Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Haverhill Care Center,	)	Date: March 10, 1998
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-97-533
	)	Decision No. CR522
Health Care Financing Administration.	)	
	)	

DECISION

I decide that Petitioner, Haverhill Care Center, was in substantial compliance with Medicare participation requirements at the time of the April 1997 survey but was not in substantial compliance with Medicare participation requirements at the times of the July and August 1997 surveys. Further, I decide that the Health Care Financing Administration (HCFA) was authorized to terminate Petitioner's Medicare provider agreement.

PROCEDURAL BACKGROUND

HCFA initially found that Petitioner was not in substantial compliance with Medicare participation requirements based on a November 1996 survey by the State of Florida's Agency for Health Care Administration (State survey agency). Subsequently, HCFA found that Petitioner remained out of compliance with Medicare participation requirements following three revisit surveys in April, July, and August 1997 (April, July, and August surveys). By letters dated August 8 and 15, 1997, HCFA notified Petitioner that its Medicare agreement would be terminated, effective September 2, 1997.[1] Petitioner timely requested a hearing.

The hearing was held from November 3 - 6, 1997, in West Palm Beach, Florida. Testimony and exhibits were received in evidence at the hearing as shown by the transcript (Tr.). Following the hearing, HCFA submitted the deposition of Florence Treakle,

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[1] Termination was actually effective January 3, 1998; see telephone conference transcript of January 14, 1998, at 8 - 9.

identified as HCFA Exhibit (Ex.) 21, which I admit in evidence. The parties and I agreed that I would decide initially only the termination issue, regarding the April, July, and August surveys.[2]

Based on the evidence of record and applicable law, in light of the parties' arguments, I determine that Petitioner was in substantial compliance with Medicare participation requirements at the time of the April survey but was not in substantial compliance with Medicare participation requirements at the times of the July and August surveys.

APPLICABLE LAW

Medicare, a federally subsidized health insurance program for the elderly and disabled, was established under Title XVIII of the Social Security Act (Act). Medicare provides reimbursement for certain services rendered by providers, such as a skilled nursing care facility (SNF) like Petitioner, who participate in the Medicare program under "provider agreements" with the United States Department of Health and Human Services (DHHS). In order to enter into such an agreement, SNFs must meet certain requirements imposed by applicable statute and regulations. Section 1819 of the Act [42 U.S.C. § 1395i-3]; 42 C.F.R. Parts 483, 488, and 489. The requirements for participation in Medicare by SNFs are set forth in 42 C.F.R. Part 483. A SNF is subject to the survey, certification, and remedies provisions of 42 C.F.R. Part 488 and to the provisions governing provider agreements in 42 C.F.R. Part 489.

The survey process is the means by which DHHS (through HCFA) assesses providers' compliance with participation requirements. State survey agencies, under agreements with HCFA, perform the surveys of SNFs and make recommendations to HCFA as to whether such facilities meet federal requirements for Medicare participation. Act, section 1864(a); 42 C.F.R. §§ 488.10, 488.11, 488.20. The results of these surveys are used by HCFA as the basis for its decisions regarding a SNF's initial or continued participation in Medicare. HCFA, not a State survey agency, makes the determination as to whether a facility is eligible to participate or remain in Medicare. Id.

The regulations define "substantial compliance" as "a level of compliance with the requirements of participation such that any

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[2] The parties filed post-hearing submissions. Petitioner filed: Petitioner's Motion to Strike (P. M. Str.); Petitioner's Brief (P. Br.); and Petitioner's Reply Brief (P. R. Br.). HCFA filed: HCFA's Response to Motion to Strike (HCFA R. Str.); Respondent's Post-Hearing Memorandum (HCFA Br.); and HCFA's Response to Petitioner's Brief (HCFA R. Br.).

identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. HCFA terminates a SNF's provider agreement if it is not in substantial compliance within six months from the last day of a survey from which it was found to be out of substantial compliance. 42 C.F.R. § 488.412. However, HCFA is authorized to terminate the participation of a SNF which it determines is not in substantial compliance with participation requirements even if it has not been out of substantial compliance for six months. 42 C.F.R. §§ 488.412, 488.456(b)(1)(i), 489.53(a)(3).

The burden of proof is governed by the decision of an appellate panel of the Departmental Appeals Board in the case of Hillman Rehabilitation Center, DAB No. 1611 (1997). Under Hillman, HCFA bears the burden of coming forward with evidence sufficient to establish a prima facie case that Petitioner was not in substantial compliance with a participation requirement at issue. Once HCFA has established a prima facie case, Petitioner has the ultimate burden of persuasion: to prevail, Petitioner must prove by a preponderance of the evidence that it was in substantial compliance with the requirement.

ISSUE

The issue is whether Petitioner was in substantial compliance with Medicare participation requirements at the times of the April, July, and August surveys.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Petitioner was in substantial compliance with Medicare participation requirements at the time of the April survey. Section I of Discussion, below.

2. Petitioner was not in substantial compliance with Medicare participation requirements at the time of the July survey. Section II of Discussion, below.

3. Petitioner was not in substantial compliance with Medicare participation requirements at the time of the August survey. Section III of Discussion, below.

