Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Omni Manor Nursing Home
(CCN: 365433),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-373

Decision No. CR2391

Date: June 27, 2011

DECISION

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to impose civil money penalties of $550 per day against Petitioner, Omni Manor Nursing Home, for each day of a period that began on April 24, 2008 and that ran through May 21, 2008.

I. Background

Petitioner is a skilled nursing home in the State of Ohio. It participates in Medicare, and its participation is subject to the requirements of sections 1819 and 1866 of the Social Security Act as well as to implementing regulations at 42 C.F.R. Parts 483 and 488. Its hearing rights are governed by regulations at 42 C.F.R. Part 498.

This case began with a determination by CMS that Petitioner failed to comply substantially with Medicare participation requirements. CMS determined to impose civil money penalties against Petitioner of $550 per day for each day of a

period that began on April 24, 2008 and that ran through May 21, 2008. Petitioner requested a hearing, and the case was assigned originally to another administrative law judge.

Petitioner then conceded that it had failed to comply substantially with Medicare participation requirements. It also conceded that the $550 per day civil money penalty amount was reasonable. It persisted, however, in challenging the duration of the remedy, arguing that it had attained compliance with Medicare participation requirements on April 29, 2008.

After a period of time, the case was reassigned to me for a hearing and a decision. I issued summary judgment in favor of CMS. Petitioner appealed the case to the Departmental Appeals Board (Board), and a Board appellate panel remanded the case to me, ordering that I afford Petitioner a hearing on the issue of duration. Petitioner then waived its right to an in-person hearing. I granted the parties a final round of briefing.

All of the exhibits that the parties proffered were received previously by me and remain in the record of the case. These were previously identified by the parties and received as CMS Ex. 1 – CMS Ex. 24 and P. Ex. 1 – P. Ex. 49. Petitioner, however, submitted on May 2, 2011 a declaration from Paulette Trexler, Petitioner's Quality Assurance Director, together with P. Ex. 49, and a new exhibit marked as P. Ex. 50.

II. Issue, Findings of Fact, and Conclusions of Law

A. Issue

The sole issue in this case is the duration of Petitioner's noncompliance with Medicare participation requirements.

B. Findings of Fact and Conclusions of Law

For the reasons that I discuss below, I find that Petitioner was substantially noncompliant with Medicare participation requirements from April 24 through May 21, 2008.

Where there is noncompliance, the burden is on the facility to prove that it came back into compliance. *Texan Nursing and Rehabilitation of Amarillo, LLC,* DAB No. 2323 (2010). Simply asserting that compliance was achieved by a particular date is insufficient to satisfy this burden. Nor is documentation that staff attained in-service training sessions or that other forms of training were provided to staff necessarily proof of compliance, where the noncompliance consisted of staff

failures to provide nursing care to residents that is consistent with regulatory requirements. Proof that the staff attended training sessions is not proof that the staff actually provided care in compliance with the training that they received. That is particularly the case where a staff's failures include failures to comply with an explicit order by a physician, or with facility protocols and policies that had been in effect previously. In that circumstance, simply telling an employee to comply with a directive is never proof that the employee is actually doing so.

Petitioner did not prove that it attained compliance with all regulatory requirements prior to May 21, 2008. The evidence that Petitioner relies on to show compliance consists largely of documents showing that staff were retrained or instructed to do their jobs correctly. What is singularly lacking from Petitioner's evidence is proof that the staff actually implemented, at any date prior to May 21, the training that was provided to them.

For example, CMS found – and Petitioner does not deny – that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25. This regulation requires a skilled nursing facility to provide each of its residents with the necessary care and services to attain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. The unchallenged evidence of noncompliance is that Petitioner failed to provide respiratory care to a resident who is identified as Resident # 180. CMS Ex. 5 at 5-8. This evidence shows that, between about 4 and 5 a.m. on April 9, 2008, the nursing staff failed to recognize obvious signs that the resident was in respiratory distress (the resident had a respiratory rate of 32 breaths per minute) and failed to keep close watch on the resident and record their observations. The staff did not intervene until after the resident became non-responsive. *Id.* at 7-8. The staff failed to perform their duty to protect the resident, despite a physician's order that had been issued at 4 a.m. on April 9 that, among other things, directed the staff to transfer the resident to a hospital if the resident showed continued signs of respiratory distress.

