Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Taos Living Center,
(CCN: 32-5101),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-12-8

Decision No. CR2867

Date: July 23, 2013

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) that Taos Living Center (Petitioner or the facility) was not in substantial compliance with Medicare program participation requirements. I also sustain as reasonable CMS's imposition of two per instance civil money penalties (PICMPs), one in the amount of $4,500 and one in the amount of $5,000, and CMS's imposition of denial of payment for new admissions (DPNA) for the period of June 3 through June 9, 2011.

I. Background

The Social Security Act (Act) sets forth long-term care facility requirements for participation in the Medicare and Medicaid programs and authorizes the Secretary of the U.S. Department of Health and Human Services (Secretary) to promulgate regulations implementing those statutory provisions. Act §§ 1819 (42 U.S.C.§ 1395i-3), 1919 (42 U.S.C. § 1396r); *see* 42 C.F.R. Part 483 (implementing regulations). 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 and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a) (42 U.S.C. § 1395aa); 42 C.F.R. § 488.20. A facility must be surveyed once every twelve months, and more often if necessary, to ensure the correction of deficiencies. Act § 1819(g)(2)(A) (42 U.S.C. § 1395i-3); 42 C.F.R. §§ 488.20(a), 488.308.

Petitioner is a long-term care facility located in Taos, New Mexico. Its appeal involves two surveys conducted by the New Mexico Department of Health, Health Facility Licensing and Certification Bureau (the state agency). After the first survey, ending April 7, 2011, the state agency found four deficiencies, three of which were at a scope and severity level of "J," indicating an isolated incidence of immediate jeopardy. The state agency then performed a revisit/complaint survey, which ended June 1, 2011.[1] The state agency found continued noncompliance (three deficiencies) two of which were at the immediate jeopardy level. On September 8, 2011, CMS notified Petitioner that it had achieved substantial compliance as of June 10, 2011. In addition, CMS notified Petitioner that it was revising the previously imposed remedies and only the following remedies were being imposed: a PICMP of $4,500 for the April survey with respect to Tag F323 (accident prevention and adequate supervision) – 42 C.F.R. § 483.25(h); a PICMP of $5,000 for the June survey with respect to Tag F314 (prevention of pressure sores) – 42 C.F.R. § 483.25(c); and a DPNA for the period of June 3 through June 9, 2011.[2] CMS Br. at 2-3.

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[1] Petitioner's hearing request with respect to the April survey was consolidated with its hearing request for the June survey by my Acknowledgment and Consolidation Order dated October 4, 2011.

[2] I will not review CMS's immediate jeopardy scope and severity finding here. An Administrative Law Judge may review CMS's scope and severity findings (which include a finding of immediate jeopardy) only if: (1) a successful challenge would affect the range of the CMP; or (2) CMS has made a finding of substandard quality of care that results in the loss of approval of a facility's nurse aide training program. Here the penalties imposed are PICMPs for which the regulations provide only one range ($1,000 to $10,000) so the level of noncompliance does not affect the range of the CMP. 42 C.F.R. § 488.438(a)(2). Additionally, CMS's scope and severity finding does not affect approval of a nurse aide training program because the facility has been assessed a CMP of $5,000 or more which precludes state agency approval of a nurse aide training program. Act § 1819(f)(2)(B) (42 U.S.C. § 1395i-3); 42 C.F.R. § 483.151(b)(2)(iv).

Petitioner timely requested a hearing, and the case was assigned to me for hearing and decision. I convened a prehearing conference with the parties on February 1, 2012. In that conference I articulated the issues that I would be deciding, I admitted to the record without objection CMS exhibits (Exs.) 1-17 and Petitioner's exhibits (P. Exs.) 1-3, and the parties indicated which witnesses they wished to cross-examine at a video hearing.

I convened a video hearing on May 30, 2012, for the purpose of cross examination and redirect examination of CMS's two witnesses. I also admitted into the record without objection an article entitled, "Dysphagia Management: Using Thickened Liquids," as P. Ex. 4. The parties filed pre-hearing briefs (CMS PH Br. and P. PH Br.), post-hearing briefs (CMS Br. and P. Br.), and post-hearing reply briefs (CMS Reply and P. Reply).

II. Analysis

A. Issues

The issues are whether Petitioner failed to comply substantially with the requirements of:

1. 42 C.F.R. § 483.25(h) (Tag F323) relating to accident prevention and adequate supervision involving Resident 10;

2. 42 C.F.R. § 483.25(c) (Tag F314) relating to the prevention of pressure sores as cited in the June survey; and

3. If I find Petitioner was not in substantial compliance, are the penalties CMS imposed reasonable: the $4,500 and $5,000 PICMPs and a DPNA for the period of June 3 through June 9, 2011.

