Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of: The Cottage Extended Care Center, Petitioner, - v. - Centers for Medicare & Medicaid Services.	DATE: January 10, 2008 Civil Remedies CR1629 App. Div. Docket No. A-08-1 Decision No. 2145

FINAL DECISION ON REVIEW OF
ADMINISTRATIVE LAW JUDGE DECISION

The Cottage Extended Care Center (Cottage), a long-term care facility, appealed the July 31, 2007 decision of Administrative Law Judge (ALJ) Carolyn Cozad Hughes. The Cottage Extended Care Center, DAB CR1629 (2007) (ALJ Decision). The ALJ concluded that Cottage was not in substantial compliance with Medicare and Medicaid program participation requirements from January 12 to February 13, 2006, including 42 C.F.R. § 483.13(c) (requirement to develop and implement written policies and procedures that prohibit neglect); 42 C.F.R. § 483.10(b)(11) (requirement to consult with the resident's physician when there is a significant change in the resident's physical, mental, or psychosocial status); and 42 C.F.R. § 483.25 (requirement to provide the necessary care and services for each resident to attain or maintain the highest practicable physical, mental, and

psychosocial well-being).[1] All of these findings involved the care of Resident #7 after she had a seizure on January 2, 2006 and a second seizure on January 4, 2006.[2] The ALJ also concluded that Cottage's noncompliance was at the immediate jeopardy level for one day, and upheld the determination by the Centers for Medicare & Medicaid Services (CMS) to impose a civil money penalty (CMP) of $3300 for that day and a CMP of $50 a day for noncompliance during the next month. ALJ Decision at 15-16. As the ALJ noted, Cottage did not contest CMS's findings that during the same period the facility also was not in substantial compliance with three Medicare requirements for comprehensive care plans (42 C.F.R. §§ 483.20(d), 483.20(k)(1), and 483.20(k)(3)(ii)). ALJ Decision at 3-4.

For the reasons stated below, we affirm the ALJ Decision, adopting all of its findings of fact and conclusions of law (FFCLs). We have considered all of the arguments in Cottage's appeal and reply briefs, and rely on the ALJ's analysis of any issues not explicitly addressed in this decision.[3]

Analysis

The Board's standard of review on a disputed issue of law is whether the ALJ decision is erroneous. Its standard of review on a disputed factual issue is whether the ALJ decision is supported by substantial evidence on the record. Guidelines for Appellate

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[1] We cite to the 2006 Code of Federal Regulations throughout this decision; all the relevant regulations were unchanged during the times at issue here.

[2] For reasons of privacy, we refer to the resident by the number assigned by the state surveyors. CMS initially cited only section 483.13(c) based on these factual findings. The ALJ added the issues of whether Cottage was in substantial compliance with sections 483.10(b)(11) and 483.25, pursuant to 42 C.F.R. § 498.56. Neither party objected.

[3] As indicated below, a number of the arguments made by Cottage are related to both the section 483.13(c) (neglect) deficiency and the section 483.10(b)(11) (consulting with physician) deficiency, or to both the section 483.13(c) deficiency and the section 483.25 (quality of care) deficiency. Although the ALJ addressed some of these arguments under a single FFCL (such as III.B.2 "quality of care" or B.3 "notification of changes"), the same analysis supports all of the FFCLs to which the arguments relate.

Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs (at http://www.hhs.gov/dab/guidelines/prov.html).

As noted above, all of the disputed CMS factual findings relate to the care of Resident #7 during the three-day period from January 2 to 4, 2006. The findings were based on a state survey of the facility ending January 18, 2006 and a revisit survey on February 27, 2006. Pet. Exs. 1, 4. It is undisputed that Resident #7 was a 54-year-old woman, admitted to Cottage on November 11, 2005, suffering from insulin dependent diabetes mellitus, congestive heart failure, polyneuropathy, peripheral vascular disease, hypertension, and hypothyroidism. Upon her admission to Cottage, she had a physician's order for hospice care due to end stage diabetes mellitus. ALJ Decision at 5, citing Pet. Ex. 39, at 1; CMS Ex. 2, at 3.

