Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Palm Garden of Sun City
(CCN: 10-5736),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-878

Decision No. CR2432

Date: September 19, 2011

DECISION

Petitioner, Palm Garden of Sun City (Petitioner or facility), is a long-term care facility, located in Sun City Center, Florida, that participates in the Medicare program. Based on a survey completed April 30, 2010, the Centers for Medicare and Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare program requirements.

Because of its deficiencies, CMS imposed against the facility a civil money penalty (CMP) of $250 per day for 30 days of substantial noncompliance (April 30 – May 29, 2010), for a total penalty of $7,500. Petitioner appealed CMS's determination.

For the reasons set forth below, I find that the facility was not in substantial compliance with program requirements and that the penalty imposed is reasonable.

I. Background

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819. The Secretary's regulations

are found at 42 C.F.R. Part 483. To participate in the Medicare program, a 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 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 § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308.

Here, following a recertification survey completed April 30, 2010, CMS determined that the facility was not in substantial compliance with five Medicare participation requirements, specifically:

- 42 C.F.R. § 483.10(b)(11) (Tag F157 – resident rights, notification of changes);
- 42 C.F.R. § 483.25 (Tag F309 – quality of care);
- 42 C.F.R. § 483.25(c) (Tag F314 – prevention/treatment of pressure sores);
- 42 C.F.R. § 483.25(d) (Tag F315 – urinary incontinence); and
- 42 C.F.R. § 483.25(h)(2) (Tag F323 – accident prevention).

CMS Ex. 1; Order Summarizing Prehearing Conference (March 28, 2011). CMS subsequently determined that the facility returned to substantial compliance on May 30, 2010, and has imposed against the facility a CMP of $250 per day for 30 days of substantial noncompliance, from April 30 through May 29, 2010. CMS Ex. 15 at 7, 11.

Petitioner timely requested a hearing.

On April 20, 2011, I convened a hearing, via teleconference, from the offices of the Departmental Appeals Board in Washington, D.C. Mr. Howard Lewis appeared on behalf of CMS,[1] and Mr. R. Davis Thomas appeared on behalf of the Petitioner. Witness Sandra Santiago testified from St. Petersburg, Florida.

I have admitted into evidence CMS Exhibits (CMS Exs.) 1-21 and Petitioner's Exhibits (P. Exs.) 1-6. Order Summarizing Prehearing Conference at 4 (March 28, 2011). The parties have filed pre-hearing briefs (CMS Pre-hrg. Br.; P. Pre-hrg. Br.), post-hearing briefs (CMS Post-hrg. Br.; P. Post-hrg. Br.), and Petitioner filed a reply brief (P. Reply).

[1] Ms. Erin Shear also represents CMS in this matter but was not present for the hearing.

II. Issues

The issues before me are:

1. From April 30 through May 29, 2010, was the facility was in substantial compliance with Medicare participation requirements, specifically:

   42 C.F.R. § 483.10(b)(11) (Tag F157 – notification of changes);

   42 C.F.R. § 483.25 (Tag F309 – quality of care);

   42 C.F.R. § 483.25(c) (Tag F314 – prevention/treatment of pressure sores);

   42 C.F.R. § 483.25(d) (Tag F315 – urinary incontinence); and

   42 C.F.R. § 483.25(h) (Tag F323 – accident prevention).

2. If the facility was not in substantial compliance, is the penalty imposed – $250 per day for 30 days of substantial noncompliance (total $7,500) – reasonable?

III. Discussion

A. The facility was not in substantial compliance with 42 C.F.R. §§ 483.10(b)(11), 483.25, and 483.25(d) because its staff did not immediately consult a physician or otherwise appropriately address one resident's complaints of painful urination.

Program requirements. The facility must protect and promote the rights of each resident. In this regard, it must immediately inform the resident, consult the resident's physician, and (if known) notify the resident's legal representative or interested family member, when there is a significant change in the resident's physical, mental or psychosocial status (*i.e.*, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications), or a need to alter treatment significantly (*i.e.*, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment). 42 C.F.R. § 483.10(b)(11).