4. HCFA was authorized to terminate Petitioner's Medicare agreement. Section IV of Discussion, below.

DISCUSSION

I. Petitioner was in substantial compliance with Medicare participation requirements at the time of the April survey.

Following the April survey, HCFA cited Petitioner with deficiencies in four categories, discussed in sections A through D, below.

A. One regulation subsection cited following the April survey, 42 C.F.R. § 483.13(c)(1)(i),[3] states:

> 42 C.F.R. § 483.13 Resident behavior and facility practices.
>
> (c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
> (1) The facility must--
> (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

42 C.F.R. § 483.13(c)(1)(i); HCFA Ex. 4 at 4, 5.

To support the allegation that Petitioner failed to comply with this requirement, the situations of two residents, Residents 2 and 14, are detailed at tag F 224 on the HCFA 2567.[4] HCFA Ex. 4 at 5 - 7. The specific allegation is that Petitioner failed to adequately implement procedures which prohibit neglect in the care of residents.

Resident 2

No one alleged that Resident 2 was mistreated or abused. It is alleged on the HCFA 2567 that Petitioner failed to prohibit neglect of Resident 2 by failing to notify her physician "of all the changes in the resident's condition." HCFA Ex. 4 at 6.

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[3] Regarding the April survey, the citation of 42 C.F.R. § 483.13(c)(1)(i) is not appropriate. There is no allegation and no evidence that the facility used verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. The appropriate citation, which corresponds to the allegation that "[t]he facility failed to adequately implement procedures which prohibit neglect in the care of residents" (HCFA Ex. 4 at 5), is 42 C.F.R. § 483.13(c).

[4] For each survey there is a HCFA 2567, which is a statement of deficiencies. The HCFA 2567s are HCFA Exs. 1, 4, 7, and 11.

Petitioner asserts that there were no changes in condition for which the doctor was not notified.

Resident 2 was found on the bathroom floor on March 26, 1997, at about 11:00 a.m., by a CNA (certified nurse's assistant). Resident 2 stated she felt dizzy and fell to the floor. She sustained a large bump on her forehead and a small skin tear on her left hand. An ice pack was applied to her forehead to reduce swelling. Her doctor, Dr. Stern, was called immediately. Her family was called and recalled, until her daughter was reached at 2:30 that afternoon. She was given Tylenol for complaint of a headache. Dr. Stern ordered a skull x-ray at 3:15 that afternoon.

In the event of an incident, Petitioner's "POLICY-TIMELY NOTIFICATION OF CHANGES"[5] requires the doctor and family member to be notified; nurses' notes to reflect an entry and full vital signs every shift for 72 hours; and if the incident involves a head/scalp injury, neurochecks to be performed. HCFA Ex. 10 at 14. Resident 2's vital signs and neurochecks were monitored immediately (11:00 a.m.) and periodically thereafter. They remained within normal ranges. HCFA Ex. 5 at 6 - 10; P. Ex. 2 at 2 - 5. [Vital signs include blood pressure, temperature, pulse, and respirations. Neurochecks include pupil size and reaction, extremity strength, consciousness level, orientation, alertness, speech, responsiveness, and presence or absence of symptoms such as headache, vomiting, or seizure. HCFA Ex. 5 at 10.] Resident 2's vital signs and neurochecks were recorded on her Neurological Assessment (HCFA Ex. 5 at 10) and in the nurses' notes. HCFA Ex. 5 at 6 - 9; P. Ex. 2 at 2 - 5. Below, I show the shift-by-shift recordings of her vital signs and neurochecks:

SHIFT	Mar 26	Mar 27	Mar 28	Mar 29
11 pm - 7 am:	N.A.	6:35 am	6:45 am	6:30 am
7 am - 3 pm:	11:00 am 2:00 pm	8:00 am 10:00 am 12:00 noon 2:00 pm		
3 pm - 11 pm:	3:15 pm	10:00 pm	10:00 pm	

HCFA Ex. 5 at 6 - 10; P. Ex. 2 at 2 - 5.

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[5] Petitioner's Policy expands upon the requirements of 42 C.F.R. § 483.10(b)(11) Resident rights, Notification of Changes, with which Petitioner was in compliance.

Additional observations of Resident 2, including any complaints she made, were recorded by the nurses as follows:

SHIFT	Mar 26	Mar 27	Mar 28	Mar 29
11 pm - 7 am:	N.A.	12:00 mid 6:35 am	6:45 am	6:30 am
7 am - 3 pm:	11:00 am 2:00 pm	2:00 pm		2:00 pm
3 pm - 11 pm:	3:15 pm 5:30 pm 9:00 pm 9:45 pm	10:00 pm	10:00 pm	8:00 pm

Id.

During the 72 hours following Resident 2's fall, one shift shows no record of Resident 2's vital signs and neurochecks, the 7:00 a.m. - 3:00 p.m. shift on the third day. Nevertheless, I find that her vital signs and neurochecks were appropriately monitored, and they remained within normal ranges.

Not every failure to perform a facility policy or procedure will constitute a deficiency. A facility may develop policies and procedures exceeding the requirements of the regulations and exceeding professionally recognized standards of care. Consequently, where a facility fails to implement its own policies or procedures, a deficiency may or may not have been proved. The law and the evidence must be carefully examined to determine whether the facility's failure to perform constitutes a deficiency.

