Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Carrington Place at Muscatine, (CCN: 16-5578),	)	Date: October 21, 2009
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-08-750
	)	Decision No. CR2019
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose remedies against Petitioner, Carrington Place at Muscatine, consisting of the following:

- Civil money penalties of $50 per day for each day of a period that began on August 28, 2008 and which ran through October 8, 2008;

- Civil money penalties of $250 per day for each day of a period that began on October 9, 2008 and which ran through November 13, 2008; and

- Denial of payment for new Medicare admissions for each day of a period that began on August 1, 2008 and which ran through November 13, 2008.

I. Background

Petitioner is a skilled nursing facility in Muscatine, Iowa. It participates in the Medicare program. Its participation in Medicare is governed by sections 1819 and 1866 of the Social Security Act (Act) and by implementing regulations at 42 C.F.R. Parts 483 and 488. Its right to a hearing in this case is governed by regulations at 42 C.F.R. Part 498.

Medicare compliance surveys were conducted at Petitioner's facility in January (January survey), July (July survey), August (August survey) and October (October survey) 2008. Numerous findings of noncompliance with Medicare participation requirements were made at these surveys. CMS determined to impose against Petitioner the remedies that I describe in the opening paragraph of this decision based on the noncompliance findings that were made at the July, August, and October surveys.[1]

Petitioner requested a hearing and the case was assigned to me for a hearing and a decision. I held an in-person hearing in Davenport, Iowa on August 6, 2009. At the hearing, I received into evidence exhibits from CMS which I identified as CMS Ex. 1 – CMS Ex. 30. I received into evidence exhibits from Petitioner which I identified as P. Ex. 1 – P. Ex. 33. I received an additional exhibit into evidence which I identified as ALJ Ex. 1. I heard the cross-examination and redirect testimony of several witnesses.[2]

II. Issues, findings of fact and conclusions of law

A. Issues

The issues in this case are whether:

1. Petitioner failed to comply substantially with Medicare participation requirements; and

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[1] More than once I invited CMS to explain to me why it considered the January survey's noncompliance findings to be relevant to this case. I observed to counsel that no remedies were imposed based on those findings and that, in fact, Petitioner would have had no right to a hearing to challenge those findings in the absence of a remedy determination. CMS has not provided me with any explanation of the relevance of the January survey findings despite my invitation and so I rule them to be irrelevant.

[2] On October 8, 2009, after I had closed the record of this case, Petitioner filed a motion to supplement its evidence with what it asserts to be an excerpt of a transcript of a deposition relating to a State compliance hearing. The transcript excerpt contains testimony of Margaret Eileen Brotherton, a State agency surveyor, who also testified at the August 6, 2009 hearing that I conducted. Transcript (Tr.) at 40-46. Petitioner asserts that I should receive this testimony because it contradicts the testimony that Ms. Brotherton gave at the August 6, 2009 hearing and because Ms. Brotherton now admits that she was not truthful at that hearing. I deny the motion for two reasons. First, I rely on none of Ms. Brotherton's testimony to decide this case. Whether there are inconsistencies between her August 6 hearing testimony and her October 6, 2009 deposition is consequently irrelevant. Second, it does not appear to me that the testimony that Ms. Brotherton gave during her October 6 deposition is materially inconsistent with the testimony she gave at the August 6 hearing.

2. The remedies that CMS determined to impose are authorized and reasonable.

B. 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.

1. Petitioner failed to comply substantially with Medicare participation requirements.

As I discuss above, this case involves three compliance surveys at which numerous findings of noncompliance were made. In this decision, however, I make Findings about only some of these noncompliance findings. It is unnecessary that I address other noncompliance findings because the noncompliance findings that I do address are, by themselves, sufficient to support the remedies that CMS determined to impose.[3] The noncompliance findings that I discuss in this decision are Petitioner's failure to comply substantially with the requirements of:

- 42 C.F.R. § 483.25(i)(1) (July and October surveys). The regulation requires a facility to ensure, based on a resident's comprehensive assessment, that the resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.

- 42 C.F.R. § 483.35(i)(2) (August survey). The regulation mandates that a facility store, prepare, distribute, and serve food under sanitary conditions.

a. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(i)(1).

There are two distinct instances of noncompliance with this regulation alleged by CMS. I discuss these separately, beginning with the allegations that were made at the July survey.

