**Department of Health and Human Services**

**DEPARTMENTAL APPEALS BOARD**

**Civil Remedies Division**

Longwood Health Care Center
(CCN: 10-5377),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-688

Decision No. CR2295

Date: December 20, 2010

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to impose civil money penalties of $100 against Petitioner, Longwood Health Care Center, for each day of a period that began on February 15, 2010, and that ended on March 10, 2010.

## I. Background

Petitioner is a skilled nursing facility that is located in Longwood, Florida. It participates in the Medicare program. Its Medicare participation is governed by sections 1819 and 1866 of the Social Security Act and by implementing regulations at 42 C.F.R. Parts 483 and 488.

CMS determined to impose against Petitioner the remedy that I describe in the opening paragraph of this decision, based on findings of noncompliance that were made during a survey of Petitioner's facility conducted on February 15, 2010 (February Survey). Petitioner requested a hearing, and the case was assigned to me for a hearing and a decision.

The parties agreed to waive an in-person hearing. CMS filed a pre-hearing brief, a final brief, and 14 proposed exhibits that I have identified and received as CMS Ex. 1 – CMS

Ex. 14.[1] Petitioner filed a pre-hearing brief, a final brief, and six proposed exhibits that I have identified and received as P. Ex. 1 – P. Ex. 6.

## 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 the requirements of 42 C.F.R. § 483.20(k)(3)(i); and

2. CMS's remedy determination is reasonable.

### B. Findings of Fact and Conclusions of Law

I make the following findings of fact and conclusions of law.

#### *1. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.20(k)(3)(i).*

The regulation that is at issue requires a skilled nursing facility to provide services to each of its residents that meet professional standards of quality. 42 C.F.R. § 483.20(k)(3)(i). CMS alleges that Petitioner failed to comply with this regulation in providing care to a resident who is identified in the report of the February Survey as Resident # 20.

On February 11, 2010, Resident # 20 was transferred from Petitioner's facility to a local kidney stone center to undergo invasive procedures consisting of cystoscopy and stent removal. CMS Ex. 1 at 2; CMS Ex. 4 at 1. She returned to Petitioner's facility late in the afternoon on that same day. The discharge instructions directed Petitioner to consult with the resident's physician if the resident manifested excessive drainage or bleeding, an increase in body temperature to 101 degrees Fahrenheit or more, an increase in pain not relieved by medication, a foul drainage odor, or any difficulty with breathing. P. Ex. 2 at 3.[2]

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[1] CMS submitted the "2nd Declaration of Mindy Seltzer, RD" as rebuttal evidence. The declaration was not marked. I have marked the declaration as CMS Ex. 14.

[2] Petitioner was unable to produce these instructions during the February survey but produced them as part of its pre-hearing exchange.

Effectively, the discharge instructions directed Petitioner's staff to assess Resident # 20's condition and to monitor the resident for signs and symptoms that might indicate post-operative complications.[3] Petitioner was obligated to carry out these instructions or, if its staff disagreed with them in any respect, to consult with the resident's physician about them.

Petitioner's records are devoid of any documentation that the staff complied with the discharge instructions. There is no documentation that the resident was assessed for pain, discomfort, bleeding, or discharge, following her return to the facility. There are no documents in the record discussing the possibility that the resident might experience pain following her procedure, nor are there any documents that address the possibility that there might be post-operative bleeding. The nurse who was responsible for the care given to Resident # 20 upon her return to the facility admitted that an assessment should have been done upon the resident's return but that one was not performed. CMS Ex. 12 at 2.

CMS contends, and I agree, that this absence of documentation, coupled with the admission of Petitioner's nurse, is prima facie proof of a failure by Petitioner's staff to assess the resident's condition and to carry out the other directives in the discharge instructions. It was the staff's duty to assess the resident to determine whether there might be any problems that the staff would have to plan for and address. A skilled nursing facility does not comply with the requirement that it provides care of professional quality only by reacting to a resident's complaints of pain or by waiting to see whether a resident will encounter side effects or complications from a procedure such as the one performed on Resident # 20.

