Department of Health and Human Services

**DEPARTMENTAL APPEALS BOARD**

Civil Remedies Division

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| In the Case of: | ) | |
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| Highland Pines Nursing Home, | ) | Date: February 06, 2007 |
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| Petitioner, | ) | |
| | ) | |
| - v. - | ) | Docket No. C-06-229 |
| | ) | Decision No. CR1563 |
| Centers for Medicare & Medicaid Services. | ) | |
| | ) | |

## DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to deny Petitioner, Highland Pines Nursing Home, Ltd., payment for new Medicare admissions for a period that began on December 21, 2005, and which ran through January 10, 2006.

### I. Background

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

Petitioner was surveyed for compliance with Medicare participation requirements on November 18, 2005 (November survey) and on January 11, 2006 (January survey) and at each survey was found to be out of compliance with various requirements. CMS concurred with the surveyors' findings of noncompliance and imposed against Petitioner the remedy of denial of payment for new Medicare admissions covering a period running from December 21, 2005 through January 10, 2006. Petitioner requested a hearing and the case was assigned to me for a hearing and a decision.

I held a hearing at Dallas, Texas on November 6, 2006. At the hearing I received into evidence from CMS exhibits (Ex.) consisting of CMS Ex. 1 - CMS Ex. 40. I received exhibits from Petitioner consisting of HP. Ex. 1 - HP. Ex. 18. I also heard the cross examination of several witnesses whose written direct testimony had been received in the form of exhibits.

After the hearing Petitioner moved that I receive into evidence an additional exhibit which it designated as HP. Ex.19. I am receiving the exhibit. The exhibit consists of a notice and attachments that the Texas Department of Aging and Disability Services sent to Petitioner on December 5, 2005. I find no prejudice to CMS in my receiving the exhibit in that it is a public record document.

## II. Issues, findings of fact and conclusions of law

### A. Issue

The issue in this case is whether Petitioner failed to comply substantially with one or more Medicare participation requirements during the period that began on December 21, 2005 and which ran through January 10, 2006.

### B. Findings of fact and conclusions of law

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

The surveyors who conducted the November and January surveys found that Petitioner was not complying substantially with several Medicare participation requirements. However, and as I explain in more detail below, I do not find it necessary for me to address each of these findings of noncompliance in order to sustain CMS's remedy determination. A failure by a facility to comply with only one participation requirement is sufficient basis for CMS to impose denial of payment for new Medicare admissions for so long as the noncompliance persists. 42 C.F.R. § 488.417(a).

I rest my decision in this case on Petitioner's failure to comply with the requirements of 42 C.F.R. § 483.25 during the period in question. The noncompliance with this regulation was found at the November survey. CMS Ex. 3, at 1 - 8. In this case the evidence is overwhelming that Petitioner failed to comply substantially with the regulation's requirements. Petitioner failed to offer persuasive evidence proving that it corrected its noncompliance prior to January 10, 2006.

***1. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25.***

The regulation at issue mandates that each resident of a skilled nursing facility must receive, and that the facility must provide, the necessary care and services for the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being. CMS alleges that Petitioner failed to comply with the regulation's requirements in providing care to a resident who is identified in the report of the November survey as Resident # 1. CMS Ex. 3, at 1 - 8. CMS contends that Petitioner's staff failed to assess the resident accurately and timely in order to prevent a decline in his physical and psychosocial well-being. More specifically, CMS asserts that Petitioner failed to assess this resident's needs for assistance with eating and toileting and failed to assess and address observations by Petitioner's staff that the resident suffered an extreme loss of weight, 50 pounds, in a two-week period.

CMS offered prima facie evidence that strongly supports these contentions. The evidence supports a conclusion that Petitioner's staff was put on notice – by the resident, by his family, and by events occurring during the resident's stay – that there were at least potential serious problems concerning the resident's ability to eat and use the toilet. Moreover, Petitioner's reported loss of more than 50 pounds in a period of less than two weeks was an event that should have caused Petitioner to assess the resident's condition thoroughly. Yet, Petitioner failed to address these potential problems systematically or effectively.

