Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Morrisons Cove Home,	)	Date: March 23, 2007
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-05-108
	)	Decision No. CR1581
Centers for Medicare	)	
& Medicaid Services.	)	
	)	

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose a per instance civil money penalty of $7,500 against Petitioner, Morrisons Cove Home.

I. Background

Petitioner is a skilled nursing facility in Martinsburg, Pennsylvania. It participates in the Medicare program. Its participation in Medicare is governed by sections 1819 and 1866 of the Social Security Act (Act) and regulations at 42 C.F.R. Parts 483 and 488.

On October 14, 2004, CMS notified Petitioner that it intended to impose a civil money penalty of $7,500 against it based on Petitioner's alleged failure to comply with Medicare participation requirements. Petitioner requested a hearing and the case was assigned to an administrative law judge for a hearing and a decision. The case was reassigned to me in September 2006 when that judge retired.

exhibits from Petitioner that I identified as P. Ex. 1 - P. Ex. 95. Additionally, I received the cross-examination and redirect testimony of witnesses whose written direct testimony was in evidence as exhibits. Each party filed a pre-hearing brief and a post-hearing brief.

II. Issues, findings of fact and conclusions of law

A. Issues

The issues in this case are whether:

1. Petitioner failed to comply substantially with a Medicare participation requirement; and, if so;

2. A per-instance civil money penalty of $7,500 is reasonable.

B. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below as a separate heading. I discuss each Finding in detail.

1. Petitioner failed to comply substantially with a Medicare participation requirement.

CMS alleges that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25. The regulation requires that each resident of a participating facility receive, and the facility must provide, the necessary care and services for the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. Implicitly, the regulation requires that a facility provide each resident with care of a quality that meets professionally recognized standards of nursing care.

CMS asserts that Petitioner failed to comply with this regulation in providing care to a resident who is identified as Resident # 2. CMS alleges that Petitioner failed to provide the resident with necessary follow-up care after the resident was sent to Petitioner's facility for an anticipated brief stay following surgery to repair the resident's fractured right ankle. Petitioner's derelictions, according to CMS, include a failure by Petitioner's staff to bring the resident to a post-surgical visit ordered by the orthopedic surgeon who repaired the ankle and failure by the staff to monitor the resident's surgical wound, after it became infected, consistent with professionally recognized standards of nursing care.

CMS argues that, at the very least, the alleged derelictions by Petitioner's staff posed a high potential for very serious harm to the resident. Moreover, according to CMS, these alleged derelictions establish that the overall quality of care at Petitioner's facility was so deficient as to put at risk the health and safety of residents other than Resident # 2.

The evidence offered by CMS in support of its contentions establishes a solid prima facie case of noncompliance by Petitioner. The evidence that Petitioner offered in response does not prove that Petitioner, in fact, complied. Consequently, I sustain CMS's allegations of noncompliance.

Resident # 2 was admitted to Petitioner's facility on May 24, 2004, for short term rehabilitation following surgery to repair her fractured right ankle. CMS Ex. 9, at 5, 24; CMS Ex. 10, at 1. The surgeon who operated on the resident's ankle, Dr. William Tyndall, ordered that she be seen by him at a follow-up visit on June 2, 2004. CMS Ex. 9, at 35. The purposes of the follow-up visit were to: change the dressing on the resident's wound; check the wound for satisfactory progress; remove staples if appropriate; and apply a cast to the resident's ankle. *Id.* at 2, 30.

There is no dispute that Petitioner's staff failed to bring Resident # 2 to the scheduled follow-up visit. Petitioner did not contact Dr. Tyndall about the visit until at least June 8, 2004, and did not bring the resident in for the follow-up visit until June 11, 2004, the earliest date Dr. Tyndall could schedule an appointment for Resident #2.

The failure by Petitioner's staff to comply with Dr. Tyndall's order that the resident be brought in for a follow-up visit on June 2, 2004, is prima facie proof of a breach of a professionally recognized standard of nursing care and a failure by Petitioner to comply with regulatory requirements. CMS offered persuasive evidence that the standard of care for a post-surgical wound such as Resident # 2's wound is to examine the wound within 10 - 14 days after surgery and to provide whatever additional care is necessary as is dictated by the wound's appearance and condition. CMS Ex. 39, at 4. Petitioner made it impossible for Dr. Tyndall to provide this necessary care to Resident # 2 by failing to bring the resident to the scheduled follow-up visit on June 2.

