Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	
Brighton Pavilion, Petitioner,	Date: December 10, 1997
- v. -	Docket No. C-96-081 Decision No. CR510
Health Care Financing Administration	

DECISION

In this case, Brighton Pavilion (Petitioner) challenges the determination of the Health Care Financing Administration (HCFA) to impose the enforcement remedy known as "Denial of Payment for New Admissions" (DPNA) for the period from November 20, 1995 through January 31, 1996. The imposition of this enforcement remedy means that, if Petitioner had admitted any Medicare and Medicaid beneficiaries as residents to its facility during the specified period, Petitioner would receive no Medicare or Medicaid payments for the services it rendered to those newly admitted residents. See 42 C.F.R. § 488.401 (1995).[1]

I sustain the imposition of the DPNA remedy against Petitioner for the reasons and period specified by HCFA. I do so because a preponderance of the evidence supports HCFA's contention that, during a revisit survey conducted in October 1995, Petitioner was out of substantial compliance with program participation

[1] Unless otherwise indicated, I am using the version of the regulations which was revised and codified effective October 1, 1995, because the dispositive survey in this case was conducted in October 1995 and Petitioner's hearing request was filed in December 1995. The regulations applicable to this case have not undergone substantive changes since October 1, 1995.

requirements contained in the regulation codified at 42 C.F.R. § 483.20(d)(3)(ii) (titled "Resident assessment").

Additionally, I have concluded as a matter of law that I do not have the authority to supplant HCFA's choice of enforcement remedies where there exists substantial noncompliance with program requirements.

I. BACKGROUND

A. Statutory and regulatory framework

Petitioner, a 205-bed long-term care facility located in Quincy, Illinois, has been participating in the Medicare and Medicaid programs as a dually certified "SNF/NF"[2] at all times relevant to this case. Therefore, disposition of this case is governed by the statutory provisions enacted as part of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, Title IV, Subtitle C, as well as the implementing regulations promulgated by the Secretary of Health and Human Services (Secretary). The applicable statutory provisions, commonly known as the Nursing Home Reform Act of 1987, are codified at section 1819 (for Medicare) and 1919 (for Medicaid) of the Social Security Act (Act). The federal regulations implementing the Nursing Home Reform Act of 1987 became effective on July 1, 1995 (59 Fed. Reg. 56,116 (1994)) and were codified at 42 C.F.R. Part 401, et seq.

The implementing regulations specify that each long-term care facility participating in the Medicare or Medicaid programs must undergo a "standard survey" at least once every 15 months. 42 C.F.R. § 488.308(a). A "standard survey" is a "resident-centered inspection which gathers information about the quality of services furnished in a facility to determine compliance with the requirements for participation." 42 C.F.R. § 488.301. In addition to the "standard surveys," there are other surveys which may be conducted as frequently as necessary to determine, for example, whether previously cited deficiencies have been eliminated. 42 C.F.R. § 488.308(c).

Surveys must be conducted unannounced. 42 C.F.R. § 488.307(a). The survey team should consist of a multidisciplinary group of

[2] Long-term care facilities providing services under the Medicare program are called "skilled nursing facilities" (SNFs). 42 C.F.R. § 488.301. Long-term care facilities providing services under the Medicaid program are called "nursing facilities" (NFs). Id.

professionals, with at least one registered nurse in the group. 42 C.F.R. § 488.314(a). Generally, state surveying agencies under contract with the Secretary of Health and Human Services have responsibility for conducting surveys in their respective states. 42 C.F.R. §488.10(a)(1), 488.330(a). Based on the survey results, these state survey agencies then certify the compliance or noncompliance of dually participating SNF/NFs, subject to HCFA's review.[3] 42 C.F.R. § 488.330(a)(1)(D).

For current program providers, a certification of compliance constitutes a determination that the provider is in "substantial compliance" with the applicable program participation requirements. 42 C.F.R. § 488.330(b)(1). "Substantial compliance" means "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm."[4] 42 C.F.R. § 488.301.[5]

In contrast, a certification of "noncompliance" requires the imposition of at least one enforcement remedy against the current program provider. 42 C.F.R. § 488.330(b)(2). Except where a state is taking action under the Medicaid program

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[3] However, if HCFA disagrees with the state survey agency's certification, a finding of noncompliance must take precedence over the finding of compliance. 42 C.F.R. § 488.330(a)(1)(D).

[4] "Minimal harm" is not defined in the statute or regulations. HCFA points out in its posthearing brief that the State Operations Manual (SOM), HCFA Pub. 7, Transmittal No. 274, contains relevant interpretations. HCFA Br., 4. According to HCFA, the SOM interprets "potential for causing minimal harm" as "the potential for causing no more than a minor negative impact. . . ." Id. (quoting from SOM, Section V, subsection B, paragraph 1 at page P-49). "[P]otential for more than minimal harm, but not immediate jeopardy," a phrase used in 42 C.F.R. § 488.404(b)(1)(ii), is interpreted by the SOM to signify--

> noncompliance that results in minimal physical, mental and/or psychosocial discomfort to the resident and/or has the potential (not yet realized) to compromise the resident's ability to maintain and/or reach his/her highest practicable physical, mental and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.

HCFA Br., 4; Tr. 368 (quoting SOM, Section V, subsection B, paragraph 2 at page P-49).

[5] From time to time in this decision, I will use also the word "compliance" as an abbreviation for the regulatory definition of "substantial compliance." I will also use the words "noncompliance" or "out of compliance" to mean not in "substantial compliance" as defined in the regulations.

against a non-state operated SNF, HCFA has responsibility for imposing the enforcement remedy and issuing the requisite written notice. 42 C.F.R. § 488.330(c).[6]

A dually participating SNF/NF has the right to request an administrative hearing where the findings of noncompliance have resulted in HCFA's imposing against it one of the enforcement remedies listed in 42 C.F.R. § 488.406. 42 C.F.R. § 498.3(b)(12).

The regulations permit the imposition of DPNA as an optional remedy whenever a facility is out of substantial compliance with program participation requirements. 42 C.F.R. § 488.417(a). However, the regulations mandate the imposition of this remedy when the facility has remained out of substantial compliance for three months after the last date of the survey identifying the noncompliance. 42 C.F.R. §§ 488.412(c), 488.417(b)(1). If DPNA has been imposed against a facility without repeated findings of substandard quality of care, this remedy will end "on the date that the facility achieves substantial compliance, as indicated by a revisit [survey] or written evidence acceptable to HCFA (under Medicare) or the State (under Medicaid)." 42 C.F.R. § 488.417(d).

B. Relevant surveys and the enforcement remedy imposed by HCFA

In the foregoing regulatory context, the Illinois Department of Public Health (IDPH) surveyed Petitioner during early August 1995, pursuant to its contract with the Secretary.[7] HCFA Ex. 2, 4. After finding that Petitioner was not in substantial compliance with several participation requirements, the IDPH sent Petitioner a notice letter dated August 18, 1995. HCFA Ex. 3. Said letter explained which deficiencies required a plan of

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[6] As explained in the preamble to the regulations, the statute requires a division of responsibilities between the state and the federal government in the enforcement of federal certification requirements. 59 Fed. Reg. 56,218 (1994). Under the Medicare program, section 1819(h) of the Act reserves all enforcement decisions to the Secretary and permits states to only make recommendations based on the surveys they perform under their contract with the Secretary. Id.

[7] Petitioner described this August survey as its annual certification and licensure survey. P. Br., 3. HCFA described it as a standard survey. HCFA Br., 7. Since neither party has taken issue with the other's characterization of the August survey, I assume that these different descriptive terms do not impact on the outcome of any material issue.

correction,[8] which ones constituted substantial compliance, and which ones constituted noncompliance. Id. Additionally, IDPH's letter informed Petitioner that, unless Petitioner achieves substantial compliance by September 24, 1995, IDPH would recommend that HCFA impose remedies such as DPNA. Id. at 2.

In response to IDPH's notice, Petitioner submitted written representations that it had corrected its deficiencies and had come into compliance with program requirements. See HCFA Ex. 6. IDPH accepted Petitioner's allegations and presumed that substantial compliance had been achieved by September 24, 1995. Id. IDPH then informed Petitioner that a revisit survey would be conducted to verify Petitioner's compliance as of September 24. Id.[9] IDPH informed Petitioner also that, if the IDPH were to find noncompliance during the revisit survey, remedies such as DPNA would be imposed. Id.

IDPH conducted the resurvey during October 1995 and determined that Petitioner had remained out of substantial compliance with program requirements. HCFA Ex. 12, 13. In a notice dated November 1, 1995, HCFA imposed against Petitioner the DPNA remedy, as recommended by IDPH, for effectuation on November 20, 1995.[10] HCFA Ex. 13 at 2. HCFA's notice letter alleged that, since the August survey, Petitioner had continued to remain out of compliance with certain federal requirements, including the following ones:

> the regulation titled "Resident assessment" (F 282), 42 C.F.R. § 483.20(d)(3)(ii); and the regulation titled "Quality of care" (F 309), 42 C.F.R. § 483.24.

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[8] A plan of correction need not be submitted for isolated deficiencies which have caused no actual harm and have a potential for causing only minimal harm. 42 C.F.R. § 488.402(d)(2).

[9] Even though IDPH did not specify a date for the revisit survey, it committed to certifying Petitioner as being in compliance effective September 24, 1995 if the revisit survey (whenever conducted) found substantial compliance as of the revisit survey date. HCFA Ex. 6 at 1.

[10] As relevant to the facts of this case, the regulation codified at 42 C.F.R. § 488.402(f)(4) imposed the following notice requirement:

> (4) No immediate jeopardy - 15 day notice: Except for civil money penalties and State monitoring, notice must be given at least 15 calendar days before the effective date of the enforcement action in situations in which there is no immediate jeopardy.

Id. at 1.[11]

Thereafter, during February 1996, IDPH conducted another revisit survey and found that Petitioner had attained substantial compliance with all program requirements. HCFA Ex. 20. HCFA then notified Petitioner that the DPNA enforcement remedy had ended on January 31, 1996.[12] Id.

C. Proceedings in this case

This action was commenced upon Petitioner's timely filing of its request for hearing dated December 15, 1995. After I had set this case for an in-person hearing, HCFA filed a memorandum of law objecting to a portion of my Scheduling Order dated June 11, 1996, which did not draw clear distinctions between the burden of production and the burden of persuasion, and which also did not specify the party bearing the burden of persuasion. Petitioner did not file a response or request relief from my scheduling order.

On September 11, 1996, I issued in this case my "Ruling on the Health Care Financing Administration's (HCFA's) Objection to Paragraph 2 of the Scheduling Order Assigning the Burden of Proof to Respondent and Order Allocating Ultimate Burden of Persuasion" (Ruling). In this Ruling, I rejected HCFA's arguments that the ultimate burden of proof (i.e., the burden of persuasion, or the risk of non-persuasion) rested on Petitioner. I ruled also that HCFA had the ultimate burden of proof in this case with the effect that, if the weight of all conflicting evidence were in equipoise, I would set aside HCFA's findings of noncompliance and the resultant imposition of an enforcement remedy against the facility.

On September 13, 1996, the parties entered into a written stipulation, wherein Petitioner waived challenges to the survey findings from the August 1995 survey, agreed that the findings

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[11] F 282" and "F 309" are identifiers used by the surveyors to denote certain categories of deficiencies in their survey reports. See, e.g., HCFA Ex. 15. HCFA's November 1, 1995 notice letter identified another area in which Petitioner had remained out of compliance. However, HCFA does not assert that area of alleged noncompliance in these proceedings. See, e.g., HCFA Br., 31.

[12] HCFA notes that it erred in Petitioner's favor by having ended the DPNA as of January 31, 1996, instead of on February 9, 1996--the date on which Petitioner's compliance was certified by the IDPH. HCFA Br., 29 at n.33 (citing HCFA Ex. 19 at 1, 11).

from the August 1995 survey constituted noncompliance, and acknowledged that Petitioner was not in substantial compliance with participation requirements during the August survey. ALJ Ex. 1. In the same stipulation, HCFA agreed that no DPNA would have been imposed if Petitioner had been found in compliance with participation requirements in 42 C.F.R. Part 483, subpart B, during the October revisit survey. Id.

Thereafter, the case proceeded to an in-person hearing on the factual disputes left unresolved by the parties' stipulations.

After the parties submitted their posthearing briefs[13] in accordance with 42 C.F.R. § 498.63, the Appellate Division of the Departmental Appeals Board (DAB) issued its decision in Hillman Rehabilitation Center, DAB No. 1611 (1997). The Appellate Panel reversed an administrative law judge's ruling which had placed the burden of persuasion on HCFA, instead of on the health care provider whose program participation agreement had been terminated as a sanction for alleged noncompliance. I then gave the parties the opportunity to comment on the effect of Hillman and to suggest whether additional proceedings were necessary. Letter dated March 13, 1997. The parties provided their responses, which I will discuss below in Section II of this decision.

II. DISPOSITION OF OUTSTANDING MOTIONS, LEGAL ISSUES, AND ARGUMENTS BASED ON UNCONTESTED FACTS

A. Determination on the effect of the Hillman decision

Since the Hillman decision was issued by an Appellate Panel of the DAB, its legal conclusion on the burden of proof issue would automatically supersede any contrary ruling issued by an administrative law judge of the DAB in a similar case. Therefore, I solicited comments from the parties on whether the Hillman decision should affect how this case is decided and whether additional proceedings were warranted in light of Hillman. Letter dated March 13, 1997. I did so also because Petitioner's posthearing brief made arguments in reliance upon my Ruling of September 11, 1996.[14]

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[13] I will use the abbreviations of "HCFA Br., (page)" and "P. Br., (page)" to refer to the parties' respective, main posthearing brief. I will use "HCFA Reply, (page)" and "P. Reply, (page)" to refer to their respective reply briefs. I will cite to the transcript of the hearing as "Tr. (page)."