Both the registered nurse called by HCFA to testify regarding this issue and the registered nurse called by Petitioner were credible witnesses. Their conclusions differed on whether a change in Resident 2's condition had occurred such that her doctor should have been called again. I find the testimony of the registered nurse called by Petitioner to be more persuasive on this issue.

The registered nurse called by HCFA testified that the physician should have been called again, to up-date the physician, when, over the two days following the fall, the resident sometimes complained of being dizzy, sometimes not, and one time complained of being very dizzy; and, four days after the fall, there was discoloration of the forehead and around the eyes. Tr. 160. On cross-examination, the HCFA witness expanded her opinion to state that the physician should have been called each time the resident complained of being dizzy, if it was a change, and with each complaint of headache, and when bruising appeared on the resident. Tr. 204, 205.

I disagree. Resident 2 was dizzy before she hit her forehead. She explained to the CNA who found her on the floor that she felt dizzy and fell to the floor. HCFA Ex. 5 at 6; P. Ex. 2 at 2. During the monitoring of her condition and her complaints during the following three days, she had dizziness at some times and not at other times. I find that her complaint of being "very dizzy" on March 27, 1997, at 10:00 p.m., was not a significant change in her condition, given the dizziness she had reported the previous afternoon and evening. At 2:00 p.m., three hours after she was found, she had no complaints; at 3:15 p.m., she reported dizziness and pain in her left upper arm; at 5:30 p.m., she reported dizziness and reduced pain in her left upper arm; at 9:00 p.m., she reported no dizziness and no pain in her left upper arm. HCFA Ex. 5 at 6 - 9; P. Ex. 2 at 2 - 5. At 9:45 p.m. she denied any headache or pain to her left lower arm, and the nurse's notes at 9:45 p.m. are an example of the monitoring being done [abbreviations and nursing terminology left intact]:

> [r]esident remains oriented to self only. Left lower arm remain disclored. small open area noted on left hand between 2 & 3rd digits. Skin tear noted to mid left forearm. Op site applied to area. discloration noted with slight edema to left forehead. Skin intact to forehead continues to deny any H/A [headache] or pain to left lower arm.
>
> HCFA Ex. 5 at 7; P. Ex. 2 at 3.

Furthermore, Resident 2's dizziness had been reported when Dr. Stern's order for a skull x-ray was relayed to the x-ray unit. P. Ex. 2 at 3. Her dizziness continued an off-and-on course, as did her headache and her arm discomfort, throughout the three-day period following her fall. Also, the discoloration and slight swelling that became increasingly evident during that three-day period were not a change in her condition but were merely the expected course of her injury. I find there was no change in her condition that warranted calling Dr. Stern again. My findings are supported by the testimony of the registered nurse called by Petitioner. Tr. 278 - 281, 336 - 340.

HCFA maintained that Petitioner neglected Resident 2 by failing to notify her physician "of all the changes in the resident's condition." HCFA Ex. 4 at 6. Failure to notify the physician in Resident 2's case is claimed to be an example of failure to

adequately implement procedures which prohibit neglect[6] in the care of residents.

To further my evaluation of whether there was any significant omission in Resident 2's care, I take administrative notice of the decision of Administrative Law Judge Steven T. Kessel in the case of Lake City Extended Care Center, DAB CR494 (1997). In Lake City, Judge Kessel evaluates whether the facility's failure to report a resident's fever exceeding 101 degrees to the resident's treating physician was a failure to follow a professionally accepted standard of care. Although the alleged deficiency before Judge Kessel was cited under the quality of care regulation, his analysis is helpful here. He concludes: "[t]he standard of care is that a long-term care facility should report a fever when the fever indicates a significant deterioration in the resident's condition." Lake City, at 14 -15 and see 20 - 21. He continues, "[t]he standard of care, either in the case of a fever or in the case of other problems, such as respiratory distress, is to notify a resident's physician of any change in the resident's condition which shows a significant deterioration in that resident's condition." Lake City, at 28.

Regarding Resident 2 in this case, there is no evidence showing a significant deterioration in her condition. Specifically, Resident 2's complaint on March 27, 1997, at 10:00 p.m., of being "very dizzy," was not a significant deterioration in her condition. The nursing staff took into account not only her complaint, but also much other data, for example, her vital signs and neurochecks staying within the normal range, her skull x-ray being negative, their observations, and her history.

The most pertinent language in the regulations is helpful here. The facility is to consult with the resident's physician when there is a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications). 42 C.F.R. § 483.10(b)(11). Although that regulation is not cited regarding Resident 2, it is nevertheless instructive.

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[6] Careful reading of 42 C.F.R. § 483.13 persuades me that it is entirely inapplicable here. This regulation is directed against medically unnecessary use of restraints, abuse, corporal punishment, involuntary seclusion, mistreatment, neglect, and misappropriation of resident property. This regulation is not meant to address every type of policy or procedure which addresses resident care. Resident 2's situation is actually a question of compliance with a general nursing standard of care, which is better addressed under 42 C.F.R. § 483.25 Quality of care.

