Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Highland Pines Nursing Home, Ltd.,
(CCN: 67-5133),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-09-750

Decision No. CR2204

Date: August 10, 2010

DECISION

Petitioner, Highland Pines Nursing Home, Ltd. (Petitioner or facility), is a long-term care facility, located in Longview, Texas, that participates in the Medicare program. Based primarily on the facility's response when one of its residents developed a painful, necrotic leg wound, the Centers for Medicare and Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare requirements, and that its deficiencies posed immediate jeopardy to resident health and safety.

CMS has imposed civil money penalties (CMPs) of $5,650 per day for 20 days of immediate jeopardy and $1,100 per day for 20 days of substantial noncompliance that was not immediate jeopardy.

For the reasons set forth below, I find that the facility was not in substantial compliance with Medicare program requirements; its deficiencies posed immediate jeopardy to resident health and safety; and the penalties imposed are reasonable.

I. Background

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

Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months and more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308.

Here, following a complaint investigation/partial extended survey, conducted from July 7 through 10, 2009, CMS determined that the facility was not in substantial compliance with Medicare participation requirements, specifically: 42 C.F.R. § 483.10(b)(11) (Tag F157 – notification of changes); 42 C.F.R. § 483.20(k)(3)(i) (Tag F 281 – comprehensive care plans); and 42 C.F.R. § 483.25 (Tag F309 – quality of care), and that its deficiencies posed immediate jeopardy to resident health and safety. CMS Exs. 1, 3. CMS subsequently determined that, as of July 11, 2009, the facility's deficiencies no longer posed immediate jeopardy, and that it returned to substantial compliance on July 31, 2009. CMS Ex. 1 at 4.

CMS has imposed against the facility a CMP of $5,650 per day for 20 days of immediate jeopardy (June 21 through July 10, 2009), and $1,100 per day for 20 days of substantial noncompliance that was not immediate jeopardy (July 11 through July 30, 2009), for a total CMP of $135,000. CMS Ex. 1 at 4.

Petitioner timely requested a hearing.

The parties agree that this matter may be decided based on the written record, without need for an in-person hearing. *See* Order Summarizing Pre-hearing Conference at 2 (April 19, 2010); 42 C.F.R. § 498.66.

I have admitted into evidence CMS Exs. 1 - 14 and P. Exs. 1 - 9. *Id*. The parties filed initial briefs (CMS Br.; P. Br.). CMS filed a reply brief (CMS Reply); and Petitioner filed a sur-reply (P. Sur-Reply).

II. Issues

1. Whether, from June 21 through July 30, 2009, the facility was in substantial compliance with Medicare program requirements, specifically 42 C.F.R. §§ 483.10(b)(11); 483. 20(k)(3)(i); and 483.25;

2. If the facility was not in substantial compliance from June 21 through July 10, 2009, did its deficiencies then pose immediate jeopardy to resident health and safety?

3. If the facility was not in substantial compliance with program requirements, were the penalties imposed -- $5,650 per day for 20 days of immediate jeopardy and $1,100 per day for 20 days of substantial noncompliance that was not immediate jeopardy – reasonable?

Order Summarizing Prehearing Conference at 1-2.

III. Discussion

A. Because facility staff did not meaningfully consult a resident's physician about her deteriorating wound and disregarded an emergency room physician's order for wound care, the facility was not in substantial compliance with 42 C.F.R. §§ 483.10(b)(11),483.20(k)(3)(i), and 483.25.[1]

Resident 1 (R1): This case centers around the facility's response when one of its residents developed a necrotic wound on her leg.

R1 was a 104-year woman, who was blind and suffering from peripheral vascular disease, ischemic heart disease, arthritis, anxiety and other impairments. P. Ex. 3 at 3, 6, 30; CMS Ex. 7 at 93. Given her age and physical condition, she was at significant risk for skin deterioration.

Facility records describing R1's skin condition are not wholly consistent, but include the following:

In May 2009, toenails on R1's right foot became infected. She was treated by a podiatrist, who drained an abscess, debrided her toenails, and prescribed antibiotics. P. Ex. 3 at 30, 34; *see* P. Ex. 3 at 8, 45; CMS Ex. 7 at 15.