[3] Indeed, the finding of noncompliance that was made at the August survey which I address in this decision is not, strictly speaking, necessary to support CMS's remedy determinations. I discuss it only because that finding of noncompliance provides additional – if not requisite – evidence to support increasing the civil money penalty amount imposed against Petitioner from $50 to $250 per day.

i. The July survey findings

The allegations of noncompliance that were made at the July survey center around the care Petitioner gave to a resident who is identified as Resident # 3 in the July survey report. CMS Ex. 7, at 25-30. Specifically, the report and CMS allege that Petitioner failed to provide interventions for Resident # 3 to address her weight loss.

The resident was admitted to Petitioner's facility in January 2008. CMS Ex. 7, at 26. At the time of admission the resident's weight was recorded at 132 pounds and the resident was not noted as having a history of weight loss. *Id.*

By April 2008 the resident was assessed by Petitioner's staff as having experienced a weight loss. Beginning on April 8, 2008, Petitioner's staff – in evident recognition of the resident's weight loss – began weighing the resident weekly. CMS Ex. 7, at 27. Her weight was documented on April 13, 2008 as 126 pounds. *Id.* at 26. On April 15, Petitioner's dietician notified the resident's physician that the resident lost 5.7 pounds over 30 days, a weight loss that the dietician described as "significant." CMS Ex. 18, at 57. The dietician noted that the resident's weight had been previously very stable. However, Resident # 3 had not only lost significant weight, but, as of April 15, was displaying poor appetite. *Id.* The dietician requested the physician to prescribe that Resident # 3 be given Resource 2.0, a dietary supplement.

A care plan prepared for the resident on April 15, 2008 identified nutrition as being one of the resident's problems. CMS Ex. 7, at 26. As an intervention, the resident began receiving Resource 2.0 twice daily, on April 16, 2008. *Id.* at 27.

The resident continued steadily to lose weight. On May 2, 2008, the resident's weight was recorded at 124 pounds. On May 8, it was recorded at 123 pounds. On May 16, her weight had declined to 120.5 pounds and it declined further to 120 pounds on May 23, 2008. The resident's weight continued to decline in June 2008. On June 5, it was recorded at 117 pounds, on June 16, 117 pounds, and, finally, at 118 pounds on June 27. CMS Ex. 7, at 27.

Resident # 3 received the supplement as prescribed from April 16 until April 30, 2008. However, the supplement was discontinued without explanation by Petitioner's staff after April 30. CMS Ex. 7, at 28-29. There is no physician's order rescinding the order for the supplement. There is no record showing that Petitioner's staff communicated with the resident's physician during the months of May and June 2008 about the resident's continued loss of weight. *Id.* at 28. Nor did the staff discuss the resident's condition with the facility's dietician during the months of May and June 2008 despite the fact that the resident was steadily losing weight during this period. *Id.* at 29.

On June 24, 2008, the facility's dietician reviewed the resident's record. On that date the dietician reordered the supplement for Resident # 3. CMS Ex. 7, at 28.

A surveyor observed the resident being fed on July 1 and 2, 2008. At lunch on July 1 the resident ate only a few bites of her meal. The resident left the facility dining room with the meal unfinished. Petitioner's staff did not cue or encourage the resident to eat more. CMS Ex. 7, at 28. At breakfast on July 2 the resident was again observed as eating only a few small bites of the meal, then leaving, without being assisted during the meal by facility staff. *Id.* at 29.

These facts, if unrebutted by Petitioner, are sufficient to establish noncompliance with 42 C.F.R. § 483.25(i)(1). A facility must ensure that a resident maintain sufficient parameters of nutritional status. That means aggressively pursuing all reasonable measures that would or might serve to assist a resident in maintaining his or her weight. Here, the evidence offered by CMS shows that Petitioner failed to undertake necessary measures on behalf of Resident # 3 even though the staff was on notice of and, in fact, documented a decline in the resident's weight accompanied by a loss of appetite that Petitioner's dietician determined to be substantial. The evidence shows that after April 2008 the staff simply neglected to provide care to address the resident's weight loss. They failed to maintain contact with the resident's physician and the facility's dietician notwithstanding the dietician's expressed concern about the resident's loss of weight. They failed to follow the physician's treatment order for Resident # 3. They failed assertively to assist the resident with eating and to encourage the resident to eat.