Moreover, it is axiomatic that Petitioner was obligated to comply with Dr. Tyndall's orders. A nursing facility does not have discretion to disregard or ignore an order by a resident's treating physician. Here, Dr. Tyndall ordered that the resident be brought to him for a follow-up examination on a specific date and Petitioner's staff disregarded that direction.

The prima facie evidence is that delaying the follow-up visit put Resident # 2 at risk for post-surgical complications including infection. One purpose of conducting a follow-up visit is to investigate for the possibility of post-surgical infection at the wound site. The incision and the repair performed by Dr. Tyndall on Resident # 2 was potentially vulnerable to post-surgical complications due to a tenuous blood supply to that region. CMS Ex. 39, at 4. Consequently, it was important to check the wound within a 10 - 14 day post-surgical time frame. *Id.* A delay in performing a follow-up examination might not have prevented the development of a post-surgical infection in Resident # 2. However, delayed follow-up potentially resulted in a delayed diagnosis of an infection. That in turn raised the risks that necessary treatment of the resident's wound would be more difficult and the outcome less favorable. *Id.*

When Dr. Tyndall finally saw the resident's wound on June 11, 2004, he determined that it was not healing satisfactorily. He referred Resident # 2 immediately to be seen by Dr. Neil Kaneshiki, a specialist in wound care. CMS Ex. 40, at 2. Dr. Kaneshiki debrided the wound. He ordered that the wound be cultured for a possible infection. The culture revealed an infection consisting of a moderate growth of the organism pseudomonas aeruginosa. CMS Ex. 11, at 3, 10. Based on Dr. Kaneshiki's findings, the attending physician at Petitioner's facility ordered that the resident's wound be monitored for infection, that her wound be treated daily, and that she be treated with an antibiotic. CMS Ex. 10, at 33 - 34.

The prima facie evidence is that professionally recognized standards of care mandate daily documentation of a wound's appearance. CMS Ex. 43, at 14. Moreover, Petitioner's internal policy mandated that Petitioner's staff perform documentation of the wound's appearance when changing the wound's dressing, which was required daily for Resident #2. CMS Ex. 10, at 33 - 34; Tr. at 239. Mandatory documentation includes accurate measurements of wound length, width, depth, and tunneling. Other essential documentation includes: a description of the skin around the wound; the wound's surface; and, the drainage or exudate found in the wound. CMS Ex. 43, at 14 - 15. Monitoring of a wound requires documentation of its appearance at regular intervals in order to be able to compare the wound's status from one point in time to another. CMS Ex. 40, at 4.

CMS offered evidence to prove that, in providing wound care to Resident # 2 after June 11, 2004, Petitioner's staff failed to document daily the appearance of the resident's wound or to perform detailed assessments of the wound's day-to-day status. This is proof that Petitioner breached professionally recognized standards of care and its wound policy as well. CMS Ex. 41, at 2, 7. Such a breach is, consequently, a failure to comply with the regulatory requirement that Petitioner provide care that meets professionally

recognized standards. Evidence introduced by CMS showed that the staff performed assessments and documented closely the appearance of the wound on only two dates prior to June 17, 2004, those dates being June 11 and June 15, 2004. CMS Ex. 10, at 12, 13. Petitioner's staff generated no documentation whatsoever on two dates, June 12 and June 16, 2004. *See* CMS Ex. 10, at 9, 11.

The evidence offered by CMS demonstrates that this failure by Petitioner to comply with professionally recognized standards of care governing wound care, and regulatory requirements, posed potentially extremely grave consequences for Resident # 2. In the absence of effective documentation of a wound's appearance and status over time, there is no way that a facility or a staff can determine whether the wound is healing or deteriorating. CMS Ex. 41, at 6; Tr. at 155. Failure to document a wound's appearance and progression adequately deprives professional staff and physicians from potentially critical evidence as to how a wound is progressing. It follows logically that staff can misjudge the status of a wound or miss signs of a developing infection if it does not regularly document a wound's progress.

CMS argues, and I agree, that the evidence of Petitioner's derelictions in providing care to Resident # 2 is proof that Petitioner's staff was committing more than isolated or random practice errors. The evidence supports the conclusion that the care that Petitioner gave to Resident # 2 was deficient from the inception of her stay until June 18, 2004, when the resident was discharged to a hospital. It is reasonable to infer that Petitioner's staff – while not deliberately disregarding the needs of the resident – systematically failed to provide the resident that which was ordered for her and which professionally recognized standards of care required. From this systematic failure I draw the inference that the staff was lacking in basic skills and an understanding of what was needed to provide post-surgical wound care for all of its residents, not just Resident # 2.