A nursing note dated May 26, 2009, says that the resident "has multiple scabbed over areas to her [lower] legs." P. Ex. 3 at 9. Her weekly skin assessment, dated June 8, 2009, also describes an "old brown scabbed area" on her lower right leg. CMS Ex. 7 at 16. This is strange, since no prior skin assessment refers to an earlier right leg wound that might have evolved into an "old brown scabbed area." CMS Ex. 7 at 11-16; P. Ex. 3 at 41-46. Moreover, a June 9, 2009 physician's progress note mentions "some infection in

[1] My findings of fact/conclusions of law are set forth, in italics and bold, in the discussion captions of this decision.

toenail last month," but says nothing about any other wound. It does not mention any scabbed area. P. Ex. 3 at 31. According to R1's attending physician, Robert T. Tompkins, M.D., if "a large necrotic wound had existed and required aggressive treatment, I would have included that assessment in my progress notes." P. Ex. 6 at 1 (Tompkins Decl.).

Prior to June 11, 2009, R1's only consistently documented skin problem involved her infected toenail.[2] If she had any scabs, Dr. Tompkins did not note them. Assuming he examined her leg on June 9 – and no one suggests that he did not – he must have concluded that any scabs were of no consequence.

June 11, 2009. A new wound appeared on June 11.

R1 showed signs of leg pain so the nurse aides asked treatment nurse, Judy Smith, R.N., to take a look. P. Ex. 4 (Daniels Decl.); P. Ex. 5 (Smith Decl.). According to the assessment form that Nurse Smith filled out, a new wound appeared on R1's right lower leg. The wound was painful; it measured 7 x 4.2 cm., slightly smaller than a standard size credit card. Nurse Smith could not assess its depth because it was obscured by necrosis (dead tissue). She describes firmly adherent, hard, black eschar (dead tissue) and indicates no drainage. CMS Ex. 7 at 22-23; *see* CMS Ex. 13 at 2 (Lockwood Decl.).

Other contemporaneous records confirm the presence of necrotic tissue. *See* P. Ex. 3 at 12, 13, 35, 36; CMS Ex. 7 at 26, 28.

According to Nurse Smith, she instructed "LVN C" to contact R1's physician "about the cellulitis assessed in the limb." P. Ex. 5 at 1 (Smith Decl.). At 11:00 a.m., an LVN (who may have been LVN C) sent a fax to Dr. Tompkins and called his office. The fax said: "Assessed by treatment nurse, cellulitis noted to right foot. Requesting antibiotic treatment or other related suggestions." The fax did not mention necrotic or dead tissue, nor did it mention the resident's significant pain. CMS Ex. 7 at 19; CMS Ex. 13 at 3; *see* P. Ex. 3 at 11.

No one from the facility actually spoke to Dr. Tompkins. According to the LVN's 12:35 p.m. note, the "operator" told her that the office was closed and would reopen at 1:15 p.m. The LVN left a message, but Dr. Tompkins did not return the call. At 5:00 p.m., another nurse, LVN Moton, called Dr. Tompkins' office to request possible antibiotic therapy for R1's right foot, describing redness and mild warmth. Unable to reach the doctor, she called R1's daughter who agreed to call the physician "to hurry him in

[2] Petitioner claims that R1 had "chronic stasis ulcers." P. Br. at 2, *citing* CMS Ex. 7 at 11-18. No weekly skin assessment – or any other record prior to the July 7 survey – mentions a stasis ulcer.

responding to our request." [3] According to the note, "immediately after talking to the doctor's office," the facility received back a faxed order for antibiotics. P. Ex. 3 at 11; CMS Ex. 7 at 19, 27. The document shows that Dr. Tompkins returned the fax, having filled in and signed the requested order. CMS Ex. 7 at 19.