Careful review of the Neurological Assessment and the nurses' notes leads me to conclude that Petitioner adequately implemented procedures which prohibited neglect of Resident 2. There was no failure to meet participation requirements, and further, I am impressed not only with the frequency of the attention given to Resident 2, but also with the quality of the care the record reflects that Resident 2 apparently received. HCFA Ex. 5 at 6 - 10; P. Ex. 2 at 2 - 5.

Resident 14

No one alleged that Resident 14 was mistreated or abused. Rather, HCFA alleges that Petitioner failed to prohibit neglect of Resident 14 by failing "to investigate the reasons for the frequent falls by the resident." HCFA Ex. 4 at 7. Petitioner asserts that it did investigate, and the HCFA 2567 contains an acknowledgement that Petitioner did investigate: "[i]nvestigation of the falls by the facility resulted in referring the resident for physical therapy 5 times/week in March 1997." Id.

What HCFA expects from Petitioner is a thorough investigation of every injury, every incident, every accident, every fall. The regulation, 42 C.F.R. § 483.13(c), requires a thorough investigation of "all alleged violations involving mistreatment, neglect, or abuse, including injuries of an unknown source." There is no allegation of mistreatment, neglect, or abuse. Further, Resident 14's injuries are not of an unknown source, as I explain below.

What the HCFA 2567 actually calls into question, somewhat obliquely, is the appropriateness of Resident 14's Risperdal prescription. The HCFA 2567 cites Resident 14's situation also under a separate tag for the April survey, tag F 329. The regulation for tag F 329 specifies that a drug regimen must be free from unnecessary drugs. HCFA Ex. 4 at 14 - 17. The discussion of the Risperdal prescription is more complete at Section I.D., below.

Resident 14 had fallen two times in February 1997 and two times in March 1997. HCFA Ex. 4 at 6. Resident 14's treating physician, Dr. Stern, and consulting psychiatrists, Drs. Schvehla and Dreyfuss, were trying to control Resident 14's agitation and delusions without sedating her, a difficult balance. HCFA Ex. 5 at 11 - 19. She tended to sleep all day and wander all night, and facility staff observed, "she has to be watched at all times." P. Ex. 2 at 22. Resident 14 could be quite combative and of potential danger to herself and to other residents, according to Dr. Stern's notes written in December 1996. P. Ex. 2 at 14.

Resident 14's diagnoses included a delusional disorder, marked or severe agitated dementia, progressing Alzheimers' disease, and a seizure disorder. P. Ex. 2 at 9 - 19. Dr. Stern's treatment plan in January 1997 was "[m]aintain basic supportive care. Has very advanced dementia." P. Ex. 2 at 14.

Given Resident 14's condition, including her agitated endless wandering, and her seizure disorder, her falls were not likely preventable. See Section I.D., below. Petitioner was well aware of her falls and had thoroughly investigated them. Petitioner had many interventions in place and invested an inordinate amount of time and effort to address her many difficulties and to try to prevent her from falling. I conclude that Petitioner adequately implemented procedures which prohibited neglect of Resident 14.

B. One regulation subsection cited following the April survey, 42 C.F.R. § 483.15(e)(1), states:

> 42 C.F.R. § 483.15 Quality of life. A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.
>
> > (e) Accommodation of needs. A resident has the right to--
> >
> > (1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered . . .

42 C.F.R. § 483.15(e)(1); HCFA Ex. 4 at 7 - 11.

To support the allegation that Petitioner failed to comply with this requirement, the situations of three residents, Residents 10, 9, and 5, are detailed at tag F 246 on the HCFA 2567.[7] The specific allegation is that Petitioner failed to provide reasonable accommodations to each resident based on individual needs and preferences. HCFA Ex. 4 at 7 - 11.

Resident 10

Petitioner chose to keep Resident 10's privacy curtain closed, in accordance with the request of Resident 10's family. Keeping the privacy curtain closed was necessary to accommodate Resident 10's individual needs and preferences, unless so doing endangered Resident 10's health or safety.

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[7] Although the HCFA 2567 also cites a deficiency at paragraph #2 of tag F 246, HCFA does not rely on this alleged deficiency to support Petitioner's termination, and I do not discuss it here. P. M. Str. at 4; HCFA R. Str.

Resident 10 had a tracheostomy, and HCFA's concern was whether nursing staff would be aware of a need to suction her tube, in order to maintain the airway. Tr. 170 - 171. Resident 10 had had a stroke and was aphasic (unable to communicate by speech, writing, or sign, or to comprehend written or spoken language) and at least partially paralyzed. She could not speak, and she could not use her hands, so she could not use a call bell or signal for help. HCFA's original emphasis regarded the call bell, and whether Resident 10's position, with the head of her bed elevated, prevented her from using it. When testimony revealed that Resident 10's condition prevented her from using her call bell at all, HCFA stressed its contention that Resident 10's closed privacy curtain prevented adequate monitoring by staff. Tr. 205, 376, 378, 379, 546 - 550.