I do not conclude from the evidence presented by CMS that failures by Petitioner's staff to provide necessary care to Resident # 2 caused the resident to experience a wound infection or contributed to the worsening of that infection.[1] It is not necessary for me to reach that conclusion in order to find from the prima facie evidence that Petitioner contravened professionally recognized standards of care and regulatory requirements. Under regulations which govern Medicare participation, the potential for harm is all that is needed to establish a failure to comply with a participation requirement. 42 C.F.R.

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[1] On June 17, 2004, the resident's infection was found to have worsened greatly. She was hospitalized and subsequently, an amputation was performed on her lower extremity.

§ 488.301. Here, the evidence offered by CMS is overwhelming that Petitioner's noncompliance put Resident # 2 at great risk for harm.

Petitioner makes several arguments to support its assertion that it, in fact, complied with participation requirements. I do not find them to be persuasive. Petitioner challenges the credibility of CMS's witnesses, and in particular its experts, and asserts that I should not make findings based on these witnesses' conclusions and opinions. I disagree with Petitioner's assertions that CMS's witnesses were unqualified. I find that Dr. Tyndall and Dr. Kaneshiki are both qualified to render opinions as to their respective specialties (orthopedic surgery and wound care). In particular, Dr. Tyndall is qualified to testify as to the standard of care for post-surgical follow-up visits. In addition, I find that CMS's third expert, Cathy Hess, R.N., is well-qualified to testify about her area of professional expertise, nursing standards for wound care and for the documentation and assessment of wound appearance. CMS Ex. 43.

Petitioner contends that the deterioration of Resident # 2's wound while she stayed at Petitioner's facility was clinically unavoidable. Consequently, according to Petitioner, it cannot be held accountable for such deterioration.

I do not find this contention to be persuasive because Petitioner was bound to provide care to Resident # 2 that is consistent with professionally recognized standards of care and regulatory requirements whether or not the bad outcome in her case was inevitable. I do not find that the delay in bringing Resident # 2 for a follow-up visit caused her to experience an infection nor do I find that failure by Petitioner's staff to document the wound's appearance caused the wound to deteriorate. It is simply unnecessary for me to conclude that there was a causal relationship between the care the resident received from Petitioner's staff and the outcome of her case in order to find that Petitioner's care was deficient. The standard for noncompliance, stated at 42 C.F.R. § 488.301, is a failure of care that poses a *potential* for more than minimal harm. Here, and as I have discussed in detail, above, Petitioner's failures posed a potential for great harm to Resident # 2, and moreover, showed an overall laxness of care at Petitioner's facility that posed a potential for harm to other residents as well.[2]

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[2] Petitioner's argument that the resident's deterioration was inevitable would be relevant had Petitioner shown that it was scrupulous in providing care to Resident # 2 consistent with professionally recognized standards of care. A bad outcome per se is not a basis for finding that a facility is deficient. But, here, the evidence shows that Petitioner's care was deficient because Petitioner's staff failed to provide care in accord with professionally recognized standards. That evidence is a basis for a finding of

However, one of the contentions that Petitioner makes in support of its assertion that the resident's decline was inevitable actually undercuts Petitioner's ultimate argument that it, in fact, complied with participation requirements. Petitioner asserts that the decline in Resident # 2's condition was unavoidable due to the resident's co-morbidities which, according to Petitioner, included diabetes, malnourishment, vascular insufficiency, a previously sustained stroke, and general frailty associated with the resident's advanced age of 84 years. Petitioner's post-hearing brief at 3. But, these assertions underscore the duty of care that Petitioner's staff owed to the resident and make more glaring the staff's failure to perform that duty. Petitioner's staff knew or should have known about the resident's many infirmities when she entered the facility. That knowledge should have alerted Petitioner's staff that it owed the resident a high degree of diligence to ensure that Dr. Tyndall's orders were carried out scrupulously and to ensure that the resident's wound was watched carefully.

Petitioner seems to suggest at times that surgery never should have been performed on the resident due to her age and poor condition and that any adverse consequences subsequently experienced by her were a consequence of an ill-advised decision to operate on her. Petitioner implies that it should not be held responsible for any lapse in judgment on the part of the resident's surgeon. However, the wisdom of deciding whether or not to operate on Resident # 2 is irrelevant to my decision. The standards of care governing a follow-up visit and documentation of wound appearance are applicable here *even if* the decision to operate on the resident was ill-advised.