R1's care plan was amended on June 11 to add as a problem cellulitis on the right lower leg. According to the plan, the cellulitis was to be treated with antibiotics, and the wound kept clean and dry. P. Ex. 3 at 63, 64; CMS Ex. 7 at 93, 94. The care plan does not mention necrosis.

The wound deteriorated and continued to cause R1 significant pain. *See, e.g.*, P. Ex. 3 at 12, 14 (resident crying out for medication because her "leg hurt so bad"); P. Ex. 4 at 2 (Daniels Decl.) (R1 "saying her leg was killing her. . . ."); CMS Ex. 7 at 26. On June 14 it began to seep serous fluid. The resident was referred to a nurse for a pain prescription. P. Ex. 3 at 14; CMS Ex. 7 at 34. Nurse Smith apparently wrote a nursing order "to assure that the wound would be monitored and assessed daily, and to provide for the [resident's] safety. P. Ex. 5 at 1 (Smith Decl.). No one consulted Dr. Tompkins and no physician looked at the wound.

Nor did the weekly skin assessment, dated June 15, 2009, reflect R1's deteriorating condition. It indicates "no new areas noted," no physician notified, no treatments ordered, and no care plan update. CMS Ex. 7 at 16. Surveyor Marcie Lockwood questioned the LVN responsible for conducting the weekly assessments. LVN Mayvonne Moton told the surveyor that she did not recall ever seeing an injury on R1's right leg, nor did she recall treating R1's right leg, although she saw a "scab" during her June 8 assessment. CMS Ex. 13 at 3 (Lockwood Decl.).

June 21, 2009. On June 21, a nurse aide found R1 lying face-down on the floor of her room. She had a hematoma on her forehead "[with a] split down [the] middle." Staff called the physician's office and the resident's family and sent her to the emergency room (ER). P. Ex. 3 at 16; CMS Ex. 7 at 151-155.[4]

Even though R1's leg wound had been festering for ten days, no physician examined it until she arrived at the ER on June 21. The ER physician, Christopher Dunnahoo, M.D.,

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[3] It seems that it may have been Dr. Tompkins' policy to refuse phone calls. According to a July 8 nurse's note, Nurse Smith called the office to speak to the doctor, but "was told that they did not take phone calls [and] to fax Dr. Tompkins." P. Ex. 3 at 24. A physician's unwillingness to converse with nursing staff obviously compromises the facility's ability to consult, and may be a practice that the facility's medical director should address. *See* 42 C.F.R. § 483.75(i) (Medical director responsible for implementing resident care policies and coordinating medical care in the facility).

[4] Someone other than Dr. Tompkins ordered her taken to the ER. CMS Ex. 7 at 152.

looked at the necrotic wound, and referred the resident to the hospital's wound care clinic for evaluation and weekly treatments. CMS Ex. 7 at 49.

R1 returned to the facility at 12:45 a.m. on June 22. She had three sutures to her head. Nurses' notes do not mention any referral for wound care. P. Ex. 3 at 16; CMS Ex. 7 at 29.[5]

On June 25, 2009, Nurse Smith wrote a nurse's note and an order to apply to the leg wound a Betadine (which is a topical antiseptic) compress and to wrap the leg. On the same day, R1's care plan was amended to add Betadine compress and wrap. P. Ex. 3 at 64. The order had not been signed when the surveyors arrived almost two weeks later. Dr. Tompkins finally signed it on July 9. P. Ex. 3 at 12, 37.

The wound continued to deteriorate and to cause the resident pain. P. Ex. 3 at 12; CMS Ex. 7 at 22. By July 4, 2009, it measured 8 x 8 cm., and is described as "full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structure." CMS Ex. 7 at 24.

When the surveyors arrived on July 7, they saw a wound that measured 8.5 x 10.2 cm. The wound bed was totally obscured with black necrotic tissue. CMS Ex. 13 at 3 (Lockwood Decl.); CMS Ex. 6 at 8.

On July 10, Dr. Tompkins finally assessed the right leg wound, and diagnosed chronic stasis ulcer secondary to cellulitis. Among other instructions, he called for debridement at the wound care clinic "if the family requests." P. Ex. 3 at 32.