Had the privacy curtain been kept open, Resident 10 would have been more visible from the hallway, but Resident 10's bed was on the far side of the room. There is no evidence that Resident 10 being more visible from the hallway would have made a difference in the monitoring of her tracheostomy tube. No assertion is made that Resident 10 required intense monitoring, as could be provided only in a hospital. No evidence suggests that the staff failed to monitor Petitioner's condition adequately, including her tracheostomy. Petitioner reasonably accommodated Resident 10's individual needs and preferences, and I find no deficiency here.

Resident 9

Resident 9 was not able to reach her call bell while she was sitting in a chair on one side of her bed, and her call bell was attached to the far side of her bed. Resident 9 had a urinary catheter. She stated she was having back pain and had not been able to request medication. The testimony indicated that the CNA had just brought Resident 9 out of the bathroom and left her beside the bed, when the CNA was called to help a nurse with another resident. The CNA left the room for less than a minute. Furthermore, Resident 9 could move about in her wheelchair. Tr. 376 - 378; P. Ex. 2 at 37 - 43. HCFA did not brief this deficiency, implying that the potential for harm was no more than minimal. HCFA Br. at 16. I find no deficiency here; Petitioner reasonably accommodated Resident 9's individual needs and preferences.

Resident 5

Resident 5 was having trouble reaching his food from his geri-chair. The plate guard did not stay in place. He complained that he was not getting enough food and that it was hard for him to reach his utensils and his food. Petitioner's consultant dietician testified that she had spent multiple follow-up visits with Resident 5, because he was very particular regarding his

food preferences and had a tendency to change his mind about what he liked. Therapy had also worked with him, regarding the fit between his chair and table. Sometimes he used a pillow in his chair for support and sometimes he did not. Tr. 436 - 440; P. Ex. 2 at 44 - 50. The evidence, taken as a whole, indicates that Petitioner reasonably honored Resident 5's requests, given his frequent changes of preference. I find no deficiency here; Petitioner reasonably accommodated Resident 5's individual needs and preferences.

C. One regulation subsection cited following the April survey, 42 C.F.R. § 483.15(h)(2), states:

> 42 C.F.R. § 483.15 Quality of life. A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.
>
> > (h) Environment. The facility must provide--
> > (2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;
>
> 42 C.F.R. § 483.15(h)(2); HCFA Ex. 4 at 12 - 14.

To support the allegation that Petitioner failed to comply with this requirement, observations are detailed at tag F 253 on the HCFA 2567. The specific allegation is that Petitioner was not maintained in a sanitary, orderly, and comfortable manner. HCFA Ex. 4 at 12 - 14.

Housekeeping and maintenance problems concerned air conditioning vents and units in several rooms, privacy curtains in two rooms, a closet and a mirror in one room, a geri-chair, the floors of two showers, the hose under a bathroom sink, a paper towel rack, a pair of latex gloves at the foot of a bed, and a shower chair.

Two of these identified problems, mold on one air conditioning vent, and a broken arm and exposed screw on one shower chair, might have led to a finding of a deficiency had they been indicative of a systemic problem. There was just one occurrence of each, however, and I do not believe that these incidents, standing alone, constitute a deficiency. HCFA Ex. 4 at 12, 13. Also, I do not believe that the housekeeping and maintenance allegations combined constitute a deficiency, as indicated below.

The dust and baby powder and small amounts of rust on the air conditioning vents may have been unsightly to some people. However, Petitioner dusted the vents weekly and thoroughly cleaned and painted them annually. Tr. 389, 390. Moreover, there was no evidence that the rust, dust, and baby powder caused residents or their visitors any discomfort.

The other housekeeping and maintenance items strike me as similar in that regard, and a few were quite temporary: the geri-chair with food particles, dried liquid and dust; the soiled latex gloves at the foot of a bed; the hose under the bathroom sink and the two shower floors with a brown substance on them; and the mirror above the hand washing sink which was covered with water splashes. Others, though not as temporary, also seemed to cause no discomfort or other problem: the reflective material missing from the mirror base; stains on two privacy curtains; rust on a paper towel rack; the strip of baseboard that had come loose and was pulled away from the wall under an air conditioner; the base of a closet warped and bulging; and the displaced front panel of an air conditioner vent.

Testimony confirmed that a shower floor was promptly cleaned and sanitized if a resident relieved himself while being bathed and that the environment was safe, sanitary, and clean. Tr. 388 - 394. The total of these housekeeping and maintenance items is not significant, and, again, did not constitute a systemic breakdown of Petitioner's housekeeping and maintenance. Further, there was no actual harm, and any potential was for no more than minimal harm.

D. One regulation subsection cited following the April survey, 42 C.F.R. § 483.25(l)(1), states:

> 42 C.F.R. § 483.25 Quality of care. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
>
> > (l) Unnecessary drugs-(1) General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:
> > (i) In excessive dose (including duplicate drug therapy); or
> > (ii) For excessive duration; or
> > (iii) Without adequate monitoring; or
> > (iv) Without adequate indications for its use; or
> > (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
> > (vi) Any combinations of the reasons above.
>
> 42 C.F.R. § 483.25(l)(1); HCFA Ex. 4 at 14 - 17.

To support the allegation that Petitioner failed to comply with this requirement, the situations of two residents, Residents 14 and 13, are detailed at tag F 329 on the HCFA 2567. The specific allegation is that Petitioner failed to ensure that each

resident's drug regimen was free of unnecessary drugs. HCFA Ex. 4 at 14 - 17.

