Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	Date: April 12, 2007
IHS of Kansas City at Alpine North, (CCN: 26-5379)	)	
Petitioner,	)	
	)	Docket No. C-04-472
v.	)	Decision No. CR1585
Centers for Medicare & Medicaid Services.	)	

DECISION

Petitioner, IHS of Kansas City at Alpine North, did not violate 42 C.F.R. § 483.25[1] as alleged based upon the survey completed at the facility on May 20, 2004. There is no basis for the imposition of an enforcement remedy.

I. Background

Petitioner, a long-term care facility authorized to participate in the Medicare program as a skilled nursing facility (SNF) and in the Missouri Medicaid program as a nursing facility (NF), is located in Kansas City, Missouri. The Missouri Department of Health and Senior Services (the state agency) completed a complaint investigation survey of Petitioner on May 20, 2004, the results of which are reported in a Statement of Deficiencies (SOD) dated May 20, 2004. Joint Stipulation of Fact, Court Exhibit (Ct. Ex.) 1. Based upon the survey findings, the Centers for Medicare & Medicaid Services (CMS) notified Petitioner by letter dated June 7, 2004, that it was terminating Petitioner's provider agreement effective June 12, 2004, and that it was imposing against Petitioner a per instance civil

[1] All references are to the revision of the Code of Federal Regulations (C.F.R.) in effect at the time of the survey, unless otherwise indicated.

money penalty (PICMP) of $10,000 based upon the deficiency cited under Tag F309[2] (a violation of 42 C.F.R. § 483.25) at the level of immediate jeopardy. The CMS notice also advised Petitioner that the state agency had imposed a denial of payment for new admissions effective May 26, 2004, which would remain in effect until Petitioner achieved substantial compliance with program requirements or its provider agreement was terminated. CMS Exhibit (CMS Ex.) 1, at 13-15; Petitioner's Exhibit (P. Ex.) 32. CMS advised Petitioner by letter dated June 15, 2004, that, based upon a state agency revisit survey, it had determined that immediate jeopardy to patient health and safety had been removed and that Petitioner's provider agreement would not be terminated. However, the revisit survey did not find Petitioner in substantial compliance with program requirements, and CMS advised that termination would be effectuated in six months if substantial compliance was not achieved. CMS Ex. 1, at 22-23; P. Ex. 33.

Petitioner requested a hearing by an administrative law judge (ALJ) through correspondence dated July 23, 2004. The case was assigned to me for hearing and decision on August 3, 2004. A hearing was held in Kansas City, Missouri, on January 5 and 6, 2005. I admitted CMS exhibits 1 (subject to my rulings during the hearing) and 2. Transcript (Tr.) 23-31, 209. I also admitted Petitioner's exhibits 1 through 54. Tr. 36. Testifying for CMS were Deborah Lou Stevens, R.N., the surveyor who conducted the May 4, 2004 survey (and who also participated in Petitioner's annual survey from April 20-27, 2004) (Surveyor Stevens), and Daniel Lee Swagerty, Jr., M.D. (Dr. Swagerty), CMS's expert witness. Testifying for Petitioner were Bruce Allen Kauk, M.D. (Dr. Kauk) and Man Anand, M.D. (Dr. Anand), the involved Resident's treating physician and psychiatrist, respectively; facility employees Mary Elizabeth Cook, L.P.N. (LPN Cook), Sarah Ann Meyer, C.N.A. (CNA Meyer), Sheila Perkins-Koch, R.N. (RN Koch), Lalaine Poras, R.N. (RN Poras), Susan Miller, R.N. (RN Miller), Regina Renee Smith, L.P.N. (LPN Smith); and nurse consultants Connie E. Cheren, R.N. (RN Cheren), and Sarah McGinley, R.N. (RN McGinley). The parties filed post-hearing briefs (CMS Brief and P. Brief) and post-hearing reply briefs (CMS Reply and P. Reply).

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[2] This is a "Tag" designation as used in the State Operations Manual (SOM), Appendix PP – Guidance to Surveyors for Long Term Care Facilities. The "Tag" refers to the specific regulatory provision allegedly violated and CMS's guidance to surveyors. Although the SOM does not have the force and effect of law, the provisions of the Social Security Act (Act) and regulations interpreted clearly do have such force and effect. *State of Indiana by the Indiana Department of Public Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991); *Northwest Tissue Center v. Shalala*, 1 F.3d 522 (7th Cir. 1993). Thus, while the Secretary of Health and Human Services (Secretary) may not seek to enforce the provisions of the SOM, he may seek to enforce the provisions of the Act or regulations as interpreted by the SOM.

II. Discussion

It is alleged in the May 20, 2004 SOD that Petitioner's staff failed to recognize a change in condition in one resident when the Resident[3] continued to have an elevated temperature, decreased intake, and declined from her normal level of activity for approximately one week before she was sent, on May 4, 2004, to the emergency room, unresponsive, with a blood pressure of 66/33 (a critically low blood pressure), a 94 degree core body temperature, septic shock, respiratory failure, urinary tract infection (UTI), and renal insufficiency. The resident died on May 13, 2004.[4] The deficiency was assessed to be at a level of immediate jeopardy (scope and severity level of J). CMS Ex. 1, at 53.

A. Findings of Fact

The following findings of fact are based upon the exhibits admitted and the testimony at hearing. Citations to exhibit numbers related to each finding of fact may be found in the analysis section of this decision if not indicated here.

1. The Resident was admitted to Petitioner's facility on May 27, 2003, with diagnoses of hypertension, degenerative joint disease, depression, schizophrenia, SIADH (syndrome of inappropriate antidiuretic hormone with hyponatremia (low blood sodium)), compulsive water drinking, and third degree burns in the upper thighs and perineal area. Ct. Ex. 1; P. Ex. 1, at 23-24.