[14] For example, Petitioner stated:

> It is not Brighton's burden to prove that they complied with this resident's care plan, it is HCFA's burden to establish that they

By letter dated April 8, 1997, HCFA responded that Hillman is not distinguishable from the present case and that Hillman controls the burden of persuasion allocation in this case. HCFA stated also that it was satisfied with the record in this case and did not perceive a need for further proceedings.

By letter dated April 11, 1997, Petitioner stated also that no additional proceedings would be necessary. However, Petitioner was of the view that the Hillman decision should not have any impact on my decision in this case because Petitioner agrees with my Ruling of September 11, 1996. Petitioner said it had introduced evidence in reliance upon that ruling.

I have considered the parties' arguments on the effect of the Hillman decision and conclude that, in this case, I should have allocated the burden of persuasion to Petitioner in accordance with the analysis set forth by the Appellate Panel in Hillman.

Petitioner Brighton's relationship to HCFA is not distinguishable from the one which existed between the provider and HCFA in the Hillman case. Both Petitioner herein and Hillman Rehabilitation Center provided services under the Medicare and Medicaid programs. Like Hillman Rehabilitation Center, Petitioner herein is also challenging HCFA's determination of noncompliance, which has resulted in the imposition of an enforcement remedy. The program goals and policy considerations relied upon by the Appellate Panel in Hillman are equally applicable to this case. Therefore, I am bound by the Appellate Panel's analysis and conclusion on the burden of persuasion allocation in Hillman.

Even though Petitioner stated that it had relied upon my September 11, 1996 Ruling in presenting its evidence at hearing, it did not avail itself of the opportunity to submit other evidence or to amend its posthearing written arguments. Additionally, neither party has argued that the weight of all evidence in this case is in equipoise or that the burden of persuasion allocation would have dispositive effect. As the Appellate Panel noted in Hillman, the allocation of the burden of persuasion has practical use only when the evidence is in equipoise. Hillman at 10.

> did not, according to the ruling of the Administrative Law Judge on this issue dated September 11, 1996. They have failed to meet that burden on this issue.

P. Reply, 9.

For the foregoing reasons, I issue the following formal Findings of Fact and Conclusions of Law (FFCL):

1. In accordance with the Hillman decision, Petitioner herein bears the burden of persuasion.

2. No additional proceedings are necessary in this case in light of the Hillman decision.

B. Rejection of Petitioner's request that a "less severe" enforcement remedy be substituted for the DPNA imposed by HCFA

In its main posthearing brief, Petitioner argued as follows:

> even if a deficiency is found, and if it is found to pose a potential for more than minimal harm, it is not mandated that HCFA's choice of penalties be sustained. Surely, the relatively minor nature of any deficiency that could be sustained under this set of facts should warrant a much less severe penalty than that which was imposed.

P. Br., 21 (emphasis in original).

According to HCFA, it had imposed the DPNA against Petitioner not as a matter of discretion, but because the regulations mandated that a DPNA be imposed. HCFA Reply, 19. HCFA must impose DPNA as a remedy whenever it finds that a facility has remained out of compliance with program requirements for three months after the last date of the survey which identified the noncompliance. 42 C.F.R. § 488.417(b). Therefore, the DPNA remedy imposed by HCFA pursuant to the mandates of 42 C.F.R. § 488.417(b) cannot be set aside unless the evidence establishes that Petitioner had come into compliance within three months of the initial August survey (i.e., Petitioner had achieved compliance by the time the October resurvey was conducted to verify Petitioner's allegations of compliance).[15]

Even if HCFA had imposed the DPNA against Petitioner as a discretionary act (see 42 C.F.R. § 488.417(a)), the right to exercise said discretion is reposed in HCFA, not in me. 42 C.F.R. §§ 488.402, 488.404,[16] 488.408. HCFA and the state survey

[15] As noted above, the first survey was conducted in August 1995 and Petitioner has stipulated to the noncompliance determination of that survey.

[16] I take notice that the preamble to the regulation now codified as 42 C.F.R. § 488.404 ("Factors To be Considered in Selecting Remedies") explained

agency are authorized to choose from several enforcement remedies corresponding to the level of noncompliance they have determined. 42 C.F.R. § 488.408. Their determination as to the level of noncompliance is, in turn, based on their evaluation of the seriousness of the deficiencies. 42 C.F.R. § 488.404(a).

The regulations make clear that a facility "may not appeal the choice of remedy, including the factors considered by HCFA or the State in selecting the remedy. . . ." 42 C.F.R. § 488.408(g)(2); 42 C.F.R. § 498.3(b)(12). The level of noncompliance found by HCFA in a SNF or NF is not an appealable determination unless a civil money penalty has been imposed. 42 C.F.R. § 498.3(b)(13). Explanations contained in the preamble to the relevant regulations show that the "level of noncompliance" corresponds to or is determined by the seriousness of the deficiencies as found by HCFA or the state survey agency. 59 Fed. Reg. 56,173 (1994) (discussing 42 C.F.R. § 488.404); 59 Fed. Reg. 56,179 (discussing 42 C.F.R. § 498.61(b)).

I have allowed into the record explanations of the severity or "seriousness" levels of noncompliance because certain exhibits of relevancy to this case for other reasons contain codes referring to those levels and the surveyors, in recounting their activities and thoughts, referred to the codes. Additionally, the severity levels were introduced to explain that HCFA was not alleging noncompliance at the highest level. Explanations of the severity levels helped me to understand certain testimony and portions of exhibits.

For the foregoing reasons, I issue the following formal FFCL in denying Petitioner's motion to substitute the DPNA imposed by HCFA with a "less severe" remedy:

3. I am without the authority to substitute any enforcement remedy for the one selected by HCFA.

C. Denial of Petitioner's request to strike HCFA's evidence and arguments concerning the August 1995 survey

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that the enumerated factors must be used to assess the seriousness of a facility's deficiencies and the enforcement actions must correlate with the seriousness of the deficiencies. 59 Fed. Reg. 56,173 (1994). The regulation specifically leaves to the "judgment of both HCFA and the States whether to impose alternative remedies at all, regardless of the seriousness of the facilities' deficiencies." Id.

Petitioner has stipulated that it would not challenge the findings from the August 1995 survey and that such findings constituted noncompliance with program participation requirements. ALJ Ex. 1. HCFA has stipulated that no DPNA would have been imposed if it had found Petitioner in compliance as of the October 1995 resurvey. Id. Therefore, Petitioner argues in its main posthearing brief that the issues in this case can be decided "solely with reference to the October 1995 survey." P. Br., 3. In its reply brief, Petitioner asks that HCFA's evidence and arguments concerning the August survey be stricken from the record. P. Reply, 2.

I deny Petitioner's request to strike evidence. HCFA has properly introduced evidence and explanations concerning the August survey findings as background for the factual disputes concerning the October survey.

The October survey was a revisit or follow-up survey specifically made in order to ascertain whether certain deficiencies found during the August survey continued to exist. Tr. 29, 37. The surveyors were instructed not to cite any new deficiency in a follow-up survey unless the problem was glaring or a matter of actual harm. Tr. 38; see Tr. 327 - 329. The team which conducted the October resurvey had concluded that two areas of deficiencies cited previously during the August survey had remained uncorrected. Tr. 58.

Additionally, as noted above, HCFA's position is that the DPNA was imposed only because Petitioner's noncompliance had continued for three months after the August survey. In its November 1, 1995 notice to Petitioner, HCFA stated that the enforcement remedy was imposed because certain deficiencies "remain not met." HCFA Ex. 13 at 1. Given all these facts, it is appropriate for the record to contain evidence explaining the two areas of deficiencies from the August survey which were the focus of the resurvey and which have allegedly remained uncorrected for three months.

For the foregoing reasons, I issue the following formal FFCL in denying Petitioner's request that I strike HCFA's evidence concerning the August 1995 survey:

4. Evidence of the survey conducted in August 1995 is useful as background information for explaining the October 1995 resurvey findings in controversy.

D. Rejection of Petitioner's argument that the noncompliance determination at issue is wrong due to some of the surveyors' allegedly inadequate training and surveying experience

During the hearing, Petitioner moved for a directed verdict and argued that all October deficiency citations should be stricken because the survey was conducted by individuals who lacked adequate training. Tr. 377 - 379. In support of its motion, Petitioner pointed out that not all members of the October resurvey team had complied with the statutory requirement for completing a training and testing program set up by the Secretary. Id.

HCFA responded by pointing out that the regulations permit trainees on survey teams, so long as they are accompanied by a surveyor who has successfully completed the required training course. Tr. 380 (quoting 42 C.F.R. §§ 488.314(c) and 488.318(b)). Moreover, the regulation states that inadequate survey performance does not relieve a facility of its obligation to meet all participation requirements; nor does inadequate survey performance invalidate adequately documented deficiencies. Tr. 381 (quoting 42 C.F.R. § 488.318(b)).

I denied Petitioner's motion for a directed verdict. Tr. 381. However, in its posthearing brief, Petitioner argued again that the noncompliance determination should not be credited because most of the surveyors who conducted the October resurvey lacked adequate training and experience. P. Br., 18. Petitioner is not contending in its brief (as it had done during the hearing) that such inadequacies make their survey findings invalid as a matter of law. Instead, Petitioner appears to be contending that the noncompliance determination at issue is wrong because the surveyors who lacked adequate training or experience were unable to apply the "noncompliance" concept properly. See P. Br., 18 - 19.

I have considered the relevant evidence and reject the new arguments submitted by Petitioner.

According to the uncontradicted evidence presented by HCFA (see, e.g., transcript pages cited at HCFA Br., 7 - 12), the resurvey at issue was conducted following the State survey agency's receipt of Petitioner's plan of correction and representations that, as of September 24, 1995, Petitioner had corrected all deficiencies found during the August 1995 survey. Therefore, in October 1995, a team of surveyors was given the responsibility

for conducting a focused resurvey in order to check on the status of Petitioner's compliance in specific problem areas.

The October revisit survey was coordinated by Janet McIntyre, a registered nurse who had been employed as a surveyor by the State agency for 15 years. On direct examination as well as cross-examination, her testimony concerning her qualifications shows that she did receive relevant training from HCFA and the State. The other members of the October team were three IDPH "health facility surveillance nurses" (Kathleen Stapleton, R.N.; Shirley Miller, R.N.; and Judith Bradshaw, R.N.) and two surveyors employed by the Illinois Department of Public Aid (Annabel Blackorby, R.N. and Gary Streitmatter, sanitarian). See HCFA Ex. 8 at 7, 8.

Also, according to the uncontradicted evidence presented by HCFA, the resurvey team performed seven tasks in accordance with established protocols for resurveys.

"Task 1" of the October resurvey consisted of the off-site preparatory work performed by the team coordinator (Ms. McIntyre), such as her review of the previous survey report and her discussions with the other team members concerning the deficiencies they would need to resurvey.

"Task 2" consisted of the team's unannounced entry onto Petitioner's premises, as well as the discussions the team coordinator (Ms. McIntyre) held with Petitioner's staff to explain the purpose of the resurvey and to request certain information from Petitioner.

"Task 3" consisted of the team's activities while walking through the facility in the company of Petitioner's personnel. During this tour, the resurvey team members made observations, asked questions, and noted potential issues for inquiries.

"Task 4" consisted of the resurvey team's activities when its members met as a group after the walk-through tour. During this meeting, the team members discussed their initial impressions and selected the sample residents for focused review; Ms. McIntyre, the team coordinator, then divided up the charts of these sample residents among the team members for focused reviews.

"Task 5" consisted of the surveyors' gathering information about their assigned residents. The surveyors studied Petitioner's records, observed the residents in person, conducted interviews

with the residents or their families where feasible, met with one another to discuss their observations and respective impressions, and met with Petitioner's administrative staff in order to provide Petitioner with the opportunity to disclose information pertinent to the surveyors' preliminary findings.

"Task 6" consisted of the team's meeting as a group to discuss whether Petitioner had eliminated each of the areas of noncompliance found during the August survey.

"Task 7" consisted of the exit interview held with Petitioner's administrator, at which time Ms. McIntyre, as the team coordinator, disclosed the team's tentative compliance/noncompliance findings, the details of each example of alleged noncompliance noted by the surveyors, and the identity of the residents involved. Additionally, Petitioner's administrator was given the opportunity to provide pertinent information to the surveyors during the exit conference.[17]

Following this multistep process, the surveyors prepared a written report containing the team's formal findings of noncompliance under the "Resident assessment" (F 282) and "Quality of care" (F 309) requirements. HCFA Ex. 8.

The foregoing uncontested evidence does not show the invalidity of the noncompliance determination made by the survey team as a group. Nor have I found any evidence proving that any individual surveyor's personal observations were facially unreasonable due to the extent of his or her training or surveying experience. See P. Br., 18. The evidence does not establish the extent to which any individual surveyor's alleged lack of training or experience had impacted on the noncompliance determination at issue. There is no evidence showing that more training or surveying experience for any of the surveyors would have resulted in the team's making a collective determination that Petitioner was in substantial compliance during October 1995.

