Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Villa Toscana at Cypress Woods,
(CCN: 67-6239),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-3524

Decision No. CR4934

Date: September 6, 2017

DECISION

Petitioner, Villa Toscana at Cypress Woods, is a long term care facility located in Houston, Texas, that participates in the Medicare program. Based on four surveys, completed from January 8 through May 1, 2015, the Centers for Medicare & Medicaid Services (CMS) determined that the facility was not in substantial compliance with multiple Medicare requirements and that its deficiencies posed immediate jeopardy to resident health and safety. CMS imposed civil money penalties of $5,050 per day for four days of substantial noncompliance that posed immediate jeopardy and $700 per day for 21 days of substantial noncompliance that did not pose immediate jeopardy (total penalty of $34,900).

Petitioner filed two appeals (Docketed as C-15-2046 and C-15-3524), which I have consolidated. CMS has moved for summary judgment, which Petitioner opposes.

I grant CMS's motion. As discussed below, the undisputed evidence establishes that, from at least the time of the January survey through May 21, 2015, the facility was not in substantial compliance with Medicare program requirements; from April 27 through 30,

2015, its deficiencies posed immediate jeopardy to resident health and safety; and the penalties imposed are reasonable.

Background

The Social Security Act (Act) sets forth requirements for nursing facilities to participate 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 survey skilled nursing facilities in order to determine whether they are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. Each facility must be surveyed annually, with no more than fifteen months elapsing between surveys, and must be surveyed 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. The state agency must also investigate all complaints. Act § 1819(g)(4).

This case involves four surveys.

January 8, 2015 survey. Responding to a complaint, surveyors from the Texas Department of Aging and Disability Services (state agency) visited the facility to investigate, completing a partial survey on January 8, 2015. CMS Exhibit (Ex.) 3; CMS Ex. 27 at 1; CMS Ex. 31. They found that the facility was not in substantial compliance with the following program requirements:

- 42 C.F.R. § 483.20(k)(3)(ii) (Tag F282) (resident assessment: comprehensive care plans/services provided) at scope and severity level E (pattern of noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.25(c) (Tag F314) (quality of care – prevention of pressure sores) at scope and severity level D (isolated instance of noncompliance that causes no actual harm with the potential for more than minimal harm); and

- 42 C.F.R. § 483.25(k) (Tag F328) (quality of care – special needs) at scope and severity level E;

CMS Ex. 31.

February 3, 2015 survey. Responding to another complaint, surveyors returned to the facility, completing an investigation/partial survey on February 3, 2015. They found that the facility was not in substantial compliance with 42 C.F.R. § 483.15(h)(1) (Tag F252) (quality of life – environment) at scope and severity level E. CMS Exs. 4, 5; CMS Ex. 27 at 1; CMS Ex. 32. Based on these and the January 8 survey findings, CMS denied payment for new admissions, effective February 6, 2015. CMS Ex. 27 at 2; *see* 42 C.F.R. § 488.408(d)(1)(i).

Thereafter, the facility apparently changed ownership.

March 8, 2015 survey. In part because of the change of ownership and in part because the state agency received yet another complaint, surveyors revisited the facility, completing another partial survey on March 8, 2015. They found that the facility was not in substantial compliance with 42 C.F.R. § 483.25(a)(3) (Tag F312) (quality of care: activities of daily living – necessary services) at scope and severity level D. CMS Ex. 11; CMS Ex. 27 at 6; CMS Ex. 33.

May 1, 2015 survey. Within days of the March survey, the state agency received more complaints and reports of "incidents." On March 20, surveyors returned to the facility to investigate. Based on the problems they found, they performed a more comprehensive survey, which they completed on May 1, 2015. CMS Ex. 15; CMS Ex. 27 at 8; CMS Ex. 34. They found that the facility was not in substantial compliance with multiple program requirements and that its deficiencies posed immediate jeopardy to resident health and safety, specifically:

- 42 C.F.R. § 483.10(b)(11) (Tag F157) (resident rights – notice of rights and services) at scope and severity level K (pattern of noncompliance that poses immediate jeopardy to resident health and safety);

- 42 C.F.R. § 483.13(c) (Tag F224) (staff treatment of residents: policies and procedures to prohibit mistreatment, neglect, and abuse) at scope and severity level G (isolated instance of substantial noncompliance that causes actual harm that is not immediate jeopardy);

- 42 C.F.R. § 483.13(c) (Tag F226) (policies to prohibit abuse and neglect) at scope and severity level G;

- 42 C.F.R. § 483.25 (Tag F309) (quality of care) at scope and severity level K;

- 42 C.F.R. § 483.25(c) (Tag F314) (quality of care – preventing pressure sores) at scope and severity level G (**repeat deficiency**); and

- 42 C.F.R. § 483.25(d) (Tag F315) (quality of care – urinary incontinence) at scope and severity level E.

CMS Ex. 34. Because the facility's substantial noncompliance continued, CMS continued to deny payment for new admissions. In addition, CMS imposed civil money penalties of $5,050 per day for four days of immediate jeopardy – April 27 through 30 – and $700 per day beginning May 1, continuing until the facility achieved substantial compliance. CMS Ex. 27 at 8-10. Thereafter, CMS determined that the facility returned to substantial compliance on May 22, 2015, so the penalties ended that day, leaving a total civil money penalty of $34,900.

Petitioner requested review. Petitioner has filed a prehearing brief (P. Br.) with ten exhibits (P. Exs. 1-10). CMS has filed a prehearing brief and motion for summary judgment (CMS Br.) with 34 exhibits (CMS Exs. 1-34). Petitioner filed a response to CMS's motion (P. Response).

Issues

As a threshold matter, I consider whether summary judgment is appropriate.

On the merits, the issues are:

1. From the time of the January survey through May 21, 2015, was the facility in substantial compliance with the Medicare program requirements;

2. If, from April 27 through 30, 2015, the facility was not in substantial compliance, did its deficiencies then pose immediate jeopardy to resident health and safety; and

3. If the facility was not in substantial compliance, are the penalties imposed ($5,050 per day for four days of immediate jeopardy and $700 per day for 21 days of substantial noncompliance that did not pose immediate jeopardy) reasonable.

Discussion

Summary judgment. Summary judgment is appropriate if a case presents no genuine issue of material fact, and the moving party is entitled to judgment as a matter of law. *Bartley Healthcare Nursing & Rehab.*, DAB No. 2539 at 3 (2013), *citing Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986); *Ill. Knights Templar Home*, DAB No. 2274 at 3-4 (2009), and cases cited therein.

The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an

element essential to [that party's] case, and on which [that party] will bear the burden of proof at trial." *Livingston Care Ctr. v. Dep't of Health & Human Servs.*, 388 F.3d 168, 173 (6th Cir. 2004), *quoting Celotex Corp.*, 477 U.S. at 322. To avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986); *see also Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing & Rehab. Ctr.*, DAB No. 1918 (2004). The non-moving party may not simply rely on denials, but must furnish admissible evidence of a dispute concerning a material fact. *Ill. Knights Templar*, DAB No. 2274 at 4; *Livingston Care Ctr.*, DAB No. 1871 at 5 (2003).