2. The Resident had a history of resisting care, including eating, which was not easily altered; depressed, sad or anxious mood, as indicated by reduced social interaction up to five days a week; needed extensive assistance with activities of daily living; had range of motion limitations in her leg and foot; was incontinent of bowel and bladder; had problem conditions including edema and an unsteady gait; had problems chewing and swallowing; had weight gain; and was involved in activities only from one-third to two-thirds of the time while awake. CMS Ex. 1, at 645-48; P. Ex. 1, at 200-06.

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[3] In the SOD the surveyors cite a single deficiency that refers to Resident 12. Prior to hearing the parties entered a joint stipulation that refers to Resident 1. In post-hearing briefs, Petitioner refers to Resident 1 and CMS refers to Resident 12. Resident 1 and 12 are, in fact, the same person. I simply refer to "the Resident." Tr. 13-14.

[4] The parties Joint Stipulation states that Resident 1 died on May 12, 2004. Ct. Ex. 1, at 2. However, Resident 1's death certificate shows her date of death to be May 13, 2004. P. Ex. 20. Where I refer to Resident 1's death, I will cite her date of death as May 13, 2004.

3. The Resident's care plan reflects a history of upper respiratory infection in November 2003, January 2004, and February 2004, and of aspiration pneumonia. P. Ex. 1, at 265-67; CMS Ex. 1, at 628-29, 635, 704.

4. The Resident did not have a history of UTI. P. Ex. 1, at 1-476; P. Ex. 51, at 1-66; Tr. 425-26.

5. The Resident was non-compliant with prescribed diet orders for her mechanical soft diet with thickened liquids and fluid restrictions, which diet was ordered due to her swallowing difficulties. P. Ex. 1, at 226-27, 267; P. Ex. 11, at 5; P. Ex. 51, at 32-33; Tr. 402, 445-48, 463-64, 481, 521.

6. The Resident's diet/nourishment consumption record (consumption record) for April 1, 2004 through April 28, 2004 (the period just before the week in issue), reflects at least 25 days where she ate 50% or less for at least one meal and, from April 20 through 27, 2004, she refused four meals. CMS Ex. 1, at 621.

7. The Resident's consumption record for April 28, 2004 through May 4, 2004, shows at least four instances of the Resident's refusal to eat her meal, and seven instances, counting dinner on May 1, 2004, and lunch on May 2 and 3, 2004, where the boxes are empty, and her liquid intake is also reflected as down from the previous month. CMS Ex. 1, at 54, 619, 621; Tr. 97-102.

8. Staff reported changes with respect to the Resident's intake of food. CMS Ex. 1, at 54-55, 57, 61, 63-65, 179, 183, 196-96A, 212, 219, 246, 248-49, 714-15.

9. The Resident had a history of fluctuating temperatures, 97 to 99 degrees, during the period from February 26, 2004 through May 3, 2004, and, according to CMS expert witness Dr. Swagerty, this is not abnormal. P. Ex. 1, at 47-49, 52-109; P. Ex. 3; Tr. 271-72.

10. The Resident also had a history of mildly elevated temperatures in her last year at the facility, where she returned to normal without adverse problems, according to Dr. Swagerty. Tr. 271-72.

11. During the five day period from April 29, 2004 to her hospitalization on May 4, 2004:

a. On April 29, 2004, the Resident experienced an elevated axillary temperature of 99.5 degrees Fahrenheit; she complained of coughing and sneezing; Dr. Kauk, her treating physician, was notified; Tylenol was given; and the fever resolved. P. Ex. 1, at 48, 136; P. Ex. 43; P. Ex. 7, at 13; CMS Ex. 1, at 55, 295-96, 626-27.

b. The Resident's consumption record from April 29, 2004, notes that the Resident ate 50% of her breakfast, refused to drink, refused lunch and drink, ate 20% of her dinner, and drank 240 ccs of liquid (CMS Ex. 1, at 621), but the Resident reported that she ate lunch in her room (P. Ex. 1, at 48; P. Ex. 43; P. Ex. 7, at 13).

c. On April 29, 2004, laboratory specimens were collected for a metabolic panel. P. Ex. 1, at 307-09; Tr. 421.

d. Clinical review meeting notes from April 30, 2004, indicate that Dr. Kauk was to be notified if the Resident was not eating well and was refusing thickened liquids and that her temperature was to be checked and appropriate action taken, if necessary. CMS Ex. 1, at 323; P. Ex. 8, at 11.

e. On April 30, 2004, according to her consumption record, the Resident ate 50% of her breakfast and drank 120 ccs. of liquid, refused lunch, and ate 40% of her dinner. CMS Ex. 1, at 621.

f. Nursing progress notes from April 30, 2004, indicate that the Resident refused breakfast and lunch and stated "thick liquids and I don't get along;" a facsimile was sent to Dr. Kauk and he gave orders to discontinue thickened liquids and to monitor for signs and symptoms of cough or aspiration with intake. P. Ex. 1, at 48, 417, 432; P. Ex. 7, at 14; P. Ex. 22, at 2; CMS Ex. 1, at 526, 707.

g. On April 30, 2004, the Resident's temperature during the 6:00 a.m. to 2:00 p.m. shift was 97 degrees; during the 2:00 p.m. to 10:00 p.m. shift the Resident's temperature was recorded as 99.4 degrees orally, and Tylenol and Benedryl (an order for Benedryl was received on this shift) were given. P. Ex. 1, at 48, 136, 417, 435; P. Ex. 3, at 3; P. Ex. 7, at 14; P. Ex. 43.

h. On April 30, 2004, a facsimile was sent to Dr. Anand requesting that he see the Resident, and she was scheduled for a psychiatric examination with him on May 2, 2004. P. Ex. 1, at 48, 365.

i. On April 30, 2004, no odor or problems with the Resident's urine were noted. CMS Ex. 1, at 184, 239; P. Ex. 12, at 3, 4.

j. There is no record of Resident's temperature from May 1 through May 3, 2004. CMS Ex. 1, at 59-60, 240-41; P. Ex. 3.

k. On May 1, 2004, the Resident's consumption record reflects that the Resident ate 50% of her breakfast and drank 240 ccs. of liquid; the Resident ate 50% of her lunch and drank 370 ccs. of liquid; dinner consumption was not recorded. P. Ex. 51, at 47.