The crux of Petitioner's complaint is its allegation that the surveyors did not understand what the term "substantial compliance" meant because neither the regulations nor the SOM defined "potential" and "minimal harm." See P. Br., 18. However, Petitioner has introduced no evidence to show that additional training or surveying experience would have given any of the

[17] As I discuss below, Petitioner's administrator did provide additional information to the surveyors at the exit conference.

surveyors an understanding of these terms that would be substantially different than what they expressed at the hearing. Moreover, the explanations of "minimal harm" and "potential" given by individual surveyors (quoted by at P. Br., 19, 20) do not support the argument that they are unreasonable, inconsistent, and overbroad. As indicated by Petitioner's quotation of the definitions provided by the surveyors (P. Br., 19, 20), the surveyors were using what amounted to ordinary dictionary definitions of "potential" and "minimal harm." The surveyors' approach is valid, given that neither the regulations nor statutes provide specific definitions for those terms or suggest that ordinary dictionary meanings should not be used.

For the foregoing reasons, I issue the following formal FFCL in rejecting Petitioner's argument that HCFA's noncompliance determination is erroneous because some surveyors are alleged to have lacked adequate training and experience:

5. The uncontested evidence of record establishes that the noncompliance determination at issue resulted from the collective determination of the resurvey team, which was under the coordination and guidance of an experienced and qualified surveyor (Janet McIntyre), through the proper use of established procedures and goals applicable to follow-up surveys and with the consideration of information provided by Petitioner throughout the resurvey process.

6. The extent of an individual surveyor's experience or training has not been shown to have caused any material flaw in the noncompliance determination at issue.

E. Rejection of Petitioner's argument that HCFA's noncompliance determination under "Resident assessment" (F 282) is wrong due to the short duration of the survey, the small number of residents sampled, and the allegedly minor nature of some deficiencies

Petitioner contends that the number and nature of the deficiencies cited for its resident population of 197 people during a few days in October 1995, even if proven, do not demonstrate noncompliance by Petitioner. P. Br., e.g., 5, 12; P. Reply, e.g., 6, 11, 12. In making these arguments, Petitioner refers to its admitted failure to serve the prune juice

specified in physicians' orders for two residents on the one morning observed by a surveyor, and to its staff's admitted failure to reposition a resident (who had a physician's written order for repositioning every two hours) during any of the four periods of time a surveyor was making her observation of this resident.[18]

I have considered the fact that HCFA's noncompliance determination rests on the 11 distinct sets of deficiencies which were identified by the resurvey team in their review of the services Petitioner delivered to 8 of 17 residents. See HCFA Ex. 8. (Each set of deficiencies consisted of multiple observations of the same type relating to those 8 residents.)[19] I have considered also the fact that the resurvey at issue took place over a period of three days at a facility that the surveyors knew housed approximately 200 residents. See Tr. 45, 46. Additionally, the evidence shows without dispute that, in determining noncompliance as a result of the October resurvey, the resurvey team had assigned the "E" level to the deficiencies categorized under "Resident assessment" (F 282) and "D" level to the deficiencies categorized under "Quality of care" (F 309). HCFA Ex. 8. As explained by HCFA, the letters from "A" through "F" are used by the surveyors to indicate the scope and severity of the deficiencies (with "A" being the lowest). HCFA Br., 5 at n.2.

These uncontested facts provide some support for Petitioner's argument that HCFA's noncompliance determination should not be sustained due to the relatively minor nature of the problems discovered for only a handful of residents during a short period

[18] Even though Petitioner listed only certain specific survey citations in her arguments, the same process was used by the surveyors in making their finding for all of the deficiencies which underlie the noncompliance determination at issue. Therefore, I address in this section the aspect of Petitioner's arguments which has general applicability to all of the deficiencies found during October through the same resurvey process. (This process is established by the uncontested facts of record.) Elsewhere in the Decision, I will discuss the specific factual disputes concerning each alleged deficiency.

[19] The observations consisted of the surveyors' review of residents records and their visual study of the residents' care. The surveyors noted more than one time period of visual observation for each allegedly deficient service rendered to each resident--with the exception of the observation that Petitioner had failed to follow physician's orders to serve prune juice to two residents identified as R 1 and R 11. The surveyor made her visual observation concerning the latter matter during a single period of observation (from 7:50 to 8:30 AM on the second day of the resurvey). HCFA Ex. 8 at 2, 3.

of time. However, I have considered also other uncontested facts. Other uncontested facts provide the appropriate context for interpreting Petitioner's arguments. Therefore, based on the totality of the relevant uncontested facts of record, I conclude that the size of the sample, the surveyors' focus on problems which may appear minor in isolation, and the length of the resurvey do not negatively affect HCFA's determination of noncompliance under the "Resident assessment" requirement.

First, with respect to the portion of Petitioner's argument alleging that the deficiencies were minor, the evidence introduced by HCFA shows that deficiencies of levels "D" (assigned by the resurvey team to Petitioner's "Quality of care" deficiencies) and "E" (assigned by the resurvey team to Petitioner's "Resident assessment" deficiencies) are considered to constitute substantial noncompliance. HCFA Br., 5 at n.2. In reliance upon these "D" and "E" designations, HCFA has not alleged that Petitioner's noncompliance was at the most egregious end of the noncompliance continuum. However, even the less serious level of noncompliance alleged by HCFA, if proven true, would compel me to uphold the DPNA imposed by HCFA. See Section II, B, above.

With respect to Petitioner's reliance on the short duration of the survey period and its contention that certain trivial matters were improperly focused upon during the resurvey, I note that what occurred in October 1995 was a focused study of what Petitioner had done or failed to do to remedy its past noncompliance. The nature of Petitioner's past noncompliance determined the inquiries and observations made by the resurvey team and Petitioner had the opportunity to present more information to the resurvey team if Petitioner thought the resurvey was being concluded too soon. As I have discussed above, the focused survey conducted in October was done in accordance with established protocol and goals, which provided Petitioner with the opportunity to submit additional information for consideration by the surveyors before they made their final determinations.

According to the relevant uncontested facts of record (see, e.g., testimony cited at HCFA Br., 7 - 12), the October survey was a revisit made especially for the purpose of ascertaining whether Petitioner had eliminated those deficiencies at the "D" level or higher which had been found during the August survey. Therefore, in conducting the resurvey, the team properly focused on Petitioner's activities under 42 C.F.R. § 483.20(d)(3)(ii) ("Resident assessment") and 42 C.F.R. § 483.25 ("Quality of

care"), since noncompliance at the "E" level had been found in both those areas during the August survey. See HCFA Ex. 3 at 9 - 11 (referring to F 282) and 11 - 14 (referring to F 309).

The uncontroverted evidence shows also that Ms. McIntyre, the resurvey team's coordinator, had reviewed the August survey report and related documents in preparation for the resurvey. Among the examples cited in the August survey report for Petitioner's noncompliance with the "Resident assessment" requirement (F 282) were Petitioner's substitutions of other liquids for the milk shakes, thickened liquids, and prune juice specifically ordered by physicians in their written orders. HCFA Ex. 4 at 10. The August survey report also cited Petitioner's noncompliance with the "Quality of care" requirement (F 309), as evidenced by Petitioner's failure to release, reposition, and toilet the eight residents who were restrained in chairs with trays or lap locks during the three and one half hours observed by a surveyor. HCFA Ex. 4 at 11 - 14. The focus of the October resurvey was properly on these and other prior deficiencies to determine whether the underlying practices had been eliminated as alleged by Petitioner. See Tr. 49.

Under the forgoing circumstances, there is nothing improper or trivial about the resurvey team's focus during October 1995, on issues such as whether Petitioner had continued to deviate from physician's written orders for Petitioner to serve specific fluids (e.g., prune juice) to certain residents each morning or whether Petitioner had corrected its prior practice of failing to reposition those residents who needed assistance in doing so. Additionally, the relevant portions of the regulation on "Resident assessment" (quoted below) focused on a facility's delivery of care in accordance with the contents of a facility's plan of care for its residents--including any incorporated physician's orders relating to juices, medications, repositioning, or anything else. The "Resident assessment" regulation does not exempt a facility from following doctors' written orders on matters considered insignificant by its staff.[20] As acknowledged by Petitioner's administrator during the hearing, no one at a nursing facility has the authority to disregard a physician's order, even if the order can be viewed as trivial or unnecessary. Tr. 424.

[20] I discuss below Petitioner's argument that prune juice should not have been specified in a physician's order.

As for the size of the resurvey samples in relation to Petitioner's census of 197 residents in October 1995, the uncontroverted evidence of record shows also that the number of the resident samples was determined in accordance with a standard formula, which Petitioner has not challenged. Ms. McIntyre testified that the number of residents selected as samples for the October resurvey was determined with the use of a formula contained in the SOM; this formula factored in a facility's resident census and the fact that a follow-up survey was being conducted. Tr. 45, 46, 49 - 50. For a routine survey, the relevant formula would have required sampling 29 residents in a facility with Petitioner's census. Tr. 45. The formula applicable to a follow-up survey requires sampling 60 percent of those residents who would have been reviewed for a routine survey. Id. For these reasons, the October 1995 resurvey team selected a sample of 17 residents (or 60 percent of 29 residents) for their focused review.[21]

Petitioner has not challenged the validity of the formula used by the surveyors for determining the sample size. In fact, there does not appear to be any basis for such a challenge. The formula, specified by the SOM, is the same one which would have been used in any follow-up survey of a nursing facility having approximately 197 residents. By entering into the Medicare and Medicaid programs voluntarily, Petitioner has voluntarily subjected itself to the resurvey procedures and formulas applicable to the same type nursing care facilities.

In citing Petitioner for noncompliance under both the "Resident assessment" (F 282) and "Quality of care" (F 309) requirements, the resurvey team found problems in Petitioner's services to 8 of the 17 sample residents and listed 11 distinct sets of deficiencies[22] (each set consisting of multiple observations of

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[21] Under the "Quality of care" citation, the October resurvey report refers to "1 of 12 residents." HCFA Ex. 8 at 7. However, in light of the testimony explaining how the number of resident records were selected for review (Tr. 45, 46), I conclude that "1 of 17 residents" was mistyped as "1 of 12 residents" in the resurvey report.

[22] According to the survey report, the care plan for R 16 (Lloyd H.) specified ambulation to and from meals and the bathroom. HCFA Ex. 8 at 6. The surveyors noted, inter alia, that the resident was not being ambulated daily and he was not being taken to the bathroom. HCFA Ex. 8 at 6.

HCFA contends only that Petitioner has failed to ambulate this resident. HCFA Br., 23, 24, 46 - 48. HCFA does not contend that the care plan required this resident to be toileted or that Petitioner's ambulation of this resident must begin or end at the bathroom. Therefore, I do not construe the alleged

the same type) for those 8 residents. HCFA Ex. 8. All 11 sets of the citations were used to support the conclusion that Petitioner was out of compliance with "Resident assessment." Additionally, one of those 11 sets of citations (Petitioner's alleged failure to reposition R 6 (Loretta V.)) was repeated verbatim in finding Petitioner out of compliance also with the "Quality of care" regulation. HCFA Ex. 8 at 5, 7.

If proven as fact, 11 sets of like deficiencies which occurred under the "Resident assessment" requirement during a mere three-day period in Petitioner's delivery of services to 8 (or nearly 50 percent) of the 17 sample residents would constitute a facially significant incidence of problems. This, or a similar number of like problems, can reasonably lead to the conclusion that Petitioner had systemic problems under the "Resident assessment" requirement. The existence of systemic "Residence assessment" problems can, in turn, support HCFA's conclusion that Petitioner was not in substantial compliance with program participation requirements. See HCFA Reply, 3.

However, HCFA's determination of noncompliance under the "Quality of care" requirement is not supported by any numerically significant observations, even if the observations were proven true. HCFA has relied upon only a single set of observations concerning one resident (R 6) out of the 17 sampled. Additionally, this same set of observations was categorized as a "Resident assessment" deficiency as well. Even though I am not creating any universal rule prohibiting the use of the same set of facts to support more than one noncompliance allegation, the facts in this case suggest strongly that the "Quality of care" noncompliance determination in this case was made unnecessarily and without adequate justification.

There is no evidence that any concern for R 6's health or well-being had necessitated citing Petitioner for alleged noncompliance under both the "Resident assessment" and "Quality of care" requirements due to Petitioner's failure to reposition this resident. The alleged failure to reposition this single resident out of the group of 17 sampled also does not suggest a pattern of "Quality of care" problems. Additionally, there is no evidence that HCFA would have foregone imposing the DPNA against Petitioner absent the additional finding of noncompliance under "Quality of care." A basis for imposing an enforcement remedy such as DPNA exists even if noncompliance has been found under

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failure to take this resident to a bathroom as an independent citation of a deficiency.

only one regulation. Therefore, in accordance also with the parties' stipulations (ALJ Ex. 1), I will resolve only the merits of HCFA's determination of noncompliance under "Resident assessment" (F 282), 42 C.F.R. § 483.20(d)(3)(ii), pursuant to the October resurvey.

For the foregoing reasons, I issue the following formal FFCL after having evaluated Petitioner's arguments concerning the number and nature of deficiencies found during the three-day resurvey:

7. Under established resurvey protocol, it was appropriate for the resurveying team in October 1995 to consider, inter alia, whether Petitioner had corrected its past noncompliant practices of failing to provide to residents the drinking fluids (e.g., prune juice) specified in their physician's written orders and of failing to reposition residents for long periods of time.

8. There is no evidence establishing that the resurvey at issue should have been conducted for longer than the period actually used by the resurvey team.

9. The resurveying team's sampling of only 17 residents from Petitioner's total population of 179 residents in October 1995 was properly done in accordance with established resurvey protocol.

10. If proven as fact, the incidents of similar deficiencies (or a like incidence of similar deficiencies) cited by the October resurvey team can reasonably support HCFA's conclusions that Petitioner had systemic problems which were not corrected from August and, therefore, Petitioner remained out of compliance with the "Resident assessment" requirements.