Petitioner's staff was on notice that Resident # 1 had possible problems both with use of the toilet and with eating. The resident was admitted to Petitioner's facility on August 9, 2005. Forms submitted by the resident and on his behalf at time of admission show that the resident had a history of problems with using the toilet and with incontinence. CMS Ex. 7, at 84. An additional problem noted at the time of the resident's admission was that he was blind, and consequently, needed assistance with eating. *Id.*

Petitioner's records contain conflicting and inconsistent assessments of the resident's problems. For example, and notwithstanding the information communicated to the facility by the resident and his family, Petitioner's staff assessed the resident in August 2005 as being able to eat independently, requiring only help with setting up his meals. *Id.*, at 57. Moreover, Petitioner's staff assessed the resident as being able to use a toilet independently without requiring physical assistance from the staff. *Id.* A minimum data set (MDS) prepared for Resident # 1 states that the resident could eat independently. CMS Ex. 7, at 57. However, another document states that the resident required assistance with his eating due to being blind. *Id.*

Events occurring during the resident's stay at Petitioner's facility should have made it evident to Petitioner's staff that there was a need to assess the resident far more thoroughly for his possible problems and to address them to the extent that interventions were needed. On three occasions during his stay Resident # 1 fell while attempting to use the bathroom. CMS Ex. 7, at 23 - 25. Yet, these falls did not trigger thorough investigations by Petitioner's staff into the causes of, and possible remedies for, the falls. The resident was not assessed for frequency of urination in order to determine whether he might benefit from being put on a toileting schedule. CMS Ex. 3, at 5. Nor did Petitioner's staff thoroughly assess the resident's need to use the toilet after the resident was put on diuretic medicine which might have increased the frequency of his need to urinate. Transcript (Tr.) at 30.

For example, the resident sustained a fall on November 1, 2005. A document entitled "follow-up disposition" was prepared by Petitioner's staff. CMS Ex. 7, at 143 - 144. The document, which is a printed form, contains lines labeled "assessment". *Id.* But, aside from recording vital signs and a few laconic comments about the resident's condition, the document says absolutely nothing about the cause of the resident's fall, the problems that might have contributed to the fall, or the staff's proposed solutions to those possible problems. *Id.*

Furthermore, Petitioner's staff was put on notice that the Resident might be having problems seeing his food and that his blindness was interfering with his ability to eat. The facility's diet intake record states that the resident was consuming between 50 and 100% of the food that was offered to him. However, this is contradicted, both by statements made by the resident, who asserted to a surveyor that he had difficulty finding the food on his plate, and by a member of Petitioner's staff who stated that the resident consumed less than 50% of what was offered to him. CMS Ex. 3, at 6 - 7; CMS Ex. 7, at 11.

I make no findings in this decision whether Resident # 1 could eat independently or use the toilet without assistance. Whether the resident actually suffered from these problems is irrelevant to my decision. The allegation made by CMS – which is amply supported by Petitioner's own records – is that Petitioner was put on notice by the resident and his family, as well as by events occurring during the resident's stay, that he had difficulty eating due to his blindness and that he needed assistance using the toilet. That information triggered a duty on Petitioner's part to assess fully and adequately the resident's specific needs and to develop a detailed care plan to address those needs that were identified. However, the resident's treatment record fails to show that Petitioner or its staff made efforts to reconcile the conflicting information that they received or to get to the bottom of the resident's possible problems. The record is devoid of anything in the nature of a comprehensive assessment of these possible problems.

Perhaps the most compelling evidence that Petitioner's staff failed adequately to assess Resident # 1's needs is the resident's weight loss during his stay at Petitioner's facility. CMS offered strong prima facie proof that the resident sustained a dramatic weight loss during October 2005, at a time when he was complaining of dizziness and weakness, and evidencing nausea, vomiting, and gastrointestinal distress. Yet, Petitioner's staff did not interpret these facts as alarming nor did they perform an assessment of the resident in order to determine what might be the cause of the resident's problems.