l. Notes from the May 1, 2004 clinical review meeting reflect that the Resident was returned to regular fluids, but that she was to be monitored for cough and signs of aspiration. P. Ex. 10, at 1; CMS Ex. 1, at 302.

m. No odor or problems with the Resident's urine were noted on May 1, 2004. CMS Ex. 1, at 206; P. Ex. 12, at 5.

n. On May 1, 2004, the Resident was talking and cracking jokes; she was out of her room in her wheelchair, nurses providing direct care noted nothing abnormal about her eating and drinking; there were no complaints of UTI-type symptoms; the Resident complained of a headache which resolved with Tylenol. CMS Ex. 1, at 179; P. Ex. 45; Tr. 482-83, 485-86, 487-88.

o. On May 2, 2004, the Resident's consumption record reflects that she ate 25% of her breakfast and drank 240 ccs. of liquid; nothing is recorded for lunch; and she ate 15% of her dinner and drank 240 ccs. of liquid. P. Ex. 51, at 47.

p. On May 2, 2004, the Resident received a psychiatric evaluation by Dr. Anand, ordered due to her resistance to care, depression, mood swings, lack of energy and decrease in appetite, and he found she had decreased eye contact but was otherwise stable, he adjusted her medication, ordered a Thyroid profile, and planned monitoring her. P. Ex. 1, at 310, 449-50; CMS Ex. 1, at 287-88.

q. On May 3, 2004, the Resident's consumption record reflects that she ate 40% of her breakfast and drank 240 ccs. of liquid; her consumption at lunch is not recorded; and she ate 20% of her dinner and drank 300 ccs. of liquid. CMS Ex. 51, at 47.

r. On May 3, 2004, laboratory results were received and faxed to Dr. Kauk (a basic metabolic panel collected on April 29, 2004, received at the laboratory on April 29, 2004, but not reported by the laboratory until May 3, 2004 (P. Ex. 1, at 307-09)) and he noted no indication that the Resident was critically ill (Tr. 403).

s. On May 3, 2004, the Resident's lung sounds were monitored and assessed, and there were no signs of aspiration; nursing staff who observed her reported she seemed normal; during the evening shift she was cracking jokes and talking; staff who cared for her during the night reported that her urine was not dark and did not have an odor, she had to be waked to be changed, her skin was not open, and her bottom was a little red, but not too red. P. Ex. 1, at 48, 418; P. Ex. 10, at 2; P. Ex. 12, at 6, 12; P. Ex. 22, at 2; P. Ex. 40; P. Ex. 45; CMS Ex. 1, at 179, 205, 232, 300; Tr. 456, 511, 516-22.

t. On May 3, 2004, RN Miller sent a facsimile to Dr. Kauk advising that the Resident had not eaten well for the past few days and requesting that he see the Resident on Thursday, May 6, 2004. P. Ex. 51, at 2; CMS Ex. 1, at 370.

u. On May 4, 2004, the Resident was up between 6:15 and 6:30 a.m, she was reported to be laughing and joking and was taken to breakfast; she was alert; she made no complaints of not feeling well; her skin was pink; her face showed no more edema than normal; her urine had a strong odor but no stronger than usual for her. P. Ex. 12, at 2, 7, 9; P. Ex. 38; CMS Ex. 1, at 174, 180, 224.

v. On May 4, 2004, at 8:00 a.m., nursing progress notes state that the Resident was noted to have an increase in edema, had stuffiness, and her lung sounds were coarse bilaterally; she complained of a headache but was not otherwise acting sick; she had no fever; she had very little intake by mouth; and a facsimile was sent to Dr. Kauk requesting orders. CMS Ex. 1, at 388, 696; P. Ex. 1, at 49.

w. A note on May 4, 2004, at 8:30 a.m., shows that vital signs were taken with blood pressure 63/33 and a temperature of 97 degrees, oxygen by nasal cannula was started, and Dr. Kauk was called. CMS. Ex. 1, at 696; P. Ex. 1, at 49.

x. A note from May 4, 2004, at 8:50 a.m., shows that Dr. Kauk directed that the Resident be sent to the hospital. CMS Ex. 1, at 696; P. Ex. 1, at 49.

y. The Resident was transported to the emergency room at North Kansas City Hospital at 9:05 a.m. on May 4, 2004, where she was admitted with a diagnosis of urosepsis, among other things. P. Ex. 1, at 49; P. Ex. 16, at 7; CMS Ex. 1, at 134-35, 413-14, 696.

z. The evidence does not show when the Resident developed a UTI or kidney infection that resulted in the urosepsis diagnosed upon her admission to the hospital.

aa. On May 13, 2004, the Resident died of respiratory failure at North Kansas City Hospital, due to sepsis, site unknown, and aspiration. P. Ex. 20.

B. Conclusions of Law

1. Petitioner timely requested a hearing and I have jurisdiction.

2. Pursuant to 42 C.F.R. § 483.25 (Tag F309), each resident of a facility must receive, and the facility must provide, the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being possible, in accordance with the resident's comprehensive assessment and plan of care.

3. Petitioner provided the necessary care and services to the Resident pursuant to 42 C.F.R. § 483.25 (Tag F309).

4. The remedies proposed by CMS are not reasonable, because Petitioner was in compliance with participation requirements.

C. Issues

The issues in this case are:

Whether there is a basis for the imposition of an enforcement remedy; and,

Whether the remedy imposed is reasonable.

D. Applicable Law

Petitioner is a long-term care facility participating in the federal Medicare program as a SNF and in the state Medicaid program as a NF. The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Act and at 42 C.F.R. Part 483. Sections 1819 and 1919 of the Act vest the Secretary with the authority to impose remedies, including denial of payment for new admissions (DPNA) and CMPs, against a long-term care facility for the failure to comply substantially with federal participation requirements.

