Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Franklin Care Center,	)	Date: October 2, 2007
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-03-275
	)	Decision No. CR1667
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

For the reasons set forth below, I find that Franklin Care Center (Petitioner), was not in substantial compliance with program requirements during the period from October 23, through October 24, 2002. I further find that the facility's deficiency posed immediate jeopardy to resident health and safety. I therefore, affirm the imposition of a per-day civil money penalty (CMP) of $3,100 against Petitioner by the Centers for Medicare and Medicaid Services (CMS).

I. Background

Petitioner is a skilled nursing facility located in Franklin Park, New Jersey, and is licensed to participate in the Medicare program. Its participation in that program is governed by sections 1866 and 1819 of the Social Security Act and by implementing regulations at 42 C.F.R. Parts 483 and 488.

On August 21, 2002, Petitioner was surveyed by the New Jersey Department of Health and Senior Services (NJDOHSS) for compliance with Medicare participation requirements. On October 24, 2002, NJDOHSS conduced a revisit survey in connection with the annual survey of August 21, 2002. The surveyors found several distinct failures by Petitioner to comply with participation requirements including one deficiency at the immediate jeopardy level. By letter dated December 6, 2002, CMS notified Petitioner that it concurred with the surveyors' findings and that it had determined to impose certain remedies against Petitioner.

Petitioner timely requested a hearing and the case was assigned to me for a hearing and a decision. I convened an in-person hearing in Newark, New Jersey. Mr. Joseph Gorrell appeared on behalf of Petitioner, and Mr. David Rawson appeared on behalf of CMS. Each party submitted post-hearing briefs. CMS also filed a post-hearing reply brief. CMS filed 20 exhibits which it designated as CMS Ex. 1 - CMS Ex. 20. Petitioner filed 12 exhibits which it designated as P. Ex. 1 - P. Ex. 12. Neither party objected to the opposing party's exhibits. I receive the exhibits filed by both parties into evidence. At hearing, CMS presented the testimony of Kathleen Myatt, NJDOHSS Surveyor. Petitioner presented the testimony of Kathryn Maguire, Director of Social Services, and Richard Pinella, Vice President of Franklin Care Center.

II. Applicable Law

The Social Security Act (Act) sets forth requirements for skilled nursing facility participation in the Medicare and Medicaid programs, and authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations implementing the statutory provisions. Act, sections 1819 and 1919. The Secretary's regulations governing skilled nursing facility participation in the Medicare program are found at 42 C.F.R. Part 483.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance with program participation requirements. Act, section 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months, and more often, if necessary, to ensure that identified deficiencies are corrected. Act, section 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a), 488.308. The state survey agency makes a recommendation to CMS as to whether the facility has met participation requirements. CMS reviews the survey findings and provides the facility with notice of its findings and remedies of noncompliance. 42 C.F.R. § 488.402.

To participate in the Medicare program, a skilled nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may "pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. Immediate jeopardy is defined as a situation in which the provider's noncompliance with one or more participation requirements has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. 42 C.F.R. § 488.301.

Where CMS determines that a facility is not in substantial compliance with participation requirements, it may impose a civil money penalty. In instances of immediate jeopardy, CMS may impose a CMP of $3,050 to $10,000 per day. 42 C.F.R. § 488.438.

III. Issues

On December 6, 2002, CMS notified Petitioner of its determination, based on the August 21, and October 24, 2002 surveys, to impose a CMP in the amount of $100 for a period running from August, 21, 2002 through October 22, 2002; and a $3,100 CMP for one day of immediate jeopardy on October 23, 2002. Petitioner was cited with a Level "J" deficiency (immediate jeopardy) for noncompliance with participation requirements at 42 C.F.R. § 483.25(h)(2). Petitioner did not challenge the $100 CMP running from August 21, 2002 through October 22, 2002. However, Petitioner does challenge the immediate jeopardy level deficiency.

Therefore, in this decision I only address whether:

> A. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h)(2); and
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> B. A per-day civil money penalty of $3,100 for noncompliance is reasonable.

IV. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below as a separate heading. I discuss each Finding in detail.

A. Petitioner violated 42 C.F.R. § 483.25(h)(2) and there is a basis for imposing a CMP.

I consider first whether the incidents alleged by CMS establish that the facility was not in substantial compliance with the regulations at 42 C.F.R. § 483.25(h)(2). Under the statute and the "quality of care" regulation, a facility must ensure that "[e]ach resident receives adequate supervision and assistance devices to prevent accidents." 42 C.F.R. § 483.25(h)(2). The Board has explained the requirements of 42 C.F.R. § 483.25(h)(2) in numerous decisions. *Golden Age Skilled Nursing & Rehabilitation Center*, DAB No. 2026 (2006); *Estes Nursing Facility Civic Center*, DAB No. 2000 (2005); *Northeastern Ohio Alzheimer's Research Center*, DAB No. 1935 (2004); *Woodstock Care Center*, DAB No. 1726, at 28 (2000), *aff'd*, *Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). Section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, but it does require that a facility take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents. *Woodstock Care Center v. Thompson*, 363 F.3d at 590 (a SNF must take "all reasonable precautions against residents' accidents"). A facility is permitted the flexibility to choose the methods of supervision it uses to prevent accidents, but the chosen methods must be adequate under the circumstances. *Id*.