The resident's weight was recorded at 200 pounds upon his admission in August 2005. On subsequent dates up to and including October 24, 2005, his weight was consistently recorded at or very close to 200 pounds. CMS Ex. 7, at 13. However, on November 4, 2005, his weight was measured at 147 pounds. *Id.* Thus, according to Petitioner's own records the resident's weight declined by more than 50 pounds in a period of less than two weeks.

The resident's apparent weight loss occurred during a period of time when the resident was complaining of and evidencing weakness and dizziness. On October 24, 2005, the resident told Petitioner's staff that he was weak and dizzy. CMS Ex. 7, at 90. On October 31, 2005, Resident # 1 again complained to the staff that he felt weak and dizzy. *Id.*

Resident # 1 was admitted to a hospital on November 4, 2005 to evaluate his weight loss and possible dehydration and malnutrition. CMS Ex. 7, at 73. At admission the resident's weight was recorded at 148 pounds. CMS Ex. 3, at 4. He was found to be suffering from hypotension (low blood pressure) as well as signs of dehydration, poor nutritional uptake, and gastrointestinal illness. CMS Ex. 7, at 73. He stayed in the hospital for a week. He was returned to Petitioner's facility on November 11, 2005, weighing 168 pounds, having gained 18 pounds during his approximately one week stay at the hospital. *Id.*

I make no findings in this decision as to the cause of Resident # 1's weight loss. Nor do I find that Petitioner's staff caused the resident to lose weight by failing to attend to his needs on any given day. Any number of possibilities exist for the resident's weight loss, ranging from the effects of diuretic medications, to malnutrition, to some sort of gastrointestinal illness. And, it is certainly possible that Petitioner's staff may not have recorded the resident's weights with complete accuracy.[1] Rather, I premise my finding

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[1] If the resident's weight was not recorded accurately, the inaccuracy lay in a measurement taken prior to November 4, 2005. The resident's weight of 147 on that date is virtually identical to his weight at the hospital on the subsequent day. That means that

(continued...)

that Petitioner's care of the resident was deficient on the fact that the resident's complaints, his obvious deterioration, and the staff's measurements of the resident's weight put Petitioner on notice that this resident had at least a potential severe problem of which rapid weight loss was a sign. That evidence triggered an obligation by Petitioner's staff to assess the resident thoroughly and completely in order to ascertain the reasons for the apparent problem and to plan the resident's care based on that assessment.

The prima facie evidence is that Petitioner failed utterly to do that. The record is devoid of a comprehensive assessment of the resident's weight loss.

The prima facie evidence presented by CMS establishes a consistent and long standing pattern of failures by Petitioner's staff to assess Resident # 1's apparent problems and to develop a rational plan of care to address those problems that were established. Under 42 C.F.R. § 483.25 a facility has a duty to conduct exactly the type of assessment that Petitioner failed to conduct here. It is not possible for a facility to maximize a resident's physical, mental, and psychosocial well-being unless it is aware of and has developed a plan to deal with each problem that is evidenced by a resident.

Petitioner did not offer evidence that overcame CMS's prima facie case. Petitioner argues, first, that it performed all required assessments for Resident # 1, that it reported significant changes in the resident's medical condition to the resident's treating physician, and that when a significant change was observed, its staff obtained and implemented new treatment orders for the resident. Petitioner's post-hearing brief at 2; *see* HP Ex. 13, at 43- 47. I find this argument to be unpersuasive. The evidence cited by Petitioner to support its contention – HP Ex. 13, at 43 - 47 – consists of interdisciplinary progress notes made about Resident # 1 on November 4, 2005. They address the resident's physical condition, his complaints, and his appearance on that date, the date of his admission to the hospital. They are not in any sense of the word an assessment of his underlying problems, including his weight loss, or their causes, nor do they consist of an analysis of the care that was needed to address the resident's problems. Finally, although the notes are relevant to the resident's condition on November 4, they say nothing whatsoever about the resident's condition or problems in the preceding months.

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[1](...continued)
one or more of the previous measurements was inaccurate. In a sense, that makes the resident's weight loss and the failure of Petitioner's staff to assess it even more troubling. Obviously, a loss of about 25% of body weight over a period of time would produce a change in the resident's physical appearance. That should have been evident to Petitioner's staff. However, I see nothing in the record of this case showing that the staff observed such change or recorded it.