Petitioner does not assert that its staff assessed Resident # 20's condition or that they planned for the possibility that the resident might experience pain or post operative complications. Instead, it contends that the staff monitored the resident and that the absence of any documentation showing that the resident was experiencing pain, side effects, or complications, proves that the staff did a good job providing the resident with care. As support for this assertion, Petitioner points to documents, such as the resident's Medication Administration Record (MAR), which contain no mention of complaints of pain by the resident. According to Petitioner, the absence of documented complaints can only mean that the resident experienced no pain.

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[3] The discharge instructions additionally directed Petitioner's staff to "push water" in the resident, presumably to deal with the effects of the procedure that the resident underwent. P. Ex. 2 at 2. The report of the February Survey did not allege that Petitioner failed to comply with this directive, but CMS now makes this allegation. Petitioner objects, on the ground that the allegation is made untimely and that it has not had sufficient notice to prepare a defense to it. I find it unnecessary that I address the allegation to decide this case.

I find this argument not to be persuasive. First, simply "monitoring" the resident – even if Petitioner's staff did that – is not enough to meet Petitioner's obligations to provide care of professionally acceptable quality. As Petitioner uses that term, "monitoring" means observing the resident and recording either signs of problems or the resident's complaints. "Monitoring" in this sense does not encompass anticipating problems, planning for them in advance, and perhaps, preventing them before they eventuate. Monitoring without assessment is not enough to discharge a facility's duty to its residents.

Second, the exhibits relied on by Petitioner do not prove that the staff actually monitored the resident. For example, Petitioner asserts that the resident's MAR shows that the resident was monitored for complaints or signs of pain and that she evinced no pain. This contention is unconvincing. The MAR is devoid of any persuasive documentation that the staff monitored the resident for complaints or signs of pain. *See* CMS Ex. 4 at 5-9.

One might argue that the absence of entries on the MAR showing that pain medication was given to the resident is something from which one could infer that the resident was monitored for complaints of pain and that she expressed none. But, one could just as easily infer from the absence of evidence that pain medication was given that the staff did not monitor the resident for pain, did not inquire whether the resident was in pain, and so, saw no need to provide the resident with pain medication.

There is a column on the resident's MAR that is captioned: "Monitor for Pain Q Shift Using Unstable Pain Flow Sheet." CMS Ex. 4 at 8. This column contains initials for shifts on dates just after the resident returned from her procedure, and one might infer from these entries that the resident was at least monitored for pain. However, the unstable pain flow sheet that Petitioner maintained for the resident is completely blank and undated. CMS Ex. 4 at 12. There are no entries on this sheet showing either that the resident experienced pain or did not experience pain. Given that, I do not infer from the initials on the MAR that the facility staff actually monitored the resident for pain.

Petitioner argues, however, that the fact that no entries were made on the resident's unstable pain flow sheet is proof that the resident was monitored for pain and that she had no complaints. *See* CMS Ex. 4 at 12. However, a different inference may as easily be drawn from this blank document, that being that the staff simply made no observations of the resident's complaints or signs of pain and failed to complete the sheet for that reason. The unstable pain flow sheet allows for entries showing the absence of pain. None were made. Moreover, the document is undated, and it is unclear when this document was created. *See id.* For these reasons, I find that the document offers no evidentiary support for Petitioner's assertion that the resident was monitored by the staff, and, as I explain above, I do not find the initials on the MAR to be credible proof that the resident actually was monitored for pain.

Petitioner argues also that a nursing note proves that the resident was monitored for pain, bleeding, and hematuria (blood in her urine). The note Petitioner refers to is a late entry dated February 15, 2010, the date of the February Survey, which makes reference to an earlier date and time, February 11, 2010 at 5:30 p.m. CMS Ex. 4 at 4. I do not find this note to be persuasive proof that the staff monitored the resident for pain and hematuria, much less that it assessed the resident for the possibility that she might develop these problems. The note was made after the fact and either during or immediately after the February Survey, when it would have been in Petitioner's self interest to create documentation to show that it had complied with participation requirements. For that reason, the note is not credible.