In examining the evidence for purposes of determining the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *Brightview Care Ctr.*, DAB No. 2132 at 2, 9 (2007); *Livingston Care Ctr.*, 388 F.3d at 172; *Guardian Health Care Ctr.*, DAB No. 1943 at 8 (2004); *but see Brightview*, DAB No. 2132 at 10 (entry of summary judgment upheld where inferences and views of non-moving party are not reasonable). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cf. Guardian Health Care Ctr.*, DAB No. 1943 at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.").

Here, CMS has come forward with evidence – including the facility's own documents and the surveyors' written declarations and reports – establishing facts showing that the facility was not in substantial compliance with program requirements. For its part, Petitioner has not challenged any of these underlying facts.

1. ***CMS is entitled to summary judgment because the undisputed evidence establishes that facility staff did not change a resident's central catheter dressing as ordered by her physician and directed by the facility's written policy; failing to change a dressing as required put the facility out of substantial compliance with 42 C.F.R. §§ 483.20(k)(3)(ii) and 483.25(k).***[1]

Program requirement: 42 C.F.R. § 483.20(k)(3)(ii) (Tag F282). Initially and periodically, the facility must conduct a "comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity" and must use the results of that assessment to develop, review, and revise the resident's comprehensive care plan.

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

Services provided or arranged by the facility must be provided by qualified persons in accordance with the resident's written plan of care.

42 C.F.R. § 483.25(k) (Tag F328). Under the statute and 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. To this end, among other requirements, the facility must ensure proper treatment and care for residents who receive parenteral and enteral fluids (i.e., fluids delivered by means other than through the digestive tract, such as intravenously or by intramuscular injection). 42 C.F.R. § 483.25(k).

Resident 1-A (R1-A).[2] R1-A was an 86-year-old woman, admitted to the facility on December 13, 2014, suffering from an infection, an inflammatory reaction to an internal orthopedic device, and other problems. CMS Ex. 1 at 2. She required intravenous medications and had a peripherally inserted central catheter (PICC) in her upper right arm. A PICC is a thin, flexible tube inserted into the vein, through which medications and nutrition can be given, and blood can be drawn. CMS Ex. 1 at 2.

In an entry, dated December 23, 2014, R1-A's care plan indicates that she required intravenous therapy. However, the plan does not mention that R1-A had a PICC, an omission that violates section 483.20(k)(3)(ii). CMS Ex. 1 at 4.

According to the facility's written policy for PICC dressings, staff are required to use a transparent dressing and to change it upon admission and at least weekly thereafter. A transparent dressing applied over a gauze dressing is considered a gauze dressing, which, per the policy, must be changed upon admission and every 48 hours thereafter. CMS Ex. 1 at 4-5. Such frequent dressing changes make sense because staff cannot assess the PICC site through non-transparent gauze. *See* CMS Ex. 23 at 3 (Cortes-Vargas Decl.).

In an order, dated December 13, 2014, R1-A's physician directed staff to change R1-A's PICC dressing every week and whenever it became damp, loose, or soiled, or if the resident developed problems at the PICC site requiring further inspection. The physician

[2] To protect privacy, surveyors identify residents by number. Here, with each survey, they begin numbering anew. To avoid confusion, CMS has designated the residents by number and letter, with the letter representing the survey (e.g., R1-A is a resident identified in the January 8 survey; R1-B is a resident identified in the March 8 survey; and R1-C is a resident identified in the May 1 survey. No residents were identified in the February 3 survey).

also ordered staff to assess the site for redness, drainage, swelling, and pain. CMS Ex. 1 at 2; CMS Ex. 23 at 2 (Cortes-Vargas Decl.).

Staff did not comply with either the physician order or the facility policy. On the morning of January 6, 2015, Surveyor Blanca E. Cortes-Vargas observed R1-A's PICC dressing. First, she saw that a transparent dressing had been applied over a gauze dressing that covered the insertion site, which violated the facility policy. Even more troubling, the dressing was dated *December 11, 2014*, indicating that it was last changed on that date, two days *before* R1-A was admitted to the facility. CMS Ex. 1 at 2; CMS Ex. 23 at 2 (Cortes-Vargas Decl.). Thus, her dressing was not changed upon admission (which may explain why the dressing did not comport with facility policy requiring transparent dressings) or at any other time during the three to four weeks she had been there. This violated both the facility policy and the physician order (not to mention putting the resident at risk of infection). When questioned by Surveyor Cortes-Vargas, the facility's director of nursing ultimately conceded that the dressing should have been changed earlier. CMS Ex. 1 at 4; CMS Ex. 23 at 3 (Cortes-Vargas Decl.).

Even though the facility nurses had not changed R1-A's PICC dressing, they reported doing so in record entries dated December 20, December 27, and January 3. CMS Ex. 1 at 4. Petitioner has not claimed that these entries were valid. This is a very serious violation, rendering the facility records suspect, but CMS has not pursued the issue. *See, e.g.*, 42 C.F.R. § 483.75(*l*). Even accepting that these entries were valid (which I do not), the facility was nevertheless deficient. Staff would have applied the wrong type of dressing and, having applied the gauze dressing, failed to change it every 48 hours as the policy required. Moreover, staff could not have been following the physician order to assess because they could not have viewed the insertion site through the gauze.

The facility thus did not provide R1-A with proper care and treatment for her PICC line and was not in substantial compliance with section 483.25(k).

2. CMS is entitled to summary judgment because the undisputed evidence establishes that facility staff did not take necessary precautions to protect residents from developing preventable pressure sores; and, when one of its residents developed a pressure sore, staff – without first obtaining a physician order or considering less invasive interventions – inserted an indwelling catheter. These deficiencies put the facility out of substantial compliance with 42 C.F.R. §§ 483.13(c), 483.25, 483.25(c), and 483.25(d).

Program requirement: 42 C.F.R. § 483.13(c) (Tag F224). "Neglect" means failure to provide a resident with the goods and services necessary to avoid his suffering physical harm, mental anguish, or mental illness. 42 C.F.R. § 488.301. Facilities must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. 42 C.F.R. § 483.13(c). A facility's failure to follow its anti-neglect

policy can put it out of substantial compliance with section 483.13(c), as can its failure to follow its other policies and procedures where those policies define what the facility deems "the goods and services necessary to avoid physical harm." *Avalon Place Kirbyville*, DAB No. 2569 at 9 (2014).

Program requirements: 42 C.F.R. §§ 483.25 and 483.25(c) (Tags F309 and F314). As noted above, the statute and quality-of-care regulation mandate that each resident receive, and the facility provide, necessary care and services. Act § 1819(b); 42 C.F.R. § 483.25. To ensure that each resident receives necessary care and services, the regulation also mandates that the facility ensure that a resident who enters the facility without pressure sores does not develop them unless his/her clinical condition shows that they were unavoidable, based on the resident's comprehensive assessment. 42 C.F.R. § 483.25(c)(1). If the resident already has pressure sores, the facility must ensure that he/she receives the treatment and services necessary to promote healing, prevent infection, and prevent new sores from developing. 42 C.F.R. § 483.25(c)(2).