The exhibits offered by Petitioner included a collection of various assessment forms completed for Resident # 1 by Petitioner's staff. HP Ex. 8. The exhibit does not show that Petitioner performed the assessments indicated by the resident's potential problems. For example, Petitioner's staff performed a "falls assessment" of Resident # 1 on August 9, 2005. *Id.*, at 7. But, no follow up falls assessments appear to have been performed despite the three falls that the resident sustained after August 9, 2005. *See Id.* A nutrition screening and assessment data collection form also was prepared for the resident on August 9, 2005. *Id.*, at 12 - 13. But, Petitioner's staff did no follow-up assessment of the resident's nutritional status until November 15, 2005, after the resident had lost more than 50 pounds and after he had been hospitalized for problems that included possible malnutrition. *Id.*, at 13.

Second, Petitioner argues that the resident's record while at Petitioner's facility is "well-documented", most significantly in respect of the resident's gastrointestinal problems in October 2005. Petitioner's post-hearing brief at 2. But, this case is not simply a case of failure to document the resident's problems. I make no findings as to how faithfully or accurately Petitioner's staff recorded the resident's complaints and vital signs and the care that the staff gave to him. What is alleged here – and what CMS's prima facie evidence establishes – is that Petitioner's staff failed to use their observations and findings as a basis for *assessing and treating* the resident's apparent problems.

Third, Petitioner contends that the deficiency findings in this case were written without any regard to the resident's diagnosis, his physician's recommendations and treatment orders, and the care provided to Resident # 1 as documented in the resident's records. Petitioner's post-hearing brief at 3. I disagree with this assertion. The evidence and argument offered by CMS very much takes into account the resident's condition and what was or was not done for him by Petitioner's staff. What CMS alleges, and what I find to be supported by CMS's prima facie case and not rebutted by Petitioner, is that Petitioner's staff did not do enough to meet the resident's apparent needs.

Implicit in Petitioner's argument seems to be an assertion that the staff was not remiss in caring for Resident # 1 because it attended to his specific problems as they arose and because the staff was faithful in executing the resident's physician's orders. I make no findings here as to whether that is true, because it begs the question of whether Petitioner was deficient. The requirements of 42 C.F.R. § 483.25 are that a facility and its staff aggressively assess the needs of a resident and plan for his or her care. Simply reacting to problems as they arise and faithfully following a resident's treating physician's orders is not sufficient to satisfy the regulation's requirements. Consequently, Petitioner's diligence in carrying out prescribed care for the resident – if that is true – is not enough to satisfy the regulation's requirements.

Fourth, Petitioner argues that CMS's findings of noncompliance are based on hearsay assertions by the resident's sister and brief telephone interviews with the resident. Petitioner's post-hearing brief at 3. That is not an accurate characterization of the evidence relied on by CMS. Much of CMS's findings are based on the clinical records developed by Petitioner's staff. Moreover, the complaints vocalized to the surveyors by the resident and his sister echo statements that were made previously to Petitioner's staff by the resident or his family. It is important to note that I do not base my decision in this case on findings that the resident's statements or those made by his family are necessarily true. The point is that statements made by the resident and his family to Petitioner's staff put the staff on notice of *potential* problems which the staff had the duty to investigate, assess, and to remedy if substantiated. The deficiency here lies squarely in Petitioner's staff failure to act on what it was told.

Fifth, Petitioner suggests that the hospitalization of Resident # 1 on November 4, 2005 was likely unnecessary and, consequently, should not reflect adversely on the care that Petitioner's staff gave to the resident. Petitioner's post-hearing brief at 3 - 5. It is certainly hard to square this argument with the objective findings of hypotension, dehydration, and possible malnutrition that were made at the hospital. Moreover, the fact that the hospital retained the resident for a full week after November 4, 2005 is strong evidence as to his condition and his need for hospitalization. But, whether or not the resident actually needed to be hospitalized in November 2005 is ultimately immaterial. Again, the point is the failure by Petitioner's staff to assess whatever problem the resident manifested or appeared to manifest.