Pursuant to the Act, the Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. Facilities that participate in Medicare may be surveyed on behalf of CMS by state survey agencies in order to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-488.28, 488.300-488.335. Pursuant to 42 C.F.R. Part 488, CMS may impose a CMP or PICMP against a long-term care facility when a state survey agency concludes that the facility is not complying substantially with federal participation requirements. 42 C.F.R. §§ 488.406; 488.408; 488.430. The regulations in 42 C.F.R. Part 488 also give CMS a number of other remedies that can be imposed if a facility is not in compliance with Medicare requirements. *Id.* Pursuant to 42 C.F.R. § 488.301, "*(i)mmediate jeopardy* means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." (emphasis in original). Further, "*(s)ubstantial 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." *Id.* (emphasis in original).

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, of from $3,050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). The lower range of CMP, from $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). There is only a single range of $1,000 to $10,000 for a PICMP, which applies whether or not immediate jeopardy is present. 42 C.F.R. §§ 488.408(d)(1)(iv); 488.438(a)(2).

The Act and regulations make a hearing before an ALJ available to a long-term facility against whom CMS has determined to impose a CMP. Act, section 1128A(c)(2); 42 C.F.R. §§ 488.408(g); 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et al*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Cal Turner Extended Care Pavilion*, DAB No. 2030 (2006); *The Residence at Salem Woods*, DAB No. 2052 (2006). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e) and 498.3. However, the choice of remedies by CMS or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge would affect the amount of the CMP that could be collected by CMS or impact upon the facility's nurse aide training program. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i). CMS's determination as to the level of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9, 38 (2000), *aff'd, Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g.*, *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Review of a CMP by an ALJ is governed by 42 C.F.R. § 488.438(e).

When a penalty is proposed and appealed, CMS must make a *prima facie* case that the facility has failed to comply substantially with federal participation requirements. "*Prima facie*" means that the evidence is "(s)ufficient to establish a fact or raise a presumption unless disproved or rebutted." *Black's Law Dictionary* 1228 (8th ed. 2004). *See also*, *Hillman Rehabilitation Center*, DAB No. 1611, at 8 (1997), *aff'd Hillman Rehabilitation Center v. U.S. Dept. of Health and Human Services*, No. 98-3789 (D.N.J. May 13, 1999). To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004); *Emerald Oaks*, DAB No. 1800 (2001); *Cross Creek Health Care Center*, DAB No. 1665 (1998); *Evergreene Nursing Care Center*, DAB No. 2069, at 7-8 (2007). Petitioner does not agree with the allocation of the burden of proof in a manner similar to that described in these prior cases from the Board (P. Brief at 3). However, the burden of persuasion is not an issue in this case because the evidence is not in equipoise. *Tri-County Extended Care Center*, DAB No. 2060 (2007).

E. Analysis

1. Petitioner proved by a preponderance of the evidence that it was in substantial compliance with 42 C.F.R. § 483.25 (Tag F309) at all relevant times.

The general quality of care standard is established by 42 C.F.R. § 483.25, which provides:

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

CMS alleges based upon the May 2004 SOD that Petitioner violated 42 C.F.R. § 483.25 (Tag F309) by failing to provide necessary care and services for the Resident. CMS alleges specifically that Petitioner's "staff failed to recognize a change of condition and to assess, and fully inform the physician of changes in one resident . . . when the resident continued to have an elevated temperature, her intake decreased, and her normal activity level declined during a period of approximately one week before the facility sent her to the emergency room in an unresponsive state." CMS Brief at 1-2, citing CMS Ex. 1, at 53. The parties stipulated that the Resident was a resident at Petitioner's facility from May 27, 2003 to May 4, 2004, except for periods of hospitalization. She was admitted to North Kansas City Hospital on May 4, 2004, where she died on May 13, 2004. Ct. Ex. 1, at 2; P. Ex. 20. Petitioner's care of the Resident involved was not perfect in this case, but, given the Resident's complex medical situation, Petitioner's staff acted reasonably in providing necessary care and services. Based upon all the evidence, I conclude that Petitioner has proved by a preponderance of the evidence that it provided necessary care and services to Resident 1; that it was in compliance with Tag F309 at all relevant times; and that there was no violation of 42 C.F.R. § 483.25.

Petitioner initially argues (P. Brief at 3-5) that the deficiency was not properly cited and that, if a deficiency was to be cited at all, it should have been cited under Tag F157 as a violation of 42 C.F.R. § 483.10(b)(11). However, it is clear to me from the language of the SOD, the testimony of the surveyor, the arguments of counsel (CMS Brief at 2 n.2), and the discussion on the record (Tr. 41-44), that the surveyor intended to cite a general failure by Petitioner to care for the Resident rather than the more specific citation of a failure to contact the Resident's physician and notify the physician regarding a significant change in the Resident's condition under Tag F157. I see no rationale for limiting the surveyor's or CMS's discretion to cite an alleged violation under one tag or regulation or another. The question I need to resolve is whether or not the evidence presented by CMS

makes a *prima facie* case of a deficiency under the regulation cited. Because CMS chose to proceed with an alleged violation of the regulations under Tag F309, I analyze the case as a violation of 42 C.F.R. § 483.25, Tag F309.

Petitioner next argues that, even if CMS had properly cited a violation of the participation requirement at Tag F309, the facility should only be held responsible for identifying [and reporting] "significant changes" rather than "subtle" changes in the Resident's condition. Petitioner also refers to two cases where it asserts that ALJs have not held facilities to be responsible for failing to identify subtle changes in a resident's condition. P. Brief at 6-7, citing *Autumn Care of Norfolk*, DAB CR1017 (2003) and *Beverly Health and Rehabilitation - - Springhill*, DAB CR553 (1998), *aff'd,* DAB No. 1696 (1999). Petitioner confuses the standard applicable under Tag F157 (which requires reporting of "significant changes" to the attending physician), with the standard applicable under Tag F309 (which requires the provision of care such that residents can attain or maintain their highest practicable physical, mental, and psychosocial well-being consistent with their comprehensive assessment and plan of care). In reviewing this case under Tag F309, I focus on the facts in order to determine whether or not Petitioner delivered the appropriate quality of care required to this Resident.[5]