11. It is not necessary for me to reach the issue of whether Petitioner was also out of compliance with the requirements for "Quality of care," which HCFA has attempted to establish with the use of only one set of observations (repeated from the "Resident assessment" determination) concerning one resident out of the 17 sampled.

12. The issue of whether HCFA had a basis for imposing the DPNA remedy against Petitioner will be decided on the merits of the problems cited by the resurvey team under "Resident assessment" (F 282), 42 C.F.R. § 483.20(d)(3)(ii).

III. EVIDENCE AND DISPUTES CONCERNING THE "RESIDENT ASSESSMENT" REQUIREMENT (F 282)

A. The regulation relied upon by HCFA

To participate in the Medicare and Medicaid programs, each NF/SNF must conduct a comprehensive assessment of each resident's functional needs and then develop a comprehensive care plan for each resident. 42 C.F.R. § 483.20(b), (d). The regulations also explain what a care plan must contain, how it must be formulated, and the relationship it must bear to the goal of having each resident attain or maintain his or her highest level of well-being. The regulations state:

> (1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following--
> (i) [t]he services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under § 483.25 . . .
> (2) A comprehensive care plan must be--
> (ii) [p]repared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs

42 C.F.R. § 483.20(d)(1)(i), (2)(ii).

In the foregoing context, HCFA found Petitioner out of compliance with the following regulatory requirement during the October resurvey:

> (d) Comprehensive care plans.
> (3) The services provided or arranged by the facility must-
> ***
> (ii) [b]e provided by qualified persons <u>in accordance with each resident's written plan of care</u>.

42 C.F.R. § 483.20(d)(3)(ii) (emphasis added).[23]

HCFA seeks to prove Petitioner's noncompliance with use of the 11 sets of deficiencies found by the resurvey team during their review of Petitioner's delivery of services to 8 out of 17 sample residents.[24]

According to HCFA, Petitioner's noncompliance with 42 C.F.R. § 483.20(d)(3)(ii) is established by two broad categories of omissions, which are evidenced by the 11 sets of deficiencies:

> 1. PETITIONER'S FAILURE TO FOLLOW WRITTEN PHYSICIANS' ORDERS, as shown by:
>
> A. Petitioner's failure to apply hand splints and hand rolls on four residents (R 17, R 12, R 4, and R 16) as ordered by their physicians for avoiding or retarding the residents' development of hand contractures;
>
> B. Petitioner's failure to provide prune juice to two residents (R 1 and R 11) as ordered by their physicians for maintaining regular bowel movements;
>
> C. Petitioner's failure to reposition one bedridden resident (R 6) as ordered by her physician;
>
> 2. PETITIONER'S FAILURE TO IMPLEMENT THE WRITTEN CARE PLANS IT DEVELOPED FOR RESIDENTS, as shown by:
>
> A. Petitioner's failure to treat the significant weight loss of one resident (R 12) by referring her to a registered dietician in accordance with the care plan;
>
> B. Petitioner's failure to reduce the episodes of inappropriate behavior for two residents (R 4 and R 9) in accordance with their care plans;
>
> C. Petitioner's failure to ambulate one resident (R 16) daily in accordance with the care plan.

I discuss below these two broad categories and the 11 sets of deficiencies.

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[23] The testimony shows also that a "plan of care" is used to mean the written document developed by the facility which encompasses all of the care to be given a resident. Tr. 54, 55.

[24] For each of the 11 sets of alleged deficiencies, I will summarize below the corresponding evidence and theories presented by the parties. Thereafter, in Section IV of this Decision I will evaluate the merits of the parties' respective position.

B. Petitioner's failure to follow physicians' written orders to provide specified services to certain residents

The regulations codified at 42 C.F.R. § 483.20 do not specifically mention physician orders. However, all facilities are required to provide services "in accordance with each residents' written plan of care" (42 C.F.R. § 483.20(d)(3)(ii)) and each written plan of care must be prepared with the participation of the resident's attending physician and include a description of the services that are to be furnished to the resident by the facility. 42 C.F.R. § 483.20(d)(1)(i), (2)(ii). Therefore, it follows that a facility's failure to provide services to residents in accordance with the written orders of their physicians can constitute noncompliance under this regulation. Additionally, Petitioner has not argued that, as a matter of law, failure to follow a physician's written order cannot constitute noncompliance under 42 C.F.R. § 483.20(d)(3)(ii).

1. Failure to Apply Hand Splints and Hand Rolls for Four Residents in accordance with Written Physician's Orders

HCFA's evidence and conclusions

There is no material dispute to HCFA's evidence defining hand contractures and explaining the need to use hand rolls or hand splints. As explained by one of the nurse surveyors, contractures are the loss of the ability to move a joint to the fullest range or extent. Tr. 144. If residents do not voluntarily move their joints, the joints become stiff, and bone will actually develop in the joints; in those situations, the joints can become immovable and pressure sores or infections can develop in the skin of the contracted hand. Id.; Tr. 147. To avoid or retard the development of these problems, hand splints are used to stretch out the hand (Tr. 145, 148, 149) and hand rolls are used to keep the hand from closing completely to the point where finger tips are pressed against the palms (Tr. 146, 147).

The parties are in substantial agreement that a hand roll should be in place if the hand splint is not being used. A surveyor so testified on behalf of HCFA. Tr. 147, 148. Petitioner's assistant director of nursing agreed that it would be "pretty bad nursing practice" to leave a contracted hand without either a splint or hand roll in place. Tr. 520. She agreed that a hand

roll should be in place if there is no passive range of motion exercise being performed and the splint is off. Tr. 498.[25]

According to a nurse surveyor who testified for HCFA, contractures get worse every day that they are untreated. Tr. 153. The worsening of contractures can debilitate an individual's activities of daily living and quality of life. Tr. 306. Petitioner's assistant director of nursing agreed that the potential for compromising an individual's condition increases every day that the hand rolls and splints are not in place. Tr. 519, 523. Petitioner's director of operations acknowledged that a failure to apply splints and hand rolls constituted a deficiency and that it may have a potential for more than minimal harm. Tr. 665.

Petitioner does not dispute that four of its residents in the October resurvey sample (Residents R 17, R 12, R 4, R 6) had physicians' orders for the application of hand splints and/or hand rolls in order to slow down the progress of their contractures.

In the case of R 17 (Alvina L.), this resident had contracture and a physician's order for the application of hand rolls and hand splints on both hands. HCFA Ex. 8 at 4; HCFA Ex. 22. Her physician had ordered in writing that hand splints be placed on both hands every morning and be kept on for up to eight hours. Id.; Tr. 497, 498. The written physician's order required also that hand rolls be used when her splints were removed. Id.

During two days of the resurvey, surveyor Annabel Blackorby, R.N., observed that this resident was not wearing hand splints or hand rolls. Tr. 145, 146; HCFA Ex. 8 at 4. The surveyors' report of deficiencies[26] shows that when this resident was

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[25] Petitioner's assistant director of nursing testified also that, if a resident is ordered to wear a splint for six to eight hours, a staff member would usually remove the splint for five to ten minutes every two hours in order to do passive range of motion exercises with the resident. Tr. 497, 498. However, the staff member would usually remain with the resident in order to reapply the hand splint. Tr. 498.

[26] Petitioner argues that it had no meaningful opportunity to dispute the surveyor's observations since Ms. Blackorby did not provide testimony at the hearing concerning the particular times of her observations concerning Alvina L. or other residents. P. Reply, 3. I reject this argument, as well as Petitioner's contention that little weight should be given to Ms. Blackorby's observations because she did not specify the corresponding times in her testimony. See P. Reply, 3.

observed at 11:30 a.m. and 4:00 p.m. on October 3, 1995, she did not have any hand splint or hand roll in place. HCFA Ex. 8 at 4. The report shows also that when this resident was observed again on October 4, 1995, at 9:00 a.m., 11:00 a.m., 1:00 p.m., and 1:45 p.m., she also did not have any hand splint or hand roll in place. Id.

In the case of R 12 (Louise M.), this resident had contractures of her hands, fingers, and wrist. Tr. 156, 159; HCFA Ex. 22. Petitioner does not dispute HCFA's contention that her care plan contained a physician's written order for the use of hand rolls. See HCFA Ex. 22; HCFA Br., 13; P. Reply, 2 - 5.

On October 3, 1995, a surveyor observed R 12 (Louise M.) to be without handrolls at 11:20 a.m., 1:15 p.m., and 2:40 p.m. HCFA Ex. 8 at 4; Tr. 156, 159. On October 4, 1995, this resident was again observed by a surveyor to be without handrolls at 9:00 a.m., 1:00 p.m., and 3:45 p.m. Id.

In the case of R 4 (Connie P.), this resident had a physician's order for the use of a hand splint for up to eight hours each day. HCFA Ex. 8 at 5; HCFA Ex. 22. Her care plan indicated that she had a decreased range of motion and, moreover, she was at risk for developing further decreases and contractures of the right hand. Tr. 337. Petitioner does not dispute that this resident needed to wear a hand splint as ordered by her physician.

According to a surveyor, Judy Bradshaw, R.N., resident R 4 was not wearing a hand splint at any time when Ms. Bradshaw observed her during each of the three resurvey days. HCFA Ex. 8 at 5; Tr. 301, 302, 304. Ms. Bradshaw first saw R 4 in her room during the initial walk-through tour. Tr. 297. Then Ms. Bradshaw saw R 4 again on October 3, 1995, at 11:10 a.m. and 2:00 p.m. and on October 4, at 9:15 a.m.; at those times she noted other problems

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Petitioner was on notice as to the timing of the observations relied upon by HCFA, and Petitioner had a meaningful opportunity to dispute the timing and substance of such observations at hearing. The dates and timing of the relevant observations for each resident were listed in the report of deficiencies (HCFA Ex. 8) issued to Petitioner long in advance of these proceedings. This report of deficiencies was admitted into the record without objections from Petitioner. Ms. Blackorby testified that she made observations concerning Alvina L. on two days. Tr. 145. There is no evidence to indicate that dates and times of the observations noted on the survey report were fabricated. In the absence of specific challenges from Petitioner as to the dates and times of observations listed in the survey report, I would have considered any witness testimony on these matters to have been cumulative and unnecessary

as well. HCFA Ex. 8 at 5.[27] Ms. Bradshaw testified that she was also in R 4's room to observe R 4's roommate, R 6 (Loretta V.). Tr. 296, 297.

In the case of R 16 (Lloyd H.), this resident had a care plan which stated that he was at risk for finger contractures of the left hand. Tr. 337. He already had a contracture of his left hand, and the doctor had ordered the application of a hand splint for up to eight hours each day. HCFA Ex. 8 at 6; Tr. 333. During two days of the survey (October 3 and 4), Ms. Bradshaw, the surveyor responsible for observing this resident, did not see a hand splint in place. HCFA Ex. 8 at 6.

As I understand HCFA's evidence and arguments, HCFA made its determination of noncompliance based on the numerosity and relatedness of the above incidents observed by the surveyors. HCFA contends that the Petitioner's repeated failures to apply hand rolls and splints as ordered by physicians manifested a "system breakdown." HCFA Reply, 3. According to HCFA, it would be "far-fetched" to believe that the absence of hand rolls and splints had occurred by chance. Id. Relying especially on the evidence that either a hand roll or splint should be in place at all times, HCFA argues that both these devises would not have been absent during the random periods noted by the surveyors, if Petitioner had been complying with the physicians' orders for the residents to use a hand splint for six to eight hours each day. HCFA Reply, 4, 5 and transcript pages cited therein.

Petitioner's evidence and defenses

Petitioner does not contend that all of the observations made by the surveyors are wrong. Ms. Janet Dickhut, Petitioner's assistant director of nursing, testified that when she was in the company of the surveyors during their initial tour of the facility at about 9:00 a.m. on October 3, 1995, she also had observed that there were no hand rolls or splints on R 17

[27] Petitioner argues that neither the report of deficiencies nor witness testimony specifies the periods of time during which the surveyor made her observations that Connie P. was without a hand splint. P. Br., 14. However, the survey report stated that the surveyor observed Connie P. on each of the three resurvey days, and it listed the specific hours during which she saw other problems with the services Petitioner's staff delivered to Connie P. HCFA Ex. 8. Therefore, it was possible for Petitioner to ascertain from the survey report the number of times and the precise hours during which the surveyor saw that Connie P. had no hand splint on. Petitioner has not contested that observations were made by the surveyor, as set forth in the report.

(Alvina L.) (Tr. 442) nor on R 4 (Connie P.). Tr. 456; P. Br., 14. Ms. Dickhut admitted also that when she made her rounds at about 2:45 p.m. on October 3, she did not see hand rolls on R 12 (Louis M.). Tr. 447. Nor could Ms. Dickhut recall seeing hand rolls on this resident during October 4, 1994, the second day of the resurvey. Id.

Instead, Petitioner's evidence and defenses rely on the fact that the surveyors did not have the opportunity to keep each of the above mentioned four residents under continuous observation. Petitioner contends that the surveyors did not see all there was to see. According to Petitioner, it was following physician's orders when the surveyors were not making their observations.

For example, Petitioner pointed out that the physicians' orders for R 4 (Connie P.) and R 16 (Lloyd H.) did not specify that a hand splint must be applied during any particular hours of the day. P. Br., 14, 16. Their physicians' orders required only the daily use of a hand splint for up to six or eight hours, as tolerated. Id. Since no surveyor has testified to having kept the resident under direct observations for full days, Petitioner concludes that HCFA has not shown any deviation from the physician's orders on the use of hand rolls or splints for six to eight hours, as tolerated. P. Br., 16.