The evidence and arguments offered by Petitioner to counter CMS's case of noncompliance are without merit. Petitioner argues that the resident's weight loss may have been due to a variety of factors having nothing to do with nutrition. It contends that the resident had a history of medical conditions that might have caused the resident to lose weight even if she was consuming adequate calories. Petitioner's brief in support of summary judgment motion (summary judgment brief) at 39.[4]

[4] Prior to the hearing, Petitioner filed a detailed motion for summary judgment which I denied. At the close of the hearing, I commented that Petitioner's brief was so extensive that Petitioner could opt to treat it as a brief on the case-in-chief and offer its post-hearing brief as a supplement. It has done so, and thus, I consider both briefs in addressing Petitioner's arguments and contentions of fact. However, I note that Petitioner attached several documents to its post-hearing brief as its "Attachment 1" and evidently, it contends that I should either receive them into evidence or should have received them at the hearing. At the hearing, I explained why I would not receive the parties' stipulation that is part of the attachment and why I was rejecting certain other proffered documents which also appear to be part of the attachment. I do not receive these documents now, nor do I consider them in deciding this case.

There is no conclusive evidence in the record of this case establishing precisely what caused the resident to lose weight. The resident's weight loss may have been due to underlying medical conditions or it may have been due simply to the resident's poor appetite and failure or refusal to eat. However, I find the underlying cause of the resident's weight loss to be irrelevant. What is relevant is that Petitioner's own staff recognized that the resident had lost a significant amount of weight between the date of the resident's admission and April 15, 2008 and determined that it was necessary to address this weight loss through interventions that included providing the resident with a dietary supplement. Moreover, the resident's treating physician, by ordering that a supplement be given to the resident, concurred with this assessment of the resident's condition. Once the staff identified the weight loss as a significant problem it had a duty to address that problem. The unrebutted evidence offered by CMS shows that the staff failed to take even the measures that they had identified as essential. They failed to provide the resident with the dietary supplement that had been prescribed by the resident's physician and they failed to communicate with the two professionals most knowledgeable in the causes and treatment of weight loss – the treating physician and Petitioner's dietician – even as the resident continued to lose weight.

Next, Petitioner asserts that Resident # 3 did not, in fact, lose a significant amount of weight. Summary judgment brief at 40-41. Petitioner argues that the resident's "usual weight" was not 132 pounds, the resident's weight on admission to the facility, but 122 pounds. *Id.* According to Petitioner, the nearly 10 pounds of allegedly excess weight manifested by the resident at the time of her admission was due to her receipt of "massive amounts" of intravenous (IV) fluids during a hospital stay just prior to the resident's admission to Petitioner's facility. *Id.*

I find Petitioner's assertion to be speculative and unsupported by the evidence. It may be that the fluid administered to the resident while she was in the hospital over hydrated the resident causing the resident's weight to be abnormally high on admission to the facility. But, the evidence supports an alternative explanation for the resident's admission weight. The resident was dehydrated prior to her hospital stay. Nausea, vomiting and dehydration were the reasons for the resident's hospitalization. P. Ex. 32, at 1-2. Thus, the fluids given to the resident while the resident was hospitalized appear to have been given so that the resident could attain a relatively normal level of hydration and body weight.[5]

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[5] Petitioner observes that the resident was administered the medication Lasix, a diuretic, immediately after her admission to the facility so as to eliminate excess fluid. But, even if some of the weight that the resident manifested on admission was due to fluid retention, there is nothing in the record to show that all of it was due to that fact. Indeed, the resident's weight was documented at 126 pounds on April 13, 2008, about three months after her admission. The resident continued to lose significant weight after that date, when the staff first expressed concern about the resident's weight loss and poor eating habits.

However, even assuming that Petitioner's assertion that the resident was over hydrated is true, it ignores the evidence establishing that Petitioner's staff – and in particular its dietician – and the resident's treating physician concluded in April 2008, more than four months after the resident's admission to the facility, that the resident had lost significant weight possibly due to poor appetite. In other words, the staff and the treating physician assessed the resident's condition as an abnormal weight loss and determined to treat the resident accordingly. That assessment imposed on the staff a duty to diligently attempt to assure that the resident ate adequately. As I have discussed, the staff clearly failed to perform that duty when it ceased providing the prescribed supplement to the resident and failed to communicate the resident's continuing weight loss either to the dietician or to the treating physician. Moreover, even if the resident's "usual" weight was 122 pounds, the unequivocal evidence is that the resident's weight declined to 117 pounds – in the face of the dietician's expressed concern about the resident's weight loss – without the facility carrying through on the interventions that had been developed for Resident # 3.