Under the statute and the "quality of care" regulation, each resident must receive, and the facility must provide, the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. Act § 1819(b); 42 C.F.R. § 483.25. To this end, the facility must, among other requirements, ensure that a resident who is incontinent of bladder "receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible." 42 C.F.R. § 483.25(d).

Resident 68 (R68). R68 was a 63-year-old woman, readmitted to the facility on December 21, 2009. CMS Ex. 1 at 4; CMS Ex. 2 at 1, CMS Ex. 7 at 1. Among other problems, she suffered from heart disease, chronic kidney disease, and diabetes. Because of a stroke, she also had dysphasia and was not easily understood. CMS Ex. 7 at 3; CMS Ex. 11 at 9. She had a history of urinary tract infections (UTIs). CMS Ex. 1 at 4; CMS Ex. 2 at 1; CMS Ex. 7 at 7; CMS Ex. 21 at 14.

The parties agree that, on April 10, 2010, R68 complained of burning when she urinated (dysuria). CMS Exs. 3, 5; CMS Ex. 11 at 11, 17; P. Ex. 2 at 2, 11, 21. She may even have started complaining earlier than that; at least one nurse later reported that R68's complaints began on April 9. CMS Ex. 11 at 17; P. Ex. 2 at 14. In any event, facility staff noted a potential "need for meds" and called her brother but did not report the complaints to R68's physician. CMS Ex. 2 at 7; CMS Ex. 5; P. Ex. 2 at 2. Instead, without first obtaining the required physician's order, staff performed a UTI screening test, referred to as a diascreen.[2] They did not then inform R68's physician of the test results. CMS Ex. 18 at 3 (Santiago Decl. ¶¶ 8, 9); P. Ex. 2 at 3, 4.

R68's physician examined her on April 22, but his notes do not mention complaints of painful urination. P. Ex. 2 at 10. On April 27, however, he diagnosed her with dysuria and prescribed pyridium, a medication that treats urinary tract pain and other symptoms sometimes associated with a UTI. P. Ex. 2 at 2; CMS Ex. 13.

The parties argue about the duration of R68's bout of dysuria. CMS claims that she suffered the condition from April 10 until her physician treated her for it on April 27. Petitioner concedes that R68 complained of pain on April 10 and April 27, but asserts that the initial condition resolved quickly and only re-appeared on April 26. I consider this dispute irrelevant to the question of whether facility staff complied with the physician consultation requirement. Facility staff were simply not supposed to wait until they could verify that the resident's pain would endure or that she had a full-blown UTI. They are supposed to consult the physician *immediately* whenever a resident exhibits a significant change or need to alter treatment. "Significant" means "all cases, whether or not there is a medical emergency." 56 *Fed. Reg.* 48,826, 48,833 (Sept. 26, 1991). "Immediately" means "as soon as the change . . . is detected, without any intervening interval of time." *Magnolia Estates Skilled Care*, DAB No. 2228 at 8 (2009); *The Laurels at Forest Glen*, DAB No. 2182 at 13 (2008).

Citing the testimony of its Director of Nursing (DON), Andrea Cornwell – offered during a state administrative hearing – Petitioner argues that "there was no need to notify the physician on April 10 after the urine test was done and came back negative." P. Post-hrg. Br. at 6 (*citing* P.

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[2] The test involves placing a reagent strip in the resident's urine and comparing the resulting strip color against a chart printed on the bottle label. CMS Ex. 18 at 3 (Santiago Decl. ¶ 8); P. Ex. 2 at 3-7.

Ex. 1 at 29). There are significant problems with this position: 1) it wrongly assumes that R68's physician would alter treatment only if the resident tested positive for a UTI, when, in fact, he treated her complaints of urinary pain (when he knew about them) without regard to test results; 2) staff were not supposed to perform the test without a physician order; and 3) the test did not come back negative.

First, DON Cornwell wrongly assumes that R68's physician would alter treatment only if the resident tested positive for a UTI. She should have known otherwise. On March 19, 2010, without diagnosing a UTI, the physician ordered Cranberry Tab 450 mg. to treat R68's "pain on urination." CMS Ex. 11 at 10. On April 27, when the physician learned that R68 complained of painful urination, he did not order any testing, but altered her treatment by ordering medication (pyridium) for her pain. P. Ex. 1 at 33-34; P. Ex. 2 at 2.