Finally, Petitioner asserts that CMS is simply basing its case against Petitioner on the medical decline of Resident # 1 in October and November 2005 without considering the care that Petitioner's staff actually provided to the resident. Petitioner's post-hearing brief at 5. This argument is simply incorrect. The allegations – and, more importantly, my findings of noncompliance – are not based on the outcome that Resident # 1 experienced but on the failure of Petitioner's staff to react to and to address aggressively problems manifested by the Resident as they were brought to the attention of Petitioner's staff.

Petitioner's several arguments, whether considered singly or in combination, avoid addressing the central point of CMS's case. CMS alleged that Petitioner failed to perform the assessments of Resident # 1's apparent problems and to plan the resident's care accordingly and it backed up these allegations with prima facie evidence showing that Petitioner knew or should have known about the resident's apparent problems but failed to develop assessments and plans to address them. If Petitioner had performed the requisite assessments and plans it could have addressed CMS complaints simply by producing copies of those documents. It failed to do so.

***2. Petitioner's noncompliance with the requirements of 42 C.F.R. § 483.25 persisted through January 10, 2006.***

Petitioner asserts that, if it was deficient as of the November survey, it corrected its deficiencies prior to the implementation date of CMS's denial of payment for new admissions. According to Petitioner there is no basis for a remedy in this case because Petitioner was complying with Medicare participation requirements on the dates (December 21, 2005 through January 10, 2006) for which the remedy was imposed.

Petitioner's assertion is without merit. Petitioner did not prove that it corrected its failure to comply with the requirements of 42 C.F.R. § 483.25 prior to January 11, 2006.

Where there is a substantiated finding of noncompliance with a participation requirement – as is the case with Petitioner's noncompliance with 42 C.F.R. § 483.25 – the burden falls entirely on the noncompliant facility to prove when and how it remedies its deficiency. In other words, a facility, once established to be noncompliant is presumed to remain noncompliant until it proves that it has remedied the deficiency.

Petitioner argues that it submitted an "acceptable plan of correction" to the Texas Department of Aging and Disability Services, the State agency which performed the November and January surveys on behalf of CMS. Petitioner's post-hearing brief at 11. It argues that the State agency "determined that all corrections had been made on December 18, 2005." *Id.; see* HP Ex. 19. From this Petitioner asserts that I must find that it corrected all of the deficiencies that were identified at the November survey by December 18, 2005, three days prior to implementation of CMS's remedy. Consequently, according to Petitioner, there were no deficiencies resulting from the November survey for which CMS could impose a remedy. *Id.*

Petitioner's assertions notwithstanding, no document cited by Petitioner states that either the Texas State agency or CMS found Petitioner to be in compliance with participation requirements at any time prior to January 11, 2006. The exhibit relied on by Petitioner is a letter that the Texas State agency sent to Petitioner on December 5, 2005. HP Ex. 19. The letter plainly states that the findings of the November survey were that Petitioner was not in substantial compliance with participation requirements. *Id.*, at 1. It directs Petitioner to submit a plan of correction to address the survey's deficiency findings. *Id.* Nothing in the letter states or suggests that mere submission of a plan – even one that the Texas State agency finds to be acceptable – will, *in and of itself* be sufficient to establish compliance.

Moreover, there is no communication to Petitioner from CMS, the agency that ultimately determined to impose a remedy, suggesting that mere submission of a plan of correction by Petitioner would be enough to establish compliance with participation requirements. Petitioner was never told, either by the Texas State Agency or by CMS, that submission of a plan would in and of itself resolve the issue of compliance.