Petitioner asserts that Resident # 3's physician, Matthew Sojka, M.D., testified that he did not consider it to be significant that a resident would lose one to two pounds "a week." Petitioner's post-hearing brief at 19; *see* Tr. at 26. From this assertion Petitioner seems to argue that the physician did not consider the resident's weight loss to be significant, thereby excusing Petitioner from its regulatory duties with respect to Resident # 3.

This argument is without merit for two reasons. First, Dr. Sojka did not testify that a weight loss of one to two pounds "a week" was not significant. Rather, he testified that he would not consider it to be significant for a resident to lose one or two pounds "in a week." Tr. at 26. A very short-term weight loss of one or two pounds is, perhaps, not a significant event. But, what is at issue here is a substantial weight loss over a period of *months* and one which Petitioner's own dietician considered to be significant.

Second, Dr. Sojka testified that, even assuming that the resident remained above her ideal body weight at all times during her stay at Petitioner's facility, a weight loss of 11 pounds in six months was a basis for further investigation. Tr. at 24-25. He also testified that he expected that his treatment orders be followed. *Id.*

Petitioner also contends that it is "undisputed" that the resident was, in fact, receiving adequate nutrition. Summary judgment brief at 41. Petitioner bases this argument on the amount of calories that its staff *offered to* Resident # 3. *Id.* It asserts that the resident's planned menu delivered from several hundred to nearly a thousand calories more per day to the resident than the resident needed to maintain her body weight. *Id.* Assuming this to be true, it simply begs the question of whether Petitioner's staff was doing what was needed to assure that Resident # 3 consumed adequate amounts of food. As was observed by the surveyors, the resident was only picking at the food that was offered to her, consuming only small amounts of the totals provided. Moreover, the resident was continuing to lose weight steadily, notwithstanding what was offered to her. The resident's steady weight loss and the dietician's expressed concern that this was due

to poor appetite imposed on Petitioner's staff the duties to investigate, assess, and determine why simply offering adequate quantities of food to the resident was not all that was needed to maintain the resident's weight. Petitioner's staff failed to do any of these things.

Next, Petitioner asserts that, if Resident # 3 did lose weight due to not eating, that was not due to any misfeasance on Petitioner's part. As support for this assertion, it contends that failure to provide the resident with the prescribed supplement was "the result of a pharmacy error, not . . . [Petitioner's] error." Summary judgment brief at 42. This argument is incorrect as a matter of law. It was Petitioner, and not a pharmacy, that assumed responsibility for the resident's care. If the resident's supplement was not provided due to a pharmacy error, it was Petitioner's obligation to identify that error immediately and to do whatever was necessary to rectify it. The undisputed facts of this case are that Petitioner's staff neglected to provide the prescribed supplement to Resident # 3 for nearly two months.

Petitioner asserts also that it discussed the resident's condition at weekly weight meetings between its director of nursing, its MDS coordinator, its dietician, and its food service supervisor. Summary judgment brief at 42; P. Ex. 20, at 8. I find the evidence relied on by Petitioner as support for this contention to be unpersuasive. It consists of the deposition testimony of Ms. Donna Stewart, who served as Petitioner's director of nursing at the time of the July survey. *Id.* at 2. However, Ms. Stewart did not assert that she had been present at any meetings involving Petitioner's staff and the dietician nor did she specifically rebut the dietician's assertion to the surveyor that she had received no communications from the staff about the failure to provide the supplement to the resident or the resident's continued weight loss in May and June 2008. Moreover, Petitioner has offered no documents, in the form of assessments, minutes of meetings, or staff notes, which would show communications with the dietician or the physician about Resident # 3's weight loss in the May-June 2008 period.

Petitioner argues next that, if Resident # 3 lost weight, it was a volitional act over which Petitioner had no control and against which Petitioner had no right to intervene. Summary judgment brief at 43. As support for this assertion Petitioner argues that any resident in a nursing facility has a right to refuse care and that Resident # 3 was simply exercising that right by rejecting the food that was offered to her. P. brief at 19.