B. Findings of Fact and Conclusions of Law

1. Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h) because it did not reasonably reduce the foreseeable risk of aspiration for Resident 10 when its staff did not provide him properly thickened liquids in accordance with his care plan.

Program Requirements. The introductory language in section 483.25 states: "Each resident must receive, and the facility must provide, the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care."

Subsection (h) of 483.25 specifies:

> *Accidents*. The facility must ensure that –
>
> (1) The resident environment remains as free of accident hazards as is possible; and
>
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

The Board has held that subsection 483.25(h)(1) requires that a facility address foreseeable risks of harm from accidents "by identifying and removing hazards, where possible, or where the hazard is unavoidable because of other resident needs, managing the hazard by reducing the risk of accident to the extent possible." *Maine Veterans' Home - Scarborough*, DAB No. 1975, at 10 (2005) (explaining the inherent standard of care in section 483.25(h)(1)). With regard to subsection 483.25(h)(2), the Board requires 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." *Briarwood Nursing Ctr.*, DAB No. 2115, at 11 (2007), (citing *Woodstock Care Ctr.*, DAB No. 1726 (2000) (facility must take "all reasonable precautions against residents' accidents"), *aff'd*, *Woodstock Care Ctr. v. Thompson*, 363 F.3d 583, 589 (6th Cir. 2003)). Further, the Board has also held that accident precautions contained in a resident's plan of care represent a facility's judgment about what measures are necessary to keep the resident safe, and failure to implement such precautions supports a conclusion that a facility did not meet its obligation under section 483.25(h)(2) to provide adequate supervision. *St. Catherine's Care Ctr. of Findlay, Inc.*, DAB No. 1964, at 13 n.9 (2005); *Cedar Lake Nursing Home*, DAB No. 2288, at 6-11 (2009), *aff'd*, *Cedar Lake Nursing Home* v. *U.S. Dep't of Health & Human Servs.*, 619 F.3d 453 (5th Cir. 2010).

Here, Resident 10 was diagnosed with Parkinson's disease and suffered from dysphagia, *i.e.*, swallowing difficulties. CMS Ex. 2 at 3, 4, 7, and 13. He also had a history of aspiration pneumonia. CMS Ex. 16 at 7; CMS Ex. 1 at 9. Resident 10's plan of care indicated he was at risk for aspirating, and he was prescribed a diet with mechanically, soft textured foods and *nectar thickened liquids*, including thickened water. CMS Ex. 3 at 5; CMS Ex. 2 at 2, 3, 4, 7, and 8. I am aware of no evidence that allowed for a reduction of the thickness of Resident 10's liquids to accommodate Resident 10's taste preferences.

A nurse surveyor observed two instances on March 28, 2011, when Petitioner's staff gave Resident 10 what she believed were improperly thickened liquids.

First, the Statement of Deficiencies (SOD) reported the surveyor observed, at 12:45 p.m., a certified nursing assistant (CNA 2) preparing and serving Resident 10 drinking water that the surveyor determined was not properly thickened. CMS Ex. 1 at 4. The SOD reported that the surveyor observed Resident 10 cough during his meal. CMS Ex. 1 at 4. The SOD reported the CNA admitted to the surveyor she did not properly follow the directions provided with the resident's thickening agent and that she prepared it less thick, with one and a half scoops, because Resident 10 liked it that way. CMS Ex. 1 at 4. The SOD reported that the duty nurse (RN1) confirmed that CNA 2 used a twelve-ounce cup and that two large scoops should be used because the cup was not completely full. The SOD also reported the Speech Therapist stated that two large scoops were needed to obtain nectar consistency. CMS Ex. 1 at 8-9.

Then, at 5:05 pm, the state surveyor observed another CNA (CNA 3) providing Resident 10 with coffee that she determined had not been properly thickened. CMS Ex. 1 at 4-5, 9; CMS Ex. 2 at 4. The SOD reports that when the surveyor questioned the Speech Therapist, the Speech Therapist confirmed that the coffee was not a nectar-like thickness and was too thin. CMS Ex. 1 at 9, P. Reply at 3.

CMS has the "burden of coming forward with evidence related to disputed findings that is sufficient (together with any undisputed findings and relevant legal authority) to establish a prima facie case of noncompliance with a regulatory requirement." *Evergreene Nursing Care Ctr.*, DAB No. 2069, at 7 (2007); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, *Batavia Nursing& Convalescent Ctr. v. Thompson*, 129 F. App'x 181 (6th Cir. 2005). CMS relies on the SOD to make its prima facie case of a deficiency here. *See Guardian Health Care Ctr.*, DAB No. 1943, at 15 (2004) (holding that a prima facie showing of noncompliance may be based on the SOD, if the factual findings and allegations it contains are specific, undisputed, and not inherently unreliable).