Second, Petitioner wrongly claims that staff were authorized to perform the diascreen test without a physician order. In her testimony, DON Cornwell suggested that staff could first run the test and then obtain a physician's order for it:

> We have a standing agreement with our physicians that if we suspect a resident possibly has a UTI, that [staff] will go ahead and administer the diascreen and they would write the order. We are not going to call a physician to ask is that something we can do. That's a nursing practice and our physicians have given us the okay to do that.

P. Ex. 1 at 20. The record includes no evidence that staff ever obtained a physician's order for R68's April 10 diascreen test, either before or after the test was administered. Further, as DON Cornwell conceded, the facility had no standing order or written policy allowing staff to perform the test without consulting a physician and obtaining an order. *See* CMS Ex. 21 at 14; *see also* CMS Ex. 18 at 3 (Santiago Decl. ¶ 9) (declaring that the facility did not have such a standing order). In fact, the facility's protocol says the opposite: "[t]his test is considered a routine urinalysis and *requires a physician's order*." P. Ex. 2 at 3 (emphasis added).

I may reasonably rely on the facility's protocol as evidence of professional standards of quality as well as the facility's "own judgment as to what must be done to attain or maintain its residents' highest practicable physical, mental and psychosocial well-being, as required by section 483.25." *Agape Rehab. of Rock Hill*, DAB No. 2411 at 7, 18 (2011); *Senior Rehab and Skilled Nursing Ctr.*, DAB No. 2300 (2010), *aff'd Senior Rehab and Skilled Nursing Ctr. v. HHS*, No. 10-60241 (2011) (*quoting Sheridan Health Care Ctr.*, DAB No. 2178 at 15 (2008)); *Spring Meadows Health Care Ctr.*, DAB No. 1966 at 18 (2005) (holding that "it is reasonable to presume that the facility's policy reflects professional standards of quality, absent convincing evidence to the contrary").

Third, the test result was not completely negative. At 250, R68's glucose level was significantly elevated. P. Ex. 2 at 8. According to the facility's protocol, staff must contact the physician whenever the test can be considered positive. Among the examples of what could be considered positive is: "glucose is positive, indicating elevated blood glucose level which may require additional clinical testing if the resident is not known as a diabetic." P. Ex. 2 at 6-7. I recognize that R68 was diabetic and that her underlying condition may have explained the high level of glucose found in her urine. On the other hand, as Petitioner concedes, a high glucose level may indicate a UTI. P. Br. at 2. A high glucose level in a diascreen can also cause a false negative result. CMS Ex. 18 at 3 (Santiago Decl. ¶ 10); Tr. at 18. Or, it may suggest that the resident's diabetes is not well-controlled. Tr. at 19. The test results should therefore have been reported to the resident's physician so that he could determine the significance of the elevated glucose.

The diascreen protocol also includes documentation guidelines. Staff were supposed to record: 1) the date and time they initiated the procedure; 2) the resident evaluation; 3) the diascreen results; 4) nurse/physician communications; and 5) signature and title of the reporting staff. P. Ex. 2 at 7. Facility staff plainly did not document as instructed; on the report form, they note that the resident's glucose is elevated but leave blank the time staff initiated the procedure, the spaces for documenting physician notification, and the signature and title of the reporting staff. P. Ex. 2 at 8.

The facility also had in place a protocol for handling potential cases of UTI. Staff were supposed to chart the resident's vital signs and UTI symptoms for 72 hours following the onset of symptoms. CMS Ex. 3. In response to R68's April 10 complaints, facility staff supposedly initiated the protocol but did not follow through on it. CMS Ex. 3. They maintained no nursing notes and recorded no vital signs from April 10 through April 27. Tr. at 23.

The facility excuses its failure to document by claiming that its policy was to "document by exception." P. Post-hrg. Br. at 3. Not only is this claim incompatible with the facility's written protocol requiring staff to chart the resident's vital signs, Petitioner produces no written policy nor any other reliable evidence showing that staff were instructed to limit their documentation to abnormalities. In fact, even though the record here includes few nurses' notes, the page submitted shows that staff regularly reported "no complaints." CMS Ex. 5; P. Ex. 2 at 2; Tr. at 29.

