unreasonable in light of the facility's "long and dismal history of substantial noncompliance," which included twelve surveys over seven years with significant deficiencies. The facility did not meet the standard for a reduction based on financial condition, which requires proof, by a preponderance of the evidence, that paying the CMP would render the facility insolvent or would compromise the health and safety of its residents. Additionally, the facility was culpable because the deficiencies involved the facility administrator and multiple staff members who repeatedly disregarded facility policies when they declined to investigate, report, and protect the residents. Accordingly, the ALJ upheld a total penalty of $269,550 for violations of Tags F223 (abuse and staff treatment of residents), F225 (investigate/report allegations of abuse),

F226 (policies to prohibit abuse and neglect) and F490 (administration), at level K (pattern of noncompliance that poses immediate jeopardy to resident health and safety).

No Appealable Remedy; Appeal Dismissed. In *NMS Healthcare of Hagerstown, LLC v. CMS*, CR 3825 (Apr. 30, 2015) (Kessel, ALJ), the ALJ dismissed a Maryland SNF's request for a hearing because CMS, after initially notifying the facility that it planned to impose a denial of payment for new admissions (DPNA), withdrew the proposed DPNA before it went into effect, and therefore there was nothing for the ALJ to decide. "Where, as here, CMS does not impose a remedy, rescinds all proposed remedies, or a remedy does not go into effect, a facility has no hearing right because no determination subject to a hearing exists. It is the final imposition of an enforcement remedy or sanction and not the citation of a deficiency that triggers a facility's right to a hearing." The facility argued that: i) the underlying alleged deficiencies were inappropriately cited, without merit and should be stricken; ii) CMS cannot "sua sponte, vitiate the right to a hearing simply by announcing that it has rescinded the penalty, but leave in place damaging allegations of noncompliance"; and iii) there are constitutional concerns if there is no right to a review of CMS's actions. The ALJ responded that he could not reach the first issue without a right to a hearing and that an ALJ cannot address constitutional issues. In support of the second argument, the facility cited two cases, *Grace Healthcare of Benton v. DHHS*, 603 F.3d 412 (8th Cir. 2009) and *Golden Living Center-Grand Island Lakeview v. Sebelius*, 2011 WL 6303243 (D. Neb. 2011). The ALJ did not find these authorities persuasive due to the lack of authority permitting the ALJ to hear and decide cases when all remedies imposed by CMS have been rescinded or never went into effect, and on the authority of the DAB in *NMS Healthcare of Hagerstown*, DAB No. 2603 (2014), in which "the board was unmoved by the decisions in *Graceland* or *Golden Living*."

Consultation with Physician upon Change in Condition. In *Lake County Nursing & Rehab. Ctr. v. CMS*, CR 3804 (Apr. 21, 2015) (Sickendick, ALJ), the ALJ concluded that an Indiana skilled nursing facility was not in substantial compliance with Tag F157, 42 C.F.R. § 483.10(b)(11), for one resident, because after discovering bleeding, at 10:45 p.m., from the site of a peripherally inserted central catheter (PICC) line, staff did not consult the resident's physician until the following morning. Even if, as the facility argued, the bleeding was not a change in condition, the need to stop the bleeding should have prompted the night nurse to consult immediately with a physician, rather than waiting several hours to convey the information to the day nurse. For a second resident, the staff delayed from July 12 to July 15 in consulting with the physician about the results of a laboratory test showing that the resident's anticoagulant result was low. Based on the fact that the physician was closely monitoring and starting or stopping the resident's anticoagulant, the low test results on July 12, 2013, reflected a significant change in condition that should have triggered an immediate consult with the physician. The ALJ also found that the facility violated Tag F329, 42 C.F.R. § 483.25(*l*) (which requires that each resident's drug regime is free of unnecessary drugs), because for one resident there was an order for PT/INR testing on the first Monday of each month, but the facility did not perform testing as ordered on the first Mondays of June and July 2013 to ensure that the resident was not receiving an unnecessary blood thinner.

The ALJ emphasized that the requirement to consult with the physician means more than simply notifying or leaving a message for the physician: "Consultation implies the requirement for a dialogue with and a responsive directive from the resident's physician as to what actions are needed" or to leave a message for the physician. In addition, the term "immediately" indicates that consultation is to be done as soon as the change is detected, without any intervening interval of time. It does not mean that the facility can wait hours or days before notification of the resident and his or her representative and consultation with the physician. Further, the facility cannot pick and choose whom to notify and whom

to consult, but the regulation instead requires it to immediately inform the resident, consult the physician, and notify the resident's legal representative or interested family member.

The case includes a thoughtful discussion of the "clearly erroneous" standard for reviewing CMS's immediate jeopardy determination. The ALJ, cautioning about the importance of "ensuring meaningful review rather than rubber-stamping agency decisions," referred to the Black's Law Dictionary definition of "clearly erroneous" as a standard of appellate review "under which a factual determination is upheld unless the appellate court has the firm conviction that an error was committed." Nevertheless, in this case, the ALJ did not have a firm conviction that the immediate jeopardy was erroneous and thus upheld the immediate jeopardy and the remedies imposed.

Access to Visitors: Involuntary Seclusion; Professional Standards. In *NMS Healthcare of Hagerstown v. CMS*, CR 3772 (Apr. 10, 2015) (Kessel, ALJ), the ALJ entered summary judgment in favor of CMS and against a Maryland skilled nursing facility, under: i) 42 C.F.R. § 483.10(j)(1)(vii), which requires a SNF to provide "immediate access" to members of the immediate family of any of its residents; ii) 42 C.F.R. § 483.13, which prohibits a skilled nursing facility from involuntarily secluding a resident; and iii) 42 C.F.R. § 483.20(k)(3)(i), which requires a SNF to provide care that meets professional standards of quality. CMS alleged, and the ALJ agreed, that the facility restricted visitation from an immediate family member (a daughter) and an attorney who sought to provide her with legal counsel based solely on the request of a daughter, who held a power of attorney. In addition, the facility placed the resident in a locked wing against her wishes, without making any determination as to whether confinement and visitor restrictions were clinically justified or whether seclusion and restrictions were the least restrictive and most reasonable means of protecting the resident. CMS's findings of immediate jeopardy were not clearly erroneous because regardless of whether the facility's actions harmed the resident, there was a very high likelihood that the facility's approach to confinement would harm residents. Those who are confined against their will or without medical reason may be too feeble to protect themselves, the ALJ reasoned. The result is that they suffer the psychological trauma that goes with imprisonment and the hopelessness that comes with the knowledge that there may be no way out. The ALJ also found no dispute as to the facility's compliance with two other regulations, 42 C.F. R. § 483.10(k), which states that a resident shall have the reasonable right to use a telephone where his or her calls cannot be overheard, and 42 C.F.R. § 483.75(l)(1), which requires a facility to maintain complete and accurate clinical records, among other things, which justified the imposition of daily CMPs at the non-immediate jeopardy level until the facility achieved substantial compliance.