CMS's position is that Petitioner did not fully assess the Resident and then failed to inform her attending physician regarding changes in her condition, including two elevated temperatures, a decline in her intake of food and fluid, and a change in her activity level. CMS's expert witness, Dr. Swagerty, testified on behalf of CMS that, in his opinion, Petitioner's staff failed to do a medical assessment sufficient to diagnose the Resident's condition, to rule out various potential causes of her condition, and to provide care consistent with her assessed condition and need for care. CMS Brief at 9, citing Tr. 211-13, 228, 288-89. Dr. Swagerty's testimony, however, is obviously influenced by his review of the surveyor allegations in the survey documents. His opinions were developed with the benefit of hindsight and the ability to examine the entire record submitted by the parties, including the records from the Resident's hospitalization. I do not find Dr. Swagerty's opinions and conclusions to be particularly weighty in analyzing the reaction of Petitioner's staff as events with the Resident unfolded.

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[5] The deficiencies alleged by the surveyors and CMS were based on a review of Petitioner's records. My review as to whether or not Petitioner provided the quality of care required focuses upon what is reflected in Petitioner's records regarding the Resident. I give more weight to what is reflected in these contemporaneous documents than the potentially faulty memories of staff, whether in testimony, by affidavit, or as recorded by the surveyor in the SOD or the surveyor notes.

The Resident's records reflect that she presented a complicated medical picture. Her records also reflect that her treating physician, a psychiatrist, and Petitioner's staff were all significantly involved in assessing and treating the Resident's multiple conditions.

The Resident was admitted to Petitioner's facility on May 27, 2003, with diagnoses of hypertension, degenerative joint disease, depression, schizophrenia, SIADH (syndrome of inappropriate antidiuretic hormone with hyponatremia (low blood sodium)), compulsive water drinking, and third degree burns in the upper thighs and perineal area. Ct. Ex. 1; P. Ex. 1, at 23-24. The Resident's March 23, 2004 minimum data set (MDS) (the MDS apparently completed closest to the May 20, 2004 survey date) reflects, among other things, that the Resident had problems with long and short-term memory; had moderately impaired decision-making skills; exhibited socially inappropriate and disruptive behaviors; resisted care, including eating, which was not easily altered; had indicators of depressed, sad or anxious mood, as indicated by reduced social interaction up to five days a week; needed extensive assistance with activities of daily living; had range of motion limitations in her leg and foot; was incontinent of bowel and bladder; had problem conditions including edema and an unsteady gait; had problems chewing and swallowing; had weight gain; and was involved in activities only from one-third to two-thirds of the time while awake. CMS Ex. 1, at 645-48. This is consistent with a March 9, 2004 MDS, which also indicated that the Resident was not involved in group activities, but was at ease interacting with others, doing planned or structured activities, or doing self-initiated activities, and that a wheelchair (where she wheeled herself) was her primary mode of locomotion. P. Ex. 1, at 200-06.

The Resident's care plan reflects a history of upper respiratory infection in November 2003, January 2004, and February 2004, and of aspiration pneumonia. P. Ex. 1, at 265-67; CMS Ex. 1, at 628-29, 635, 704. Neither the Resident's care plan nor her medical records reflect a history of UTI. P. Ex. 1, at 1-476 (especially page 212); P. Ex. 51, at 1-66; Tr. 425-26. Records reflect that the Resident was non-compliant with prescribed diet orders for her mechanical soft diet with thickened liquids and fluid restrictions, which diet was ordered due to her swallowing difficulties. The Resident would refuse food served at mealtimes, confiscate food and drink from other residents' food trays, and borrow money to purchase soft drinks. The Resident hid food in her wheelchair. P. Ex. 1, at 226-27, 267; P. Ex. 11, at 5; P. Ex. 51, at 32-33; Tr. 445-48, 463-64, 481, 521. Dr. Kauk, the Resident's physician, was aware that the Resident kept food in her wheelchair, got food from vending machines, and often ate meals in her room. Tr. 402.

The Resident's resident assessment protocol (RAP) for behavioral symptoms, dated March 9, 2004, specifically noted that there were times when she was verbally abusive, socially inappropriate, and resistive to care, especially pertaining to fluid restriction. The behavior occurred any time the Resident was approached by staff regarding her fluid

restriction and her order regarding the receipt of thickened liquids. The Resident's behavior increased her risk for edema, and such fluid build-up could lead to pneumonia. Petitioner's staff tried to redirect the Resident by reminding her about the affect of her behavior on her health. P. Ex. 1, at 216-17. Due to the Resident's fluid restrictions, the Resident's RAP protocol for March 9, 2004, noted that she needed to be monitored for electrolyte imbalance, dehydration, and fluid overload. P. Ex. 1, at 229.

The Resident's consumption record for April 1, 2004 through April 28, 2004 (the period just before the week in issue and including the annual survey in which Surveyor Stevens participated), notes at least 25 days where she ate 50% or less for at least one meal. And, from April 20 through 27, 2004, she refused four meals. CMS Ex. 1, at 621. The Resident's consumption record for April 28, 2004 through May 5, 2004, shows at least four and possibly seven instances of the Resident's refusal to eat her meal (seven counting dinner on May 1, 2004, and lunch on May 2 and 3, 2004, where the boxes are empty) and her liquid intake is also reflected as down from the previous month (CMS Ex. 1, at 54, 619, 621; Tr. 97-102). Staff reported changes with respect to the Resident's intake of food. CMS Ex. 1, at 54-55, 57, 61, 63-65, 179, 183, 196-96A, 212, 219, 246, 248-9, 714-15.

The Resident's RAP for mood state, dated March 9, 2004, indicated that the Resident had never been very socially active (although she was up in her wheelchair and out of her room daily), but that she interracted with staff. P. Ex. 1, at 214. The Resident was independent and vocal. Prior to May 1 and 2, 2004, she would stay in her room to watch T.V. She would also take meals in her room. Tr. 481-82; 490.