Construing the surveyors' observations to mean only that hand splints and hand rolls had not been placed on the residents during those moments observed by the surveyors, Petitioner has introduced evidence to show that the absence of a hand splint for a couple of hours, or even for a day, could not exacerbate contractures or cause the potential for more than minimal harm to any resident. See testimony cited at P. Br., 8. With respect to R 12 (Louise M.), Petitioner especially introduced the opinion that this resident was already terminally ill due to Alzheimer's Disease and dementia, and, therefore, not placing a hand roll on her for short periods of time during a couple of days should not have constituted even a deficiency.[28] Tr. 448, 449.

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[28] However, Petitioner's witness admitted also that rehabilitative efforts should continue even with terminally ill residents. Tr. 449.

As relevant to the issue of whether a terminal resident might be harmed within the meaning of the law by the absence of hand rolls, I note that the care plan (which includes the physician order for Louis M. to use hand rolls) must specify the services that are to be furnished "to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being. . . ." 42 C.F.R. § 483.20(d)(1)(i).

Petitioner's assistant director of nursing, Ms. Dickhut, testified that she saw hand rolls or splints on the residents when she was not with the surveyors. With respect to R 17 (Alvina L.), Ms. Dickhut testified that the hand splints were being reapplied when she made her rounds at noon on October 3, 1995--after this resident was seen without hand splints at approximately 9:00 a.m. of the same day--because her splints had been removed that morning for a bath. Tr. 442, 443. (However, Ms. Dickhut admitted that she did not check on Alvina L.'s use of hand rolls or splints on October 4, 1995. Tr. 499.) With respect to R 12 (Louise M.), Ms. Dickhut testified that she saw a hand roll on this resident at approximately 12:15 p.m. on October 3, 1995 (Tr. 447)--before a surveyor saw this resident without a hand roll at 2:45 PM of the same day. Tr. 447. With respect to R 4 (Connie P.), Ms. Dickhut testified that she saw this resident wearing a hand splint at 12:30 p.m. on October 3, 1995 (Tr. 456)--after a surveyor had seen this resident without such devices earlier that morning at approximately 9:00 a.m. Tr. 456.

With respect to R 16 (Lloyd H.), Ms. Dickhut testified that this resident had a habit of asking his wife to remove his hand splint and that his wife was present during the October resurvey. Tr. 470, 502, 504. However, Ms. Dickhut did not see anyone remove his hand splint during the days at issue. Tr. 502, 504. She acknowledged also that this resident's wife had died several months before the October resurvey.[29] Tr. 507, 508.

Previous to the hearing, Ms. Dickhut had not disclosed her foregoing observations concerning the application of hand rolls and splints. Ms. Dickhut admitted, for example, that she did not say anything about having seen Alvina L. with hand splints at noon on October 3, even though she heard Ms. McIntyre report Ms. Blackorby's specific observations of Alvina L.'s having been without splints or hand rolls at 11:30 and 4:00 that day. Tr. 494 - 497. Ms. Dickhut's explanation was that she did not know she could have brought up such matters at the exit conference.[30]

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[29] Petitioner explained that Ms. Dickhut had mistaken this resident's sister-in-law for his wife. P. Reply, 11.

[30] At the hearing, Ms. Dickhut was asked this question by Petitioner's counsel:

> [a]nd at the exit, when this issue was brought up, were you under the impression that you could offer rebuttal information at that time?

Tr. 551. Ms. Dickhut responded: "I didn't realize that." Id.

Petitioner asserts also as a defense that the "rehab aide" who usually applied the hand rolls and splints was not at work during the entire resurvey period. During the survey, Petitioner's staff told the surveyors that hand splints were not applied as ordered by physicians because the "rehab aide" had gone home sick during the first day of the survey (October 3) and that she did not return to duty until the third and final day of the survey.[31] Tr. 66, 151, 302. At the hearing, Ms. Dickhut testified that the "rehab aide" responsible for applying hand splints had returned to work by October 4, the second day of the resurvey. Tr. 448. According to Petitioner, "[g]iven the fact that the person whose job it was to apply and remove hand splints was not at work on the days in question and that other staff were performing those functions in addition to their normal duties at a time when tension was high due to the presence of the surveyors, it is wholly believable that the splints could have been on at the times testified to by Ms. Dickhut [but not during the times observed by the surveyors]." P. Reply, 4.

2. Failure to Serve Prune Juice to Two Residents as Specified in the Written Physician Orders

HCFA's evidence and conclusions

As noted above, the October follow-up survey of Petitioner's compliance under 42 C.F.R. § 483.20(d)(3)(ii) was conducted in part because, a few months earlier, Petitioner had been cited for noncompliance under the same regulation for its substitution of other drinks for the milk shakes, thickened liquids, or prune juice ordered in writing by physicians. Petitioner had submitted a plan of correction and alleged that compliance had been attained.

During October 1995, the resurvey team reviewed Petitioner's plan of care for (R 1 (Ruth F.) and R 11 (Anna C.)) and found written physician's orders for Petitioner to serve them prune juice with their morning meals. HCFA Ex. 8 at 2; Tr. 245. According to the care plan Petitioner prepared for these two residents, prune juice was intended to help these two residents

[31] The evidence does not show at what time on October 3 the "rehab aide" left work, or how many residents were affected by her departure. According to Petitioner's assistant director of nursing, the "rehab aide" usually applied the splints at 4:00 a.m. each morning, whether the residents were awake or not; on request by the resident, her time for applying splints could be changed to 8:00 or 9:00 a.m. Tr. 520, 521.

maintain regular bowel movements. Tr. 243. Petitioner agrees that both these residents had care plans "dealing with the issue of constipation." P. Br., 4.

On the morning of October 4, a surveyor observed that both these residents were served orange juice instead of prune juice. HCFA Ex. 8 at 3. Petitioner agrees that prune juice was not served to these residents that morning. P. Br., 5.

One of the surveyors, Kathleen Stapleton, R.N., raised the matter with Petitioner's nursing staff and was informed that these two residents were served orange juice instead of prune juice because there was no prune juice in their unit's refrigerator that morning, and the dietary department had not sent any prune juice that morning.[32] HCFA Ex. 8 at 3; Tr. 244. When Ms. Stapleton spoke with the dietary department staff, they told her it was up to the residents' unit to request the prune juice and that the dietary department had prune juice on hand. Tr. 244.

At the hearing, several witnesses gave testimony showing that prune juice is a more effective stool softener than orange juice. Tr. 245 (testimony of Ms. Stapleton, R.N.); see Tr. 509 (testimony of Ms. Dickhut, R.N., for Petitioner); Tr. 602 (testimony of Petitioner's director of operations, Kathleen Baker, R.N.). According to the other relevant evidence introduced by HCFA, R 1 (Ruth F.) was at an increased risk for constipation because she was taking anti-psychotic medications. Tr. 243. Moreover, increased age also places a resident at risk for constipation. Tr. 246, 509.

Petitioner's evidence and defenses

Petitioner's administrator acknowledged during the hearing that no one at a nursing facility has the authority to disregard a physician's order, even if the order can be viewed as trivial or unnecessary. Tr. 424.

Nevertheless, Petitioner's primary defense appears to be that it need not have served prune juice to either R 1 (Ruth F.) or R 11 (Anna C.). In Petitioner's view, no physician should have issued a written order to direct the serving of prune juice. Petitioner

[32] At the hearing, Petitioner's administrator also confirmed that there was no prune juice in the Alzheimer unit, which housed 20 residents. Tr. 416, 417.

contends that the physicians' orders for prune juice were not individualized approaches for the care of these two residents. P. Br., 6.

Petitioner introduced testimony to show that the standards of professional practice do not require doctors to issue a written order to specify the serving of prune juice for constipation. Tr. 429. Petitioner's administrator, Jeff Nusbaum, testified that the care plans for R 1 (Ruth F.) and R 11 (Anna C.) contained physicians' orders for prune juice only because Petitioner had not revised its previous owner's policy of serving prune juice for constipation only on a physician's written order. Tr. 411, 412. According to Petitioner's director of operations, Kathleen Baker, it has become an "expectation" that doctors issue written orders for prune juice at facilities which hope to receive Medicare reimbursement for their bowel restorative services--because reimbursements under the programs will be more readily forthcoming if all aspects of the bowel restorative program are under a physician's supervision, including the serving of prune juice.[33] Tr. 600, 601. Ms. Baker indicated that no physician would have reason to issue a written order to serve prune juice to a private-pay patient. Tr. 601.

Petitioner introduced evidence to show also that the substitution of orange juice for prune juice was not likely to cause either resident any harm. Its witnesses testified that prune juice and orange juice are clinically similar and they can be used safely as substitutes for one another. Tr. 429, 430, 602.

Additionally, as it had done in challenging the surveyors' observations concerning the absence of hand rolls and splints, Petitioner defends itself also by alleging events not seen by the surveyors. Petitioner introduced testimony to show that, unbeknownst to HCFA, Petitioner was preventing and relieving the two residents' constipation by the other means specified in their care plans, such as the use of medications and exercise. See P. Br., 5 and transcript page citations therein. Petitioner

[33] In summarizing Petitioner's evidence concerning why most doctors might or might not issue written orders for prune juice, I do not imply that there is any evidence showing that the particular physicians treating R 1 or R 11 had written their orders for prune juice because they were concerned about Petitioner's policies or possible Medicare or Medicaid reimbursement issues. In fact, nothing in the record shows that these two residents' physicians wrote the prune juice orders for any reason other than to require Petitioner to serve prune juice, instead of other juices, with these residents' morning meals.

contends also that out of 197 residents in its facility, only the two residents observed by the surveyors were not served prune juice on that single morning. P. Br., 5.[34]

3. Failure to Follow Written Physician Order to Reposition one (1) Bedridden Resident

HCFA's evidence and conclusions

According to Petitioner's assessments, R 6 (Loretta V.) had contractures of her knees and hips, and she was at risk for developing pressure ulcers. Tr. 327.

Shortly before the resurvey began, this resident had fallen and fractured her left hip near the site of a prior fracture. Tr. 319; P. Ex. 13 at 2. When she was returned to Petitioner's care on September 29, 1995, after her fall, her physician wrote an order for treatment of her hip fracture. Her physician's order directed that she be repositioned every two hours in a particular sequence: on her right side for two hours, then on her left side for two hours, "and then repeat sequence." P. Ex. 13 at 5; HCFA Ex. 8 at 5, 7; Tr. 320.

The physician's order directed also the placement of pillows between this resident's legs in order to maintain good body alignment for her and to inhibit her from rolling over and repositioning herself. Tr. 337 - 339; P. Ex. 13 at 5.

According to Ms. Bradshaw, one of the surveyors, she saw Loretta V. lying on her left side whenever she made her observations. HCFA Ex. 8 at 5, 7; Tr. 321, 323 - 325. For example, on October 4, Ms. Bradshaw saw Petitioner's staff feed this resident at noon by keeping her on her left side. Tr. 324. During this resident's passive range of motion exercises, Ms. Bradshaw again saw Petitioner's staff maintaining her on her left side. Tr. 324, 325. Ms. Bradshaw testified that she did not see the staff availing themselves of the opportunity to move this resident onto her back or her right side during the passive range of motion exercises. Tr. 324.

[34] At the hearing I asked why Petitioner would have omitted to serve prune juice as ordered by the two residents' physicians when Petitioner knew that the resurvey team had returned because Petitioner had been out of compliance due to its previous failure to serve prune juice as ordered by a physician. Tr. 415, 416. Petitioner's administrator answered that Petitioner did serve prune juice to residents on October 4, 1995 but "[a] couple of them were missed that morning, and received orange juice instead of prune juice." Tr. 416.

When she saw Petitioner's failure to reposition this resident during feeding, Ms. Bradshaw considered the possibility that this resident might have been kept lying on her left side during the noon meal because there was a relevant eating or swallowing evaluation which made this posture necessary. Tr. 324. However, when Ms. Bradshaw made such inquiries during the survey, no one presented such an evaluation for this resident. Id. Therefore, Ms. Bradshaw saw no justification for keeping this resident lying down and on her left side even while she was being fed. Id.

When observing the passive range of motion being administered while this resident was kept lying on her left side, Ms. Bradshaw wondered whether the resident's left shoulder could be exercised properly in that position. Tr. 324, 325. Her opinion was that the left shoulder could not be exercised properly while the resident was kept on her left side and that it would have been appropriate to work on her left shoulder by turning her onto her right side. Id. Yet, Petitioner's staff performed the exercise on this resident's upper extremities in Ms. Bradshaw's presence while they kept this resident lying continuously on her left side. Id.

During the resurvey, Ms. Bradshaw told Petitioner's staff that Loretta V. did not appear to be repositioned in accordance with her physician's schedule. Tr. 323. The staff's answer was that this resident had a tendency to move herself onto her left side after having been repositioned on her right side. Tr. 323. Given that the hallway was to the left of the resident's bed and this resident has had pressure sores on her left foot before, Ms. Bradshaw considered it possible that this resident was turning herself onto her left side in order to watch the activities in the hallway. Tr. 323. Ms. Bradshaw's testimony indicated that, "if she [R 6 (Loretta V.)] was turning back" and thereby thwarting her doctor's order for repositioning every two hours, then Petitioner's care plan for this resident should have noted and addressed this problem; however, the care plan did not indicate the existence of such a problem. Id. (emphasis added).

In addition, HCFA noted that the physician's written order directed the use of pillows between this resident's legs in order to inhibit spontaneous repositioning by this resident and Petitioner's assistant director of nursing testified that pillows were placed under the resident's legs and toward her back within the scope of the physician's order. HCFA Br., 25. HCFA also obtained the assistant director of nursing's

acknowledgement on cross-examination that a great deal of pain would result even if a health, younger individual with Loretta V.'s injuries were to reposition herself to her left side (Tr. 545, 546) and elderly confused residents might move about to cause even more pain to themselves if they do not realize that staying still would alleviate the pain. Tr. 539, 540. As also pointed out by HCFA, Petitioner's witnesses never testified to having seen this resident turn onto her left side after having been repositioned onto her right side. See Id.