Resident 14

Resident 14 was discussed above in Section I.A. regarding alleged neglect. Resident 14 had fallen two times in February 1997 and two times in March 1997. HCFA Ex. 4 at 6. Resident 14 tended to sleep all day and wander all night, and facility staff observed, "she has to be watched at all times." P. Ex. 2 at 22. Resident 14's treating physicians prescribed the antipsychotic drug Risperdal (P. Ex. 2 at 8), to address her agitation and delusions, disrupted sleep, and "sundowning" symptoms. P. Ex. 2 at 11 - 19.

HCFA faults Petitioner for not emphasizing Resident 14's falls to her treating physicians, suggesting that Risperdal may have contributed to the falls. HCFA alleges also that Petitioner's paperwork shows no indication for an antipsychotic drug, that the symptom of "continuous yelling" or "yelling" is an inadequate cause to prescribe Risperdal and that Petitioner should have initiated more attempts to influence Resident 14's physicians to reduce her dose of Risperdal.

Resident 14's treating physicians, and she had three of them, including two consulting psychiatrists, carefully evaluated her psychotropic regimen. They took Resident 14's falls into account. They analyzed, reduced, restored, and increased the dose of Risperdal. P. Ex. 2 at 11 - 19. They were trying to control Resident 14's agitation and delusions without sedating her, a difficult balance. Resident 14 could be quite combative and of potential danger to herself and other residents, according to Dr. Stern's notes written in December 1996. P. Ex. 2 at 14. I find that Petitioner's interaction with Resident 14's treating physicians was appropriate and effective. There is no evidence that Resident 14 was given any unnecessary drugs, and I find no deficiency here.

Resident 13

Resident 13 was admitted on a Friday evening, March 28, 1997, at 8:30 p.m. P. Ex. 2 at 55, 56. Orders from the transferring facility were not received until 11:00 p.m. Tr. 297 - 299. The survey was done less than four days later, on Tuesday, April 1. Petitioner administered Resident 13's medications as those medications had been ordered prior to Resident 13's admission to Petitioner's facility.

The HCFA 2567 indicates that administering those medications, which included two antidepressants, with no indication of need, was administering unnecessary drugs. There is no evidence that giving Resident 13 his two prescribed antidepressant medications

was giving him unnecessary drugs. There was no contraindication. As of the date of the April survey, Petitioner had not yet had adequate time to assess Resident 13's situation. It was appropriate for Petitioner to follow the physician's orders regarding Resident 13's medications, which is what Petitioner did. P. Ex. 2 at 53 - 56. There is no evidence that Resident 13 was given any unnecessary drugs, and I find no deficiency here.

II. Petitioner was not in substantial compliance with Medicare participation requirements at the time of the July survey.

At issue from the July survey are two categories of alleged deficiency, discussed in sections A and B, below.

A. One regulation subsection cited following the July survey, 42 C.F.R. § 483.13(c)(1)(i), states:

> 42 C.F.R. § 483.13 Resident behavior and facility practices.
>
> > (c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
> > (1) The facility must-
> > (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
>
> 42 C.F.R. § 483.13(c)(1)(i); HCFA Ex. 7 at 1.

To support the allegation that Petitioner failed to comply with this requirement, the situation of one resident, Resident 3, is detailed at tag F 224 on the HCFA 2567. HCFA Ex. 7 at 1 - 4. The specific allegation is that Petitioner failed to adequately implement procedures which prohibit neglect in the care of residents.[8]

Resident 3

The State surveyor observed Resident 3 walking in the facility with a splint on her left wrist. Review of the nurses' notes for June 28, 1997, at 5:00 p.m., indicated that Resident 3 sustained an injury to her left wrist during a physical altercation with another resident in the dining room. This altercation began when Resident 3 was seated at another resident's table in the dining room. The other resident grabbed Resident 3's arm; Resident 3 pulled her arm away; and the other resident fell down (Tr. 242). Immediately following this incident, Resident 3 complained of

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[8] Footnote 3 regarding the April survey is applicable here to the July survey also.

pain to her left forearm, an ice pack was applied, and her forearm was elevated in a sling. At the time, no swelling or discoloration was noted. Nurses' notes of that date further document that Resident 3's family was notified of the incident at 5:20 p.m. However, there is no documentation in the nurses' notes of that date that Petitioner notified Resident 3's physician, although the facility notified the physician of the resident who fell down (Id.). On June 29, 1997, Resident 3 did not complain of pain; however, at 8:00 p.m., nurses' notes indicate swelling and discoloration of Resident 3's left forearm. There is no documentation her physician was called. On June 30, 1997, Resident 3 complained of pain at 11:00 a.m. and she was given Tylenol. At 1:30 p.m. her physician was called. He ordered an x-ray, which was done at the facility and revealed a possible non-displaced fracture of the distal ulna shaft. On July 1, 1997, at 10:00 a.m., Petitioner made an appointment for Resident 3 to see an orthopedic physician. On July 1, 1997, physical therapy put a splint on Resident 3's left wrist and hand. As of July 2, 1997, Resident 3 had not been examined by a physician. HCFA Ex. 7 at 2, 4; HCFA Ex. 8 at 21 - 25; P. Ex. 3 at 2 -3.