In assessing the facility's compliance with this requirement, the relevant question is: did the facility "take all necessary precautions" to promote healing, prevent infection, and prevent new sores from developing. If it did so, and the resident develops sores anyway, I could find no deficiency. But if the evidence establishes that the facility fell short of taking all necessary precautions, it has violated the regulation. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 13-14 (2010), *aff'd, Senior Rehab. & Skilled Nursing Ctr. v. Health & Human Servs.*, 405 F. App'x 820 (5th Cir. 2010); *Koester Pavilion*, DAB No. 1750 at 32 (2000).

Facility policy: preventing pressure sores. The facility had in place a written policy for preventing pressure sores (also referred to as pressure ulcers or decubitus ulcers). For a person who spends most of her day in bed, the policy requires staff to change her position every two hours or more frequently, if necessary. They are to determine whether she needs a special mattress, and, if so, select one that contains foam, air, gel, or water, as indicated. Staff should not raise the head of the resident's bed unless needed for meals, treatments, or other medical reason.

For someone who spends a lot of time in a chair, the policy directs staff to change her position at least every hour and to use foam, gel, or an air cushion to relieve pressure. CMS Ex. 19 at 1. Among other requirements, staff should assess routinely the condition of the resident's skin for any signs and symptoms of irritation or breakdown. They should immediately report to their supervisors any signs of a developing pressure ulcer. CMS Ex. 19 at 2. Staff are required to record in the resident's medical record any skin care given, the positioning of the resident, condition of the skin, the resident's ability to participate in the procedure, and other relevant factors. CMS Ex. 19 at 4.

Program requirement: 42 C.F.R. § 483.25(d) (Tag F315). The quality-of-care regulation directs the facility to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless her clinical condition demonstrates that it is necessary. 42 C.F.R. § 483.25(d).

Facility policy: foley catheter insertion. The facility had a policy in place for inserting foley catheters. According to the policy, the purpose of the procedure is to monitor the kidney functions of a seriously ill resident or to obtain a urine specimen for diagnostic purposes. In preparing to insert the catheter, staff are required to *verify a physician's order* for the procedure and to review the resident's care plan to assess any special needs. The policy lists the steps in the procedure and directs staff to document the date and time it was performed, the name and title of the individual performing it, all assessment data obtained during the procedure, and other information. CMS Ex. 22 at 1-3.

Resident 2-A (R2-A). R2-A was an 81-year-old woman admitted to the facility on December 18, 2012, with an altered mental status, muscle wasting and disuse atrophy, cellulitis, and abscesses (although her records did not specify where those abscesses were). She had an abnormal gait. CMS Ex. 2 at 2. According to a December 7, 2014 assessment, she required a two-person assist for bed mobility, transfers, and toilet use; she was frequently incontinent of both bowel and bladder. Her cognitive ability was impaired. CMS Ex. 2 at 2.

In October 2014, R2-A apparently suffered some skin breakdown on her sacrum because a physician order, dated October 13, 2014, indicates that she had a "rash and other non-specific skin eruptions" and instructs staff to "[c]leanse sacrum every am shift . . . with normal saline, pat dry[,] apply zinc ointment." CMS Ex. 2 at 2. R2-A's December 7, 2014 assessment identifies her as at risk for developing pressure sores (although she did not then have pressure sores). A subsequent assessment, dated December 17, 2014, characterizes her as at mild risk for pressure sores. CMS Ex. 2 at 3. R2-A's care plan, dated January 2, 2015, identifies skin breakdown as a problem, noting that the resident was confined to a chair most of the time. CMS Ex. 2 at 3. Nevertheless, she was not provided a pressure-relieving device and was not on a turning/repositioning program. CMS Ex. 2 at 8.

A "late entry" nurse's note, written on January 3, 2015, reports that, during R2-A's morning shower on January 2, staff observed a "small open area . . . to [the] sacrum." They applied zinc and, according to the note, the wound care nurses would evaluate and treat. Staff did not notify the resident's physician, and they performed no skin assessment. CMS Ex. 2 at 3, 4; CMS Ex. 23 at 3, 4 (Cortes-Vargas Decl.).[3]

[3] For reasons it has not explained, CMS did not cite a deficiency under 42 C.F.R. § 483.10(b)(11), which requires the facility to consult "immediately" with the resident's

Continued on next page

R2-A was in the emergency room at 11:12 p.m. on January 2, sent there because she experienced chest pain, shortness of breath, and decreased responsiveness. A hospital assessment, dated January 4, reports that she had a stage II pressure ulcer central to her bilateral buttocks area.[4] It measured 6 cm X 2 cm. The hospital applied a silver gel dressing and instituted a pressure relief positioning program. On January 7, Surveyor Cortes-Vargas observed the resident, who was still in the hospital. The resident told her that she was in pain. Surveyor Cortes-Vargas examined the wound, which was then approximately 5 cm X 2 cm, with a red base. CMS Ex. 2 at 3, 5; CMS Ex. 23 at 3-4 (Cortes-Vargas Decl.).

Surveyor Cortes-Vargas interviewed the nurse aide who showered R2-A on the morning of January 2. The nurse aide told her that, while showering the resident, she noticed blood dripping down. It was coming from a new open area on the resident's buttocks. The nurse aide immediately reported the observation to the licensed vocational nurse (LVN) on duty. CMS Ex. 2 at 4; CMS Ex. 23 at 4 (Cortes-Vargas Decl.).

Surveyor Cortes-Vargas interviewed the LVN to whom the nurse aide reported the wound. She admitted that she did not inform the resident's physician or family and said that she was waiting for the wound care nurse to evaluate the wound. CMS Ex. 2 at 4-5.

Surveyor Cortes-Vargas also interviewed the wound care nurse, who reported that she was not aware of the pressure sore until R2-A was at the hospital. CMS Ex. 2 at 10.

Petitioner challenges none of these facts. Nor does it argue (much less present any evidence) that staff took any steps to prevent R2-A from developing a pressure sore. It does not dispute CMS's showing that, when staff noticed the sore, they did not report it to

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Footnote continued

physician and to notify the resident's legal representative or family member of a significant change in status. (*See* discussion, below).

[4] Pressure sores are classified by stage, based on the extent of the damage to skin and underlying tissues. At stage I, the skin may appear reddened, like a bruise. Although the integrity of the skin remains intact, the area is at high risk of further breakdown, so it is crucial that the area be identified promptly and treated properly. At stage II, the skin breaks open, wears away, and forms an ulcer. At stage III, the sore worsens and extends beneath the skin surface, forming a small crater, presenting a high risk of tissue death and infection. By stage IV, deeper tissues (muscles, tendons, bones) suffer extensive damage, which can cause serious complications, such as osteomyelitis (infection of the bone) or sepsis (infection carried through the blood). John L. Zeller et al., *Pressure Ulcers*, 298 JAMA 1020, 1020 (2006), *available at* http://jamanetwork.com/journals/jama/fullarticle/203224.

her physician nor did they assess or treat the wound. This puts the facility out of substantial compliance with sections 483.25 and 483.25(c).