HCFA interprets the foregoing information to mean that Petitioner was not repositioning Loretta V. from her left side to her right side every two hours, in accordance with her physician's written order. HCFA Br., 48 - 50. HCFA doubts that an elderly and injured resident like Loretta V., with pillows placed around her as alleged by Petitioner's assistant director of nursing, could obtain enough leverage to move herself even from her back to her side. HCFA Br., 49. HCFA also does not believe that Petitioner's failure to follow the physician's repositioning order was limited to the several periods personally observed by the surveyor. HCFA Br., 50. Therefore, HCFA relies upon a nurse surveyor's testimony that Petitioner's failure to reposition Loretta V. was compromising her ability to recover from her hip fracture, as well as placing her at greater risk for the aggravation of her hip and knee contractures and for the development of pressure ulcers on her left side. HCFA Br., 50 (citing portions of Ms. Bradshaw's testimony).

Petitioner's evidence and defenses

Like its defenses to other survey citations discussed above, Petitioner's arguments focus on what the surveyors did not see. Its arguments suggest that Petitioner made some modifications to the physician's repositioning order because the resident did not need Petitioner to comply fully with the order.

Petitioner's position is that no surveyor had R 6 (Loretta V.) under constant observation, and, therefore, the surveyor's observations at random times are "not dispositive" on the issue of whether this resident was being repositioned on a regular schedule. P. Br., 11. Petitioner suggests that Ms. Bradshaw's testimony at hearing is not fully credible because, after listing in the survey report the four specific times on October 4 when she made her observations that this resident was lying on her left side, Ms. Bradshaw gave less precise testimony about

when she made those observations. P. Br., 10 - 12.[35] Petitioner argues also that, even with Ms. Bradshaw's four random observations, HCFA has not established that Petitioner was failing to provide repositioning services ordered by her physician when the surveyor was not looking. See P. Br., 12.

Petitioner relies upon several pieces of evidence: the testimony showing that repositioning a resident every two hours is to maintain skin integrity and to avoid the development of pressure sores, Ms. Dickhut's testimony that this resident is a "great scooter," and Ms. Bradshaw's acknowledgement that this resident might have liked to be on her left side in order to see the hallway. P. Br., 11. Petitioner emphasizes also its witness' testimony that the absence of skin breakdown on a resident at risk for skin breakdowns indicates that this individual was not staying in any position for long. P. Br., 12 (citing Tr. 454). Therefore, Petitioner contends that Loretta V.'s repositioning of herself at will "accomplished the goals of repositioning even though she may not have kept to the precise schedule established by her physician"[36] (id.)--as proven by the healing of recent skin breakdowns during the resurvey.[37] Id. at 12. In this regard,

[35] I do not find any material conflicts between Ms. Bradshaw's testimony and the contents of the survey report. The survey report stated that the surveyor saw this resident on her left side all morning. HCFA Ex. 8 at 4. The survey report also listed her observations on October 4 as 11:00 a.m. (when she saw the resident on her left side), 12:30 p.m. (when she saw no repositioning from the left side when the resident was being fed), 1:30 p.m. (when she saw no repositioning from the left side when the resident was given passive range of motion exercises), and 3:00 p.m. (when she saw the resident still on her left side). HCFA Ex. 8 at 4. In context, Ms. Bradshaw's testimony does not imply that she saw everything on October 4th at or shortly after noon, as suggested by Petitioner's brief; I interpret Ms. Bradshaw's reference to noon of that day as her context for describing her observations about the feeding and exercising of Loretta V. See Tr. 324. Additionally, Petitioner had the opportunity to cross-examine Ms. Bradshaw about any alleged conflicts in the timing of her observations.

[36] In recounting this argument from Petitioner, I do not suggest that I have found any evidence indicating that Loretta V. was repositioning herself on any regular schedule, or at any ascertainable interval. Nor do I suggest that I find credible Petitioner's contention that, when the surveyors were not present, its staff had repositioned this resident every two hours as ordered by her physician before and after this resident had allegedly placed herself onto her left side.

[37] The surveyor, Ms. Bradshaw, testified that Petitioner's documents indicated recent healing of earlier skin breakdowns on the resident's left foot. Tr. 352. She did not testify to having personally observed any signs of healing. She also did not testify that she believed Loretta V. was spontaneously turning back to her left side since she fractured her left hip

Petitioner's arguments appear to be that it was this resident herself (and not Petitioner) who was carrying out the essential elements of her physician's order and accomplishing its goal.

There are two main areas not addressed by Petitioner. First, Petitioner does not address the fact that the physician's order for repositioning was given to treat the resident's left hip fracture. Therefore, Petitioner does not discuss how Loretta V.'s allegedly spontaneous placement of her weight on her left side is beneficial for the recovery of her left hip fracture. Second, Petitioner does not address the fact that the physician's order concerning the placement of pillows indicated that the doctor did not want to permit spontaneous turning by this resident. Therefore, Petitioner does not discuss why it has chosen to interpret the repositioning order literally, as meaning that it need only reposition this resident once every two hours-- without regard for how long or how soon thereafter she allegedly changed her position onto her right side. See P. Reply, 12.

C. Petitioner's failure to implement its written plans of care for residents

1. Failure to Implement Written Plan of Care for Treating One Resident's Significant Weight Loss

HCFA's evidence and conclusions

In examining Petitioner's written assessment of R 12 (Louise M.), the surveyors found that this resident had undergone a significant weight reduction--i.e., loosing more than five percent of her total body weight, and falling well below her "ideal body weight"--between June and July 1995. HCFA Ex. 8 at 4, 5. According to Petitioner's assessment of this resident, her ideal body weight ranged between 87 and 107 pounds (P. Ex. 11 at 1, 12; Tr. 166, 168, 169) but her weight had dropped from 87.5 pounds to 82.5 pounds between June and July 1995. P. Ex. 11 at 1; Tr. 169. Because a five percent loss in body weight is considered a significant change in a resident's condition, Petitioner was required to effectuate a new assessment of this resident. Tr. 169 - 70, 578, 579, 619, 620; see 42 C.F.R. § 483.20(b)(4)(iv).

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and was returned to Petitioner's care. Ms. Bradshaw used the phrase, "if she was turning back." Tr. 323

In reviewing Petitioner's records relating to Louise M.'s weight loss problem of June to July, 1995, the surveyor found that Petitioner's assistant food service supervisor had written in the Resident Assessment Protocol[38] module and in a nutritional progress note during July 1995[39] that Louise M.'s weight loss problem would be addressed by referring her to the facility's registered dietician. HCFA Ex. 8 at 4; P. Ex. 11 at 10, 12, 13A. However, when the resurvey was being conducted three months later, this resident had not yet been seen by a registered dietician in accordance with Petitioner's written assessment of her needs. Id.

Petitioner's food service supervisor confirmed to the surveyor in October that the dietician had not yet evaluated this resident. Tr. 175. It was not until the resurvey team discovered this problem that Petitioner's food service supervisor then placed this resident's name on the list of residents to be seen by the dietician on her next visit to the facility.[40] Tr. 175, 182.

At the hearing, surveyor Annabel Blackorby, R.N., noted also that this resident's nutritional needs were last assessed by the registered dietician on January 5, 1995; at that time, the registered dietician had noted a loss of 4.7 pounds over the prior six months. Tr. 176. Then between January and June of 1995, this resident had lost also 2.8 pounds (i.e., dropping from 90.3 to 87.5 pounds). Tr. 176 - 77; P. Ex. 11 at 1. There is no dispute that this resident had been experiencing a steady weight loss (see Tr. 674) up to and including the five percent decrease --from 87.5 to 82.5 pounds--between June and July 1995.

According to the testimony of Ms. Blackorby, falling below the ideal body weight indicates a deterioration in the tissues of

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[38] The Resident Assessment Protocol, or RAP, is an in-depth assessment of the resident's needs in a targeted area identified by the nursing facility's staff. Tr. 51, 116 - 119. The instrument is the starting point for developing a care plan to treat the particular needs of a resident. Id.

[39] HCFA noted especially that Petitioner's determinations regarding the referral to a registered dietician related to the weight loss of June to July and they were written on July 7 and July 26--which post-dated the physician's orders of June 12 and June 16 to weigh this resident at stated intervals due to previous weight losses. HCFA Reply, 8. HCFA emphasized these dates and chronology of events because Petitioner had asserted in its main posthearing brief, at page 9, that this resident's physician had merely ordered more frequent weight monitoring when notified of her weight loss.

[40] A registered dietician visited Petitioner twice each month. Tr. 577.

the body and malnutrition. Tr. 179. The individual is likely to experience a loss of energy, as well as to become more susceptible to developing pressure ulcers and infections. Tr. 179 - 189.

Petitioner's evidence and defenses

Petitioner does not deny that its registered dietician had not evaluated R 12 (Louis M.) in accordance with its written plan of care as of the October resurvey.

Nor does Petitioner deny that this resident's loss of five pounds between June and July 1995 constituted a "significant weight loss" with the federal guidelines. P. Reply, 7. However, Petitioner contends that the weight loss was caused by the resident's "advancing disease process" and was not "catastrophic" given her history and overall condition. Id. According to Petitioner, this resident was in the later stages of dementia, which caused her gradual weight loss and decline. P. Reply., 8 (citing Tr. 569, 621).

Petitioner points to its witness' testimony that other actions were taken to improve this resident's nutritional in take under a multifaceted plan, such as feeding her super cereal (which is high in calories) and having the staff members more familiar to her encourage her to eat more and better. P. Reply, 7, 8 (citing Tr. 569).

The registered dietician did not give evidence in this case. However, Petitioner's director of operations testified that, even if this resident had been referred in accordance with Petitioner's written plan of care, the registered dietician would not have given high priority to this resident's weight loss from June to July, if there had been other, more medically compromised residents for the dietician to see as well.[41] Tr. 620, 621. The witness said also that the registered dietician would have been familiar with this resident's general condition since she has been admitted some years before. Tr. 621.

According to Petitioner, its failure to have Louise M. evaluated by a registered dietician until the October resurvey did not

[41] There is no evidence on which residents had been referred to the registered dietician from July to October, 1995. Nor is there evidence showing that the registered dietician saw residents with more compromised medical conditions than Louise M.'s from July to October 1995.

pose a potential for more than minimal harm to this resident. P. Reply, 8.

2. Failure to Implement Plan of Care for Reducing Two Residents' Inappropriate Behavior

HCFA's evidence and conclusions

HCFA introduced evidence showing that R 9 (Mabel H.) was medicated with antidepressant and antipsychotic drugs. Tr. 248. According to Petitioner's care plan, this resident was showing "socially inappropriate" behavior consisting of tearfulness, withdrawal from self-care and eating, and episodes of crying out, "Help me, help me." HCFA Ex. 8 at 3 - 4; Tr. 514, 515. One of goals set by Petitioner's care plan was to reduce the frequency of these behaviors. Id.; see Tr. 466. As acknowledged by Petitioner's director of operations, withdrawal from self-care can lead to serious harm for a resident of a nursing home. Tr. 667.

The surveyors found noncompliance with respect to Mabel H. because Petitioner did not share its record of this resident's episodes of socially inappropriate behavior with her psychiatrist, whom she visited periodically in the company of her family. According to the testimony introduced by HCFA, Petitioner was tracking this resident's episodes of tearfulness and crying out at its facility; this resident did not exhibit tearfulness or crying out when she was in the company of her family; this resident's psychiatrist did not witness these episodes of tearfulness and crying out because this resident was always accompanied by her family on her visits to the psychiatrist. Therefore, since Petitioner did not send to the psychiatrist its records of this resident's episodes of tearfulness and crying out, the psychiatrist could not assist Petitioner in implementing its plan of care; the surveying team concluded that Petitioner was not delivering services (i.e., reducing these episodes of inappropriate behavior) in accordance with the care plan for this resident. HCFA Br., 20, 21 (citing HCFA Ex. 8 at 3 - 6).[42]

[42] HCFA noted the testimony of Petitioner's director of operations, which indicated that, in order to help this resident reach her highest practical level of emotional well-being, her psychiatrist may wish to know that her episodes of tearfulness were related to her being in a nursing home, and not to the presence of her family members. HCFA Br., 21 (citing Tr. 667). HCFA noted also this witness' testimony that a withdrawal from self-care may lead to serious harm for an individual in a nursing home. Id.

For the other resident, R 4 (Connie P.), the surveyors found that Petitioner's plan of care included an assessment that this resident yelled and screamed on an average of eight times each day. HCFA Ex. 8 at 5; Tr. 307 - 309. In its care plan for this resident, Petitioner set as a goal the reduction her screaming from eight to seven episodes each day. Id. Petitioner's care plan for this resident specified these approaches or interventions for achieving the reduction of her screaming episodes: calling her by name, asking her what she wanted, reassuring her that she was safe, reassuring her that her family visited her, talking to her about her interests, touching her, and offering her a glass of water. HCFA Ex. 23; Tr. 309, 310, 524 - 526. It was expected that one or more of these foregoing interventions be tried during each episode to see which efforts would work at a give moment. Tr. 459, 460, 532.