Petitioner asserts that the delay in bringing the resident to the follow-up visit to Dr. Tyndall was clinically acceptable. Consequently, according to Petitioner, any error by its staff in keeping the originally scheduled appointment was harmless. Petitioner's post-hearing brief at 4 - 6.

As principal support for this contention Petitioner relies on the testimony of Stephen F. Conti, M.D., an orthopedic surgeon. Dr. Conti is the director of the Division of Foot and Ankle Surgery at the Human Motion Center, in Pittsburgh, Pennsylvania, and is also director of the Allegheny Hospital Advanced Wound Healing and Lymphedema Center. P. Ex. 79, at 1. Petitioner asserts that, in his direct testimony, Dr. Conti opined that Resident # 2's post-operative appointment was scheduled within a clinically acceptable time frame and that any delay in the appointment did not cause harm or have the potential for causing harm to the resident. Petitioner's post-hearing brief at 5.

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noncompliance, for the reasons I have discussed, regardless whether the outcome was inevitable.

But, Dr. Conti's testimony actually reinforces CMS's assertion concerning the applicable standard of care. He agreed with CMS's experts that the standard of care for a post-operative follow-up visit on a a patient such as Resident # 2 is for the patient to be seen within 10 - 14 days of surgery (Dr. Tyndall had ordered that the resident be seen 13 days post-surgery). P. Ex. 79, at 6.

Furthermore, and notwithstanding Petitioner's assertions, I can find nothing in Dr. Conti's testimony in which he asserts that delaying a post-surgical follow-up visit beyond a 10 - 14 day period poses no potential of harm to a patient. Dr. Conti agreed with Dr. Tyndall that the purpose of scheduling a follow-up within 10 - 14 days is to check a wound for satisfactory healing. And, obviously, the reason for the professionally recognized time frame within which to conduct a follow-up exam is that a delay beyond that period poses a potential for harm and complications arising from unsatisfactory healing. Dr. Conti said nothing in his testimony to refute that general principle. Indeed, he agreed with CMS that "if a wound is infected the sooner the staff knows about it, the sooner they can begin appropriate therapy." Tr. at 171.

The thrust of Dr. Conti's testimony focuses on Resident # 2's condition. In his opinion the resident's post-surgical complications were the consequence of her underlying condition and were thus unavoidable. As I discuss above, whether the delay in providing care to the resident caused her to experience actual harm is an issue that I do not decide. I find Dr. Tyndall's and Dr. Kaneshiki's conclusions to be persuasive on the issue of whether delaying a post-surgical follow-up posed the potential for harm to the resident. The potential for harm resulting from a delayed follow-up is axiomatic and is acknowledged by Dr. Conti. There would be no need for a standard of care that requires a follow-up within 10 - 14 days post-surgery if delays in scheduling follow-ups beyond the 10 - 14 day period are, as a rule, benign.

Petitioner asserts that it provided adequate documentation of the characteristics of Resident # 2's wound in the period after the June 11, 2004 follow-up visit and the resident's visit to Dr. Kaneshiki. Petitioner's post-hearing brief at 6 - 9. In support of this argument Petitioner contends that there is adequate documentation in the resident's treatment record to establish that Petitioner's staff provided wound care to the resident between June 11 and June 18, 2004, in accordance with physicians' orders. *Id.* at 6. In making this argument Petitioner focuses on its staff's diligence in changing the resident's wound dressing, administering antibiotics, and monitoring her overall condition. Petitioner's argument is that the care that the resident's attending physician directed be given to the resident, consisting of daily treatment and administration of an antibiotic, was provided whether or not the wound's appearance was documented.

Petitioner's argument confuses apples with oranges. There is no question that Petitioner's staff was obligated to document the treatment and care that it provided to Resident # 2. But, even if it did that, it had an additional documentation duty. That consisted of a professionally recognized requirement that the staff document and assess, at least daily, the appearance of the resident's wound. Asserting that the staff documented the *care* that it gave to the resident simply begs the question of whether the staff met the additional requirement that it document and assess the resident's wound's appearance daily.

Petitioner notes, in support of its argument that it adequately documented the care that it provided to Resident # 2, that the appearance of the resident's wound was documented by Petitioner's staff on June 11 and 15, 2004. It asserts that, as of June 15, there was no clinically significant change in the resident's wound or general condition warranting additional interventions. Petitioner's post-hearing brief at 7. From these assertions Petitioner evidently argues that no harm resulted to the resident from the staff's failure to document the resident's wound between the 11th and 15th of June. But, whether harm occurred during that period (and, for the reasons I discuss above, I make no finding whether harm occurred), the *potential* for grave harm resulting from failure of the staff to document and assess the wound's appearance was obvious.