I do not disagree with the general premise that a resident in a skilled nursing facility has the right to refuse care. 42 C.F.R. § 483.10(b)(4). However, the right to refuse care is not a license to a skilled nursing facility to avoid discharging its responsibilities to the resident. A facility must assess a resident's needs, plan that resident's care, and attempt to implement that care *even if* the resident exercises his or her free will and decides to

decline that which the facility offers. *Koester Pavillion*, DAB No. 1750, at 28 (2000). Where a resident refuses care despite a facility's best efforts to provide it, the facility must document that refusal and the efforts it made to induce the resident to accept care. *Innsbruck HealthCare Center*, DAB No. 1948, at 7-8 (2004).

Here, Petitioner has not contended that it closely assessed Resident # 3's eating patterns and any possible refusal by the resident to accept care. There is not even a hint of evidence showing that Petitioner discontinued providing the nutritional supplement to Resident # 3 because the resident refused to accept it. Nor does the evidence suggest that the lack of communication between Petitioner and its dietician and the resident's treating physician in May and June 2008 was directed by the resident's knowing refusal to accept care.

Finally, Petitioner argues that the resident was consuming adequate amounts of food even if she was losing weight. Summary judgment brief at 41. Petitioner premises this assertion on its contention that laboratory tests showed that the resident had normal pre-albumin levels, test results that were compatible with adequate nutrition. *Id.*; P. Ex. 18, at 41. However, while pre-albumin levels are a measure of nutritional adequacy, they are not the only measure. A significant weight loss over a period of time is an independent measure of possible nutritional problems. Tr. at 25. And, in this case, Petitioner's dietician determined that the resident's weight loss was significant. That imposed on Petitioner the duty to address the problem and to implement the interventions it developed. It manifestly failed to do that.

ii. The October survey findings

The allegations of noncompliance with the requirements of 42 C.F.R. § 483.25(i)(1) that were made at the October survey center around the care that Petitioner provided to a resident who is identified as Resident # 1 in the October survey report. This resident was admitted to Petitioner's facility on or about August 8, 2008. CMS Ex. 9, at 5. His weight was documented on admission to be 188 pounds. *Id.* at 6. Petitioner's dietary manager planned to monitor the resident's weight weekly for four weeks. Thereafter the resident would be weighed monthly assuming his weight remained stable during the initial four weeks. *Id.*

The undisputed evidence is that the resident rapidly lost weight. Petitioner's staff documented a total weight loss for Resident # 1 of 17 pounds in a one-month period. On August 15, 2008, the resident's weight had declined to 181 pounds. On August 18, it was recorded at 180.5 pounds. On August 29, 2008 it had declined to 175 pounds and by September 9, 2008, it had declined further to 171 pounds. CMS Ex. 9, at 6-7.

On August 26, 2008, Petitioner's dietician reviewed Resident # 1's record and became concerned about his weight loss. CMS Ex. 9, at 6. As of that date, the resident's weight had declined by about eight pounds from his admission weight. The dietician talked with

the resident's family regarding his weight loss and documented that the family planned to bring in the resident's favorite foods from home in order to encourage him to eat. *Id.* However, the resident's care plan was not amended to record this possible intervention and no instructions were provided to Petitioner's staff.

Petitioner's staff did not notify the resident's physician about his weight loss until September 9, 2008. On that date, the dietician faxed a note to the physician advising him about the weight loss and recommending that the resident be prescribed a dietary supplement. CMS Ex. 9, at 7. As of that date, the resident's weight had declined by nearly 10 additional pounds.

The evidence offered by CMS describes a lack of comprehensive planning and consultation by Petitioner's staff in the face of a sudden and very substantial weight loss by one of Petitioner's residents. Between August 8 and September 4, 2008 the only intervention that the staff developed was to encourage the resident's family to bring food from home in order to tempt the resident to eat. But, even that intervention was not closely documented, planned, or monitored by Petitioner's staff. During that first month of the resident's stay, there was no consultation with the resident's physician about the substantial loss of weight experienced by the resident, nor was there any comprehensive planning done by Petitioner's staff to address the problem. Tr. at 126.

Petitioner makes several arguments and contentions in opposition to CMS's evidence. I do not find them to be persuasive.