It is also undisputed that Resident #7 had a care plan that imposed the following responsibilities on Cottage:

- To prevent hypertension complications, the plan required the staff to monitor the resident's blood pressure and report any abnormal readings; monitor and report any shortness of breath, drowsiness, confusion, numbness, or tingling; and notify her physician of any signs or symptoms of hypertensive crisis.

- For the resident's risk of a repeat CVA or stroke, the plan required the facility's staff to monitor laboratory values, blood pressure, and changes in cognitive or functional levels, and to report any signs or symptoms of a repeat CVA to the physician.

- For complications related to her diabetes, the plan required staff to monitor and report to her physician any abnormal laboratory values or other signs or symptoms of hypo/hyperglycemic reactions, such as moist clammy skin, blurred vision, headache, and weakness (hypoglycemia) or dry skin, fruity smelling breath, hypotension, and lethargy (hyperglycemia).

ALJ Decision at 5, citing Pet. Ex. 37, at 1, 2, 4; CMS Ex. 7, at 1, 2, 4.

Cottage makes five major arguments on appeal. First, it argues that the ALJ ignored evidence in the record showing it had provided sufficient care and services to Resident #7. It also

argues that it was excused from providing the care and services in Resident #7's comprehensive care plan because she had agreed to hospice care. Cottage also asserts that it could not be cited for neglect without proof that the resident's condition worsened as a result of that neglect. With respect to the sanctions the ALJ upheld, Cottage argues that CMS's finding of immediate jeopardy was clearly erroneous and that the amounts of the CMPs were not reasonable. We discuss each of these arguments below.

I. Substantial evidence in the record supports the ALJ's findings that Cottage was not in substantial compliance with 42 C.F.R. §§ 483.13(c) (neglect), 483.10(b)(11) (consulting with physician), and 483.25 (quality of care).

A. The ALJ fully weighed and did not ignore the evidence in the record regarding the care and services provided to Resident #7.

The first issue on appeal is whether the ALJ ignored evidence submitted by Cottage. Cottage claims that its evidence shows that, contrary to what the ALJ found, its staff did provide care and services to Resident #7 during the periods after her first seizure (on January 2 at slightly before 11:30 a.m.) and after her second seizure (on January 4 at 4:30 p.m.). Pet. App. Br. at 6-7, 9, 11; Pet. Reply Br. at 2-5. Cottage also claims that some of its staff members' contacts with Resident #7 were not documented because the resident had stabilized, and that documentation should not be expected in a period when a resident is stable. Pet. App. Br. at 8-9; Pet. Reply Br. at 2-4. Thus, Cottage argues, there is not substantial evidence in the record to support the ALJ's conclusion that there was a pattern of neglect evidencing a failure to implement an anti-neglect policy, in contravention of 42 C.F.R. § 483.13(c).[4]

However, in evaluating Cottage's claim that it provided appropriate services to Resident #7 following her seizures, the ALJ fully analyzed the evidence in the record and reached a

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[4] Cottage has not disputed that examples of neglect can demonstrate that the facility has not implemented an anti-neglect policy. ALJ Decision at 8, citing Barn Hill Care Center, DAB No. 1848, at 9-12 (2002); Emerald Oaks, DAB No. 1800, at 18 (2001); and 59 Fed. Reg. 56,130 (Nov. 10, 1994); see also Liberty Commons Nursing & Rehab Center - Johnston, DAB No. 2031, at 7-17 (2006), aff'd, Liberty Nursing & Rehab Ctr. - Johnston v. Leavitt, 2007 WL 2088703 (4th Cir. 2007).