Petitioner did not dispute the specific and reliable facts that surveyors reported in the SOD, so CMS met its burden to present a prima facie case that Petitioner failed to provide Resident 10 with requirements from his care plan to help prevent risk of aspiration from liquids. Petitioner, therefore, bears the burden of persuasion – namely, to demonstrate by a preponderance of the evidence that the facility was in fact in substantial compliance with section 483.25(h)(2). *Evergreene*, DAB No. 2069, at 7.

Petitioner argues that the nurse surveyor concluded the observed liquids were not nectar consistency without considering how big the cup was, how much time had expired since the mixing, or the temperature of the liquids. P. PH. Br. at 4. However, Petitioner has not provided any evidence showing staff raised these concerns with the nurse surveyor at the time of the cited deficiency. Instead, the uncontroverted evidence shows CNA 2

explained to the nurse surveyor that she did not follow the thickening directions and prepared the water less thick because Resident 10 liked it that way, even though I saw no evidence that Resident 10's assessments or plans included any provision for liquids at less than a nectar thick consistency. Also it is uncontroverted that the facility's speech therapist opined that the coffee CNA 3 prepared for Resident 10 was "too thin." To now argue that the liquids *may* have been of the required consistency due to the factors of cup size, passage of time, or temperature is a post hoc rationalization, which I do not find persuasive. Petitioner's cross-examination of the surveyors did not discredit the SOD reports. Further, Petitioner did not come forward with its own witness testimony to help prove other viscosity factors caused the staff to stray from the thickener directions for Resident 10's drinks on March 28, 2011. Therefore I do not find that Petitioner met its burden of persuasion.

The testimony of CMS's expert witness and federal nurse surveyor not only helps show that the deficiency had the requisite potential for more than minimal harm, but it also had the potential for serious harm. She credibly testified about the importance of thickened liquids for patients with dysphagia or swallowing difficulties because these patients may choke or cough on normal, thin liquids. CMS Br. at 5 n.4; CMS Ex. 16; Tr. 14-16. Generally, with swallowing difficulties, muscles may not react fast enough to swallow properly and some of the liquid may go into residents' airways leading to the lungs. CMS Ex. 16 at 7; CMS Br. at 5 n.4. The introduction of fluid into the lungs in this manner could cause aspiration pneumonia in addition to airway obstruction, inflammation of the lung, acute respiratory distress syndrome, bronchitis, interstitial pneumonitis, bronchiectasis, fibrosis, and asthma-like symptoms. *Id.* She indicated that the viscosity of a liquid therefore is very important because a patient with dysphagia can choke on thinner liquids. Tr. 14. She also credibly testified that the thickeners used for this purpose have very specific instructions stating the manufacturer-recommended amounts to use, the amount of time to stir, and what the consistency of the thickened liquid should be on observation before it is given to the patient. Tr. 15.

The federal nurse surveyor further testified that if a resident requests a thinner consistency of liquid than what the physician ordered, it is the responsibility of the facility to contact the physician and notify the physician of the resident's request for a thinner consistency liquid and for the physician to determine, with the resident, if a thinner liquid is appropriate. Tr. 15. There is no indication from the record that

Petitioner did this; instead, the record indicates CNA 2 adjusted the viscosity without consultation with the Speech Therapist, the RN, or the resident's physician. CMS Br. at 12; CMS Ex. 1 at 5-10.

I find it was a foreseeable, and undisputed, risk that Resident 10 could easily aspirate, and Petitioner planned accordingly by requiring that Resident 10 only receive properly thickened beverages in his plan of care. I find the evidence shows that Petitioner's staff did not properly thicken the beverages it provided to Resident 10. Therefore it did not take all reasonable steps to prevent the risk of him aspirating, which justifies CMS's determination that Petitioner was not in substantial compliance with Medicare requirements to prevent accidents and provide adequate supervision.

Petitioner also argues that Resident 10 had been receiving thickened liquids since at least October 18, 2010, with no indication that he experienced any incidents of aspiration at the facility. P. PH. Br. at 5. Further, Petitioner argues that Resident 10 received total assistance and supervision from Petitioner's staff for all meals and beverages he consumed. *Id.* Although I may consider a facility's history of noncompliance when determining whether the penalty CMS imposed is reasonable, an absence of past aspiration incidents involving Resident 10 would not excuse the deficiency itself. Further, I do not find that a resident should have had to actually aspirate, even while supervised, before a deficiency may be upheld for improperly thickened liquids.