Indeed, Petitioner's principal argument concerning its failure to document and assess the appearance of Resident # 2's wound daily is that its staff's contravention of professionally recognized standards of care and Petitioner's internal policy governing wound care posed no threat of harm to the resident. It asserts that *weekly* documentation of the resident's wound appearance would have sufficed to meet the needs of Resident # 2. Petitioner's post-hearing brief at 8. I find this argument to be unpersuasive.

As support for this argument, Petitioner relies on the testimony of Stephen Michael Colodny, M.D., a specialist in wound care. Dr. Colodny testified that he would not expect, as a general matter, that nurses performing wound care document the appearance of a wound daily "because they just don't change all that quickly." Tr. at 121. But, Dr. Colodny undercut his opinion by admitting that it would be appropriate to document the appearance of a wound daily where – as was true in this case – the dressing is ordered to be changed daily. *Id.* at 124. In effect, all that Dr. Colodny said was that a nursing staff is not obliged to remove a resident's dressing daily and assess the appearance of a wound in the circumstance where a physician does not order that the dressing be removed and changed daily. That has nothing to do with what was ordered here. Given that, I do not find that Dr. Colodny's testimony rebutted CMS's prima facie proof as to the standard of care for documentation of wound appearance.

Petitioner also relies on Dr. Conti's testimony to support its assertion that it was unnecessary to document the appearance of Resident # 2's wound daily. Tr. at 166. Dr. Conti premised that assertion on his conclusion that daily wound appearance monitoring is generally not needed because surgical wounds are not all that likely to change in size from day to day. *Id.* at 166 - 167. But, he admitted also that an increase in wound size of more than a centimeter over a period of a few days would be significant. *Id.* at 167. In fact, the resident's wound increased in size by at least that much over a period of a few days between June 11 and June 15, 2004. The change in wound size exhibited by Resident # 2 thus weakens Dr. Conti's conclusion that daily wound monitoring is not needed because surgical wounds do not change that much from day to day.

In arguing that its staff documented the appearance of Resident # 2's wound adequately, Petitioner seems to be saying that, even if the staff failed to generate a specific daily report and assessment of the wound's appearance, it generated other records in which one may find adequate documentation of wound characteristics. In particular, Petitioner seems to suggest that its record of treatments administered to Resident # 2 suffice as adequate documentation. However, the treatment administration record that the staff generated for the resident fails to contain any of the information that is required to document adequately and assess a wound's appearance. CMS Ex. 10, at 40; CMS Ex. 43, at 14 - 15.[3]

Petitioner also asserts that its staff *monitored* Resident # 2's wound daily even if staff members did not record their observations of the wound's condition. Petitioner's post-hearing brief at 8. I find this argument to be unpersuasive.

Petitioner does not explain precisely what it means when it contends that its staff monitored the resident's wound. Petitioner does not explain how its staff monitored the wound and yet failed to document the wound's appearance or assess it on several days between the 11th and 17th of June. What Petitioner may be contending is that its staff looked at the wound and was aware of the wound's condition on a daily basis even if it failed to document and assess in writing the wound's appearance. Such "monitoring" does not comport with professionally recognized standards of care or Petitioner's internal policy governing wound care. As I discuss above, there is a distinct need to document a

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[3] There are reasons to conclude that the treatment administration record for Resident # 2 is not a credible record of the care that Petitioner's staff provided to the resident. Petitioner suspended one of its staff for falsifying a nurse's initials on the treatment record. P. Ex. 87, at 1 - 3.

wound's appearance at least daily. "Monitoring" includes such documentation. As Dr. Kaneshiki testified:

> A basic component of monitoring includes adequate documentation in the nurses notes or an acceptable form in a patient or resident's medical record. Monitoring requires documentation at regular intervals to compare conditions from one point in time to another.

CMS Ex. 40, at 4.[4]

It appears that Petitioner may also be asserting that its staff adequately monitored the resident's wound because it faithfully carried out physicians' orders to change the resident's dressing and to administer antibiotics to the resident. That Petitioner's staff arguably may have done a good job performing these duties does not alter the fact that the staff failed, in contravention of the applicable standard of care, to document the wound's appearance systematically.

2. A civil money penalty of $7,500 is reasonable.

CMS determined to impose a per-instance civil money penalty against Petitioner of $7,500. Under regulations governing the imposition of civil money penalties, a per-instance penalty must fall within a range of from $1,000 to $10,000. 42 C.F.R. § 488.438(a)(2).