different conclusion. ALJ Decision at 5-6, 8-10. As the ALJ correctly concluded, the evidence does not demonstrate that Cottage took the steps required by Resident #7's care plan. Id. After the resident's first seizure occurred on January 2, the nurse took her vital signs. CMS Ex. 5, at 4-5. However, there is no indication in Resident #7's medical record that the nurse tested for hypoglycemia or hyperglycemia, as required by the resident's care plan, despite the resident's clammy skin. Id.; Pet. Ex. 37, at 2. In fact, there is no evidence in the nursing record showing that testing for hypoglycemia or hyperglycemia was done until more than two days later, at the time of the second seizure. CMS Ex. 5, at 4-6.[5] No further vital signs were recorded during that ensuing two-day period, nor is there evidence that Cottage monitored the resident for signs or symptoms of stroke or hypertensive crisis, although the resident's care plan required these steps. Pet. Ex. 37, at 1, 4; CMS Ex. 7, at 1, 4 (care plan). Moreover, the ALJ found and Cottage does not dispute that despite the resident's seizure, Cottage's staff performed no neurological assessment. ALJ Decision at 8-11. The foregoing failures to provide Resident #7 with the care required by her care plan support the ALJ's findings of noncompliance with both section 483.13(c) (neglect) and section 483.25 (quality of care).

The ALJ was also correct in her conclusion that Cottage did not timely notify or consult with the resident's physician, as the

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[5] The nursing records show a 52-hour gap in care and services between the nurse's taking of vital signs and call to the hospice and physician right after the first seizure on January 2nd and the next nursing care with the onset of seizures at 4:30 p.m. on January 4th. CMS Ex. 5, at 4-5. There is no reliable evidence that Resident #7 received any of her care plan services in this interim period. The ALJ, after stating that the record was ambiguous, "[gave] the facility the benefit of the doubt and assume[d] that [the resident's] blood [sugar level] was tested approximately five hours after her first seizure," relying on the affidavit of Nurse Daniel J. McElroy, one of CMS's witnesses. ALJ Decision at 9, citing CMS Ex. 12. However, as the ALJ noted, Nurse Linda Wilkerson (Cottage's witness) appears to have conflated the nursing note entries when she reviewed them, combining those for the morning of January 2nd with those for the afternoon and evening of January 4th. ALJ Decision at 10, referring to CMS Ex. 12 and Pet. Ex. 32 (Wilkerson's unsigned report). Nurse McElroy may have similarly conflated the nursing note entries for January 2nd and 4th in writing his affidavit. See ALJ Decision at 8-9; CMS Ex. 12 (McElroy Affidavit) at 5-6.

care plan and regulations required. ALJ Decision at 8, referring to the care plan at Pet. Ex. 37 and CMS Ex. 7. The nurse "placed" a call to the physician on call at 12:05 p.m. on January 2nd, to inform him of the first seizure. CMS Ex. 5, at 5. The nurse's notes state "waiting for return call." Id. Contrary to what Cottage asserts, this is not evidence that Cottage notified the physician of the seizure. Moreover, Cottage points to no evidence that the physician returned the call, visited the resident, or consulted about her condition during the next 55 hours. The next nurse's contact with his office was during the evening of January 4th, at least two and one-half hours after the resident's second seizure and apparent lapse into unconsciousness, when the nurse called to inform the physician that the hospice had recommended that the resident go to the hospital. CMS Ex. 5, at 6; CMS Ex. 4, at 2. These omissions provide ample support for the ALJ's findings of noncompliance with both section 483.13(c) (neglect) and section 483.10(b)(11) (consulting with physician).

As noted above, there was at least a two and one-half hour delay between the time when the nurse observed the repeat seizure and when she contacted the physician. There was an approximately five-hour delay between the time when the nurse observed the repeat seizure and when the resident was taken to the hospital. CMS Ex. 5, at 5-6. During that time, the nurse left the resident alone while the nurse went to help with the evening meal, and when she returned it appeared that the resident had lost consciousness. CMS Ex. 9, at 5. At the hospital, the resident was diagnosed with a massive left hemispheric cerebrovascular accident (CVA, or stroke) and acute right hemiplegia (paralysis), and as having had an acute tonic-clonic seizure, probably secondary to the CVA. Pet. Ex. 38; CMS Ex. 6.