Resident 6-C (R6-C). R6-C was a 63-year-old woman, admitted to the facility on March 11, 2015, with diagnoses of encephalopathy, urinary tract infection, muscular wasting and disuse atrophy, secondary diabetes, and a non-ruptured cerebral aneurysm. She had an abnormal gait and lacked coordination. CMS Ex. 15 at 2, 52. Her assessments reflect that she rarely or never understood; she was unable to complete a mental status exam. She required extensive assistance (two-person) for bed mobility and transfers and limited assistance for eating. She was incontinent of bowel and bladder. CMS Ex. 15 at 2, 53. She was at high risk for developing pressure sores, but, at the time of her admission, she had no rashes, redness, wounds, or open areas. CMS Ex. 15 at 29-30, 52-53; CMS Ex. 26 at 9 (Cortes-Vargas Decl.).

Notwithstanding her high risk, the facility did not put her on a turning/repositioning program nor provide her with a pressure-relieving mattress or a pressure-reducing device for her chair. Her care plan identified fragile skin as a problem, but the sole intervention was to apply lotion to dry skin. The plan did not even mention the need to keep her clean and dry. CMS Ex. 15 at 30, 53-54; CMS Ex. 26 at 9 (Cortes-Vargas Decl.). Her nutrition assessment, dated March 12, 2015, included no recommendations for preventing pressure sores. CMS Ex. 15 at 53.

A nurse's note, dated March 27, 2015 (a Friday), indicates that R6-C had a pressure ulcer on her buttocks. Staff applied zinc, notified her nurse practitioner and her husband, and, according to the note, were supposed to turn her every two hours. The wound care nurse was to assess on the following Monday, and the wound was finally assessed on March 30, 2015. The resident had a stage II pressure sore to the right buttock, measuring 2.5 cm X 2.0 cm with moderate bloody exudate (fluid that has seeped out). CMS Ex. 15 at 54, 55.

Only *after* the resident developed the pressure sore did the facility's dietician recommend that staff monitor her food and fluid intake and encourage hydration; staff did not even plan to implement these steps until March 30, and, as the discussion below shows, they did not adequately or timely respond to her deteriorating condition. CMS Ex. 15 at 53.[5]

The pressure sore deteriorated. By April 13, 2015, it was "unstageable,"[6] measuring 4 cm X 4 cm with moderate bloody exudate and tissue necrosis. CMS Ex. 15 at 55-56.

[5] As discussed below, the uncontroverted evidence establishes that R6-C also had a serious eating disorder, for which the facility did not provide necessary care and services.

[6] A pressure sore is "unstageable" because dead tissue (referred to as "slough" or "eschar") obscures the wound. *See* CMS Ex. 26 at 10 n.1 (Cortes-Vargas Decl.).

The resident was finally given an air mattress. Staff inserted a foley catheter "to allow for wound healing." CMS Ex. 26 at 9 (Cortes-Vargas Decl.). Although a nurse's note mentions R6-C's nurse practitioner, the facility could not produce, and the surveyors could not find, a physician (or nurse practitioner) order for the catheter. CMS Ex. 15 at 54. In an interview with Surveyor Cortes-Vargas, the responsible LVN confirmed that the facility had not obtained a physician order. CMS Ex. 15 at 59.

On April 18, R6-C was taken to the hospital (which I discuss below). At that time, hospital staff described her wound as: an open area, stage II periphery: length 6.2 cm, width 8.5 cm. It had a thick black eschar area inside the wound, measuring 3.4 cm X 3.5 cm. CMS Ex. 15 at 57; CMS Ex. 26 at 9-10 (Cortes-Vargas Decl.).

On April 21, 2015, Surveyor Cortes-Vargas visited the resident in the hospital. She observed that R6-C, who was non-verbal, had a large open area (an "inverted C" shape) on the sacrum, extending to her bilateral upper buttocks. The black area in the middle of the open area covered about 70% of the wound. The remaining 30% of the wound base was red. The surrounding area was red with a small amount of yellow drainage. CMS Ex. 26 at 10 (Cortes-Vargas Decl.).

Surveyor Cortes-Vargas interviewed R6-C's family member, who told her that the resident developed a pressure sore within two weeks of her admission to the facility and that the sore deteriorated quickly. R6-C was "always" on her back when in bed and spent long hours seated in a wheelchair. "[T]hey never turned her[;] she was always on her back." CMS Ex. 15 at 58; CMS Ex. 26 at 10 (Cortes-Vargas Decl.).

Again, Petitioner has not challenged any of these facts. It does not claim that its staff took even minimal steps to prevent R6-C from developing a serious pressure sore. She was not turned or repositioned; she was not provided pressure-relieving devices. Thus, the undisputed evidence establishes that the facility was not in substantial compliance with 42 C.F.R. § 483.25(c).

And, because the facility was not providing necessary care and services, it was not in substantial compliance with 42 C.F.R. § 483.25. Because it did not implement its policies and procedures directing staff to provide that care and those services, it was not in substantial compliance with 42 C.F.R. § 483.13(c).

Nor has Petitioner produced a physician order for the indwelling catheter. Indeed, it does not argue that the order exists. This puts the facility out of substantial compliance with 42 C.F.R. § 483.25(d). Moreover, inserting a catheter is supposed to be a last resort, when the resident's clinical condition makes it necessary. Petitioner produces no evidence – and does not argue – that inserting a catheter was the only way it could assure

that R6-C remained clean and dry.[7] The facility's failure to justify inserting the catheter also puts it out of substantial compliance with 42 C.F.R. § 483.25(d).

3. CMS is entitled to summary judgment because the undisputed evidence establishes that the facility was not clean, safe, sanitary, or comfortable; it smelled of urine; floors were sticky and covered with trash; blood-sugar-stick needles were on the floors. This put the facility out of substantial compliance with 42 C.F.R. § 483.15(h)(1).

Program requirements: 42 C.F.R. § 483.15(h)(1) (Tag F252). The facility must provide a safe, clean, comfortable, and homelike environment.

Surveyor observations. Responding to a complaint, Surveyor Megan L. Conner, MSW surveyed the facility on February 3, 2015, and documented the following:

- The floor of the activity room was sticky.
- In room #103, she saw trash on the floor. A nebulizer mask lay, uncovered, on the resident's night stand.
- The room #103 bathroom floor was sticky and smelled of urine.
- Outside room #103, she found a blood-sugar-stick needle on the floor (described as a "blue pin").
- In room #105, the resident's oxygen tubing was on the floor.
- She found a wash basin on the floor of room #105's bathroom; it was not labeled or bagged.
- She observed food particles on the floor of the hallway outside room #106.
- In room #108, a resident's call light was on the floor.
- She found three blood-sugar-stick needles on the floor outside room #111.
- The room #114 floor was sticky; food particles were on the floor.
- Hallway #200 smelled of urine, and trash was on the floor.