What this unchallenged evidence shows, then, is failure by a staff to: comply with an explicit order by a physician; recognize the clinical signs and symptoms of respiratory distress; document those signs and symptoms; and take immediate action necessary to protect the resident's welfare. Given the nature of this noncompliance, evidence that the staff was ordered to do better and was given retraining would not be persuasive proof that the staff did what they had been ordered to do. What is required is proof that that the staff actually implemented the training and directives that they received. Such proof might consist of evidence of actual treatment provided by the staff in circumstances that are analogous to those that are the basis for the finding of deficiency or of observation of the staff showing that the staff did what they had been instructed to do.

Here, Petitioner's evidence consists of proof that the staff members, who were culpable for the treatment failures in the case of Resident # 180, were disciplined coupled with proof that nursing staff attended retraining sessions. Petitioner's Final Brief at 4. Additionally, Petitioner implemented an audit form that would be utilized to monitor staff's performance of their duties to assure that changes in residents' conditions were properly detected and observed. *Id.* These measures may have been necessary elements of assuring compliance. But, their implementation is not proof that Petitioner attained compliance.

The measures that Petitioner relies on as proof that it attained compliance prior to May 21 consist in large measure of documentation that staff were told to do better and retrained. As I have explained, evidence of this type does not consist of evidence that these measures – as necessary as they may have been – were actually implemented in actual cases.

As for the audits that Petitioner asserted it performed of its staff, it has not offered documentary evidence of the results of those audits that prove that staff was actively monitored, and their performance measured against applicable standards of care. There is no proof, for example, that staff was observed providing care in individual instances of problems analogous to those experienced by Resident # 180 and that detailed observations of staff performance were made to assure that the staff were performing their duties appropriately. The audit forms that Petitioner introduced consist of cursory entries showing that, with certain residents, nurses on duty noted changes in the residents' conditions. P. Ex. 49 at 10-12. They do not consist of detailed observations about what the nurses saw, how they recognized changes in the residents' conditions, how they monitored these changes, what care they provided, and what consultation they engaged in. I find that these forms are simply not proof that staff was complying with professionally recognized standards of care in providing care to these residents.

I note also that Petitioner averred in its Plan of Correction that the audits would be performed for a period of one month after completion of staff retraining. CMS Ex. 5 at 1, 6. The inference I draw from that is that Petitioner's own management was not confident that retraining alone would produce instantaneous compliance by staff but that there would be a necessary period of observation and, if necessary, correction to assure that all staff were in compliance with necessary participation requirements.

As another example, it is undisputed that Petitioner was found not to be complying substantially with the requirements of 42 C.F.R. § 483.25(d). In pertinent part, the regulation requires a facility to 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. The undisputed facts

establish that Petitioner violated these regulatory requirements in that it failed to promptly discontinue the use of a urinary tract catheter (Foley catheter) for a resident (Resident # 102) and failed also to provide appropriate incontinence care to another resident (Resident # 4).

Petitioner asserts that it addressed this deficient care by: reviewing the records of all residents with catheters to assure that the residents continued to require them; providing in-service training to all nursing staff on April 25, 28, and 29, 2008 to assure that the staff were instructed in the circumstances under which Foley catheters should be discontinued; monitoring the residents to assure that that catheters were removed promptly when no longer medically needed; providing immediate in-service training to two nursing assistants concerning infection control during resident care; and providing in-service training to all nurse aide staff on April 22 and "continuing to" April 29, 2008 on appropriate incontinence care. Petitioner's Final Brief at 5-6.

In fact, and Petitioner's assertions notwithstanding, Petitioner did not prove that all of its nurse aides attended the in-service sessions. P. Ex. 48 at 18-22. Petitioner's own record of its in-service training shows that numerous individuals failed to sign the attendance form. That failure of proof, in and of itself, is sufficient for me to conclude that Petitioner did not attain compliance with all participation requirements prior to May 22, 2008.

Moreover, the fact that nurse aides were retrained in providing incontinence care is not by itself proof that they implemented the training that was given to them. Presumably, all of these aides had received training in providing incontinence care *prior to* April 24, 2008, and that training was insufficient to assure that they provided appropriate care. Given that, the fact that these aides received additional training, by itself, is hardly proof that they adhered to that training. Petitioner has not provided proof that its management personally observed the aides after they were retrained and assured that they applied their training correctly.

/s/
Steven T. Kessel
Administrative Law Judge