HCFA alleges that at the July 2, 1997 exit conference, Petitioner's Director of Nursing stated that no facility incident report was completed on the June 28, 1997 incident and that facility procedure requires physician notification of an incident as soon as possible. HCFA Ex. 7 at 4.

Petitioner argues that there was no indication of a need to call a physician on June 28, 1997 and that Petitioner provided appropriate nursing care to Resident 3. Petitioner asserts that Resident 3 was monitored closely for problems and denied any pain; once Resident 3 complained of pain for the first time (on June 30, 1997, at 11:00 a.m.) a physician was called. According to Petitioner, the decision as to when to call the physician was a nursing judgment, and there was no neglect. P. Br. at 12 - 14; P. Ex. 3 at 1.

Petitioner's policy on dealing with "incidents" states that an incident report will be given to the assistant director of nursing immediately after documentation of an incident is completed; a resident's physician and family member must be notified as soon as possible after the incident and the assessment of the resident (unless the incident occurs on the 11:00 p.m. to 7:00 a.m. shift, where the physician's answering service is to be notified and a message left and, if the resident has not incurred an injury, the family member must be notified before going off duty at 7:00 a.m.). HCFA Ex. 8 at 69; Tr. 521, 522.

While the facility may argue that this incident involves only a disagreement concerning nursing judgment and no neglect (P. Br.

at 13, 14), I fail to understand why such a serious altercation, involving injury, was not documented on some kind of incident assessment form.[9] The failure to prepare an incident report is a failure to meet the participation requirement.

HCFA argues that Petitioner's policy prevents neglect, because it provides a resident services (such as evaluation and or treatment by a physician), that are necessary to avoid physical harm, particularly following an "incident," which would be something unknown in a resident's medical chart. HCFA Br. at 27. HCFA argues further that an "incident" such as a fall or altercation, requires physician notification, because of the risk, especially in the elderly, of a fracture. HCFA Ex. 21 at 17. This comports with Petitioner's policy requiring physician notification as soon as possible after an incident, at least where there is an injury. HCFA Br. at 26 - 30.

I agree with HCFA that Resident 3's physician should have been called as soon as possible after the altercation between these two residents and that Petitioner's failure to timely call Resident 3's physician places Petitioner in violation of this participation requirement. Petitioner questions whether an "incident" occurred here (P. R. Br. at 6), but I fail to see how it can be termed anything else.[10] The physical altercation between two residents (resident to resident abuse) led to the injury to Resident 3's wrist, which was immediately painful (HCFA Ex. 8 at 24; P. Ex. 3 at 2), and to the other resident's fall. Petitioner is wrong when it states that Resident 3 did not complain of pain until June 30. Facility records indicate that Resident 3 first complained of pain on June 28, in response to which ice was applied to her left forearm and her forearm was elevated in a sling. Id. However, inexplicably, while a physician was called for the other resident (as per Petitioner's policy), no physician was called for Resident 3 until June 30, 1997. Petitioner has not supplied a reasonable explanation as to why a physician was not called for Resident 3, especially in light of the fact that her arm was injured and in light of her

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[9] Petitioner's policy regarding incident reports requires that both a physician and a relative or guardian be notified as soon as possible after an incident and assessment of a resident. HCFA Ex. 10 at 14.

[10] Petitioner's employees considered this an "incident," as nurses' notes of June 28, 1997, at 5:20 p.m., state that Resident 3's son was, "notified of incident." HCFA Ex. 8 at 24; P. Ex. 3 at 2.

age.[11] Petitioner also has not offered a satisfactory explanation for not following its own policy, which would require a physician to be called; Petitioner did not adequately implement a policy it recognized as necessary to prevent neglect. See 42 C.F.R. § 483.10(b)(11).

The applicable portion of the State Operations Manual defines "neglect" as a failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs on an individual basis when a resident receives a lack of care in one or more areas.[12] HCFA Ex. 15 at 3. The potential for harm is more than minimal in this case, because Resident 3 did not receive needed care in a timely manner. HCFA Ex. 21 at 19.

B. One regulation subsection cited following the July survey, 42 C.F.R. § 483.20(d)(2), states:

> 42 C.F.R. § 483.20 Resident assessment.
>
> The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.
>
> (d) Comprehensive care plans. (2) A comprehensive care plan must be--
>
> (i) Developed within 7 days after completion of the comprehensive assessment;
>
> (ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's

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[11] Petitioner contends that Resident 3 was not frail, relying on testimony from individuals who know her. P. Br. at 13. Whether Resident 3 can be termed "frail" is less significant than the testimony of the State surveyor that, because Resident 3 is an elderly woman, she has a risk of osteoporosis, making it more likely that there would be a fracture with this type of injury. HCFA Ex. 21 at 17.

[12] The State Operations Manual's actual language reads "[n]eglect occurs on an individual basis when a resident does not receive a lack of care in one or more areas." There is an obvious error here by the inclusion of the words "does not." The definition means to say that neglect occurs when a resident receives a lack of care in one or more areas. HCFA Ex. 15 at 3.

family or the resident's legal representative; and

(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.