I also do not find to be credible another nursing note dated February 15, 2010. CMS Ex. 4 at 2. This also is a late entry made either during or right after the February Survey. In this note – which purports to record the resident's condition on February 11, 2010 – Petitioner's nursing staff avers that the resident denied pain and was voiding well as of that date. Clearly, the note is intended to establish that the staff was monitoring and/or assessing the resident. However, this note is obviously self-serving, created at a time when Petitioner's staff was under criticism for not monitoring the resident.

Petitioner argues additionally that a document, entitled the "Resident Care Flow Record," proves that its staff monitored the resident for hematuria. CMS Ex. 4 at 13. The document contains an entry entitled: "Toileting, Includes Cleaning Self, Adjusting Clothes." Petitioner asserts that the staff would have monitored the resident for hematuria during toileting. But, in fact, the document contains no references to monitoring. Nor is there any evidence that the staff had been alerted to monitor Resident # 20 for hematuria.

Petitioner argues that it was under no legal obligation to document the monitoring that its staff performed. Perhaps so. But, CMS is not alleging that Petitioner contravened the regulation, because Petitioner failed to document the monitoring that its staff performed of Resident # 20. Rather, CMS contends, first, that Petitioner failed to do any assessment of the resident upon her return to the facility. Petitioner has not rebutted that contention. It has provided no proof or even argument that it assessed the resident for problems that she might experience, and its nurse, in fact, admitted that the staff should have but failed to perform such an assessment. Second, CMS argues that the absence of evidence that monitoring was performed provides no support for Petitioner's contention that its staff actively monitored Resident # 20. I agree with CMS's argument. Petitioner would have me infer that something was done from the absence of evidence that anything was done. So, while Petitioner may not have been required by law to document what its staff did, it may not now contend persuasively that its staff did what it failed to document.

Furthermore, Petitioner had the opportunity to present testimony from the staff members who actually provided care to Resident # 20. These individuals could have provided

statements explaining that they had assessed and monitored the resident notwithstanding the absence of documentation, if in fact that was the case. I find telling the failure of any staff member who had actually provided care to the resident to testify, especially in the absence of documentation of assessment and monitoring.

***2. CMS's remedy determination is reasonable.***

Petitioner has not offered evidence or argument to show that CMS's remedy determination is unreasonable. Petitioner's failure to challenge the reasonableness of the remedy determination is, in and of itself, sufficient basis for me to sustain the determination to impose civil money penalties of $100 against Petitioner for each day of a period that began on February 15, 2010 and that continued through March 10, 2010. However, there is also affirmative proof that the remedy is reasonable.

The penalties that CMS determined to impose fall within a range of penalties from $50 to $3,000 per day that may be imposed for noncompliance that is not at the immediate jeopardy level of scope and severity. 42 C.F.R. § 488.438(a)(1)(ii). Factors that may be considered in deciding the amount of any penalty within this range include a facility's compliance history and the seriousness of its noncompliance, along with other factors. 42 C.F.R. §§ 488.438(f)(1) – (4); 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)).

I note that the penalty amount that CMS determined to impose – $100 per day – is minimal, comprising only three percent of the maximum daily penalty amount for a non-immediate jeopardy level deficiency and only $50 per day more than the minimum penalty amount that may be imposed. Very little evidence is necessary to establish a penalty amount that is so low to be reasonable.

That evidence is present in Petitioner's compliance history. The uncontested evidence offered by CMS establishes that, in January 2010, only one month before the February survey, Petitioner failed to comply substantially with four health and safety requirements and two life safety code requirements. CMS Exs. 8, 11. That compliance history, in and of itself, is sufficient basis to sustain the penalties that CMS determined to impose, because it shows that at least some penalty amount is necessary to induce Petitioner to cease its noncompliance.

Additionally, the noncompliance that Petitioner committed in February and March 2010 was relatively serious. The failure to assess Resident # 20 for possible pain and complications left this resident open to the possibility that she would suffer needlessly.

That such possibility may not have eventuated in this case is fortuitous, but nonetheless, the potential for harm existed.

/s/
Steven T. Kessel
Administrative Law Judge