The ALJ cited the statement of Cottage's own witness, Linda Wilkerson, R.N., that these onsets of seizure activity and unresponsiveness constituted significant changes in the resident's condition, were potentially life-threatening, and thus should have prompted consultation with the physician. ALJ Decision at 14, referring to Pet. Ex. 32, at 4. Nurse Wilkerson also acknowledged that -

> [t]he failure of the facility to notify and inform the resident's physician of the significant change in the resident's condition had the potential to limit or prohibit the provision of care and services by the resident's physician and further prevent supervision of the medical care of the resident.

Id. These developments contributed to Cottage's noncompliance with the regulations on neglect (§ 483.13(c)), standard of care (§ 483.25), and notifying and consulting with the physician (§ 483.10(b)(11)).

Cottage had an obligation to do more than it did; it had a duty to provide care for Resident #7 in accordance with the care plan it had prepared. 42 C.F.R. §§ 483.25, 483.20(k)(3)(ii). As explained above, Cottage failed to meet a number of these responsibilities following Resident #7's first and second seizures.[6]

Given these responsibilities and the fact of Resident #7's seizure on January 2, Cottage's assertion that there were nursing or other pertinent staff contacts with the resident on January 2, 3, and 4 that were not documented because the resident was "stable" is not plausible. The seizure on January 2 was a significant change in her condition, and while the nurse's notes for later that morning state that she was "lying quietly on the bed [with] eyes closed" (CMS Ex. 5, at 4-5), Cottage does not cite any evidence that her condition had, in fact, stabilized. Cottage says the ALJ should not have presumed that she was not stabilized, but in light of the undisputed evidence that she had a seizure, Cottage had the burden to support its assertion that the reason no services were documented after 12:05 p.m. on January 2 was that her condition had stabilized. See Batavia Nursing and Convalescent Inn, DAB No. 1911 (2004), aff'd, Batavia Nursing and Convalescent Ctr. v. Thompson, No. 04-3687 (6th Cir. 2005). Moreover, one would, in any event, expect to see written records of some assessments of her condition made in order to

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[6] The ALJ also found that the facility failed to consider Resident #7's consumption of alcohol in its care planning and failed to notify the physician of the consumption. ALJ Decision at 13. Cottage argued on appeal that the ALJ should not have considered information regarding the alleged alcohol consumption because that issue had been resolved in its favor as a result of Informal Dispute Resolution (IDR). Pet. App. Br. at 11-12. The part of the IDR Report on which Cottage relies states that alcohol was not a factor leading to the unconscious condition of the resident, but also states that the "observations in the deficiency appear to be accurate." Id., quoting from Pet. Ex. 11 (IDR Determination Report). Even if this Report precluded the ALJ from considering the information regarding alcohol, however, we would find that the ALJ's conclusions regarding noncompliance and immediate jeopardy are fully supported by other substantial evidence in the record.

determine whether or not her condition had stabilized. For example, monitoring of vital signs, including blood pressure, monitoring blood sugar and other signs and symptoms of hypo/hyperglycemia, and monitoring changes in cognitive or functional levels all presumably would have been documented in writing in her medical record. Instead, with the exception of the initial check of vital signs on January 2 and the blood sugar monitoring done after the second seizure on January 4, no such steps are documented in the nursing records or attested to by any staff member in a statement.

Cottage also asserts that its Exhibits 15 and 39 document 73 contacts between the resident and staff members during a 96-hour period, from January 1-4, 2006. Pet. Reply Br. at 2. However, as the ALJ explained, this is not correct. ALJ Decision at 9-10. There are far fewer than 73 contacts documented; the contacts prior to the January 2 seizure are irrelevant to the resident's care following the seizure; and the bulk of the entries discuss hospice treatment for the resident's necrotic right toe which is also irrelevant to the deficiencies cited. Id. Of the small number of entries that are relevant, Petitioner's Exhibit 15 documents two nursing contacts with the resident, at the times of her two seizures. Petitioner's Exhibit 39 documents one phone call to the physician notifying him that Trinity Hospice had instructed Cottage staff to transfer the resident to the hospital after her second seizure (and five other unrelated telephone calls from November 11, 2005 to January 4, 2006). There are, therefore, a total of three relevant contacts, with the second nursing contact (at and after the time of the second seizure) documenting some measure of ongoing care. Thus, these documents do not undercut the ALJ's findings that facility staff failed to monitor and assess Resident #7 following her initial seizure, failed to follow up with her physician about that seizure, and on January 4 delayed in notifying her physician about her second seizure. ALJ Decision at 10.