First, Petitioner argues that the resident's "normal weight" prior to his admission to Petitioner's facility was 182, and not 188, pounds. Summary judgment brief at 44. According to Petitioner, the resident's weight of 188 pounds as of admission to Petitioner's facility was as a consequence of his having received IV fluids while hospitalized prior to admission. *Id.*; *see* CMS Ex. 23, at 7, 9.

The inference Petitioner would have me draw from this assertion is that the resident did not lose nearly so much weight as is indicated by the weights recorded at Petitioner's facility prior to September 2008. Rather than losing about thirteen pounds between the date of his admission on August 8 and August 29, the resident lost "only" about seven pounds from his pre-admission weight, according to Petitioner.

I find this argument to be unpersuasive and also largely irrelevant. First, it is speculative to assume that the resident's "normal" weight prior to his admission was 182 and not 188 pounds. The evidence cited by Petitioner to support this assertion, CMS Ex. 23, at 7, 9, does not – contrary to Petitioner's argument – describe the resident's "normal" weight. Moreover, although the resident may have received fluids while hospitalized prior to

admission to Petitioner's facility, those fluids may have been administered for the purpose of countering dehydration. Thus, the resident's weight may not have, in fact, been excessive as of the date of his admission and Petitioner certainly hasn't proven that it was.

However, even if the resident's "normal" weight was 182 – and not 188 – pounds, the fact remains that this resident lost a large amount of weight during the first three weeks of his stay at Petitioner's facility. Even by Petitioner's calculation, Resident # 1 lost about seven pounds during those first three weeks. That amount of weight loss was determined to be a matter of concern by Petitioner's dietician and it was a basis for her attempting to develop an intervention consisting of having the resident's family bring food to the resident. Given that level of concern, Petitioner's staff should have assessed the resident for his weight loss, planned his care comprehensively, and consulted with competent professionals including the resident's physician in August. It failed to do any of this.

Petitioner argues, however, that it, in fact, implemented a variety of interventions to prevent Resident # 1 from losing weight. Summary judgment brief at 44. The interventions listed by Petitioner include the following:

- Petitioner weighed the resident weekly;

- Petitioner's dietician discussed the resident's eating habits with the resident's wife and she told the dietician that she had difficulty getting the resident to eat; and

- It was agreed that the resident's family would bring food in from home in order to induce the resident to eat more.

Id. at 44-45. While I have no doubt that Petitioner did these things, they were clearly inadequate to address Resident # 1's weight loss and the concern that Petitioner's dietician expressed about it. As I discuss above, Petitioner failed completely to develop a comprehensive and methodical approach to deal with the issue. Having the family agree to bring in food for the resident may not have been inappropriate, but without comprehensive planning and a systematic approach to the resident's condition, it hardly represented a meaningful response to the resident's weight loss.

Petitioner argues also that the resident's weight loss was unavoidable and the consequence of illness that he experienced while residing at Petitioner's facility. As proof of this assertion, Petitioner recites that the resident began feeling ill on August 23, 2008 and began experiencing nausea, vomiting and diarrhea. Summary judgment brief at 45. The resident was treated for a bacterial infection and, according to Petitioner, received an antibiotic that could have reduced the resident's appetite. *Id.*

I don't question the facts cited by Petitioner concerning the resident's illness in late August and early September 2008. But, these facts do not excuse Petitioner's failure prior to early September to address the resident's weight loss in a comprehensive and systematic manner. If anything, the resident's illness should have caused Petitioner to address the resident's weight problems even more urgently.

Petitioner's argument seems to be premised on the assumption that a facility is excused from its responsibility to ensure that a resident receives adequate nutrition if the resident loses weight due to some cause other than lack of nutrition. I disagree with that assumption. The duty to assure that each resident receives adequate nutrition is not relieved if a resident loses weight due to factors other than nutrition. That duty exists independently of those factors and must be performed regardless of what may actually be causing a resident to lose weight. If a facility performs its duties acceptably, then, of course, weight loss due to factors other than nutrition would be no basis for finding the facility deficient in complying with the requirements of 42 C.F.R. § 483.25(i)(1). But, weight loss due to non-nutritional factors is never an excuse for failing to comply with those requirements.

b. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.35(i)(2).

CMS's allegations of noncompliance with the food handling regulation are based on observations of Petitioner's facility made by surveyors at the August survey. Their observations included the following:

- Observation of Petitioner's walk-in refrigerator on August 26, 2008 revealed an opened and undated 64 ounce bottle of prepared orange juice bearing the name of a resident who had died about two weeks previously and containing a label which stated "best when used by 8/15/08." CMS Ex. 8, at 3.