The Resident had a history of fluctuating temperatures during the period from February 26, 2004 through May 3, 2004. P. Ex. 1, at 47-49, 52-109; P. Ex. 3 (a summary of Petitioner's fluctuating temperatures prepared by Petitioner). Dr. Swagerty, CMS's expert witness, testified that the Resident's average temperature fluctuated from 97 to 99 degrees, and opined that a normal temperature varies even if an individual is not sick. Dr. Swagerty stated also that the Resident had mildly elevated temperatures in her last year at the facility, where she returned to normal without adverse problems. Tr. 271-72.

On April 29, 2004, the Resident experienced an elevated axillary temperature of 99.5 degrees Fahrenheit, which equates to 100.5 degrees orally. CMS Ex. 1, at 55. The Resident complained of coughing and sneezing and Dr. Kauk was notified. Tylenol was given. The coughing was not witnessed by staff. P. Ex. 1, at 48, 136; P. Ex. 43; P. Ex. 7, at 13; CMS Ex. 1, at 295-96, 626-27.

The Resident's consumption record from April 29, 2004, notes that the Resident ate 50% of her breakfast, refused to drink, refused lunch and drink, ate 20% of her dinner, and drank 240 ccs of liquid. CMS Ex. 1, at 621. The Resident reported that she ate lunch in her room (although she apparently did not eat what she was served, given the notation in her consumption record), and she ate dinner in her room. P. Ex. 1, at 48; P. Ex. 43; P. Ex. 7, at 13. On April 29, 2004, laboratory specimens were collected for a metabolic panel. P. Ex. 1, at 307-09; *see* Tr. 421. According to Dr. Kauk, normally the laboratory should have reported results in 48 hours, except in an emergency case. He opined that no urinalysis was ordered on April 29, as there were no specific symptoms identified related to a UTI. Tr. 399. On cross-examination he noted that between April 29 and May 3, 2004, there was a weekend. Tr. 421.

On April 30, 2004, clinical review meeting notes indicate that Dr. Kauk was to be notified if the Resident was not eating well and was refusing thickened liquids. It was noted that her temperature was to be checked and appropriate action taken, if necessary. CMS Ex. 1, at 323. On April 30, 2004, according to her consumption record, the Resident ate 50% of her breakfast and drank 120 ccs. of liquid, and then refused lunch. CMS Ex. 1, at 621. Nursing progress notes indicate that she refused breakfast and lunch and stated "thick liquids and I don't get along." P. Ex. 1, at 48; CMS Ex. 1, at 707. A facsimile was sent to Dr. Kauk and he gave orders to discontinue thickened liquids and to monitor for signs and symptoms of cough or aspiration with intake. P. Ex. 1, at 48; CMS Ex. 1, at 526, 707; P. Ex. 1, at 417, 432; P. Ex. 7, at 14; P. Ex. 22, at 2. The Resident ate 40% of her dinner. CMS Ex. 1, at 621.

On April 30, 2004, the Resident's temperature during the 6:00 a.m. to 2:00 p.m. shift was 97 degrees. During the 2:00 p.m. to 10:00 p.m. shift the Resident's temperature was 99.4 degrees orally. Tylenol and Benedryl (an order for Benedryl was received on this shift) were given. P. Ex. 43; P. Ex. 1, at 48, 136, 417, 435; P. Ex. 3, at 3; P. Ex. 7, at 14. There is no record that Resident's temperature was taken again until May 4, 2004. CMS Ex. 1, at 59-60, 240-41. On April 30, 2004, a facsimile was sent to Dr. Anand requesting that he see the Resident. A May 2, 2004 appointment was made. P. Ex. 1, at 48, 365. On April 30, 2004, no odor or problems with the Resident's urine were noted. CMS Ex. 1, at 184, 239; P. Ex. 12, at 3, 4.

On May 1, 2004, the Resident's consumption record reflects that the Resident ate 50% of her breakfast and drank 240 ccs. of liquid. The Resident ate 50% of her lunch and drank 370 ccs. of liquid. Her consumption at dinner was not recorded. P. Ex. 51, at 47. During a May 1, 2004 clinical review meeting, it was noted that the Resident could now have regular fluids, but that she was to be monitored for cough and signs of aspiration. P. Ex. 10, at 1; CMS Ex. 1, at 302. No odor or problems with the Resident's urine were noted on May 1, 2004. CMS Ex. 1, at 206; P. Ex. 12, at 5. The Resident was talking and

cracking jokes on May 1, 2004. CMS Ex. 1, at 179. LPN Smith did not notice anything abnormal with respect to the Resident's eating or drinking pattern on May 1, 2004. P. Ex. 45. On May 1, 2004, RN Poras provided direct care to the Resident, giving her medication and treatments to her hands. Tr. 482-83. The Resident did not complain of symptoms of a UTI. Tr. 485-86. The Resident complained of a headache and was given Tylenol, for which she had a standing order. Tr. 487. The Resident was out of her room in her wheelchair. Tr. 488.

On May 2, 2004, the Resident's consumption record reflects that she ate 25% of her breakfast and drank 240 ccs. of liquid and ate 15% of her dinner and drank 240 ccs. of liquid. Nothing is recorded with regard to her consumption at lunch. P. Ex. 51, at 47. On May 2, 2004, the Resident received a psychiatric evaluation by Dr. Anand, ordered due to, among other things, her resistance to care, depression, mood swings, lack of energy and decrease in appetite. P. Ex. 1, at 449. Dr. Anand examined her seated in her wheelchair. She had decreased eye contact. Dr. Anand found her in stable condition and adjusted her medications. Dr. Anand intended to monitor her. P. Ex. 1, at 449-50; *see* CMS Ex. 1, at 287-88.