[7] Ironically, as discussed below, R6-C was severely dehydrated, so, although incontinent, she voided very little.

- She found trash on the floor in room #204.

- Although a person was sleeping in the bed in room #214, no name was on the door.

- In room #215, the floor was sticky, and food particles were on the floor.

- The floor was sticky in room #302.

- In room #304, oxygen tubing had been left, uncovered, on the floor. The floor was sticky.

- She found a wash basin on room #304's bathroom floor.

- Food particles, trash, and a resident's call light were on the floor in room #309. The floor was sticky.

- A "urinal hat" lay on room #309's bathroom floor, not labeled or bagged.

- Two additional blood-sugar-stick needles were in the hallway outside room #506.

CMS Ex. 4 at 1-3; CMS Ex. 24 at 2 (Conner Decl.). Surveyor Conner spoke to two of the facility's residents who complained that housekeeping staff did not keep their rooms clean. CMS Ex. 24 at 2 (Conner Decl.). Petitioner has not denied any of these findings.

Because the facility was not clean, safe, sanitary, or comfortable, it was not in substantial compliance with 42 C.F.R. § 483.15(h)(1).

4. CMS is entitled to summary judgment because the undisputed evidence establishes that facility staff did not provide residents with services necessary for grooming and personal and oral hygiene, as required by 42 C.F.R. § 483.25(a)(3).

Program requirement: 42 C.F.R. § 483.25(a)(3). Among the requirements listed in the quality-of-care regulation, the facility must ensure that a resident who is unable to carry out activities of daily living receives necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

Facility policies: bathing and toothbrushing. The facility had in place written policies for providing its residents with personal care, including caring for a resident's teeth and bathing dependent residents. For toothbrushing, the policy's purpose was described as: "to clean and freshen the resident's mouth, to prevent infections of the mouth, to maintain

the teeth and gums in a healthy condition, to stimulate the gums, and to remove food particles from between the teeth." CMS Ex. 8 at 4. The policy directed staff to review the resident's care plan to assess special needs and to assist with brushing based on those individual needs. CMS Ex. 8 at 4.

With respect to bathing and showering, the policy's purpose was "to promote cleanliness, provide comfort to the resident, and to observe the condition of the resident's skin." CMS Ex. 8 at 1. In addition to describing the procedural steps staff were to follow, the policy directed them to document in the resident's records the date and time of the shower/bath, the name of the individual assisting the resident, assessment data obtained during the procedure, the resident's reaction, including his/her refusal, and interventions taken. The staff member was to sign the entry. CMS Ex. 8 at 3.

Resident 1-B (R1-B). R1-B was an 88-year-old woman, admitted to the facility in March 2014. She suffered from cellulitis and had an abscess on her leg. She had diabetes, secondary parkinsonism (medication-induced symptoms of Parkinson's disease), muscle weakness and wasting, and respiratory difficulties. CMS Ex. 9 at 1. She was totally dependent on staff for personal hygiene (hair, teeth, face, hands, pericare) and other activities of daily living. CMS Ex. 9 at 7, 31; CMS Ex. 25 at 2 (Appolon Decl.).

At 10:30 a.m. on March 6, 2015, Surveyor Mirlene E. Appolon found R1-B lying in bed. A sign posted at the head of her bed asked staff to assist her with removing and cleaning her dentures. The surveyor observed the resident's teeth and partial upper dentures. They were "almost entirely covered with old dirt as well as yellowish-brown substances." CMS Ex. 25 at 3 (Appolon Decl.); *see* CMS Ex. 13 at 6. Surveyor Appolon spoke separately to R1-B and to her daughter. Both told her that the resident could brush her teeth by herself if what she needed were set up, although she needed additional assistance to soak and clean her partial dentures. Staff were not doing that. CMS Ex. 25 at 3 (Appolon Decl.).

Resident 2-B (R2-B). R2-B was an 80-year-old woman, admitted to the facility in 2011. She had a closed fracture of her tibia. She suffered from Alzheimer's disease, dementia, atrial fibrillation, cellulitis, diabetes, and other impairments. CMS Ex. 10 at 1, 3-4. She was totally dependent on staff for personal hygiene (hair, teeth, face, hands, pericare) and other activities of daily living. CMS Ex. 10 at 5, 19, 20.

At 9:50 a.m. on March 6, Surveyor Appolon observed R2-B in bed. She was alert and verbally responsive. The resident had teeth missing, and Surveyor Appolon saw old dirt stains and yellowish, dark brown substances between the missing teeth. The resident's toothbrush was sealed in a zip-lock bag and was dry. CMS Ex. 25 at 3 (Appolon Decl.). The resident also had "slight body odor." CMS Ex. 25 at 4 (Appolon Decl.).

Surveyor Appolon interviewed R2-B, who told her that staff did not help her brush her teeth. She once asked them for help, but they could not find her toothbrush. They eventually found it sitting in the bathtub but did not replace it. Her family brought in a new toothbrush, which she had never used. Surveyor Appolon found the toothbrush, which was sealed in a zip-lock bag and was dry. R2-B also said that "once in a while," someone would give her a bath. CMS Ex. 25 at 4 (Appolon Decl.).

Petitioner has not challenged any of these facts. Thus, the undisputed evidence establishes that the facility was not providing its residents with services necessary for oral hygiene or bathing and was not in substantial compliance with 42 C.F.R. § 483.25(a)(3).

5. CMS is entitled to summary judgment because the undisputed evidence establishes that, contrary to regulatory requirements and the facility's own policies, facility staff did not immediately consult a resident's physician following significant changes in her condition; and they did not provide her with the care and services she needed, including treatment for her eating difficulties. The facility was therefore not in substantial compliance with 42 C.F.R. §§ 483.10(b)(11), 483.13(c), and 483.25.

I have already described the requirements of sections 483.13(c) (neglect) and 483.25 (quality of care).

Program requirement: 42 C.F.R. § 483.10(b)(11) (Tag F157). The facility must protect and promote the rights of each resident. In this regard, it must immediately consult with the resident's physician and notify the resident's legal representative or interested family member (if known) of: 1) an accident involving the resident that results in injury that may require physician intervention; 2) a significant change in the resident's physical, mental, or psychosocial status (i.e., deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); or 3) 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). The Departmental Appeals Board has repeatedly explained that requiring staff to consult the physician "is not a mere formality"; the requirement guarantees that the resident will timely receive his treating physician's input as to the care he requires under the circumstances. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 7 (2010), *quoting Britthaven of Goldsboro*, DAB No. 1960 at 11 (2005).