Notes of an interdisciplinary meeting, held July 10, 2010, indicate that R1's daughter decided then that she would decline further treatment, but she first consulted Dr. Tompkins. She said that she would cancel her mother's wound clinic appointment if Dr. Tompkins agreed, which he did. CMS Ex. 7 at 52. Following the meeting, Dr. Tompkins ordered antibiotics and hospice care only. P. Ex. 3 at 32, 38; CMS Ex. 7 at 36.

R1 was admitted to hospice care on July 10. CMS Ex. 7 at 1. She was diagnosed with gangrene in her right lower extremity on July 16, 2009. All routine medications were discontinued, and 24-hour pain care measures began. P. Ex. 3 at 80. The resident died on July 26, 2009. P. Ex. 3 at 29, 82.

Regulatory Requirements. The facility must protect and promote the rights of each resident. In this regard, it must immediately inform the resident, consult the resident's physician, and (if known) notify the resident's legal representative or interested family member when there is a significant change in the resident's physical, mental or psychosocial status (i.e., a deterioration in health, mental or psychosocial status in either

[5] For once, the weekly skin assessment acknowledges "new areas," but it is plainly referring to the head wound. CMS Ex. 7 at 16.

life-threatening conditions or clinical complications); or a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment). 42 C.F.R. § 483.10(b)(11).

Simply communicating information does not satisfy the regulatory requirement to "consult" the attending physician. As the Departmental Appeals Board (Board) ruled in *Magnolia Estates*, consultation requires more than just informing or notifying the physician.

> Consultation . . . requires a dialogue with and a responsive directive from the resident's physician as to what actions are needed; it is not enough to merely notify the physician of the resident's change in condition. Nor is it enough to leave just a message for the physician.

Magnolia Estates Skilled Care, DAB No. 2228 at 8 (2009).

Under the statute and the "quality of care" regulation, each resident must receive, and the facility must provide, the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. Act § 1819(b); 42 C.F.R. § 483.25.

The services provided or arranged by the facility must meet professional standards of quality. 42 C.F.R. § 483.20(k)(3)(i).

The facility did not substantially comply with these requirements because 1) when the necrotic leg wound appeared on June 11, staff provided Dr. Tompkins with incomplete information, and thereafter failed to consult him even though the wound was deteriorating; and 2) staff disregarded completely the ER physician's order for a wound clinic consult.

Staff provided incomplete information. When the leg wound first appeared, the facility was required to "consult" R1's physician. To their credit, staff members sent him a fax, and attempted to call Dr. Tompkins, who was, at best, reluctant -- if not wholly unwilling -- to take or return their calls. Eventually, he responded by returning their fax with the requested order for antibiotics. Whether such correspondence satisfies the *Magnolia Estates*' requirements for "dialogue" is questionable. However, I need not decide that issue because the LVN's June 11 fax was simply inadequate; it did not provide a complete and accurate picture of R1's wound because it did not mention the necrotic tissue.

> This is significant. Cellulitis is an inflammation of soft tissue. The condition described by the treatment nurse in her interdisciplinary note of June 11, 2009 is one of necrotic or

> dead tissue of the leg. . . .[T]he primary care physician said he was not aware on June 11, 2009 that [R1] had a large necrotic area on her leg. While the physician prescribed the antibiotic Levaquin when he became aware of the inflammation of [R1's] right foot, his treatment orders would probably have been more aggressive had he known of the necrotic area on the resident's leg.

CMS Ex. 13 at 3 (Lockwood Decl.).

Professional standards of quality mandate that staff provide the attending physician complete and accurate information. If staff provide incomplete or inaccurate information, there can be no adequate physician consultation, and the facility risks providing inadequate or inappropriate care. Whether Dr. Tompkins would have altered his treatment had he known about the necrosis is irrelevant.[6] The facility had an affirmative duty to provide him with complete and accurate information so he could make an informed judgment. R1 had a right to have her physician fully informed and involved in her medical care. *See Senior Rehabilitation & Skilled Nursing Center*, DAB No. 2300 at 12 (2010); *Sheridan Health Care Center*, DAB No. 2178 at 8 (2008), (failure to notify the attending physician of a resident's change in condition violates section 483.25).