Civil money penalty amounts are governed by criteria contained in regulations. These criteria include: the seriousness of a facility's deficiency or deficiencies; its culpability; its compliance history; and its financial condition. 42 C.F.R. §§ 488.438(f)(1) - (4); 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)).

At the hearing I invited the parties to brief the issue of whether the penalty amount proposed by CMS was reasonable. I told the parties that I was interested in whether a civil money penalty of $7,500 was reasonable if Petitioner's noncompliance posed a potential of serious injury or harm to Resident # 2 or other residents but where I did not

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[4] Moreover, Petitioner tacitly admits that its staff failed to perform its obligations to document and assess the appearance of Resident # 2's wound. It disciplined two of its staff members for failing to document adequately the appearance and characteristics of the wound. P. Ex. 66.

conclude that the noncompliance actually caused Resident # 2's condition to deteriorate. Tr. at 9 -11. However, neither CMS nor Petitioner provided meaningful analysis of the issue of penalty amount in their post-hearing briefs.[5]

In the absence of meaningful argument or analysis from the parties on the issue of penalty amount, I decide that issue based on my review of the entire record of this case in light of applicable regulatory factors. I sustain CMS's determination to impose a per-instance penalty of $7,500. I do so based on evidence relating to the seriousness of Petitioner's noncompliance and in the absence of evidence that is relevant to other regulatory factors.

Neither CMS nor Petitioner offered any evidence as to Petitioner's compliance history or its financial condition. Nor have the parties argued that Petitioner's culpability for its deficiency is a basis for increasing the penalty amount. That leaves only the question of how serious Petitioner's noncompliance was as a criterion for deciding on the amount of the penalty. *See* 42 C.F.R. §§ 488.438(f)(1) - (4); 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)).

I decide that Petitioner's noncompliance was extremely serious. The requirement that a post-surgical wound such as the one sustained by Resident # 2 be checked at a follow-up exam within 10 - 14 days of surgery is based on concern that such a wound may become infected with potentially dire consequences. Potentially, failure to spot an infection in its early stages may cause serious, even life-threatening complications. Petitioner's failure to bring Resident # 2 timely to her follow-up examination potentially brought into play all of the possible adverse consequences that might ensue from failure to follow up on the surgery. The requirement that a wound's progress be documented and assessed at daily intervals is based on concerns that are similar to the requirement for a timely post-surgery follow-up visit. It is critical that a wound's appearance be documented and assessed often in order to ensure that there is no ongoing deterioration. Failure to do so raises the risk that undetected infection may progress.

Here, Petitioner's noncompliance was particularly egregious. The staff knew that Resident # 2 was frail and in a very deteriorated state. The staff knew also that the resident had an illness (diabetes) that compromised, potentially, her vascular system.

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[5] Petitioner's brief was silent on the issue of penalty amount. CMS asserted only that it "considered all regulatory factors" in determining to impose a penalty of $7,500. CMS's post-hearing brief at 43. However, my authority to decide on a penalty amount is not an appellate review of whether CMS considered any or all regulatory factors. I am charged with the responsibility of deciding de novo what is reasonable.

That information made it imperative that the staff be ultra-diligent in caring for the resident's wound. But, in spite of that, Petitioner's staff failed to take basic measures that were mandated to protect the resident from developing serious complications. Particularly egregious is that Petitioner's staff continued to fail to provide the resident with mandated care even after it delayed bringing the resident to a follow-up visit and even after they were put on notice that the resident's wound had become infected.

Moreover, the serious deficiencies manifested by Petitioner's staff in providing care to Resident # 2 lead me to conclude that there was something more going on generally at Petitioner's facility than simple random error. I infer a more general problem than just failing to provide required care to only one resident. The failures manifested by Petitioner's staff in providing care to Resident # 2 were so egregious as to support my conclusion that there was an overall failure by Petitioner's staff to understand its obligation to treat residents' wounds in accord with professionally recognized standards of care and Petitioner's own policy. Other residents, not just Resident # 2, were at risk.

The seriousness of Petitioner's noncompliance supports a penalty of $7,500. I recognize that this penalty is relatively substantial when measured against the range of permissible per-instance penalties (between $1,000 and $10,000). But it is not a significant penalty when measured against the risk to Resident # 2 and to other residents created by Petitioner's failure to provide care that met professionally recognized standards of care.

/s/

Steven T. Kessel
Administrative Law Judge