B. Cottage was not excused from providing the care and services in Resident #7's comprehensive care plan merely because she had elected to receive hospice services.

Cottage also argues on appeal, as it did below, that because Resident #7 had elected hospice care, and allegedly had an advance directive, this "prohibited the facility from making efforts to revive the resident under the circumstances at issue in this appeal." Pet. Reply Br. at 2; see also Pet. App. Br. at 7, 13. The ALJ analyzed this argument and the relevant documents, concluding that nothing in the hospice agreement or in

what Cottage refers to as Resident #7's "advance directive" instructs the Cottage staff to ignore her care plan. ALJ Decision at 11-12. Resident #7's care plan, the ALJ found, did not purport to cure her illnesses but was designed to maintain the quality of her life, was fully consistent with the directives she had signed, and should have been followed. Id. Moreover, the regulations require that a care plan include a description of any services that would otherwise be provided, but are not to be provided due to the resident's exercise of rights under section 483.10, including the rights to refuse treatment under section 483.10(b)(4) (rights to refuse treatment and to formulate an advance directive). 42 C.F.R. § 483.20(k)(1)(ii). Resident #7's care plan did not make reference to any medical services she had exercised a right to refuse. CMS Ex. 7; Pet. Ex. 37. Therefore, the ALJ properly concluded that the care plan should have been fully implemented.

C. The ALJ's determination that Cottage was not in substantial compliance with section 484.13(c) does not require proof that Cottage's inaction worsened Resident #7's condition.

Cottage further contends on appeal, as it did below, that it should not be cited for failing to provide Resident #7 with prompt medical care and services, because even if it had done so, the care and services would not have made a difference in her outcome. Pet. App. Br. at 7, 9-11, 13, 14; Pet. Reply Br. at 5. Even assuming that Cottage's delay in furnishing medical care and services made no difference to Resident #7's condition, that fact would not preclude a finding of neglect. As the ALJ explained, the drafters of the neglect regulation deliberately rejected the idea that evidence of a particular outcome is required to support a finding of neglect. ALJ Decision at 7-8, quoting 59 Fed. Reg. 56,130 (Nov. 10, 1994); see also Beechwood Sanitarium, DAB No. 1906, at 92-95 (2004) (for resident with terminal illness subjected to facility's neglect who died, medical intervention might not have changed the outcome in the sense that death was unavoidable, but the resident's condition in the interim could have been altered by timely and appropriate physician interventions), modified on other grounds sub nom. Beechwood Restorative Care Ctr. v. Thompson, 494 F. Supp. 2d 181 (W.D.N.Y 2007). Moreover, a facility's failure to provide one resident with necessary medical care and services poses a potential for more than minimal harm to all residents in the facility, because they lack the assurance that they will be provided with necessary medical care and services when they need them. Ross Healthcare Center, DAB No. 1896, at 9 (2003).

II. The ALJ correctly determined the issues of immediate jeopardy and sanctions.

A. The ALJ correctly found that CMS's immediate jeopardy finding was not clearly erroneous.

Cottage argues on appeal that CMS's immediate jeopardy finding was clearly erroneous and should have been reversed by the ALJ pursuant to 42 C.F.R. § 498.60(c)(2). Pet. App. Br. at 13-15. Again, the ALJ addressed this issue fully and cogently in her decision. ALJ Decision at 14-15. She explained in response to Cottage's arguments that the surveyors do not have to be present at the facility at the time of immediate jeopardy in order to identify and cite it later,[7] and that CMS does not have to prove that the resident's outcome would have been different had the facility complied with the program participation requirements. Id. The ALJ reiterated the standard in the regulations for finding immediate jeopardy (noncompliance has caused or is likely to cause serious injury, harm, impairment, or death to a resident) (42 C.F.R. § 488.301; emphasis added), and again pointed to the statement of Cottage's own witness, Nurse Wilkerson, that the resident's new onset of seizure activity,