For weeks following its appearance, the wound deteriorated and the resident suffered significant pain, yet no one informed the physician.

Staff disregarded the ER physician order. When a physician finally examined R1's wound, he ordered evaluation and treatment at the hospital's wound care clinic. Yet, the facility did not inform Dr. Tompkins of the order or the ER physician's concerns.

Petitioner claims that it did not have the ER physician order, although staff admit that they were aware of its existence. P. Ex. 5 at 2 (Smith Decl.).[7] If so, I find this

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[6] I note, however, that when staff later requested an order for antibiotics, describing "eschar and bloody drainage," Dr. Tompkins declined to order the medications, writing "antibiotics not needed for stasis ulcers." CMS Ex. 7 at 21. *But see* CMS Ex. 7 at 10, 36 (Dr. Tompkins ordered oral antibiotics the following day, when R1 went into hospice care. His order does not explain the prescription's purpose.).

[7] Petitioner makes this claim for the first time in its submissions here, even though the survey report form describes the ER physician order and says that "the treatment nurse said that this form was sent to the facility when the resident returned from the emergency room on 6/21/09." CMS Ex. 3. Nowhere in its plan of correction does the facility deny receiving the order. CMS Ex. 3. This, together with the facility's complete lack of concern about any missing hospital physician's order, suggests that the facility received it.

problematic. The facility should have systems in place to ensure that it receives all orders from hospital physicians. If, in fact, the facility did not receive the order, I would expect, at a minimum, some investigation as to how such an order could be issued by a hospital physician, but not conveyed to the facility. Nothing in this record suggests that facility staff even recognized that they had a problem.

Nurse Smith admits learning about Dr. Dunnahoo's order "a day or two after" the ER visit. P. Ex. 5 at 2 (Smith Decl.). She told the surveyors that she had neither followed the order, nor consulted the resident's primary care physician, and they quote her as saying, "We don't just send them to the wound care clinic because the emergency room doctor tells us to. Everything is an emergency to an emergency room doctor." CMS Ex. 3 at 5-6; CMS Ex. 6 at 14.[8]

In her declaration, Nurse Smith says that R1's daughter told her about the physician's order, but did not want her mother to go to the wound care clinic. "She stated her mother has said, 'How much do I have to endure until I go to the graveyard.'" P. Ex. 5 at 2 Smith Decl.). I find several problems with this claim. First, although a nurse's note dated June 30 confirms that R1's daughter made the graveyard comment to Nurse Smith, nothing in the note mentions the ER physician's order, recommended treatment at the wound care clinic, or any decision to refuse treatment in this regard. P. Ex. 3 at 12; CMS Ex. 7 at 26. If, in fact, R1's daughter mentioned that she did not want to send her mother to the wound care clinic, the facility was required to document that refusal in the resident's care plan. 42 C.F.R. § 483.20(k)(1)(ii) mandates that the care plan describe otherwise required services that are not provided due to the resident's exercise of her right to refuse treatment.

But even assuming that R1's daughter made the remark, it would not have justified the facility's failure to inform Dr. Tompkins. When a resident refuses treatment, it is all the more necessary to consult the attending physician, so that he can provide the guidance a resident needs to make an informed decision, and so that he can assist in developing an *acceptable alternative*, which is what ultimately happened here at the July 10 interdisciplinary team meeting. There, Dr. Tompkins voiced his opinions -- which R1's daughter sought before she made her final decision – and, with his active involvement, the facility developed an alternative treatment plan.