- A large plastic container was positioned under the cooling condenser in the refrigerator. There was at least three inches of water, totaling 11 quarts, in the container. Water was observed to be dripping from the condenser into the container. CMS Ex. 8, at 3-4. Food was stored in close proximity to the dripping water. Tr. at 104-05.

- The refrigerator contained an unopened one-gallon container of skim milk which had 8 to 10 spots measuring two to three millimeters across of black-green fuzzy residue. CMS Ex. 8, at 4.

- There were plates stacked on both sides of a plate warmer. All of the plates were wet. Five of them had visible egg residue on them. Petitioner had served eggs to its residents that morning. CMS Ex. 8. The dietary supervisor instructed the kitchen staff to wash all of the plates in the plate warmer.

- However, about an hour after the first observation of the plate warmer the surveyor returned to observe that one of the plates continued to have food residue on its back. Others remained wet. CMS Ex. 8.

- On the morning of the next day, August 27, 2008, the surveyor returned to the kitchen and observed the top plate on the right side of the plate warmer with a dried strand of chicken or pork adhering to it. CMS Ex. 8, at 5.

- Of eight stacked plate warmers, six had a thick brown liquid residue on their top surfaces. Two of them had visible dried food on them. CMS Ex. 8.

These observations, if not rebutted by Petitioner, are sufficient to sustain a finding that Petitioner failed to store food under sanitary conditions. They support the conclusion that there was expired food in Petitioner's refrigerator and that the refrigerator had a leaking condenser that was dripping water in the vicinity of stored food. They also support the conclusion that Petitioner was using unclean and food-contaminated dishes and that the staff failed to correct the problem after the surveyor observed it.

Petitioner disputes whether the plates observed by the surveyor were contaminated with food particles or simply were scratched.[6] On this question, I find to be credible the testimony of Jeannine Gothard, the surveyor who viewed Petitioner's facility on August 26 and 27, 2008. Ms. Gothard testified that she personally scraped food residue off the plates. Tr. at 108-09. Petitioner also argues that there is no significance to the dripping water in its refrigerator, that this posed no possibility of more than minimal harm to residents. But, in fact, and as was testified to credibly by Ms. Gothard, the water was dripping into a container that was placed adjacent to stored food (cantaloupes). Tr. at 104-105.

[6] Petitioner argues that I erroneously excluded from evidence certain surveyors' notes which, according to Petitioner, show that Petitioner's food supervisor told the surveyor that the plates were scratched but not contaminated with food debris. I excluded these notes because Petitioner could have offered them prior to the hearing pursuant to the requirements of my initial pre-hearing order and failed to do so. Petitioner made no showing of good cause for failing to comply with my initial pre-hearing order. It did not claim that it was surprised by any of the evidence that was introduced at the hearing. Moreover, Petitioner had the direct testimony of CMS's witnesses in its possession for months prior to the hearing as well as the documents it sought to offer at the hearing. Petitioner could have offered them as evidence before the hearing and it failed to provide a cogent explanation for its failure to do so. Tr. at 109-10.

Petitioner suggests that CMS is attempting to hold it to a strict liability standard, apparently on the theory that CMS regards even the slightest evidence of contamination of food or utensils as proof of noncompliance with regulatory requirements. But, this is not a case of a vague or ambiguous regulation being interpreted or applied in an unfairly strict way against a facility. The regulation is clear: a facility must maintain sanitary conditions for its storage and handling of food items. Failing to wash dishes sufficiently to remove encrusted food violates the regulation's plain meaning as does maintaining a food storage facility that exposes stored food to dripping water and condensation.

2. CMS's remedy determinations are reasonable.

This case involves the imposition of civil money penalties in two amounts ($50 and $250 per day) for defined periods of time and a denial of payment for new Medicare admissions. I find these remedies to be reasonable.

a. The civil money penalties are reasonable in amount and duration.

None of the deficiencies that are at issue here were determined by CMS to be so egregious as to constitute immediate jeopardy for Petitioner's residents. Consequently, any civil money penalties imposed against Petitioner must fall within the lower range of civil money penalties of from $50 to $3,000 which are prescribed by regulation for non-immediate jeopardy level civil money penalties. 42 C.F.R. § 488.438(a)(1)(ii).