Whether supervision is "adequate" depends in part upon the resident's ability to protect himself or herself from harm. *Id*. Based on the regulation and the cases in this area, CMS meets its burden to show a *prima facie* case if the evidence demonstrates that the facility failed to provide adequate supervision and assistance devices to prevent accidents, given what was reasonably foreseeable. *Alden Town Manor Rehabilitation & HCC*, DAB No. 2054 (2006), at 5-6, 7-12. An "accident" is "an unexpected, unintended event that can cause a resident bodily injury," excluding "adverse outcomes associated as a direct consequence of treatment or care (e.g., drug side effects or reactions)." State Operations Manual (SOM), App. P, page PP-105, Guidance to Surveyors for Long Term Care Facilities, Part 2, F324, Quality of Care (Rev. 274, June 1995), *Woodstock Care Center*, DAB No. 1726, at 4 (2000).

Resident 1 (R1) is a 68 year old female with a diagnosis of, among other things, dementia, depression, and schizo affective disorder. P. Ex. 4, at 3. The records at the facility also documented that she suffered from memory loss, and manifested periods of hallucinations which included hearing voices. Transcript (Tr.) 37-38, 45, 97,110, 118; CMS Ex. 19, at 7, 10. Based on observation, interview and record review, CMS determined that

Petitioner failed to provide adequate supervision to R1, who refused to comply with the facilities policy for smoking in designated areas. CMS Ex. 9, at 1; P. Ex 1, at 2. There are several documented instances where R1 was found or observed smoking in non-designated areas. CMS Ex. 19. In fact, during the October 24, 2002 survey, the unit manager told the surveyor that they "cannot get this resident to stop smoking in her room" CMS Ex. 9, at 2.

A review of R1's medical records revealed the following:

> August 28, 2002 - "Resident was found smoking in the Franklin Hall sunroom, when spoken to, the resident refused to be reasoned and became loud and agitated."
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> October 3, 2002 - "Resident was found in the bathroom, five cigarettes in the sink and the room full of smoke."
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> October 9, 2002 - "Resident was found sitting on the toilet in room smoking cigarette. One cigarette which resident smoked earlier was found in the sink."
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> October 11, 2002 - "Resident reported to be sitting in her bathroom smoking a cigarette, refusing to stop or listen to nurse. The Director of Nursing took resident outside under the canopy in front of building for a cigarette . . . ."
>
> October 17, 2002 - "Resident was observed smoking in room 8A with oxygen concentrator going in 8B. Resident refused to stop smoking or put cigarette out . . . ."

CMS Ex. 9, at 2; CMS Ex. 19, at 1.

The records indicate that R1 was able to obtain cigarettes, a lighter or matches, and continued to smoke in her room and other non-designated areas. Tr. at 66.

During an interview, the unit manager told Kathleen Myatt, the state surveyor, that these incidents were only documented in the resident's medical records. CMS Ex. 9, at 3. This interview supports the surveyor's testimony that no incident reports were produced, nor were investigations initiated to determine how the resident was obtaining a lighter or matches. *Id*.

However, at hearing, Petitioner countered this evidence with the testimony of its employee, Kathryn Maguire, Director of Social Work. Ms. Maguire testified that she, in fact, performed her own informal investigation, but did not document her findings or report her investigations or findings to the facility administrator. I do not find her testimony to be credible.

Petitioner's smoking policy indicated that all matches or lighters are to be kept at the nurses station – under no circumstances are these devices to be stored on a resident's person or in their room.

> It is the policy of the facility to allow smoking in designated areas by Residents and Visitors. No smoking implements or ignitable materials will be retained by the residents. Supervision of smoking will be the responsibility of the Nursing Staff. Employees are not permitted to smoke on the Nursing Units at any time.
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> ****
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> All heat producing devices, e.g., matches or lighters, are to be kept at the nurses' station. Under no circumstances is a resident permitted to keep these devices stored on their person or stored in their room.
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> ****
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> Smoking or open flames in any area containing oxygen, flammable liquid, commutable gases in use or storage is prohibited.

CMS Ex. 20, Facility's "Smoke- Free Policy."

In addition, according to the Life Safety Code Guidelines published by the National Fire Protection Association, smoking materials must be removed from the area where respiratory therapy is administered. See Chapter 8, Section 6-2.1.1, National Fire Protection Association 99, Health Care Facilities. *See* CMS Brief, Attachment 2.

Contrary to the facility's smoking policy, the assistant administrator indicated that alert and oriented residents were allowed to carry their own cigarettes and lighter. CMS Ex. 9, at 4. Ms. Maguire also testified that the written smoking policy was not followed, and those residents deemed able, were allowed to maintain their own cigarettes and lighting devices.