Thus, I reject Petitioner's assertion that telling Dr. Tompkins about the order would not have affected R1's treatment. But even if I accepted the argument, I would still find that

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[8] I reject Petitioner's remarkable, and wholly unsupported, suggestion that the ER physician lacked "any prescriptive authority to order care and treatment for an existing condition outside the scope of the attending physician's order to transfer to the Emergency Room for care and treatment to a laceration of her scalp." P. Sur-reply at 6. An ER physician may order treatment for any medical problems he observes. The resident's attending physician might counter that order, but can only do so if someone tells him about it.

the facility was not in substantial compliance. As the Board held in *Senior Rehab. Skilled Nursg. Cntr.*, DAB No. 2300 (2010), rejecting an expert's recommendation without input from the attending physician "poses a risk to resident health and safety and presents the potential for more than minimal harm" regardless of whether the attending physician ultimately agrees with the expert. DAB No. 2300 at 11. *See Sheridan Health Care Center,* DAB No. 2178 at 22 -23 (facility must provide the attending physician the opportunity to "provide input and direction as to the care appropriate under the circumstances").

Petitioner also justifies its disregard of the ER physician's order by pointing out that R1's daughter/legal representative had earlier signed an advance directive. But nothing in the signed documents precluded consultation with the wound care clinic. In fact, the level of care for which she opted explicitly includes hospitalization "to diagnose or manage a significant new condition or for comfort care." P. Ex. 3 at 73. Moreover, the deteriorating wound was accompanied by significant pain, and the advance directive plainly called for palliative care. Yet, until the July 10 meeting, staff did not consult Dr. Tompkins about alleviating the pain from that wound.

Weekly skin assessment. Finally, I find completely inadequate the weekly skin assessments, because they seem to describe new wounds, but then indicate that no new areas are noted, no new treatment has been ordered, and neither the physician nor responsible party have been notified, and no changes to the care plan. Only one assessment, dated March 1, 2009, indicates new areas noted, skin tears on the lower left extremity. CMS Ex. 7 at 12. Beginning June 8, 2009, the assessments refer to "old brown scabbed areas on the lower right extremity." CMS Ex. 7 at 16. But I find no assessment indicating where or when those injuries to the lower right extremity occurred. Nor is there any suggestion that, when they occurred, the physician and responsible party were notified, or the care plan updated. *See* CMS Ex. 7 at 11-16; P. Ex. 3 at 41-46. Moreover, even though the evidence overwhelmingly establishes the new wound on June 11, R1's skin assessments do not indicate any changes to the leg. CMS Ex. 7 at 16.

For all of these reasons, I find that the facility twice failed to consult the resident's attending physician about a significant change in her condition or need to alter significantly her treatment. Staff gave the physician incomplete or inaccurate information about her wound, and disregarded a valid physician order. For all of these reasons, the facility was not in substantial compliance with the Medicare regulations governing notification of changes, comprehensive care plans, and quality of care.

B. CMS's determination that the facility's deficiencies posed immediate jeopardy to resident health and safety is not clearly erroneous.

Immediate jeopardy exists if a facility's noncompliance has caused or is likely to cause "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's

determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Departmental Appeals Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy, and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1931 at 27-28 (2004), *citing Koester Pavilion*, DAB No. 1750 (2000); *Daughters of Miriam Center*, DAB No. 2067 at 7, 9 (2007).

Here, a facility resident had a rapidly deteriorating leg wound that was causing her significant pain. Facility staff gave her physician inaccurate information as to the character of the wound and then stopped communicating with him. Ten days later, a second physician ordered new assessments and treatment. Staff not only ignored the order, they did not even tell her attending physician about it. These practices are likely to cause serious harm to the resident.

In reaching this conclusion, I recognize that R1 was very old and debilitated, but her age and condition do not excuse the facility from providing her the care and services that she needed to maintain her highest practicable well-being. Its failure to do so was likely to cause (and probably did cause) her unnecessary pain. Moreover, that staff were unaware of their obligations compromised the health and safety of other vulnerable residents as well.

CMS's immediate jeopardy determination is therefore not clearly erroneous.

C. The penalties imposed are reasonable.

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

In reaching a decision on the reasonableness of the CMP, I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Center*, DAB No. 1848, at 21 (2002); *Community Nursing*

Home, DAB No. 1807 at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800 at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638 at 8 (1999).