At different times during the resurvey, Judith Bradshaw observed Connie P. screaming and yelling in her room without intervention by Petitioner's staff. HCFA Ex. 8 at 5, 6; Tr. 297, 315, 316. During Ms. Bradshaw's initial tour of the facility at 11:10 a.m. on October 3, this resident was yelling and screaming in her room but none of the staff accompanying Ms. Bradshaw on the tour intervened. HCFA Ex. 8 at 5; Tr. 297, 306, 307. Then later, at 2 p.m. on October 3 and at 9:15 a.m. on October 4, Ms. Bradshaw again saw this resident yelling and screaming without any intervention by those members of Petitioner's staff who were in this resident's room. HCFA Ex. 8 at 5, 6; Tr. 315. Ms. Bradshaw never saw any staff members implement those approaches specified in the care plan for reducing this resident's screaming and yelling episodes. Id.

In HCFA's view, failure to implement the interventions specified in Petitioner's care plan for Connie P. had the potential for inhibiting her ability to reach her maximum psychosocial well-being as assessed by Petitioner. HCFA Br., 23 (citing Tr. 316, 317).

Petitioner's evidence and defenses

Petitioner acknowledges that when R 9 (Mabel H.) went with her family members to see her psychiatrist outside of the nursing facility, Petitioner sent along only the physician order sheet. P. Br., 6. However, Petitioner defends its actions on the bases that its care plan for this resident does not specify the information which must be sent to a private physician, and that it was following the accepted practice of providing to the psychiatrist only the information which was "pertinent or

requested." P. Br., 7, 8. According to Petitioner, the same psychiatrist had been caring for this resident for many years,[43] and, whenever an appointment was set up, the psychiatrist's nurse would request certain information from Petitioner for the visit. Id. (citing Tr. 466, 467). Petitioner points out also that the surveyor never questioned the psychiatrist concerning his need for the information at issue, and Petitioner would have made available Petitioner's records and observations if the psychiatrist had requested them. P. Br., 6, 7. Therefore, Petitioner contends that the surveyors made improper assumptions about the psychiatrist's need for Petitioner's records on this resident's episodes of tearfulness and crying out. P. Br., 7.

With respect to R 4 (Connie P.), Petitioner agrees that the care plan's goal was to reduce her average of eight yelling and screaming episodes per day to seven per day, through the use of various intervention methods listed in the plan. P. Br., 13. Petitioner does not dispute that on three occasions, the surveyor saw lack of intervention by staff while this resident was screaming or yelling. Id. However, Petitioner points out that this resident was suffering from Alzheimer's disease and that the new care plan containing the goals and intervention methods had just been completed on the first day of the October resurvey.[44] P. Br., 13 (citing HCFA Ex. 23; Tr. 309).

Additionally, Petitioner defends the lack of intervention at the three times observed by the surveyor on the basis that its staff was occupied with others: i.e., when the surveyor made her first observation of nonintervention, staff was occupied with providing explanations to the surveyors during their walk-through tour; when the surveyor made her second observation of nonintervention, staff was occupied with providing passive range of motion exercises to this resident's roommate; and when the surveyor made her third observation of non-intervention, staff was also delivering other services to this resident's roommate. P. Br., 13 (citing Tr. 315). Petitioner cites the testimony of Ms. Dickhut, Petitioner's assistant director of nursing, to show that intervention with this resident's screaming and yelling episodes would not have been effective unless Petitioner's staff were in close proximity to her. P. Br., 13 (citing Tr. 529).

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[43] Petitioner argues that the psychiatrist should be assumed to know this resident well and that this resident has had chronic problems even before she entered the nursing facility. P. Reply, 8, 9.

[44] There was no evidence introduced by Petitioner to show how soon new goals and intervention methods should be implemented after their creation.

Based on this testimony, Petitioner contends that its staff members could not have intervened during the three episodes observed by the surveyor unless they ceased delivering services to Connie P.'s roommates and violated good nursing practices. P. Br., 13, 14 (citing Tr. 461, 628).[45]

Similar to its refutations of other deficiencies cited by HCFA, Petitioner again emphasizes what the surveyor did not see. Petitioner argues, for example, "[w]e do not know what occurred when the attentions to the roommate were completed. We do not know what had occurred prior to the surveyor's arrival on the scene." P. Br., 13. Petitioner contends that the surveyor made invalid and incidental "snapshot" observations of Connie P. while focusing on the care delivered by Petitioner to this resident's roommate. P. Reply, 9. According to Petitioner, its failure to abandon the care of this resident's roommate has led to HCFA's erroneous conclusion that the intervention methods specified in the care plan were never used on this resident. P. Reply, 9.

3. Failure to Provide Ambulation in accordance with the Plan of Care for One Resident

HCFA's evidence and conclusions

The surveyors found that the care plan for R 16 (Lloyd H.), a resident who could not walk independently due to the results of a stroke, specified that he is to be walked to and from the dining room and to and from the bathroom. HCFA Ex. 8 at 6. Judith Bradshaw, one of the surveyors, testified that this resident told her he was walked only in physical therapy and he did not go to physical therapy each day. Tr. 298, 329, 363. According to Ms. Bradshaw, this resident told her also that he was taken to the dining room in his wheelchair--a fact which she confirmed by personal observation one day, when she saw him self-propelling his wheelchair from the dining room. Tr. 330, 331. HCFA inferred from the Petitioner's care plan for ambulating this resident to and from the bathroom and dining room each day that Petitioner had "implicitly determined that

[45] HCFA, however, noted in response that the care plan contained no such caveat on proximity and Ms. Dickhut acknowledged also that R 4 (Connie P.) had no visual or auditory deficit, and that an aide caring for this resident's roommate could have told R 4 (Connie P.) something loudly to the effect of "I'll get you in a minute, Connie" in accordance with the written care plan. HCFA Reply, 11 (citing Tr. 526, 534, 535).

Lloyd H. could not be expected to regain the ability to self-ambulate through physical therapy sessions alone." HCFA Br., 47.

Also, according to Ms. Bradshaw, this resident told her that he was not taken to the bathroom and that he had trouble getting staff to respond to his call light. Tr. 298, 330. Ms. Bradshaw testified that she confirmed this resident's information by questioning a member of Petitioner's staff. A primary care giver confirmed that Petitioner managed this resident's incontinence with disposable briefs and pads. HCFA Ex. 8 at 6; Tr. 330, 362.

HCFA notes that even Petitioner's assistant director of nursing acknowledged that this resident was alert. HCFA Br., 47 (citing Tr. 473). According to HCFA's interpretation of the words heard by Ms. Bradshaw, this resident had complained to the surveyor that he was not being taken to the toilet, that he must await delayed responses to his call light when he had soiled himself, and that he was not being ambulated every day. HCFA Br., 47. Therefore, for these reasons and in the absence of any indication of noncompliance in the care plan,[46] HCFA inferred that this resident wanted to be taken to the bathroom and ambulated every day. Id.

HCFA introduced evidence showing that the failure to ambulate can lead to development of pressure sores, as well as weakness in the legs, and a decline in a resident's activities of daily living. Tr. 331 - 333. HCFA's evidence also shows that Lloyd H. had developed a pressure sore on his buttocks. Tr. 331.

Accordingly, HCFA contends that by its failure to implement its entire care plan for this resident, Petitioner had retarded his ability to attain his highest practical physical well-being, as well as placed him at risk for sustaining more than minimal harm to his physical, emotional, and psychosocial well-being. HCFA Br., 47, 48.

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[46] HCFA noted that, even though Petitioner's assistant director of nursing testified that this resident was noncompliant with Petitioner's efforts to ambulate him and take him to the bathroom, the surveyor found no care plan addressing this alleged noncompliance, and Petitioner has introduced no such care plan into evidence. HCFA Br., 47.

As I discussed earlier, HCFA used this same resident, R 16 (Lloyd H.), as an example for finding that Petitioner was failing to apply hand rolls and splints in accordance with his physician's written order. Petitioner responded also with the explanation that this resident was noncompliant with his doctor's orders with respect to handrolls and splints in that he was having his wife remove them.

Petitioner's evidence and defenses

Petitioner acknowledges that it had assessed R 16 (Lloyd H.) as needing to be ambulated and toileted. P. Br., 11. It agrees with HCFA that this resident would be "better off" if he were ambulated to and from meals and the toilet. P. Br., 10. Petitioner also does not dispute HCFA's finding that this resident was not in fact ambulated and toileted in accordance with the written care plan.

Instead, Petitioner contends that this resident refused to be ambulated and toileted. P. Reply, 11. Petitioner argues that this resident's words to the surveyor did not show that he was being forced by Petitioner's staff to stay in his wheelchair or being prevented from ambulating each day. See P. Reply, 10 (citing Tr. 298, 330). Petitioner points out also that this resident never specifically informed the surveyor that he wanted to be taken to the bathroom or ambulated. P. Reply, 11.

As in its response to the surveyor's observation that this resident, Lloyd H., also did not have on the hand roll and splint required by his physician's written order, Petitioner contends that this resident had exercised his right to refuse the toileting and ambulation services available to him. P. Reply, 11. Petitioner contends that it had counseled him on the harm his refusal could and did cause. Id. Petitioner cites as support the testimony of its assistant director of nursing, Ms. Dickhut, who stated that Petitioner was concerned with this resident's noncompliance and had repeatedly given him counselling without success. Id. at 10 (citing Tr. 474, 475). Ms. Dickhut testified also that she felt Petitioner was doing as well as it could with this resident in dealing with his noncompliance. Id.

Petitioner implicitly acknowledges that its care plan contains no documentation of this alleged noncompliance by Lloyd H. See P. Br., 10. It argues that, "[a]lthough what Ms. Dickhut was describing was certainly a plan of care, it was not a written, formalized care plan that HCFA expected." Id. Therefore, Petitioner argues also that, "at most, Brighton would be guilty of paper noncompliance" with respect to this resident. Id.

IV. EVALUATION OF CONFLICTING FACTS AND THEORIES

As noted in Section I.A. of this Decision, noncompliance means that the facility has failed to satisfy the requirements of participation to the extent that its deficiencies pose a

potential for causing more than minimal harm to a resident's health or safety. See 42 C.F.R. § 488.301. I believe that the concept of harm, and its varying degrees, cannot be evaluated in isolation by use of some bright line test. The analysis requires consideration of the contents and intent of the regulations under which deficiencies have been alleged.

Here, the regulation Petitioner has allegedly failed to satisfy imposed upon Petitioner the obligation to provide services "in accordance with each resident's written plan of care." 42 C.F.R. § 483.20(d)(3)(ii). Services must be provided in accordance with each resident's written plan of care because said plan should have been developed in accordance with Petitioner's duty to describe "the services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being . . . ." 42 C.F.R. § 483.20(d)(1)(i). Therefore, I agree with HCFA that the issue of harm to residents' health in this case must be evaluated in the context of whether Petitioner's deficiencies have the potential for causing more than minimal harm to the residents' ability to attain or maintain their highest practicable physical, mental, and psychosocial well-being as provided in the individual care plans Petitioner had prepared for them. See HCFA Br., 6 ("Issue Presented.")[47]

In this case, I conclude that the totality of the evidence, including inferences arising reasonably from the evidence, preponderates in favor of HCFA's determination that Petitioner was out of compliance with the "Resident assessment" requirement at the time of the October 1995 resurvey.

First, I find in favor of HCFA on the issue of whether Petitioner had deficiencies under the "Resident assessment" requirements of 42 C.F.R. § 483.20(d)(3)(ii). HCFA's determination is supported by the numerous uncontroverted visual observations of surveyors who, at random times, saw that Petitioner was not delivering certain services to 8 of the 17 residents sampled during three days in October. The surveyors' observations establish the existence of numerous deficiencies in Petitioner's delivery of services to these residents in two areas: Petitioner's failure to implement written physicians orders and Petitioner's failure to implement other specific requirements of its care plans for residents.

[47] HCFA's definition of the issue is consistent also with the SOM's definition of "potential for more than minimal harm, but not immediate jeopardy," quoted in HCFA's brief (HCFA Br., 4).

I find in favor of HCFA also on the issue of whether the deficiencies were of the level which posed a potential for causing more than minimal harm to residents.

According to HCFA, "[t]he evidence shows that each of the deficiencies cited by the survey team in October posed the risk of compromising more than minimally the ability of affected residents to attain or maintain their highest practicable physical, emotional, or psychosocial well-being." HCFA Br., 30. I agree. HCFA's determination on the harm issue is supported by the nurse surveyors' explanations of how each of Petitioner's deficiencies had the potential for causing more than minimal harm to the residents' health, especially with reference to the goals and concerns set out in the relevant care plans. Their approach and opinions were appropriate to HCFA's allegation that Petitioner was out of compliance with 42 C.F.R. § 483.20(d)(3)(ii).

In rejecting Petitioner's defenses that some of its residents health were beyond the point of being potentially harmed by its failure to fully implement its care plans for them, I use for illustration the example of Petitioner's failure to refer R 12 (Louise M.) to its registered dietician for evaluation of her severe weight loss, as specified in the care plan. (Between June and July 1995, this resident had lost more than five percent of her total body weight and fell well below her "ideal body weight" of 87 to 107 pounds.) For the harm issue under 42 C.F.R. § 483.20(d)(3)(ii), it is immaterial whether, as asserted by Petitioner (see discussion in Section III.C.1., above), R 12 (Louise M.) was in the later stages of dementia[48] and was therefore experiencing weight loss due to her disease process. Nor is it material that her weight loss might not have been considered "catastrophic" in light of her history and overall condition. This resident was still entitled to attain and maintain her highest practicable level of physical, emotional, or psychosocial well-being under the terms of her care plan, notwithstanding her alleged dementia or other health problems.

[48] This same resident, R 12 (Louise M), also had a doctor's order for the application of hand rolls and splints. Petitioner has also used this resident's allegedly terminal condition due to Alzheimer's disease and dementia to contend that the absence of hand rolls and splints on her during the surveyor's observation periods should not been cited even as a deficiency. See Tr. 448, 449.