Facility policy: notification of change. The facility had in place a written policy requiring that it "promptly notify" the resident, her attending physician, and her representative of changes in her medical/mental condition and/or status. Among other requirements, the nurse supervisor or charge nurse must notify the physician when there has been a significant change in the resident's physical/emotional/mental condition or a need to alter her treatment significantly. The policy defines "significant change" as a

"decline or improvement in the resident's status" that: 1) will not normally resolve itself; 2) affects more than one area of the resident's health status; 3) requires interdisciplinary review and/or revision to the care plan; and 4) ultimately is based on the judgment of the clinical staff and the guidelines outlined in the *Resident Assessment Instrument* and 42 C.F.R. § 483.20(b)(ii). CMS Ex. 21 at 1.[8]

The policy requires notification within 24 hours except in medical emergencies. CMS Ex. 21 at 1.[9]

The policy also directs the nurse supervisor/charge nurse to "record in the resident's medical record information relative to [the] changes in the resident's medical/mental condition or status." CMS Ex. 21 at 1.

Finally, the policy dictates that a comprehensive assessment of the resident's condition will be conducted if a significant change in the resident's physical or mental condition occurs. CMS Ex. 21 at 2.

Facility policy: neglect. The facility had in place written policies and procedures for preventing abuse and neglect. Although focused almost exclusively on abuse, the policy defines neglect as "a deprivation of life's necessities of food, water, or shelter, or a failure of an individual to provide services, treatment, or care to a resident which causes or could cause mental or physical injury, . . . harm[,] or death to the resident." CMS Ex. 29 at 2.

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[8] This final item is confusing, and the facility did not explain its meaning. Consistent with federal regulations, I interpret it as requiring that clinical staff compare any perceived change with the resident's most recent assessment in order to determine whether there has been a significant change. Section 483.20(b)(ii) mandates that the resident's assessment include "customary routine." Why the facility's policy singles out that requirement among the 18 listed in section 483.20(b) (including cognitive patterns, mood and behavior, psychosocial well-being, medications) is a mystery.

[9] Although CMS has not pressed the issue, this provision likely violates the regulation. "Immediately" does not mean 24 hours later. As the Departmental Appeals Board has explained, when first published, section 483.10(b)(11) gave facilities up to 24 hours to consult with the physician. After commenters objected that this was too much time, CMS changed the proposed regulation to require "immediate" consultation. *River City Care Ctr.*, DAB No. 2627 at 7-8 (2015), *quoting Magnolia Estates Skilled Care*, DAB No. 2228 at 8-9 (2009) and *The Laurels at Forest Glenn*, DAB No. 2182 at 13 (2008); *see also* 56 Fed. Reg. 48,826, 48,833 (Sept. 26, 1991). In any event, here, staff did not consult the resident's physician immediately or within 24 hours. *See* discussion, below.

Facility policies: hydration. The facility also had in place policies to assure that residents at risk for dehydration would be identified, assessed, and provided with sufficient fluid intake to maintain proper hydration and health. Under one policy, staff are required to assure that each resident receives sufficient amounts of fluid, based on individual need, to prevent dehydration and maintain health. Risk factors are identified "through continual nursing assessment." The policy lists risk factors for dehydration, which include: functional impairments that make it difficult for the resident to drink, reach fluids, or communicate fluid needs; dementia in which the resident forgets to drink or forgets how to drink; *refusal of fluids*. CMS Ex. 20 at 1.

Staff are specifically instructed to check for clinical signs of insufficient fluid intake and to assess those signs through continual nursing assessment and the RAP [resident assessment protocol] check for dehydration. The signs and symptoms listed are: dry skin and mucous membranes; cracked lips; poor skin turgor and skin integrity; thirst and dry mouth; concentrated urine; lab values; and significant weight loss. CMS Ex. 20 at 1.

The facility also had a policy describing an hydration management program. It requires the dining services manager/consultant dietician to complete an initial nutritional assessment and to develop an appropriate intervention plan for each resident "to help assure optimal hydration." *Residents are to receive adequate liquids* to maintain optimal hydration, and staff are to be trained to assess accurately hydration status and to implement appropriate hydration interventions. CMS Ex. 20 at 2.

Specific requirements include: that the dining services manager and dietician assess a resident within 48 hours of admission; that the dietician identify residents at risk, calculate their fluid needs, and review labs for hydration status; that each resident be assessed every three months or more frequently as needed for all changes of condition related to nutrition; and that nursing and dining services *establish a plan of care* for adequate hydration management, with the care plan recognizing individualized needs for achieving optimum fluid intake. CMS Ex. 20 at 2.

Resident 6-C (R6-C). In my discussion of the facility's failure to provide R6-C with the care and services she needed to prevent pressure sores, I addressed just one of her problems. She had others.

On March 12, 2015, the day after her admission, R6-C was screened for swallowing problems; the screener reported no overt signs or symptoms of aspiration and concluded that the services of a speech language pathologist were not warranted. CMS Ex. 15 at 2. Shortly thereafter – on March 17 – staff reported that the resident refused to take her medications, which were crushed and mixed with juice. According to the nurse's note,

the resident was "still" pocketing food;[10] the nurse asked for a speech evaluation. CMS Ex. 15 at 3-4, 16; CMS Ex. 26 at 5 (Cortes-Vargas Decl.).

Staff did not report the behavior to R6-C's physician; he did not mention anything about the resident pocketing her food or other eating difficulties when he conducted a history and physical on March 18. CMS Ex. 15 at 3. Nor did the resident get the requested speech evaluation. A March 23 therapy screen note indicates that staff reported that R6-C held food in her mouth rather than swallowing it and that nursing staff asked for a follow-up swallow screen. But, according to the therapy screen note, an assessment was not indicated because R6-C would eat the food her family brought in. The screener concluded that R6-C simply did not like the facility's food and recommended that the family bring in her food, with her physician's clearance, to ensure that the resident received proper nutrition. CMS Ex. 15 at 2-3; CMS Ex. 26 at 4 (Cortes-Vargas Decl.).

Nothing suggests (and Petitioner does not claim) that anyone came up with an actual "plan" for R6-C's family to supply her food, nor that her physician was consulted about it. In any event, requiring family to meet the resident's nutritional needs would put the facility out of substantial compliance with 42 C.F.R. § 483.35(d), which mandates that the *facility* provide food that is palatable, attractive, and at the proper temperature, prepared in a form designed to meet individual needs. If the resident refuses the food served, the facility must offer substitutes. The facility did not do this for R6-C.

And R6-C continued to have serious issues with eating. A nurse's note dated March 24 indicates that the resident had difficulty chewing. CMS Ex. 15 at 4. Notes dated March 30 indicate that R6-C continued to hold food in her mouth, and, on occasion, staff had to clear her oral cavity. On that date, they called her husband to bring food from home. CMS Ex. 15 at 3. Remarkably, even though the facility's consultant dietician saw R6-C on March 30 (she visited every other week), no one told her that the resident had been pocketing food. CMS Ex. 15 at 8.

As noted in the above discussion of pressure sores, staff were not monitoring R6-C's food and fluid intake in March. Just two notes mention her meal intake during that month; they reflect that, on March 24 and March 26, she consumed 100% of her meal. CMS Ex. 15 at 3. But for the first two weeks in April (1-15), she consumed just 25% to 50% of her meals, according to the notes. From April 15 through 18, she refused all breakfasts, and staff did not note her intake (if any) for lunch and dinner. CMS Ex. 15 at 3. Specifically, her skilled notes document the following:

- April 4: resident continues pocketing her food;

[10] An individual who is unable to swallow can accumulate food in her cheeks, which is referred to as "pocketing."