CMS has imposed penalties of $5,650 per day, which is at the low-to-mid penalty range for situations of immediate jeopardy ($3,050-$10,000), and $1,100 per day, which is at the low end of the penalty range for per-day CMPs ($50-$3,000). 42 C.F.R. §§ 488.408(d), 488.438(a)(1). [9]

The facility has a significant history of noncompliance, a factor that justifies a higher CMP. A January 2006 survey found substantial non-compliance with 42 C.F.R. § 483.25, along with other deficiencies, a finding that was upheld following a hearing. *Highland Pines Nursing Home*, DAB CR1563 (2007).

The facility has repeatedly been cited for failing to consult physicians about changes in resident conditions. In February 2007, it was cited as noncompliant with 42 C.F.R. § 483.10(b)(11) at scope and severity level E (a pattern of noncompliance with the potential for more than minimal harm) because staff did not consult a resident's physician about a Stage II pressure sore. CMS also found that the facility was not in substantial compliance with regulations governing social services, treatment of pressure sores, medication errors, sanitary conditions, specialized rehabilitation services, dental services, pharmacy services, and administration. The worst of its deficiencies caused actual harm that was not immediate jeopardy (scope and severity level H). CMS Ex. 11 at 1-18.

Nor did the facility thereafter maintain substantial compliance. On January 10, 2008, surveyors again cited deficiencies under 42 C.F.R. § 483.10(b)(11), at scope and severity level E, because the facility did not notify physicians of abnormal lab results for four residents who had been prescribed the anticoagulant, Coumadin. CMS also found deficiencies regarding notice of rights and services, grievances, participation in resident and family groups, accommodation of needs, comprehensive care plans, accidents and supervision, infection control, proficiency of nurse aides, and use of outside resources. Again, the worst of the deficiencies caused actual harm (scope and severity level H).

And, during the annual survey that immediately preceded the complaint investigation that is the subject of this decision, the facility was cited under 42 C.F.R. §§ 483.10(b)(11) and 483.25, at scope and severity level G (isolated instance of actual harm that is not immediate jeopardy), for failing to consult a resident's physician or notify her family member when that resident became difficult to rouse, too ill to leave her bed, and suffered loose stools. CMS Ex. 11 at 35-37.

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[9] Petitioner also complains about the duration of the $1,100 per day CMP, but not because it alleges that it reached substantial compliance before that date. P. Sur-Reply at 13. In fact, CMS accepted the completion date Petitioner alleged in its plan of correction. Instead, Petitioner complains about how long it took to achieve substantial compliance, a position that has no merit.

Petitioner argues that its financial condition affects its ability to pay the penalty. In support of its position, Petitioner lists, without supplying any underlying documentation, its profits and losses for the years 2004-2009, a list of its current assets and liabilities for those years, and its "net equity" for those years. P. Ex. 9. But none of this establishes that the facility lacks "adequate assets to pay the CMP without having to go out of business or compromise resident health and safety." *Sanctuary at Whispering Meadows*, DAB No. 1925 at 19 (2004); *Guardian Care Nursing and Rehab Cntr*., DAB No. 2260 at 9-10 (2009). Since Petitioner does not claim this degree of financial insolvency, its financial condition does not render the CMP unreasonable.[10]

With respect to the remaining factors, as the above-discussion shows, the deficiencies were significant and posed a pattern of immediate jeopardy to resident health and safety. The facility is particularly culpable because its staff deliberately disregarded a physician order.

A CMP is supposed to impose a financial burden significant enough to compel corrective action. Based on its history – particularly its repeated failures to consult its residents' physicians about significant changes – I conclude that the penalty here must be very big to compel correction. I therefore do not find the penalties imposed unreasonable.

IV. Conclusion

For the reasons discussed above, I find that the facility was not in substantial compliance with the Medicare requirements, its deficiencies posed immediate jeopardy to resident health and safety, and I affirm as reasonable the penalty imposed.

/s/
Carolyn Cozad Hughes
Administrative Law Judge

[10] In fact, the facility made profits in 2008 and 2009. P. Ex. 9 at 2.