I also question whether staff reliably recorded the residents' complaints. Facility staff justified their actions (or inactions) by characterizing the resident as a "chronic complainer." CMS Ex. 2 at 7; *accord* P. Ex. 1 at 30. Yet, according to Petitioner, this "chronic complainer" voiced not one single complaint between April 10 and April 27. P. Ex. 1 at 22-23. Moreover, Petitioner submits documents titled "24-Hour Change of Condition Report" that purport to record "residents experiencing any change of condition within the past 24-hours." CMS Ex. 11 at 49-82; P. Ex. 2 at 38-54. Even though R68 unquestionably complained of dysuria on April 10 and April 26/27, staff did not document those complaints on the change-of-condtion report. DON

Cornwell testified that the resident's complaints "would have been entered on the 24-hour report possibly," but staff's obvious failure to do so did not bother her. P. Ex. 1 at 32-33.

The facility was thus not in substantial compliance with 42 C.F.R. § 483.10(b)(11) because staff did not immediately consult R68's physician when she complained of dysuria, a condition they knew, or should have known, would likely require a new form of treatment (medication). This, as well as staff's performing the diascreen without a physician's order, failing to report the test results to the physician, and failing to chart the resident's vital signs and symptoms meant that the facility was not providing appropriate treatment and services to allow R68 to attain or maintain the highest practicable well-being and to prevent urinary tract infections. The facility was therefore not in substantial compliance with 42 C.F.R. §§ 483.25 and 483.25(d).

B. The facility was not in substantial compliance with 42 C.F.R. §§ 483.25 and 483.25(c) because it failed to take all necessary precautions to prevent pressure sores from developing.

Program requirements. To assure that the resident receives necessary care and services, the "quality of care" regulation also requires that the facility ensure, based on the resident's comprehensive assessment, that a resident who enters the facility without pressure sores does not develop them unless his/her clinical condition shows that they were unavoidable. 42 C.F.R. § 483.25(c)(1). If the resident has pressure sores, the facility must ensure that he/she receives the treatment and services necessary to promote healing, prevent infection, and prevent new sores from developing. 42 C.F.R. § 483.25(c)(2). In assessing the facility's compliance with this requirement, the relevant question is: did the facility "take all necessary precautions" to prevent new sores from developing. If they did so and the resident develops sores anyway, I could find no deficiency. But if the evidence establishes that the facility fell short of taking all necessary precautions, then the regulation is violated. *Senior Rehab. and Skilled Nursing Ctr.*, DAB No. 2300 at 13-14 (2010), *aff'd , Senior Rehab. and Skilled Nursing Ctr. v. HHS*, No. 10-60241, 2010 WL5186658 (5th Cir. Dec. 20, 2010); *Koester Pavilion*, DAB No. 1750, at 32 (2000).

Resident 138 (R138). R138 had Alzheimer's disease and had suffered a stroke. He was at risk for pressure sores because of his incontinence and decreased functional mobility. He had a history of skin breakdowns. CMS Ex. 19 at 9, 27. At the time of the survey, R138 had two open sores on his buttocks. According to his treatment records, he had suffered from the open wounds since at least March 15, 2010. CMS Ex. 19 at 23, 27; P. Ex. 3 at 2. The open wounds were on "bony prominences." CMS Ex. 18 at 5 (Santiago Decl. ¶ 19); CMS Ex. 21 at 19.

Petitioner insists that the wounds were not pressure sores but "excoriations," which DON Cornwell defined as "a skin impairment caused by urine, urine/stool." P. Ex. 1 at 40. She distinguished "excoriations" from pressure sores because "[e]xcoriations can come and go rather quickly," so "it does not follow the characteristics of a pressure ulcer." P. Ex. 1 at 40-41. In contrast, according to DON Cornwell, pressure sores do not heal quickly. P. Ex. 1 at 41. She

claimed that excoriations do not require the level of monitoring that pressure sores require; they need not be measured. P. Ex. 1 at 42. She also said that pressure sores do not blanch and that this wound "blanched," which means that when pressure was applied, it turned white and then returned to its previous color. P. Ex. 1 at 44. Finally, she declared that nothing in the resident's record indicates a clinical determination, by staff or physician, that the area was a pressure sore. P. Ex. 1 at 42.