- April 7: difficulty chewing, difficulty swallowing;

CMS Ex. 15 at 4. The facility's dietary manager told Surveyor Cortes-Vargas that, on April 13, she learned that R6-C's appetite was declining and that the resident was not eating. She knew of no interventions that were put in place to address the problem. CMS Ex. 15 at 8.

- April 14 at 6:53 p.m.: needed encouragement to eat; ate 25% of her dinner;

- April 16 at 6:05 a.m.: refused a snack; ate less than 25% of her meal (breakfast);

- April 16 at 1:02 p.m.: refused to eat;

- April 16 at 8:48 p.m.: sitting in wheelchair, lethargic, sleeping; refused food and dietary supplement; nurse practitioner ordered IV for hydration; thereafter, at 9:55 p.m., staff prepared a *change of condition assessment*, recording the resident's lethargy, sleeping, and refusing to eat.

CMS Ex. 15 at 4-5. Thus, for weeks, R6-C demonstrated significant and worsening eating and swallowing problems. Yet, this is the first indication that staff consulted her physician (or, in this case, nurse practitioner) about the issue. In an interview with Surveyor Cortes-Vargas, the nurse practitioner confirmed that on April 16 she first learned that R6-C was not eating. CMS Ex. 15 at 21.

- April 17 at 1:51 p.m.: lying in bed, lethargic, arouses when she is stimulated; continues to refuse food and medications; hydration in place; unable to reach husband;

- April 18 at 1:08 p.m.: refusing meals and supplements; just turns her head away;

- April 18 at 4:12 p.m.: at family's insistence, R6-C was taken to the hospital; staff informed the nurse practitioner.

CMS Ex. 15 at 4; CMS Ex. 26 at 5 (Cortes-Valdes Decl.).

On April 18, R6-C's family members visited the resident and found her unresponsive. She had a "severely dry mouth" and sacral decubitus ulcer. At the family's insistence, R6-C was taken to the emergency room.[11] She was severely dehydrated, suffering from

[11] The facility demonstrated a baffling reluctance to send even acutely ill residents to the emergency room. R1-C was a 56-year-old man who lost more than 10% of his body weight in less than eight weeks. His weight was down to 123.4 pounds (he was 6'1").
Continued on next page

hypernatremia and acute renal failure. She also had a urinary tract infection and had suffered a left ischemic infarct (stroke). CMS Ex. 15 at 5-6, 17-18.

A nurse aide who cared for R6-C at the facility spoke to Surveyor Cortes-Vargas and confirmed that the resident had been pocketing her food and, after a spoonful or two, would refuse to open her mouth for food or fluid. Although she had a catheter, she had barely any output of urine, approximately 100 cc at the end of a shift. CMS Ex. 15 at 6-7.

R6-C's care plan, dated March 11, identified her altered nutritional status related to her "[n]eed for assistance [and] cueing with meals" but it was not amended to reflect that she was pocketing food or having problems with chewing and swallowing. In fact, it was not updated at any time to reflect her ongoing problems nor to direct any interventions. CMS Ex. 15 at 5.

Neglect. R6-C was plainly neglected because the facility did not provide her the services she needed to avoid physical harm. *See* 42 C.F.R. § 488.301. But my analysis does not stop there. Section 483.13(c) "addresses a deficiency related to lack of an effective policy as opposed to one directed at the occurrence of neglect itself." *Emerald Oaks*, DAB No. 1800 at 12 (2001).[12] The Departmental Appeals Board has repeatedly emphasized that, in considering a facility's compliance with section 483.13(c), the focus "is not simply on the number or nature of the instances of neglect (i.e., failure to provide necessary care or services) but on whether the facts . . . surrounding such instance(s) demonstrate an *underlying breakdown in the facility's implementation of the provisions of an anti-neglect policy*." *Oceanside Nursing & Rehab. Ctr.*, DAB No. 2382 at 11 (2011) (emphasis added); *see Columbus Nursing & Rehab. Ctr.*, DAB No. 2247 at 27 (2009) (holding that CMS need not show multiple incidents of abuse in order to cite

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Footnote continued

He was vomiting virtually every day and complained that he could not drink water without vomiting. On March 17, 2015, he was unable to give a urine sample. His wife complained that he was dehydrated and needed to go to the emergency room. Yet the facility would not send him to the hospital until the next day. He was admitted to the hospital suffering from a bowel obstruction and esophageal stricture. CMS Ex. 14 at 3-4; CMS Ex. 26 at 2-4. Although R1-C's treatment also illustrates the facility's substantial noncompliance, I find R6-C's care (or lack of it) sufficient to justify CMS's findings of substantial noncompliance and immediate jeopardy on those citations common to both residents.

[12] This does not mean that the regulation countenances neglect. Its drafters characterized as "inherent in [section] 483.13(c)" the requirement that "each resident should be free from neglect as well as other forms of mistreatment." 59 Fed. Reg. 56,116, 56,130 (November 10, 1994).

noncompliance under section 483.13; instead, the question is "whether the circumstances presented, viewed as a whole, demonstrate a systemic problem in implementing policies and procedures.").

A facility violates section 483.13(c) if it fails to follow its own policies defining the goods and services needed to prevent physical harm to its residents. *Avalon Place Kirbyville*, DAB No. 2569 at 9. The facility had those policies and procedures in place. They included policies for preventing pressure sores; policies for proper use of a foley catheter; policies for notifying a resident's physician about a significant change in condition; and policies to assure resident hydration. The undisputed evidence establishes that multiple staff members at all levels disregarded those policies and procedures. The facility was thus not in substantial compliance with 42 C.F.R. § 483.13(c).

Failure to consult. From at least March 17, R6-C was refusing to eat and was pocketing her food. This represented a significant physical change from the time of her March 12 assessment, and, as a result, she required a change in her treatment. Yet staff did not consult her physician or nurse practitioner until April 16. This puts the facility out of substantial compliance with section 483.10(b)(11).

Quality of care. Finally, because the facility did not provide R6-C with the care and services she needed to maintain her highest practicable physical well-being, it was not in substantial compliance with 42 C.F.R. § 483.25.

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

Immediate jeopardy. 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 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. 1962 at 11 (2005), *quoting Florence Park Care Ctr.*, DAB No. 1931 at 27-28 (2004); *see also, e.g.*, *Daughters of Miriam Ctr.*, DAB No. 2067 at 7, 9 (2007).

In challenging the immediate jeopardy determination, Petitioner relies on the administrative law judge decision in *Daughters of Miriam* to argue that a finding of immediate jeopardy requires actual harm or a "crisis situation" in which the health and safety of individuals are at serious risk in the very near future. P. Br. at 12, *citing*

Daughters of Miriam Ctr., DAB CR1357 (2005). That decision was reversed by the Board. DAB No. 2067.