2. Petitioner was not in compliance with 42 C.F.R. § 483.25(c) relating to the prevention of pressure sores.

Program Requirements. The quality of care requirement specific to pressure sore prevention and treatment provides:

> Pressure sores. Based on the comprehensive assessment of a resident, the facility must ensure that - (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

42 C.F.R. § 483.25(c). The Board has well-established the application of this pressure sore regulation. Citing the Secretary's refusal to replace the word "ensure" with less demanding language, the Board has held that a facility "should go beyond merely what seems reasonable to, instead, always furnish what is necessary to prevent new sores unless clinically unavoidable, and to treat existing ones as needed." *Koester Pavilion,* DAB No. 1750, at 32 (2000) (citing 56 Fed. Reg. 48,826, at 48,850 (Sept. 26, 1991)); *see*

also Clermont Nursing & Convalescent Ctr., DAB No. 1923, at 9-10 (2004)(citing *Koester* and rejecting provider's argument that a "standard of necessity appears nowhere in the regulation"), *aff'd*, *Clermont Nursing & Convalescent Ctr. v. Leavitt*, 142 F. App'x 900 (6th Cir. 2005).

a. CMS established that Resident 1 developed pressure sores in Petitioner's facility from March 24, 2011 – April 19, 2011.

In *Koester Pavilion* and *Clermont*, the Board held that a prima facie case of noncompliance exists when the evidence establishes that a nursing home resident having no pressure sores on admission develops a pressure sore in the facility, and the burden then shifts to the facility to establish that the pressure sore was clinically unavoidable. *Koester Pavilion*, DAB No. 1750, at 34; *Clermont Nursing & Convalescent Ctr*., DAB No. 1923, at 9; *see also Woodland Vill. Nursing Ctr.*, DAB No. 2172, at 13 (2008) (finding evidence that resident developed a pressure sore while under a facility's care is enough to show a deficiency in the absence of clinical evidence from the facility proving such negative outcomes to have been clinically unavoidable), *aff'd*, *Woodland Vill. Nursing Ctr. v. U.S. Dep't of Health & Human Servs*., 239 F. App'x 80 (5th Cir. 2007).

Here, Resident 1, a developmentally-delayed 59 year-old male, was admitted to Taos Living on March 24, 2011, with diagnoses of recurrent cellulitis, a bacterial skin infection to the right leg, poorly controlled diabetes, chronic kidney disease, hypertension, morbid obesity, and anemia. It is undisputed that he had no documented pressure sores upon admittance. CMS Ex. 7 at 27; CMS Ex. 10 at 1-2,9, 6, 67.

Resident 1's skin roster for the period March 24-April 19, 2011, documented that CNA 1 charted new skin issues for this resident on March 27, April 11, April 16, and April 17, 2011. CMS Ex. 10 at 61-62. CNA 11 also documented a new skin concern on April 17, 2011. *Id.* Petitioner's wound care logs however do not indicate that Resident 1 ever received wound care. CMS Ex. 7 at 31; Tr. 23.

Approximately 26 days after his admission, Petitioner transferred Resident 1 to a hospital emergency room (ER) on April 19, 2011, for severe abdominal pain. Resident 1's skin condition upon admission to the hospital from Petitioner's facility was so disturbing that a hospital case manager and the hospital Wound Care Specialist had to speak with ER staff and calm them down because Resident 1 was in such poor shape. CMS Ex. 7 at 11; CMS Ex. 14, at 2, 4. The case manager consequently filed a report of neglect with the state agency. Tr. 28. The state agency then initiated a complaint survey of Petitioner on May 11, 2011. CMS Ex. 17 at 2.

Upon his ER admission, a hospital Physician Assistant documented 18 wounds including 12 pressure ulcers on Resident 1's body. CMS Ex. 7 at 29-30; CMS Ex. 11 at 76. That

same day, the Director of Day Medicine from wound care came down to the ER to consult and take measurements of the decubitis ulcers that the Physician Assistant, the paramedic, and the ER Nurse observed. CMS Ex. 7 at 30. The doctor then completed a multi-system evaluation of Resident 1, which documented decubiti ulcers, candiasis in the groin, acute renal failure, dehydration, hyperkalemiam, and leukocytosis. CMS Ex. 7 at 30; CMS Ex. 11.

The hospital's wound care report, dated April 20, 2011, noted Resident 1 presented to the ER with 18 wounds including bilateral necrotic heel ulcers, multiple buttock wounds, groin wounds, sacral ulcers, right elbow eschar, and "left posterior upper thigh X2." CMS Ex. 11 at 82. Pictures were taken of each wound with a wound measuring guide. CMS Ex. 11 at 77-81. The pictures of the sores on Resident 1's heels show deep wounds the circumference of baseballs with black tissue throughout. CMS Ex. 11 at 78. On April 26, 2011, the hospital had to transfer Resident 1 to another hospital for specialty wound care of multiple necrotic ulcers. CMS Ex. 11 at 95-101. The doctor at this facility reported to a surveyor that about a third of Resident 1's 18 wounds were necrotic, and, while Resident 1 might have picked at some wounds, his heels and toes were not new wounds and were clearly pressure sores. CMS Ex. 7 at 31-32. The left heel pressure sore measured 6.5 x 5.0 cm and was noted as 100 % necrotic; the right heel sore measured 4.5 x 4.0 cm and also was noted as 100% necrotic. CMS Ex. 7 at 32; CMS Ex. 11 at 78, 90 and 92.

b. Petitioner did not meet its burden to establish that Resident 1's multiple pressure sores were clinically unavoidable because it did not prove that it properly assessed, monitored, and treated his skin conditions.