Furthermore, the fact that CMS determined to impose a remedy against Petitioner is proof that CMS never found Petitioner to be in compliance with participation requirements at any date prior to January 11, 2006. The notice of CMS's determination to impose remedies against Petitioner was CMS's final action in this case prior to Petitioner's requesting a hearing.[2]

Although Petitioner averred that it submitted an acceptable plan of correction it did not discuss the specifics of that plan in its post-hearing brief nor did it cite to the plan. *See* Petitioner's post-hearing brief at 11. It is unclear whether the plan was even offered by Petitioner as an exhibit. In any event, the fact that Petitioner submitted a plan of correction to the Texas State Agency or CMS does not mandate that I conclude that it corrected its deficiency on or prior to any given date. A plan of correction is a representation by a facility of what it intends to do in order to correct a deficiency. Acceptance of a plan by a State agency or CMS means that the elements of the plan, *if they are completed by the facility*, will be an acceptable mechanism for attaining compliance. But, acceptance of the plan by a State agency or CMS does not mean necessarily that the State agency or CMS agrees the elements of the plan *have been completed.* In all cases CMS reserves the authority to insist that a facility provide proof aside from its representations that it completed the elements of the plan.

Here, the only evidence that appears to exist in the record relating to Petitioner's correction of its noncompliance with 42 C.F.R. § 483.25 appears to be an "action plan" that Petitioner's staff prepared in or about November 2005. CMS Ex. 14. This plan contains elements which address: toileting plans for residents; weight variance; scale

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[2] Petitioner makes other arguments to the effect that imposition of the remedy in this case was not done in compliance with requirements in the State Operations Manual. Petitioner's post-hearing brief at 12 -14. I find these arguments to be without merit. Nothing in Petitioner's arguments shows that CMS was without authority to impose the remedy of denial of payment for new admissions. That authority is clearly delineated in regulations. CMS has the discretion to impose denial of payment for new admissions where there is noncompliance with as few as a single Medicare participation requirement. 42 C.F.R. § 488.417(a).

calibration; and meal intake records. Several of the corrective actions described in the plan are listed as being "ongoing," which I take to mean that completion dates for the actions were not established as of the date that the action plan was prepared. *Id.*, at 1 - 2. Others show completion dates in November 2005.

The action plan is relevant to the issue of Petitioner's correction of its noncompliance with 42 C.F.R. § 483.25 because it addresses specifically some of the problems that were identified as comprising Petitioner's noncompliance with the regulation. However, I do not find it to be persuasive proof that Petitioner attained compliance with the regulation's requirements prior to January 11, 2006.[3] For one thing, the document does not establish completion dates for all of the corrective actions that it lists. Moreover, Petitioner has not provided any corroboration that these actions were completed. For example, the action plan discusses in-service training of nurses and staff in certain specific areas. The plan states that such in-service training was completed on November 14, 2005. CMS Ex. 14, at 4 - 5. However, Petitioner has not cited to any actual documentation of the in-service training.

At bottom, Petitioner's argument that it corrected its noncompliance with 42 C.F.R. § 483.25 before the implementation date of the remedy in this case rests more or less entirely on its uncorroborated assertion of compliance. I find Petitioner's assertions of compliance not to be persuasive absent some substantial corroboration that it actually attained compliance. Petitioner has not offered corroborating evidence showing that it actually complied. For example, Petitioner has not pointed to updated and in-depth assessments of its residents' problems showing that it had taken to heart and addressed the assessment-related problems cited by the surveyors in the report of the November survey.

***3. It is unnecessary that I address other deficiencies cited at the November and January surveys in order to justify CMS's authority to impose denial of payment for new admissions during the December 21, 2005 - January 10, 2006 period.***

As I discuss above, the reports of the November and January surveys cited deficiencies in addition to Petitioner's noncompliance with the requirements of 42 C.F.R. § 483.25. Any of these deficiencies, individually or in combination, would be sufficient to establish a basis for imposition of the remedy at issue if sustained for the period in question.

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[3] I note that Petitioner did not cite or discuss the action plan in its brief as evidence of its compliance. Petitioner's post-hearing brief at 11 - 14.

However, is unnecessary that I discuss these deficiencies in order to decide this case. Petitioner's noncompliance with 42 C.F.R. § 483.25 during the period at issue is all that is necessary to sustain CMS's authority to impose the remedy. Regulations make it plain that presence of only a single deficiency is adequate to sustain imposition of denial of payment for new admissions. 42 C.F.R. § 488.417(a).

Therefore, I make no findings in this case about the presence or absence of additional deficiencies. It is simply unnecessary that I do so here in order to sustain the remedy that is at issue.

/s/

Steven T. Kessel
Administrative Law Judge