On May 3, 2004, blood was drawn from the Resident for a thyroid profile, as ordered by Dr. Anand on May 2, 2004. P. Ex. 1, at 310, 450. On May 3, 2004, the Resident's consumption record reflects that she ate 40% of her breakfast and drank 240 ccs. of liquid. She ate 20% of her dinner and drank 300 ccs. of liquid. Her consumption at lunch was not recorded. CMS Ex. 51, at 47. On May 3, 2004, an 11:30 a.m. nursing progress note stated that the Resident was taking meals in her room "this shift." It was noted that the Resident's diet order had been clarified to "Mech. Soft [with] Regular Thin Liquids." A call was placed to inform the Resident's Public Administrator about the change in the diet orders. Laboratory results were received and faxed to Dr. Kauk (a basic metabolic panel collected on April 29, 2004, received at the laboratory on April 29, 2004, but not reported by the laboratory until May 3, 2004 (P. Ex. 1, at 307-09)). The Resident's lung sounds were monitored and assessed and there were no signs of aspiration. P. Ex. 1, at 48; P. Ex. 1, at 418; P. Ex. 10, at 2; P. Ex. 22, at 2; CMS Ex. 1, at 300. Dr. Kauk testified that he reviewed the laboratory results from the lab work drawn on April 29 and reported on May 3. It did not indicate to Dr. Kauk that the Resident was critically ill. Tr. 403. On May 3, 2004, RN Miller noted the Resident came to breakfast and lunch and looked normal. CMS Ex. 1, at 205; P. Ex. 12, at 12; Tr. 511. RN Perkins-Koch noted her behavior was normal that day also. Tr. 456-57; *see* P. Ex. 40. On May 3, 2004, RN Miller sent a facsimile to Dr. Kauk stating "Res. not eating well for the past few days. Please put on your list for Thurs. We will notify if any further change." P. Ex. 51, at 2; CMS Ex. 1, at 370. LPN Smith worked with the Resident on the evening of May 3, 2004. LPN Smith did not observe anything abnormal about her behavior and the Resident did not complain of pain. The Resident was cracking jokes and talking. LPN Smith bought

her a soda and some iced tea and gave her chicken nuggets. LPN Smith provided incontinence care. Tr. 516-22; P. Ex. 45; CMS Ex. 1, at 179. LPN Smith told Surveyor Stevens that there was no difference in the Resident's behavior between May 1 when she cared for her and May 3, 2004, when she cared for her again - the Resident was talking and cracking jokes. CMS Ex. 1, at 179. An LPN who cared for the Resident during the night of May 3, 2004, told Surveyor Stevens that the Resident appeared normal, her urine was not dark and did not have an odor, she had to be waked to be changed, her skin was not open, and her bottom was a little red, but not too red. CMS Ex. 1, at 232; P. Ex. 12, at 6.

Between 6:00 a.m. and 6:45 a.m. on the morning of May 4, 2004, CNA Ganelle Jones states in her affidavit that she gave the Resident a hat and the Resident asked CNA Jones to wheel her around the nursing home to show off the hat. CNA Jones then dropped the Resident off for breakfast. P. Ex. 38. CNA Jones told the surveyor that she helped to change the Resident. The Resident's urine had a strong odor, but CNA Jones said her urine always had a strong odor and there was no change from normal. CMS Ex. 1, at 174, 224; P. Ex. 12, at 7, 9. CNA Lynn Collins told the surveyor that the Resident was ready to get up on May 4, 2004, between 6:15 and 6:30 a.m. The Resident was laughing and joking. Her skin was pink, her face no more swollen than usual. She was alert. She did not complain about not feeling well or about itching. CNA Collins did not note odor from her urine. CMS Ex. 1, at 174, 180; P. Ex. 12, at 2. On May 4, 2004, at 8:00 a.m., nursing progress notes state that the Resident was noted to have an increase in edema, had stuffiness, and her lung sounds were coarse bilaterally. The Resident was complaining of a headache. She had no fever, but was acting sick. She had very little intake by mouth. A facsimile was sent to Dr. Kauk. The facsimile sent to Dr. Kauk stated specifically that "[Resident] is having a lot of Edema, Stuffiness, etc., Lung Sounds are coarse bilaterally - Not running a temp but she states she is sick - c/o headache this am - Has had very little po intake for past few days. Orders?" CMS Ex. 1, at 388. An 8:30 a.m. note stated vital signs were taken (blood pressure 63/33, temperature 97 degrees), oxygen by nasal cannula was started, and Dr. Kauk called. An 8:50 a.m. note says Dr. Kauk gave orders to send the Resident to the hospital, and she was sent there at 9:05 a.m. P. Ex. 1, at 49; CMS Ex. 1, at 696.

The Resident died of respiratory failure at North Kansas City Hospital on May 13, 2004. The immediate cause of death listed on the Resident's death certificate was respiratory failure and the sequential conditions leading to the respiratory failure were sepsis site unknown and aspiration. P. Ex. 20. A consultative note from the hospital dated May 4, 2004, lists the impression "septic shock probably related to urosepsis" and "acute renal failure probably related to urosepsis . . . ." CMS Ex. 1, at 134-35; P. Ex. 16, at 7. A consultation report from May 10, 2004, lists the impression that the Resident had sepsis on admission to the hospital on May 4, 2004, with a UTI, presumably due to

pyelonephritis (kidney infection). CMS Ex. 1, at 413. Dr. Kauk testified that he was the Resident's attending physician throughout her hospitalization until her death and that it was never clearly determined the site or cause of her infection or sepsis and that lead to his entry on the death certificate that the site was unknown (P. Ex. 20). Tr. 412-13. He acknowledged that the Resident had a UTI on admission to the hospital that was treated aggressively and that was improved or resolved at her death. Tr. 416.

The evidence shows that the Resident did have an elevated temperature on April 29, 2004, which went down after administration of Tylenol but then increased again on April 30, 2004, that her activity-level decreased during the period in question, and that her intake of food and fluid declined during that period. CMS Ex. 1, at 5, 147, 246-49, 714-15. CMS acknowledges that the Resident appeared normal and made no specific complaints consistent with a grave illness until May 4, 2004. CMS Reply at 4.