A nursing home can overcome a prima facie case of noncompliance only by showing that it provided all the care and services needed to prevent pressure sores but that the pressure sores developed anyway because they were clinically unavoidable. *Koester Pavilion*, DAB No. 1750, at 34; *Clermont*, DAB No. 1923, at 9. Clinically unavoidable in this context means "not just unsurprising given the clinical condition of the resident, but incapable of prevention despite appropriate measures taken in light of the clinical risks." *Harmony Court*, DAB No. 1968, at 11 (2005), *aff'd*, *Harmony Court v. Leavitt*, 188 F. App'x 438 (6th Cir. 2006). A facility "cannot meet its burden of proof on the issue of whether a pressure sore is unavoidable merely by establishing that the resident's clinical condition heightens the risk that pressure sores will develop." *Id.* (quoting *Ivy Woods Health Care & Rehab. Ctr.*, DAB No. 1933, at 9 (2004), *aff'd*, *Ivy Woods Health Care & Rehab. Ctr. v. Thompson*, 156 F. App'x 775 (6th Cir. 2005)).

Here, Petitioner did not show it provided the requisite preventative care because it did not properly assess, monitor, and treat Resident 1's pressure sores. The scant and

inconsistent documentation showing what Petitioner did do to treat Resident 1's skin conditions falls far short of Petitioner's burden to prove Resident 1 developed pressure sores that were clinically unavoidable.

Early on, there are questions about the appropriateness of Petitioner's assessments. CMS's expert credibly opined that Resident 1 should have been initially assessed at high risk for pressure ulcers considering he was frequently incontinent of urine and feces, had impaired functional mobility, and poorly controlled Diabetes. CMS Ex. 16 at 8. Upon admission, however, Resident 1's Braden Scale skin assessment from the facility, dated March 24, 2011, indicated he was at low risk for pressure sores. CMS Ex. 10 at 4. Similarly, CMS's expert reports his Minimum Data Set assessment from the facility, dated April 2, 2011, indicated he was not at risk for pressure ulcers. CMS Ex. 16 at 8. However, his Interim Plan of Care indicates that as of March 26, 2011, Resident 1 was considered at risk for skin breakdown, and he should be repositioned while in bed. CMS Ex. 10 at 37. Also his Care Plan Conference Summary, dated April 6, 2011, stated that Resident 1 was at risk for pressure sore development. CMS Ex. 10 at 38. Regardless of the inconsistent assessments, the facility was required to perform skin checks on Resident 1 three times per day throughout his stay and document them on the facility's Skin Roster. CMS Ex. 10, p. 61; P. PH. Br. at 7.

Petitioner's clinical records show four "Nursing to Therapy Referral" forms for Resident 1 during the period of April 11 through April 18, 2011. CMS Ex. 10 at 45-48. Although the facility also indicated a skin issue for Resident 1 on March 27, 2011, I saw no corresponding "Nursing to Therapy Referral" form to document any care or monitoring of the issue. In her scant written declaration of direct testimony, and despite Petitioner's heavy burden of persuasion here, the Wound Care Specialist only mentions that she saw Resident 1 on April 18, 2011, after receiving two referral forms regarding his open areas to the inner and gluteal folds. P. Ex. 1. She states she inspected this area on him but did not discover any wound that appeared to be a pressure wound. *Id.* She concluded that the redness and irritation she observed was caused by excoriation and candidiasis. *Id.* Consequently, she did not provide Resident 1 with wound care. CMS Ex. 10 at 45-48; CMS. Ex. 4; CMS Ex. 7 at 31.

A note the Wound Care Specialist wrote on April 18, 2011 refers to a nursing therapy referral form for a red, soft area on Resident 1's right outer knee from his leg brace. The note states she inspected the area and because the brace is only worn when walking with "restorative rehab," she was unable to determine if the area is from the brace. The note says she will continue to monitor and make needed adjustments. She also indicates that the physician will be in to see Resident 1 the next day and she will have him look at the area "as well as the peri-area that has also been reported to have open areas that the calazime is not helping." CMS Ex. 10 at 25. She also entered another note at 2:59 p.m.

that same day indicating that she received two Nursing to Therapy Referral Forms regarding open areas to inner thigh and gluteal folds. She stated she "inspected the area when patient in bed and irritation is from brief." She suggests "switching to pull ups to see if this will make contact in a different area, encourage time in bed between meals as sitting all day in WC [wheelchair] encourages brief to bunch up in these areas. Dr. [W] to see patient tomorrow." CMS Ex. 10 at 25.