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[7] ALJ Decision at 14, n.10. As the Board has explained, the statute and the regulation governing CMPs make clear that long-term care facilities may be cited for noncompliance (including that which poses immediate jeopardy) occurring after the last standard survey and before the current survey. See North Ridge Care Center, DAB No. 1857, at 9-20 (2002) (discussing section 1819(h)(2) of the Act and 42 C.F.R. § 488.430(b), which allow CMS to cite past noncompliance occurring since the last standard survey); see also Westgate Healthcare Center, DAB No. 1821, at 25-26 (2002) (also upholding CMPs for past noncompliance, including immediate jeopardy).

The source Cottage cites for its contrary position not only is an unofficial issuance, as the ALJ noted, but, also, relates to termination based on an immediate jeopardy finding, not to imposition of a CMP. See Heaton Resources, The Facility Guide to OBRA Regulations and the Long-Term Care Survey Process (revised June 2006). As the ALJ notes, Cottage failed to provide a copy of this source, but quotes it as saying: "The key factor in the use of the immediate jeopardy termination authority is, as the name implies, limited to immediate and serious. The threat must be present when you are onsite and must be of such magnitude as to seriously jeopardize a patient's health and safety." Pet. App. Br. at 13 (emphasis added).

continuing seizure activity and/or unresponsiveness would be considered potentially life threatening. Id., citing Pet. Ex. 32, at 4. CMS's immediate jeopardy finding was well-supported in this case, and the ALJ did not err in concluding that this finding was not clearly erroneous.

B. The amounts of the CMPs were reasonable.

Finally, Cottage argues that the amount of the immediate jeopardy-level CMP ($3300 for one day) is not reasonable "because there was no actual harm and no evidence of systemic problems." Pet. App. Br. at 15. However, the ALJ answered these contentions in her decision, pointing out that the deficiencies were serious and that Resident #7's well-being was seriously jeopardized by multiple instances of staff neglect. ALJ Decision at 16. The ALJ reasonably viewed the lack of any meaningful assessment or notification of the physician for a significant period of time after the resident's first seizure (and the delay after her second seizure) as evidencing a systemic problem. In light of these factors, and the others she was required to consider pursuant to 42 C.F.R. § 488.438(f), the ALJ found the $3300 CMP for one day of immediate jeopardy reasonable. Id. at 15-16. The $3300 one-day CMP is, as the ALJ pointed out, barely above the mandatory minium of $3050. Id. at 15. We uphold the ALJ's finding that the $3300 for one day of immediate jeopardy was reasonable.

As noted above, Cottage has not specifically contested the non-immediate jeopardy-level CMP of $50 per day for one month, imposed for the three comprehensive care plan deficiency findings Cottage did not dispute and the section 483.13(c) neglect deficiency finding. Instead, Cottage made a general allegation that CMS "failed to establish a prima facie case for . . . the sanctions." Pet. App. Br. at 6; see also Pet. Reply Br. at 5. However, as the discussion above demonstrates, the survey findings and CMS's evidence regarding Resident #7 established a prima facie case of Cottage's noncompliance with section 483.13(c) (neglect), and Cottage conceded noncompliance with three comprehensive care plan requirements. Therefore, there was a basis for imposing a per day sanction of $50, an amount at the lowest end of the regulatory scale. 42 C.F.R. § 488.438(a)(ii). This CMP is reasonable in the context of this case.

Conclusion

For the foregoing reasons, we affirm the ALJ Decision and affirm

and adopt all of the FFCLs in that decision.

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Leslie A. Sussan

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Constance B. Tobias

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Judith A. Ballard
Presiding Board Member