In its factual analysis, Petitioner focuses upon the period of slightly more than four days, from April 30, 2004 to the early morning of May 4, 2004. P. Brief at 8. Petitioner's analysis, based primarily upon the testimony of staff, is that, until the morning of May 4, 2004, the Resident was normal, and that it was during the morning of May 4, 2004, that she manifested a significant change in condition that required her hospitalization that day. Petitioner argues that when the significant change occurred, its staff reacted promptly and appropriately. P. Brief at 8-10.

Petitioner specifically asserts that, prior to May 4, 2004, the evidence shows that its staff properly cared for the Resident. On April 29, 2004, the Resident had an axillary (armpit) temperature of 99.5 degrees with complaints of coughing and sneezing. The Resident's physician was called and he ordered Tylenol and the next morning "the fever was resolved." P. Brief at 12. According to Petitioner, that is all it needed to do. Petitioner asserts that contrary to the position taken by CMS and the surveyor, an elevated temperature does not warrant obtaining a urinalysis for a UTI absent other signs and symptoms. P. Brief at 15. Petitioner argues that there were no signs and symptoms displayed by the Resident consistent with a UTI that should have prompted its staff to treat the Resident as if she had a UTI; the Resident did not complain about symptoms of a UTI, and she had no history of previous UTI, while she did have a history of aspiration pneumonia. P. Brief at 16, 17. Petitioner points out that the Resident was able to communicate, and she was capable of understanding and being understood (which is consistent with her Minimum Data Set (MDS) from November 2003). P. Brief at 14; P. Ex. 1, at 182. Petitioner does not dispute that the Resident did display reduced activity during the period in issue, but notes that she had a history of isolating herself. P. Brief at 15, citing P. Ex. 1, at 200-06; CMS Ex. 1, at 644-48. Petitioner also points out that the Resident was examined at the request of her treating physician by Dr. Anand, a psychiatrist, on May 2, 2004, and that he attributed the Resident's lethargy and reduced

appetite to her long-standing depression and he did not identify any signs or symptoms of a serious illness. CMS Ex. 1, at 454; P. Ex. 1, at 449-50. After Dr. Anand's visit, when the Resident's appetite did not improve, the facility contacted her treating physician and he decided to see the Resident on his next rounds (apparently believing the loss of appetite was not an emergency condition (Tr. 407)). Petitioner points out that the records show that the Resident often consumed less fluid than recommended and the evidence does not show any change in her fluid intake in the days leading up to May 4, 2004. P. Brief at 18, citing P. Ex. 1, at 619-21; P. Ex. 51, at 46. The Resident's treating physician, while the Resident was at Petitioner's facility and after her admission to the hospital, opined that Petitioner did all it should to keep him informed of the Resident's condition. He opined that the Resident had multiple vague symptoms prior to May 4, 2004, and that he was promptly notified when she suddenly deteriorated that morning from an overwhelming infection. Tr. 416-17.

In my decision in *IHS of Kansas City at Alpine North*, DAB CR1353 (2005), I sustained CMS's finding that the facility was out of compliance with the participation requirement at Tag F309 by evaluating the facts and determining that the facility was unable to rebut CMS's *prima facie* case. In that case, the resident in question had a history of UTI and a constellation of changes in her condition consistent with the presence of a UTI, including reddened skin in her perineal area, concentrated and/or foul smelling urine, a persistent pattern of fever which did not fully resolve prior to hospitalization even after administration of Tylenol, and a change in her eating pattern. I found those changes should have alerted facility staff that the resident was ill, possibly suffering from a UTI, and that the resident's physician should have been told about the decreased intake, red perineal area, foul smelling urine, and the repeated elevation of temperature. The facts of this case are different. The evidence in this case does not show that Petitioner failed to deliver care and services to the Resident. CMS alleges that Petitioner's staff failed to recognize changes in the Resident's condition, assess those changes, and inform her physician of the changes when the Resident had an elevated temperature, her intake decreased, and her activity level declined over a period of approximately one week. However, when I evaluate the facts of this particular case, I find a Resident with a very complicated medical picture, which included a diagnoses of depression, resistance to care (including eating), reduced social interaction, and no history of UTI. While the Resident did have an elevation in temperature during the period in question, Petitioner took the Resident's temperature, her physician was notified of the temperature, and her temperature resolved with administration of Tylenol. Records indicate that her temperature rose again next evening and then resolved. Dr. Swagerty testified that the Resident had a history of fluctuating temperature.[6] The Resident did show signs of

[6] Dr. Swagerty testified that although temperature variation is normal, temperature (continued...)

decreased appetite during the week in question, resistance to care, mood swings, and lack of energy, but the facility contacted her physician to have her diet changed and procured a psychiatric consultation by Dr. Anand (decreased appetite, among the other symptoms, being consistent with the Resident's diagnosis of depression). The facility notified her physician about her ongoing lack of appetite after her diet order was changed, and he was scheduled to see her the next time he visited due to her decreased intake.

Petitioner is not strictly liable for ensuring that a resident is correctly diagnosed for all illnesses. Petitioner was not ignoring the Resident, but rather was acting in concert with her physician and her psychiatrist to address the most likely causes of her symptoms. When her condition worsened significantly during the morning of May 4, 2004, Petitioner immediately communicated with her physician, who had the Resident sent to the emergency room. The preponderance of the evidence is that Petitioner made reasonable efforts to deliver necessary care and services in this case.

2. The remedies imposed are not reasonable, as there is no basis for the imposition of any remedy.

I have found Petitioner in compliance with the participation requirement at Tag F309. Accordingly, CMS is not authorized to impose a remedy against Petitioner.

III. Conclusion

Since there is no basis for the imposition of an enforcement remedy, CMS is not authorized to impose a remedy against Petitioner.

/s/
Keith W. Sickendick
Administrative Law Judge

[6](...continued)
elevation in conjunction with other changes such as decreased activity or oral intake is concerning and requires close follow-up. Tr. 228-29. The evidence shows that Petitioner was, in fact, following this Resident and did not simply ignore her temperature variation and other signs and symptoms.