Despite the Wound Care Specialist's direct testimony only mentioning the time she saw Resident 1 on April 18, 2011, there is an interdisciplinary note dated April 12, 2011 that she drafted stating, "Nursing to Therapy Referral Form received 4/11/11 regarding patient having open areas to buttocks and left front leg. Checked resident to find excoriation to buttock and rubbing irritation to left inner thigh, recommend calazime ointment to all areas with brief change as well as a larger size brief as patient has a large abdominal panus and spends all of the day sitting in his wheelchair increasing friction to this area." CMS Ex. 10 at 28, 45.

Petitioner also submitted a declaration from one of its nurses, who documented, on the date of Resident 1's transfer to the hospital for abdominal pain, April 19, 2011, that Resident 1 had an open area on his groin and "excoriated bottom with calzamine ointment applied." CMS Ex. 10 at 25; P. Ex. 2. He also noted observing an open area on Resident 1's left heel that he treated with triple antibiotic cream and a telfa pad. P. Ex. 2. The nurse states that he does not recollect whether he checked the resident's right heel or whether there was a pressure wound on the right heel, but it was his usual practice to do so if he had discovered one on the other heel. P. Ex. 2.

Petitioner's wound care logs do not indicate that Resident 1 ever received wound care. CMS Ex. 7 at 31; Tr. 23. However, the lead surveyor credibly testified that she would have expected Resident 1's wounds to be documented on a wound log. Tr. 23. She stated that the standard of practice should have been for the Wound Care Specialist to view all areas of Resident 1's skin and to make specific notations as to an accurate assessment, which would include specific measurements of each wound—the length, the width, the depth of the wound— whether there is any drainage present, the color, whether there is any odor present which could indicate an infection, the location of each wound, and the type of wound. Tr. 23. She further testified that the wound log and clinical records should have specifically noted when the physician is notified and a request is made for treatment. The log should also note if the wound is improving after treatment for a specific period of time, and if not, whether the physician has again been contacted and a new treatment obtained. Tr. 23-24.

The lead surveyor also testified that the standard of practice is for all wounds whether they are a pressure ulcer, a deep-tissue injury, a stasis ulcer or a surgical wound, to be

included on the wound log and monitored. Tr. 24-25. The purpose of the wound log is to have ongoing monitoring and consistent measurement and assessment so as to determine if a wound is healing and progressing with treatment as prescribed and to have a method to determine whether the treatment prescribed for the wound is effective. Tr. 25. Typically, if staff finds a pressure ulcer, staff would indicate that on the wound log and stage the ulcer on the log.[3]

The lead surveyor indicated that the documentation Petitioner provided to her from Resident 1's clinical records, which were the notes and referrals from nursing to the Wound Care Specialist, noted Resident 1 had open areas to the groin and observations of oozing fluid. Tr. 26. However, she credibly opined there were no assessments showing a nurse or the Wound Care Specialist actually assessing all the areas and describing the wounds with appropriate information such as specific measurement of the length, width, depth of the wound, whether the skin was intact or open, how many layers of the skin were involved, and whether there was any odor. Tr. 23-26.

Although Petitioner's nursing staff noted skin issues with Resident 1 as early as March 27 and up through April 19, not once during this time did the Wound Care Specialist enter Resident 1's wounds on the facility's wound log after receiving referrals. Without such entries, the facility was not ensuring an accurate assessment of the size, depth, character and stage of his wounds, and no there were no reliable means to determine what course of treatment had been prescribed and whether it was effective. When Petitioner's staff transferred Resident 1 to the hospital, it also did not conduct a facility transport record documenting his skin integrity. CMS Ex. 14 at 6. Clearly, Petitioner's overall documentation does not come close to matching, let alone explaining, the serious state of Resident 1's skin conditions that were fully documented upon his arrival at the hospital.

Petitioner's arguments in response to CMS's allegations of a lack of care documentation are not persuasive. P. PH. Br. 7-12. First, Petitioner contends CMS has provided no evidence that the numerous wounds "in the area beneath where he [Resident 1] wore a brief" were pressure wounds. *Id.* at 7. Instead, Petitioner argues that Resident 1's wounds "were more likely the result of excoriation and candidiasis resulting from Resident 1's non-compliance with toileting, brief changes, and bathing. *Id.* However, even after allegedly checking Resident 10 three times per day, Petitioner still did not

[3] The lead surveyor further explained that stage 1 is when the skin is still intact but reddened and not penetrable on touch. If the skin is open and it is just a superficial layer of tissue damage, then it would be considered a stage 2 wound. Wounds or pressure ulcers are staged up to stage 4, which means the wound goes through all layers of the skin, into the muscle and to the bone. Tr. 25.

sufficiently document and monitor these skin issues on its skin roster or wound log. CMS Ex. 10 at 61; P. Br. at 7. Therefore, there is no compelling evidence that Petitioner was carefully monitoring the development any kind of skin condition on Resident 10, let alone evidence that it thoughtfully differentiated less serious skin conditions from pressure sores.