Petitioner does not support DON Cornwell's medical opinions with any authoritative source (a standard treatise, medical textbook, scholarly article), and, according to Dorland's Medical Dictionary, an excoriation is "a scratch or an abrasion of the skin." Similarly, the American Association for Long Term Care Nursing explicitly rejects the suggestion that a wound caused by exposure to urine/feces is an "excoriation." That organization defines "excoriation" as "destruction of the skin by mechanical means." http://ltcnursing.org/ask-the-wound-coach.httm. A skin impairment caused by exposure to urine or feces is referred to as "incontinence associated dermatitis" (IAD). www.ncbi.nim.nih.gov/pubmed17228207; www.ncbi.nim.nih.gov/pubmed 19374674. If not properly treated, IAD can lead to pressure sores. *Id*.; *see Senior Rehab.*, DAB No. 2300 at 13 *et seq*.

On March 15, 2010, when R138's wounds were first reported in his care plan, they were described as "open area to buttocks." According to the facility's policies for wound prevention, staff were supposed to prepare a "differentiation of non-pressure ulcer" form within 24 hours of discovery of the wound. CMS Ex. 19 at 32. I see no such document in the record.

The care plan set a goal of "area will resolve [without] further breakdown" by June 15, 2010. CMS Ex. 19 at 27. For reasons that are not explained, someone, who is not identified, crossed out "open area to buttocks" and the goal date. In an entry dated April 7, 2010, someone wrote instead "excoriation [secondary to] incontinence" and changed the goal date to July 7, 2010. CMS Ex. 19 at 27.

According to facility records, by April 12, the wound had developed into a pressure sore. A "wound treatment evaluation record," dated April 12, 2010, says that R138 had a *stage II pressure ulcer*[3] on his sacrum, measuring 4.2 cm. x 3.1 cm., which was less than .1 cm.

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[3] Pressure sores (also referred to as pressure ulcers or decubitus ulcers) are classified into stages, based on the extent of the damage to skin and underlying tissues. At stage I, the skin may appear reddened, like a bruise. Although the integrity of the skin remains intact, the area is at high risk of further breakdown, so it is crucial that the area be identified promptly and treated properly. At stage II, the skin breaks open, wears away, and forms an ulcer. At stage III, the sore worsens and extends beneath the skin surface, forming a small crater, presenting a high risk of tissue death and infection. By stage IV, deeper tissues (muscles, tendons, bones) suffer extensive damage, which can cause serious complications, such as osteomyelitis (infection of the bone) or sepsis (infection carried through the blood). J. AM. MED. ASS'N, Vol. 296, No. 8, at 1020 (available at www.jama.com).

deep.[4] The wound is described as purple red, the surrounding tissue/ulcer edge is red, and exudates is serous. CMS Ex. 19 at 28. The underlying condition contributing to the wound is listed as "pressure," although someone has also written in "excoriation." CMS Ex. 19 at 29. As discussed below, excoriation (or IAD) could well be an underlying condition contributing to the development of a pressure sore, so that notation is compatible with the finding that R138's wounds had developed into pressure sores.

Surveyor Santiago saw the wounds at the end of April and concurred that they appeared to be Stage 2 pressure ulcers. CMS Ex. 18 at 5 (Santiago Decl. ¶ 19). One of them measured 3.5 cm. x 2 cm., and the other measured 1 cm. x 0.50 cm. Both areas were surrounded by blanchable reddened tissue. CMS Ex. 1 at 8-9.

Petitioner makes much of the fact that no physician order refers to the wounds as "pressure sores." Citing DON Cornwell's testimony, Petitioner inaccurately claims that "every doctor's order dealing with treatment to the area called it an excoriation, not a pressure sore." P. Br. at 4. This is simply not so. Two of the orders refer to an "excoriation." CMS Ex. 19 at 23; P. Ex. 3 at 2, 6.[5] The other six call it an "open area," a "wound," or nothing at all. CMS Ex. 19 at 24-26; P. Ex. 3 at 2-6. Ultimately, however, it does not matter if these wounds had become pressure sores. If a facility does not carefully monitor and treat the IAD (or excoriation), it is not taking all necessary precautions to prevent the compromised skin from developing into new pressure sores.