Petitioner's provision of other services,[49] even if true, is not enough to establish that its failure to provide one of the services specified in the care plan did not have the potential for causing more than minimal harm to the resident's ability to attain or maintain her highest practicable level of well-being. Where, as in R 12 (Louise M.)'s case, Petitioner has determined that referral to a registered dietician for evaluation of her severe weight loss is necessary to her achieving and maintaining such a level of well-being, Petitioner has no legitimate basis for withholding this service for several months until the surveyors intervened. There is no evidence that the care plan specified trying one approach at a time over several months. Petitioner's failure to refer this resident to a registered dietician at the same time it was allegedly implementing the other approaches had the potential to more than minimally harm her ability to attain her highest level of well-being as quickly as possible under her care plan. As explained also by HCFA's witnesses, an individual who falls below her ideal body weight is likely to experience a loss of energy, as well as become more susceptible to developing pressure ulcers and infections. Tr. 179 - 189.

On the issue of potential harm to residents, I note also my earlier conclusion in Section II.E., above, that HCFA can prove the existence of systemic "Resident assessment" problems if it establishes the numerosity and relatedness of the deficiencies it has alleged, such as all 11 sets of the alleged deficiencies and their relationship under the "Resident assessment" regulation. I agree with HCFA that the evidence of record shows that Petitioner's practices consisted of assessing its residents' needs because such assessments were required by federal law and regulations; incorporating the assessments into plans of care, also because doing so was required by federal law and regulations; obtaining physician's orders and devising care plans to meet identified needs, also because doing so was required by federal law and regulations; and then proceeding to disregard the physician's orders and care plans when Petitioner was under an obligation to implement them. See HCFA Br., 31. I agree also with HCFA's conclusion that the October resurvey found evidence of a "systems breakdown." HCFA Reply, 3.

Since surveys are part of the enforcement scheme established to protect the health and safety of all residents who are the

[49] For several residents, Petitioner has defended its failure to deliver specified services on the basis that it took other actions also mentioned in the care plans.

intended beneficiaries of the Medicare and Medicaid programs (see Hillman, supra at 9), it is proper for HCFA to use specific survey findings to draw broader conclusions concerning the prevalence of certain practices and their likely effects on residents who were not evaluated during the survey. Since the intent of surveys is not to protect residents only when the surveys are on going, surveyors may also use a facility's performance in their presence to make reasonable projections about its activities after the surveyors have left. Petitioner's director of operations agreed that, in appropriate situations, HCFA may consider whether a given type of deficient practice is systemic in nature and likely to have a potential for causing more than minimal harm to other residents at the facility. See Tr. 665.

Under the foregoing principles, I reject Petitioner's argument that some of the cited deficiencies, such as the failure to serve prune juice to two residents, were "petty." P. Reply, 6. Potential harm to the two identified residents was shown by the previously noted evidence concerning the need to maintain regularity of bowel movements for these residents as specified in their care plans, as well as the greater effectiveness of prune juice (as opposed to orange juice) for that purpose. However, another valid conclusion from all the facts of record is that Petitioner was engaged in a prevalent practice of disregarding doctors' orders, as evidenced by Petitioner's failure to follow the physician orders for prune juice as well as the other several physician orders noted by the surveyors. Petitioner's practice of disregarding doctors' orders can have more serious and wide-spread consequences for the health of its resident population than placing two individuals at risk for having less regular bowel movements. Therefore, any weaknesses which Petitioner may have discerned from HCFA's evidence of potential harm to certain surveyed residents does not invalidate the broader conclusions that Petitioner had systemic problems in failing to satisfy the "Resident assessment" requirements and those problems had the potential for causing more than minimal harm to the health of residents (including those in the general resident population).

The validity of the harm analysis set forth by HCFA rests also on the implied conclusion that the types of deficiencies observed by the surveyors did not occur only during the three days in October when the surveyors were on Petitioner's premises. As I have noted in the previous section of this Decision, Petitioner has relied heavily on the fact that surveyors saw deficiencies on only three days. The gist of

Petitioner's arguments appears to be that, even if it had continuously made all of the omissions identified by HCFA for three full days, there would still be insufficient proof that three days of such omissions had the potential for causing more than minimal harm to residents.

I reject Petitioner's premise that survey conclusions in this case mean that deficiencies existed only during the three days of the resurvey. As I noted earlier, the resurvey was conducted in October to evaluate Petitioner's compliance under "Resident assessment" (F 282) because Petitioner had been found out of compliance with the same requirements as a result of the August survey. Additionally, Petitioner has stipulated to the findings and conclusions of the August survey. Therefore, the only conclusion possible is that the same type of deficiencies found in October were in existence prior to the resurvey period.

In the context of HCFA's evidence concerning potential harm to residents, I find also that the evidence and purpose of the surveys support the reasonableness of the inference that Petitioner was likely to have continued its deficient "Resident assessment" practices after the resurvey period, if the surveyors and HCFA had not intervened. I have determined already that surveyors may use their findings while on site for a limited period of time to extrapolate a facility's likely activities and resident outcomes at all other times when the surveyors are no longer physically present to witness them. Therefore, there exists no presumption that Petitioner was in compliance whenever it was acting outside of the surveyors' presence.

Petitioner has not controverted HCFA's evidence and conclusions on the potential harm issue by proving affirmatively that the deficiencies observed by the surveyors were atypical of its usual practices. There is no credible evidence establishing, for example, that Petitioner was in fact fully implementing the care plans of the sampled residents when the surveyors were not making their observations. Nor is there evidence showing, for example, that a significant number of Petitioner's residents received all the services specified in their care plans.

What Petitioner has done, instead, is place heavy emphasis on speculation and self-serving, uncorroborated testimony concerning events which allegedly took place outside of the surveyors' presence. As noted above, Petitioner contends, for example: that no hand rolls and splints were seen on four residents because delays in applying these devices were caused

by the absence of the "rehab aide," who normally performed these tasks, and those hand devices were applied for the six to eight hours specified by the physicians' orders during periods not observed by the surveyor; that unbeknownst to the surveyors and undocumented by Petitioner, R 16 (Lloyd H.) was having a relative remove his hand splint and consistently refusing to be ambulated in accordance with his care plan; that the prune juice ordered by physicians had been served to R 1 (Ruth F.) and R 11 (Anna C.) on every morning except the one morning observed by the surveyor; that Petitioner was repositioning R 6 (Loretta V.) every two hours when the surveyors were not watching, but she then always flipped herself onto her left side also during the times when the surveyors were not watching.

The numerosity and similarity of these contentions by Petitioner make them appear unlikely on their face. The truth of these contentions cannot be verified through corroborative evidence, since Petitioner did not document matters such as R 16 (Lloyd H.'s) alleged refusal to be ambulated in accordance with his care plan and Petitioner never asked the surveyors to verify activities such as the alleged application of hand rolls and splints on R 17 (Alvina L.) or others before and after they were observed without those devices by the surveyors. Additionally, as noted above, the coordinator of the resurvey team had explained to Petitioner's staff the purpose of the resurvey when the team entered the premise. These circumstances do not make credible Petitioner's evidence that its staff was following physicians' written orders and otherwise implementing care plans for 8 of the 17 sample residents only when the surveyors were not looking.

I note in addition that, in several instances, Petitioner is attempting to excuse its staff members' having given their own convenience greater importance than the specific contents of the residents' care plans. For example, the evidence shows that the doctors' order to serve prune juice to two of the surveyed residents was not followed by Petitioner during the resurvey only because, on one morning, prune juice was not in the refrigerator of the unit housing those two residents, and some staff member from the unit would have needed to request or secure the prune juice from the dietary department. Additionally, Petitioner is contending that R 6 (Loretta V.) had repeatedly flipped herself onto her left side only because Petitioner's staff did not take the steps necessary to maintain her on her right side for the two hour intervals specified by her physician. Similarly, Petitioner is contending that its staff could not have intervened verbally in accordance with R 4

(Connie P.'s) care plan for reducing her outbursts because its staff had failed to do so. (The evidence establishes that staff had the opportunity and ability to provide the verbal intervention cues listed in her care plan even while the staff was providing other services to her roommate.) Petitioner is contending that the registered dietician would not have given the significant weight loss experienced by R 12 (Louise M.) high priority only because Petitioner's staff had never referred this resident to the dietician.

The foregoing and like evidence of record does not suggest that, absent intervention by the surveyors and HCFA, Petitioner's staff would have likely refrained from continuing those and similar deficient practices when the surveyors were not watching. Instead, the evidence and contentions set forth by Petitioner support the inference that, even though observations were made for only three days, Petitioner's residents were at risk for suffering more than minimal harm because Petitioner's deficient practices would have likely continued had the surveyors not issued their citations and HCFA not imposed an enforcement remedy.

I reject also Petitioner's argument that it has been cited for omissions even where the relevant care plan did not require action. It contends, for example, that the care plan for R 9 (Mabel H.) did not specify that Petitioner should send its observations of her tearfulness and outbursts to her treating psychiatrist in order to implement the goal of reducing the incidents of her inappropriate behavior. I do not find such argument persuasive for supporting Petitioner's contention that it acted in compliance with the "Resident assessment" requirements.

First, the defense implies that Petitioner made a choice to do only what was specified in the care plan. This implication is contradicted by Petitioner's failures in other instances to deliver the services specifically identified in the care plans. For example, Petitioner failed to serve prune juice to R 1 (Ruth F.) and R 11 (Anna C.) even though their care plan contained a physician's order for the juice; Petitioner failed to use any of the intervention methods specifically listed in the care plan for reducing the number of R 4 (Connie P.'s) outbursts; and Petitioner failed to refer R 12 (Louise M.) to its registered dietician for evaluation of her severe weight loss, even though the care plan specified the referral. In fact, the evidence shows that Petitioner is arbitrary and selective about which

provisions of the residents' care plans it will implement. The regulation leaves no such discretion to Petitioner.

Additionally, the regulation specifies that Petitioner must provide services "in accordance with each resident's written plan of care." 42 C.F.R. § 483.20(d)(3)(ii) (emphasis added). The regulation did not limit Petitioner's obligation to provide only those services specifically identified in the plan of care. I find it reasonable to interpret the "in accordance with" phrase of the regulation in the context of the residents' right to receive services under their plan of care that are supposed to help them attain or maintain their highest practicable physical, mental, and psychosocial well-being (see 42 C.F.R. § 483.20(d)(1)(i)). Therefore, I conclude that under 42 C.F.R. § 483.20(d)(3)(ii), Petitioner must deliver services that are specified in the plans of care, as well as the services that are appropriate to accomplishing the goals specified in the plans. For these reasons, I agree with HCFA that Petitioner should have sent to the psychiatrist treating R 9 (Mabel H.) its recorded observations of her tearfulness and outbursts even though the care plan listed the reduction of such episodes as a goal without having specified the forwarding of such records to her psychiatrist.

In the absence of any evidence establishing that the psychiatrist knew of the existence or contents of these records, I do not find persuasive Petitioner's arguments that the psychiatrist did not want to see such recorded observations, did not request them, and would not have found them useful for helping the resident reduce her episodes of inappropriate behavior. Petitioner's speculations about what the psychiatrist would have wanted to see or find helpful is akin to its contention that, even if it had referred R 12 (Louise M.) to the registered dietician for evaluation in accordance with her care plan, the registered dietician might not have given her high priority or attributed great significance to her weight loss. Such speculations are self-serving and do not invalidate HCFA's conclusion that Petitioner was out of compliance with the requirements of the "Resident assessment" regulation.

For the foregoing reasons, I issue the following as formal FFCL, after having evaluated the parties' evidence and arguments on the issue of whether Petitioner was out of compliance with 42 C.F.R. § 483.20(d)(3)(ii):

13. HCFA has proven that the existence of the following deficiencies under the "Resident assessment" requirements:

A. Petitioner's failure to follow written physician's orders to--

(i) apply hand splints and hand rolls on four residents (R 17, R 12, R 4, and R 16);
(ii) provide prune juice to two residents (R 1 and R 11);
(iii) reposition one bedridden resident (R 6);

B. Petitioner's failure to implement the written care plans it had developed for residents to--

(i) treat the significant weight loss of one resident (R 12) by referring her to a registered dietician;
(ii) reduce the episodes of inappropriate behavior for two residents (R 4 and R 9);
(iii) ambulate one resident (R 16) daily.

14. The issue of harm to residents' health in this case must be evaluated on the basis of whether Petitioner's deficiencies have the potential for causing more than minimal harm to the residents' ability to attain or maintain their highest practicable physical, mental, and psychosocial well-being as provided in the individual care plans Petitioner had prepared for them.

15. A preponderance of the evidence supports HCFA's determination that the deficiencies found during the October 1995 resurvey had the potential for causing more than minimal harm to the health (as set forth in FFCL 14) of the above eight residents and other residents under Petitioner's care.

16. Petitioner has not proven that it was in compliance with the "Resident assessment" requirements of 42 C.F.R. § 483.20(d)(3)(ii) as of the October resurvey.

17. The preponderance of the evidence establishes that, as of the October 1995 resurvey, Petitioner continued to be out of compliance with the "Resident Assessment" requirements of 42 C.F.R.

§ 483.20(d)(3)(ii).

18. In accordance with the parties' stipulations (ALJ Ex. 1), Petitioner's noncompliance at the time of the October 1995 resurvey provided HCFA with a basis for imposing the DPNA remedy against Petitioner for the period from November 20, 1995 through January 31, 1996.

V. CONCLUSION

The DPNA remedy imposed by HCFA against Petitioner is hereby affirmed for the reasons and period specified by HCFA.

_____/s/_____
Mimi Hwang Leahy
Administrative Law Judge