Petitioner also contends that any pressure wounds in the area Resident 1 wore a brief "could well have developed between the time that Resident 1 was discharged from Taos Living Center and the time his wounds were first noted by the hospital" when Resident 1 was transferred to the ER on April 19, 2011. P. PH. Br. at 7. This explanation is inconsistent with other credible evidence in the record because Petitioner's own staff identified skin issues for Resident 1 in this same area on April 11, April 15, and April 17, 2011. CMS Ex. 10 at 45-48; CMS Ex. 10 at 61.

Petitioner argues that Resident 1's primary physician examined him on April 12, 2011 and that it would be highly unlikely that any examination of Resident 1's legs and groin would have failed to reveal the wounds to his heels and sacrum. P. PH. Br. at 8. However, I am not persuaded by this explanation considering the nurse surveyor reported interviews in the SOD with Resident 1's treating physicians that appear inconsistent with the proposition that Resident 1 received a comprehensive skin examination. She reported that treating MD 2 in fact confirmed Resident 1 was mostly immobile and MD 2 was aware of Resident 1's early skin breakdown. CMS Ex. 7 at 37. MD 2 reportedly could not answer specific questions when asked about Resident 1 having 18 open areas upon admission to the hospital from Petitioner's facility. *Id.* MD 2 referred questions back to treating MD 1. *Id.* MD 1 reportedly stated that when Resident 1 went to his office, he did not get to see his skin, he was not aware of any open areas or pressure ulcers, and there was no report about his feet. *Id.*

With regard to Resident 1's wounds on both heels, Petitioner states its nurse first noted the pressure wound on Resident 1's left heel on the morning of April 19, 2011, prior to Resident 1's discharge to the ER. P. PH. Br. at 8, 9, 12; CMS Ex. 10 at 25. Petitioner contends that, because of his abdominal pain, Resident 1 was sometimes "writhing in pain in his bed. This writhing action undoubtedly caused the pressure wound on his left heel noted by nurse [J.C.]." P. PH Br. at 8. The pictures of these apparently necrotic wounds contradict this suspect explanation. CMS Ex. 11 at 78-79. In fact, the Hospital Physician Director of Day Medicine confirmed that the wounds on Resident 1's heels and toes were not new wounds, but rather, they were old and necrotic. CMS Ex. 7 at 31, 32.

He opined that these wounds were clearly pressure wounds. CMS Ex. 7 at 32. It is highly unlikely then that black, necrotic wounds the circumference of baseballs would appear in, as Petitioner's nurse suggests, in a matter of hours as a result of Resident 1 "writhing" in pain.

Petitioner's Wound Care Specialist also references a one-page article, without any detailed explanation with regard to its application to Resident 1, and attempts to explain "pressure wounds can develop very quickly between the first hour and 4 to 6 hours after sustained loading." P. Ex. 1 at 2. In the face of the hospital's documentation of a multitude of wounds on Resident 1, I do not find her vague explanation persuasive at all – there is no effort to describe to which of his 12 pressure wounds she may have been referring, and it is incredible to me that she would be referring to all 12 pressure wounds.

I do not find the facility has shown, by a preponderance of the evidence, that it provided the necessary care to ensure Resident 1's pressure wounds were clinically unavoidable. Twenty-six days passed from the point where it is undisputed that Resident 1 had no pressure sores to where he presented to a hospital ER with 18 wounds including 12 pressure sores, several with necrosis. The ultimate burden was on Petitioner to prove it properly assessed and treated Resident 1's pressure sores, but the evidence before me does not fully explain Resident 1's desperate condition upon transfer to the hospital ER, a transfer which Petitioner surprisingly attributes solely to abdominal pain, and not at all for his 18 wounds.

Petitioner has not explained why it did not consistently assess Resident 1 as a risk for pressure sores during the relevant period. Although there is some documentation of skin issues for Resident 1, Petitioner also did not document proper care or monitoring for them and excluded all of Resident 1's skin conditions from its wound log. Petitioner never even documented one of Resident 1's necrotic heel wounds (the other one was documented the day before his ER transfer) and unpersuasively argues it occurred during the transfer process. It is quite a compelling contrast to see how the hospital ER treated Resident 1 upon his admittance. The hospital assessed Resident 1's wounds by photographing, measuring, staging, and otherwise describing them in detail. The hospital was then able to effectively monitor the treatment and healing it provided to Resident 1, which included a referral to a facility that specialized in wound care.[4]