The facility's protocol for "wound prevention/skin and wound treatment" does not limit itself to the care of residents with pressure sores. Contrary to DON Cornwell's assertions, it says that "*all* residents at risk will have skin condition checked and documented *daily*." It also says that all residents will have skin checks completed weekly and documented on the Weekly Skin Condition Evaluation form. "Skin integrity, color, moisture, temperature and turgor will be addressed." And it repeats that all wounds are to be evaluated upon discovery and weekly and again documented on the "Wound Treatment and Evaluation Record." A weekly wound report, titled "Weekly Wound/Skin Abnormality Tracking Log," is to be completed by the wound nurse

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[4] The document allows the reporter to select among a variety of wound types: pressure, surgical, venous insufficiency, arterial ulcer, skin tear, abrasion, laceration, diabetic neuropathic ulcer, burn, or other. CMS Ex. 19 at 28.

[5] One of these orders is dated March 19, well before the wound treatment evaluation indicated that it was a pressure sore. The other is dated April 13, one day after the wound treatment evaluation. This April 13 order is also one of three questionable treatment orders dated the same day, at least one of which DON Cornwell conceded was not completely accurate. CMS Ex. 21 at 16; see discussion, below. Moreover, the orders are not written by physicians; they are written by nurses and later signed by the physician. CMS Ex. 21 at 16. No physician testified that the wounds were "excoriations."

or her designee, with copies given to the DON, Administrator, MDS Coordinator, Dietician, and Unit Managers. CMS Ex. 19 at 32.

Elsewhere, the protocol says that if skin integrity is compromised, staff must document their findings on the "Wound Treatment and Evaluation Record." They must "evaluate, measure, stage and document findings" on the "Wound Treatment Evaluation Record." CMS Ex. 19 at 34. The complete evaluation should be done weekly and should include: 1) location; 2) staging; 3) size, depth, and any undermining or tunneling; 4) exudates, if any; 5) pain; 6) wound bed; and 7) description of wound edges and surrounding tissue. CMS Ex. 19 at 34.

Here, the facility fell far short of meeting any of these requirements. Staff assessed R138's wounds only once, on April 12. Otherwise, there is no evidence that they checked the resident's skin condition daily, or that they assessed and documented his wound's progression weekly. When the wounds first appeared, no one documented skin integrity, color, moisture, temperature and turgor; no one measured the wounds until April 12, 2010. Staff did not evaluate the wounds at any time thereafter. CMS Ex. 18 at 6 (Santiago Decl. ¶ 22). CMS Ex. 19 at 28. Thus, the facility did not follow the practices it had deemed necessary to prevent and treat the resident's pressure sores. It was therefore not is substantial compliance with 42 C.F.R. § 483.25(c).

Nor is this the only example of staff's failure to take all necessary precautions to promote healing and prevent infection. Surveyor Santiago testified that she observed a facility nurse providing his wound care. The nurse put on gloves. With a gloved hand, she closed the curtain around the resident and removed the dressings on the resident's wounds, thereby risking contamination. According to Surveyor Santiago, she contaminated the gloves when she touched the curtains. Standard nursing practice dictates that a nurse not touch anything before touching a wound. CMS Ex. 18 at 5 (Santiago Decl. ¶ 17). DON Cornwell, agreed that removing the dressing after she pulled the privacy curtain with her gloved hand was "not the best practice" and could create "an infection problem." CMS Ex. 21 at 4.

After the nurse removed R138's dressing, she changed her gloves but did not first wash her hands, as dictated by standard nursing practices. She then cleaned both wounds with the same gauze, which can result in cross-contamination. According to Surveyor Santiago, the wounds should be cleaned separately. CMS Ex. 18 at 5 (Santiago Decl. ¶ 20).

Because the facility was not taking all necessary precautions to promote the healing of pressure sores, to prevent infection, and to prevent new sores from developing, it was not in substantial compliance with 42 C.F.R. §§ 483.25 and 483.25(c).