Petitioner also argues that it knew of R1's smoking habits and constantly worked with her. For example, R1's care plan identified that the resident smokes cigarettes and included interventions to keep cigarettes and matches at the nurses station. CMS Ex. 9, at 3. However, there is no evidence that Petitioner revised R1's care plan to deal with her smoking in prohibited areas and continued possession of cigarettes, matches and a lighter. Whatever action Petitioner was taking to address R1's smoking problem was not working.

Under the written policy, no resident was allowed to keep cigarettes, lighters, or matches in his room or on his person. But, in practice, Petitioner did not comply with its own policy. Petitioner allowed some residents who smoked to keep cigarettes and lighters with them. Although Petitioner did not follow its own smoking policy, I find particularly egregious the fact that the R1 was found smoking in the same room with an oxygen concentrator. Petitioner argues that the oxygen concentrator situation was not immediate jeopardy because R1 was smoking in the bathroom with the door closed. This is not persuasive because the only evidence before me is Petitioner's assertion that the bathroom door was closed. There are no documented entries in the medical record that supports this position.

Petitioner also claims that smoking near an oxygen concentrator does not create an immediate jeopardy situation, because the oxygen concentrator by itself does not create a fire hazard. However, Petitioner did not present an expert in respiratory treatment or an expert dealing with fire hazards to prove this point. Instead, Petitioner had its Vice President Richard Pinellas testify to the safety of an oxygen concentrator. "First, an oxygen concentrator takes ambient air, which is composed of mostly nitrogen and some oxygen, and separates out the nitrogen and other parts of the air and gives a higher concentration of oxygen, which is delivered directly to the resident." Tr. at 129; *see also* Tr. at 107, 130, 133. However, in response to a question I asked him, he admitted that it is a fire hazard to have a flame near an oxygen concentrator. Tr. at 130-134.

R1 was a very heavy smoker. She was able to obtain cigarettes and a lighter or matches at will. She smoked almost constantly and the staff could not control her smoking. Because of her deteriorating mental condition, she should have been considered an "unsafe smoker" who required supervision at all times when smoking. She had been diagnosed with dementia and schizoaffective disorder and was noted to suffer from memory loss and manifestations and periods of hallucinations and hearing voices. Based on the evidence submitted, I believe that R1 was a danger to herself and to others at the facility because she was able to secure a lighter or matches to light her cigarettes.

Petitioner admitted that it did not know how R1 was able to obtain a lighter or matches. Morever, Petitioner failed to revise the care plan to manage R1 smoking in non-designated areas. CMS has sustained it burden of proving a prima facie case in this matter. Petitioner has not met its burden of proving, by a preponderance of the evidence, that is was in substantial compliance; nor has it proven that the immediate jeopardy deficiency is clearly erroneous. Thus, I agree that there was an immediate jeopardy risk to R1 and the other residents of the facility.

B. A per-day civil money penalty of $3,100 is reasonable.

In determining whether the amount of the CMP is reasonable, the following factors specified at 42 C.F.R. § 488.438 (f) must be considered: (1) the facility's history of non-compliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as set forth at 42 C.F.R.§ 404; and (4) the facility's degree of culpability. The CMP amount in this case is at the low-end of the applicable range. Petitioner has not argued or submitted any evidence that it is unable to pay the CMP. CMS has offered no evidence of past noncompliance for me to consider.

In this case, CMS imposed a per day civil money penalty in the amount of $3,100 to remedy the immediate jeopardy. Petitioner argues that the CMP in the amount of $3,100 is unsubstantiated because the immediate jeopardy lasted only 45 minutes. Therefore, Petitioner argues, it should not constitute a per day penalty. Regulations provide that CMS may impose either per-diem or per-instance civil money penalties to remedy a nursing facility's deficiencies. 42 C.F.R. § 488.438(a)(1), (2). Penalties in the range of $3,050 to $10,000 per day are imposed for deficiencies constituting immediate jeopardy. 42 C.F.R. § 488.438. The deficiency proven by CMS in this case is serious and fully supports the proposed CMP for the immediate jeopardy citation. Furthermore, the immediate jeopardy is not removed until a plan of correction is implemented. The plan of correction Petitioner provided indicated that 30 minute monitoring would take place, but it was not effectuated and documented until the next day. Based on the evidence before me, I find that the per-day CMP of $3,100 is supported by the evidence in this case and is reasonable.

V. Conclusion

Based on my review of all of the evidence before me, I find that CMS has established that Petitioner was not in substantial compliance with federal participation requirements from October 23, through October 24, 2002. I also find, that during that period, the facility's deficiencies posed immediate jeopardy to resident health and safety. Thus, I sustain CMS's imposition of a CMP in the amount of $3,100 per day for the period of immediate jeopardy. I further find that the amount of the CMP imposed is reasonable.

/s/
Alfonso J. Montano
Administrative Law Judge