[4] Petitioner also argues that by the time the hospital referred Resident 1, the new hospital only referenced three pressure ulcers versus the original twelve and suggests Resident 1 was not in such a deplorable state as CMS describes. P. PH. Br. at 11. Conversely, after considering the hospital's comprehensive wound documentation and care, I view any healing while in the hospital as an indication of the avoidably of Resident 1's sores while at Petitioner's facility. *See Crestview Parke Care Ctr.*, DAB No. 2055, at 16-17 (2006)

The record is clear that, with regard to Petitioner's insufficient assessment, monitoring, and treatment of Resident 1's pressure sores, Petitioner did not ensure that they were clinically unavoidable. This deficiency alone supports the penalty CMS imposed without the need to address the additional noncompliance CMS cited with respect to Resident 2. *See, e.g., The Residence at Salem Woods*, DAB No. 2052, at 11 (2006) (stating that an ALJ "may . . . find the CMP amount to be reasonable based on fewer deficiencies than those upon which CMS relied to impose the penalty").

3. The penalties CMS imposed, the $4,500 and $5,000 PICMPs and a DPNA for the period of June 3 through June 9, 2011, are reasonable.

CMS must consider several factors when determining the amount of a CMP (factors an ALJ considers de novo when evaluating the reasonableness of the CMP that CMS imposed): (1) the facility's history of noncompliance; (2) the facility's financial condition, i.e., its ability to pay the CMP; (3) the severity and scope of the noncompliance, the "relationship of the one deficiency to other deficiencies resulting in noncompliance," and the facility's prior history of noncompliance; and (4) the facility's degree of culpability. 42 C.F.R. §§ 488.438(f), 488.404(b), (c).

The Board has repeatedly held that "an ALJ or the Board properly presumes that CMS considered the regulatory factors and that those factors support the amount imposed." *See, e.g., Pinecrest Nursing & Rehab. Ctr.*, DAB No. 2446, at 23 (2012). Thus, CMS did not need to present evidence regarding each regulatory factor. Instead, the burden was on Petitioner "'to demonstrate, through argument and the submission of evidence addressing the regulatory factors, that a reduction is necessary to make the CMP amount reasonable.'" *Id.* (quoting *Oaks of Mid City Nursing & Rehab. Ctr.*, DAB No. 2375, at 26-27 (2011)).

Petitioner did not challenge the reasonableness of the PICMPs imposed in its appeal and did not contest any of the factors set forth in the regulation that would affect my consideration of the amount of the penalty. 42 C.F.R. § 488.438(f). While I do believe that, especially with respect to the substantial noncompliance with 42 C.F.R. § 483.25(c), CMS could have imposed a larger penalty, I will not substitute my discretion here for CMS's. I find as a whole, therefore, that the PICMPs imposed are more than reasonable given the seriousness of the noncompliance and Petitioner's culpability.

I also uphold CMS's imposition of the DPNA for the period of June 3, 2011 through June 9, 2011. It is well settled that CMS has the right to impose one or more remedies

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(explaining the fact that a new pressure sore healed quickly is further evidence that facility could have avoided a pressure sore if it had provided proper care).

specified in 42 C.F.R. § 488.406 when it determines that the facility is not in substantial compliance. 42 C.F.R. §§488.404, 488.406 and 488.408. The remedies that the Act and regulations specify 'with respect to a finding that a facility has not met an applicable requirement," include a DPNA, civil money penalties, and termination of the facility's agreement to participate in Medicare. Sections 1819(h)(2)(B) (42 U.S.C. § 1395i-3(h)(2)(B)), 1919(h) (42 U.S.C. § 1396r(h)) of the Act; 42 C.F.R. §§ 488.400, 488.406, 488.408, 488.417. A DPNA may be imposed for any deficiency, except when a facility is in substantial compliance. 42 C.F.R. §§ 488.408(d)(3), 488.417; *Desert Hospital*, DAB No. 1623, at 5-6 n.4 (1997). A DPNA continues until either "(1) The facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit" or "(2) CMS or the State terminates the provided agreement." 42 C.F.R. §§ 488.454(a), 488.417(d); section 1819(h)(3) (42 U.S.C. § 1395i-3(h)(2)). Considering Petitioner was not in substantial compliance with all participation requirements during the revisit survey, and because Petitioner did not show that it abated its noncompliance before June 10, 2011, a DPNA for this period was appropriate. CMS Ex. 8; CMS Br. at 23.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner, Taos Living Center, was not in substantial compliance with Medicare program participation requirements. I also sustain as reasonable CMS's imposition of two per instance civil money penalties, one in the amount of $4,500 and one in the amount of $5,000, against Petitioner and CMS's imposition of a DPNA for the period of June 3 through June 9, 2011.

/s/
Joseph Grow
Administrative Law Judge