But under any standard, the facility's deficiencies here posed immediate jeopardy. Even though R6-C was at high risk for developing pressure sores, the facility failed to implement basic interventions for preventing them. They did not put her on a turning/repositioning program; they did nothing to make sure that she was well-nourished and well-hydrated. Staff inserted a catheter without a physician's order, putting her at risk of a urinary tract infection. By the time she was hospitalized, she was severely dehydrated, suffering from acute renal failure and a urinary tract infection. She had a large, unstageable pressure sore. I conclude that the resident suffered actual harm.

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

7. The penalties imposed are reasonable.

To determine whether a civil money penalty is reasonable, I apply 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.

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 section 488.438(f) 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 Ctr.*, DAB No. 1848 at 21 (2002); *Cmty. Nursing Home*, DAB No. 1807 at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800 at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1683 at 8 (1999).

Here, CMS imposes penalties of $5,050 per day for each day of immediate jeopardy, which is at the lower end of the penalty range ($3,050-$10,000). 42 C.F.R. §§ 488.408(e)(1)(iii); 488.438(a)(1)(i). For the period of substantial noncompliance that was not immediate jeopardy, CMS imposes a penalty of $700 per day, which is at the low to very low end of the penalty range ($50 to $3,000). 42 C.F.R. §§ 488.408(d)(1)(iii); 488.438(a)(1)(ii).

With respect to the section 488.438(f) factors, I note first that the facility has a significant history of substantial noncompliance. Since at least 2010, the facility was subject to multiple surveys/complaint investigations every year (as it was here, for the year 2015). And the facility has consistently demonstrated its substantial noncompliance. CMS Ex. 30. Many of the deficiencies cited during these 2015 surveys were cited before:

- In surveys completed May 10, 2013, September 6, 2013, and July 24, 2014, the facility was not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(ii) (Tag F282), cited at scope and severity levels D and (as in the January 8, 2015 survey) E;

- In a survey completed April 16, 2014, the facility was not in substantial compliance with 42 C.F.R. § 483.25(a)(3) (Tag F312), which was cited again during the March 8, 2015 survey;

- In surveys ending September 28, 2010, August 15, 2011, June 5, 2012, and August 16, 2012, the facility was not in substantial compliance with 42 C.F.R. § 483.25 (Tag F309) at scope and severity levels E and G. During the May 1, 2015 survey, this deficiency was cited at the immediate jeopardy level.

CMS Ex. 30. By itself, the facility's history justifies a penalty well above the minimum.

Petitioner does not claim that its financial condition affects its ability to pay the penalty.

Applying the remaining factors, facility staff did not implement basic precautions to protect its vulnerable residents from developing pressure sores. One of its residents, R6-C, refused food and liquid for weeks before staff consulted her physician or implemented any interventions. They inserted an indwelling catheter without a physician order. She became so dehydrated as to require hospitalization. These facts show the facility's high degree of neglect, indifference, and disregard for resident care, comfort, or safety, for which it is culpable.

For these reasons, I find that the relatively modest penalties are reasonable.

8. Because the facility was not in substantial compliance with program requirements, CMS is authorized to impose a remedy; CMS is not required to afford a facility the opportunity to correct its deficiencies before it does so; and I have no authority to review those determinations.

Petitioner characterizes as a "genuine issue of material fact" CMS's failing to give it the opportunity to correct its deficiencies before it imposed a penalty – the denial of payment for new admissions. P. Response at 7-9. In fact, CMS did not impose any penalties until

after the February 3 survey, when it found that the facility's substantial noncompliance continued. CMS Ex. 27 at 2.[13]

In any event, whether CMS was required to give the facility an opportunity to correct is not an "issue of material fact"; it is a legal issue.

The plain language of the statute and regulations gives CMS the authority to impose one or more enforcement remedies – including the denial of payment for new admissions – whenever a facility is not in substantial compliance, i.e., its deficiencies pose no actual harm but have the potential for causing more than minimal harm. Act § 1819(h); 42 C.F.R. §§ 488.402; 488.301; 488.406. If I sustain deficiency findings at scope and severity level D or above, thereby finding a basis for imposing remedies, I have no authority to review CMS's determination to impose remedies nor may I review CMS's choice of remedy. 42 C.F.R. §§ 488.408(g)(2); 488.438(e); 498.3(d)(14); *Beverly Health & Rehab. Servs., Inc. v. Thompson*, 223 F. Supp. 2d 73, 111 (D.D.C. 2002) (holding that the "determination of what remedy to seek is beyond challenge.").

Further, whenever it finds substantial noncompliance, CMS may impose a remedy without affording the facility an opportunity to correct, notwithstanding its (or a state agency's) routine practice of allowing facilities such an opportunity. *See* 59 Fed. Reg. 59,116, 56,171 (Nov. 10, 1994) ("[N]either the Act nor the Constitution require that providers have the opportunity to correct deficiencies before sanctions are imposed."); *see also Guardian Care Nursing & Rehab. Ctr.*, DAB No. 2260 at 3 (2009); *Beechwood Sanitarium*, DAB No. 1824 at 15 (2002).

Finally, Petitioner makes a very confusing – and puzzling – argument criticizing CMS and the state agency for not accepting its plans of correction and for purportedly delaying revisits to the facility. According to Petitioner, had the revisits occurred within 60 days, CMS would have found the facility in compliance and not denied payment for new admissions. This argument seems to have nothing to do with the case before me. In fact,

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[13] In this regard, Petitioner makes much of the fact that its January deficiencies were cited at levels D and E. But consider: the facility took virtually no steps to prevent R2-A from developing pressure sores; even after staff noticed the sore ("blood dripping down" from an open area on the resident's buttocks), it was not reported or assessed until she was hospitalized more than 12 hours later; when the *hospital* assessed the wound, it was a 6 cm X 2 cm pressure sore. That, based on these facts, the state agency (and CMS) cited this deficiency at scope and severity level D is simply baffling. However, I have no authority to review CMS's scope and severity finding. 42 C.F.R. § 498.3(b)(14) (providing that the level of noncompliance is reviewable only if a successful challenge would affect the range of CMP amounts or if a finding of substandard quality of care causes the loss of the facility's nurse aide training program.).

surveyors were consistently physically present in the facility from January until May 2015. And the undisputed evidence establishes that the facility was *never* in substantial compliance during this time. In any event, the timing of a revisit survey is solely within the state agency's discretion, and I have no authority to review it. *Arbor Hosp. of Greater Indianapolis*, DAB No. 1591 (1996); 42 C.F.R. § 498.3.

Conclusion

The undisputed evidence establishes that the facility was not in substantial compliance with Medicare program requirements from the time of the January survey through May 21, 2015, and its deficiencies posed immediate jeopardy to resident health and safety from April 27 through 30, 2015. The penalties imposed – $5,050 per day for four days of immediate jeopardy and $700 per day for 21 days of substantial noncompliance that was not immediate jeopardy – are reasonable. I therefore grant CMS's motion for summary judgment.

/s/
Carolyn Cozad Hughes
Administrative Law Judge