Finally, CMS also alleges that the facility failed to follow R138's physician order to apply Optase gel twice a day to the resident's wounds. CMS Ex. 18 at 6 (Santiago Decl. ¶ 21). Petitioner claims that staff were correct in not applying the gel because the order had been discontinued. I decline to reach that issue because my findings are more than sufficient to sustain the penalty imposed. I explicitly reject, however, Petitioner's accusation that Surveyor

Santiago perjured herself because she testified that staff failed to follow the physician's order. According to Petitioner, "prior to the submission of her statement in this case," Surveyor Santiago had "been made aware of the discontinuation of the Order and testified, under oath in a state administrative proceeding that there was no requirement for staff to apply the Optase Gel." P. Br. at 5-6.

In fact, Surveyor Santiago testified that she "did a very thorough examination of the medical record for this resident" and "this order was not there." When she reviewed the telephone orders for that pressure ulcer," she found no such order. P. Ex. 5 at 36. The facility subsequently produced an order dated April 13, 2010 discontinuing the Optase. But, as pointed out during the state proceeding, the facility produced *three* orders – all dated April 13, 2010 – for treatment of the open wound. According to one, purportedly taken at 2:30 a.m., staff were to apply "hydrocolloid." P. Ex. 3 at 5.[6] But two other orders are dated April 13, 2010; neither indicates a time. One says to discontinue the "hydrocolloid" and apply Optase. P. Ex. 3 at 5. The other says to discontinue the Optase. P. Ex. 3 at 5. Surveyor Santiago testified that she had "never seen" three such orders "in my life." P. Ex. 5 at 37.

Thus, while Surveyor Santiago agreed that staff should not have applied the Optase if a valid physician order discontinued it, she legitimately questioned whether that order was in place at the time of the survey.

C. The penalty imposed – $250 per day – is reasonable.[7]

To determine whether a CMP is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating factor. The factors in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the section 488.438(f) factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without

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[6] No one, including DON Cornwell, believed that the physician ordered this medication at 2:30 a.m. CMS Ex. 21 at 16.

[7] I do not address the deficiencies cited under 42 C.F.R. § 483.25(h), because my findings more than justify the penalty imposed. *Senior Rehab.*, DAB No. 2300 at 6 n.5.

regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848, at 21 (2002); *Cmty. Nursing Home*, DAB No. 1807, at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800, at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638, at 8 (1999).

Here, the penalty imposed – $250 per day – is at the very low end of the penalty range for per-day CMPs ($50-$3,000). 42 C.F.R. §§ 488.408(d), 488.438(a)(1).

Petitioner has a significant history of substantial noncompliance. Since at least May 2006, it has been out of substantial compliance at every annual survey.[8] Based on the survey completed in June 2009, the facility was not in substantial compliance with regulations governing seven health requirements and one life safety code provision. Then and now, the facility was not in substantial compliance with the 42 C.F.R. § 483.25(c) (tag F314), governing prevention and treatment of pressure sores. CMS Ex. 16 at 1.

A year earlier, for the survey completed in May 2008, thirteen deficiencies were cited, including deficiencies under 42 C.F.R. § 483.25 (tag F309), governing quality of care, and 42 C.F.R. § 483.25(d) (tag F315), governing treatment of urinary incontinence.

In May 2006, the facility was also not in substantial compliance with 42 C.F.R. § 483.25(d).

The facility's history alone is thus sufficient to justify this modest CMP.

Petitioner does not claim that its financial condition affects its ability to pay this relatively small CMP.

With respect to the remaining factors, I find particularly disturbing staff's failure to assess at least weekly R138's skin, which they knew to be seriously compromised, and DON Cornwell's dismissive attitude toward their inactions. R138's wounds had been identified more than six weeks earlier and did not appear to be resolving. In that time, the staff had assessed the wounds only once, which, according to DON Cornwell, was sufficient. This demonstrates indifference and disregard for the resident's care, comfort and safety, for which the facility is culpable.

For these reasons, I find the penalties imposed reasonable.

[8] CMS proffers the facility's CASPER (Certification and Survey Provider Enhanced Reports) report, which includes a synopsis of survey findings for the years 2006 through 2009. CMS Ex. 16.

IV. Conclusion

From April 30 through May 29, 2010, the facility was not in substantial compliance with Medicare participation requirements and I affirm, as reasonable, the penalty imposed.

/s/
Carolyn Cozad Hughes
Administrative Law Judge