The civil money penalties of $50 per day that CMS determined to impose for the period beginning on August 28, 2008 and which ran through October 8, 2008 are reasonable as a matter of law. They constitute the minimum penalty amount allowed by regulation. Petitioner has not offered affirmative evidence showing that it was in compliance with participation requirements on any dates during the period. Consequently, I sustain these penalties, both in amount and in duration.

I find also that the penalties of $250 per day that CMS determined to impose for the period beginning on October 9, 2008 and which ran through November 13, 2008 are reasonable.

There are regulatory factors which must be used to decide whether penalties in a prescribed penalty range (from $50 to $3,000 per day in this case) are reasonable. These include: the seriousness of a facility's noncompliance; its compliance history; its culpability; and its financial condition. 42 C.F.R. §§ 488.438(f)(1)-(4); 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)). In this case evidence relating to these factors supports increasing the penalties from $50 to $250 per day effective October 9.

First, Petitioner's noncompliance – particularly with the requirements of 42 C.F.R. § 483.25(i)(1) – was relatively serious. The residents whose care is at issue in this case are vulnerable individuals who were dependent on Petitioner and its staff to provide care. They were not in a position to assess their own weight loss or to seek care for it. Thus, it was incumbent on Petitioner and its staff to identify these residents' problems and to deal with them effectively. Petitioner failed to do so, not once, but twice.

Furthermore, the fact that Petitioner failed to comply with the regulation's requirements in the period prior to the July survey and again, afterward, is evidence from which I infer that Petitioner and its staff did not learn from the deficiency identified in July or make serious efforts at remediation prior to the October survey. In that sense, its culpability for noncompliance was heightened as of October and that fully justified increasing the penalty amount to $250 per day.

The additional factor is Petitioner's deficiency in August. That is added basis for increasing the penalty amount. However, I would find sufficient reason to increase the penalty amount from $50 to $250 per day based solely on Petitioner's repeated noncompliance with the regulation governing nutrition. The August deficiency, therefore, is unnecessary to my decision although it does provide added evidence for increasing the penalty amount.

b. As a matter of law, CMS may impose a denial of payment for new Medicare admissions against Petitioner and, therefore, the remedy is reasonable.

CMS is authorized to impose the remedy of denial of payment for new admissions to address any substantial failure by a skilled nursing facility to comply with Medicare participation requirements. 42 C.F.R. § 488.417(a). The remedy is authorized here and is reasonable as a matter of law because of Petitioner's noncompliance beginning at least as early as the July survey and extending through November 13, 2008, the date when CMS determined that Petitioner became compliant with participation requirements.

At the hearing, the parties proffered a stipulation which I rejected. In relevant part, the stipulation states that the parties agreed that CMS would not have been justified in imposing a denial of payment for new admissions absent a finding of actual harm at the July survey. I rejected that stipulation because it is wrong as a matter of law. The regulation which permits CMS to impose the remedy of denial of payment for new admissions is explicit and unambiguous: CMS may impose the remedy where there is *any* failure by a facility to comply substantially with Medicare participation requirements. 42 C.F.R. § 488.417(a); 42 C.F.R. § 488.408(d)(1)(i) and (d)(3). CMS's authority to impose the remedy is not conditioned on a finding of actual harm. Consequently, a basis exists for a denial of payment for new admissions whenever substantial noncompliance exists and not only in those instances where actual harm to residents is established.

However, the issue of whether harm is a legal prerequisite to imposition of a denial of payment for new admissions is moot in this case. That is because the deficiencies that I have found present as of the July and October surveys were determined by CMS to have caused actual harm to residents. CMS Ex. 7, at 25; CMS Ex. 9, at 4. I have no authority to decide whether CMS's scope and severity determination is correct in a case which does not involve a challenge to the level (immediate jeopardy versus non-immediate jeopardy) of a civil money penalty or a loss of approval to conduct nurse aide training. 42 C.F.R. § 498.3(b)(14). In a case which does not involve those issues, the level of a facility's noncompliance (including a finding of actual harm) is not an initial determination which gives a facility a right to a hearing. *Id.* Petitioner has no right here to challenge the level of the deficiencies that I have sustained because none of them were at the immediate jeopardy level, nor did CMS impose a denial of Petitioner's right to conduct nurse aide training.

/s/
Steven T. Kessel
Administrative Law Judge