42 C.F.R. § 483.20(d)(2). HCFA Ex. 7 at 4 - 8.

To support the allegation that Petitioner failed to comply with this requirement, the situations of four residents, Residents 5, 8, 9, and 2, are detailed at tag F 280 on the HCFA 2567. The specific allegation is that Petitioner failed to complete an interdisciplinary comprehensive care plan on all residents.

Residents 5, 8, and 9

All three of these residents were being seen by mental health providers outside Petitioner's facility; Resident 5 was attending an outpatient mental health facility, and Residents 8 and 9 were being treated by a licensed clinical social worker. P. Ex. 3 at 16, 20, 21, 23 - 26. For each of these residents, there was a comprehensive care plan in place, which included a statement that the resident was being treated by mental health providers outside Petitioner's facility. Tr. 490 - 493; P. Ex. 3 at 11, 20, 24. The care plan prepared by Petitioner was separate from care plans prepared by the outside mental health providers and Petitioner's care plans led the reviewer to the mental health providers' care plans. Tr. 522 - 524; HCFA Ex. 8 at 30, 33 - 39, 50, 54, 62; P. Ex. 3 at 16, 20, 21, 23 - 26. The issue here is whether Petitioner is required by this regulation to integrate the outside mental health providers' care plans into its care plan or require Petitioner to have the outside mental health providers come (or at least invite them to come) to care plan meetings.

HCFA argues that the regulation does not limit participation at interdisciplinary team meetings to employees of Petitioner's staff. Rather, HCFA says the regulation envisions that other professionals will participate as determined by a resident's needs. HCFA Br. at 31. Further, HCFA asserts that a care plan is the document central to "drive" a resident's care. It includes active problems that a resident is having and what the nursing and medical staff are going to do to address those problems and assist the resident to attain or maintain their highest practicable level of well-being. HCFA Ex. 21 at 19, 20. The care plan should be coordinated to ensure that there are not conflicting goals among caregivers and that the information discovered by the outside caregiver is utilized by the facility to the maximum extent possible; it requires more than a showing that the facility references the outside therapy in its care plan. HCFA Br. at 31, 32.

While I agree with HCFA that the regulation does not limit participation at interdisciplinary team meetings to employees of

Petitioner's staff, I do not agree with HCFA that the regulation requires Petitioner to at least invite outside providers to attend meetings. The designation of "appropriate staff" must refer to individuals who are under the control of a facility and can be required to attend a meeting. (The State Operations Manual does provide that meetings need not be face-to-face, but can be by telephone or by written communication. These provisions are found in the Provider Certification, Appendix P, Survey Protocol For Long Term Care Facilities, at PP-78.). With regard to the coordination of the care plans, I do not believe that the regulation imposes upon facilities the burden to integrate the reports of every outside health care provider within a care plan. In this case, it is sufficient that the outside mental health providers' care plans were referenced in the facility's care plans, and included in the residents' records, in that they were available to Petitioner's personnel, both those personnel providing care to these residents and to the members of the interdisciplinary teams preparing their care plans. Petitioner's comprehensive care plans for these three residents were thus adequate, and I find no deficiency here.

Resident 2

Here, the deficiency in issue is HCFA's finding that information in Resident 2's record indicated a potential for falls which was not incorporated in Resident 2's care plan and also that no care plan was completed to address restraints. HCFA Ex. 7 at 6 - 8; HCFA Br. at 33 - 35.

Resident 2 was admitted to Petitioner's facility on December 30, 1996. Her initial care plan (dated January 3, 1997) indicated that she had a potential for falls and that she should be kept "accident free (from falls)." HCFA Ex. 8 at 13. On a January 3, 1997 Specialized Rehabilitation Screening Form, an occupational therapist considered a bed restraint for Resident 2 to prevent a risk of falling. HCFA Ex. 8 at 7. An occupational therapist screened Resident 2 on January 6, 1997 and issued an addendum to the screening on January 14, 1997. At both evaluations, the occupational therapist noted that Resident 2 was attempting to climb over the side rails of her bed and sticking her legs through the side rails. The occupational therapist noted that she was at risk for injury. HCFA Ex. 8 at 6. The therapist initially recommended side rail pads, then recommended that the rails be left down for safety. Id. On January 22, 1997, occupational therapy again screened Resident 2 for safety, at nursing's request. The therapist found that Resident 2 was not a "safe ambulator," and that she attempted to stand from her wheelchair and slid forward on her seat. The therapist recommended the use of a lap buddy to prevent falls. HCFA Ex. 8 at 8. Although both Resident 2's initial care plan and her occupational therapy screenings noted a potential for falls, Resident 2's first comprehensive care plan, completed on January

24, 1997, did not include a prevention program for falls (her initial Minimum Data Set [MDS] did not indicate falls prior to admission, but did indicate that she had an unsteady gait). HCFA Ex. 8 at 16; P. Ex. 3 at 30 - 33.

On February 2, 1997, a physician ordered a safety belt restraint for Resident 2's wheelchair. HCFA Ex. 7 at 7. On April 6 and April 25, 1997, Resident 2 slid out of her wheelchair and was found sitting on the floor. Id. Resident 2's quarterly MDS was completed on April 17, 1997. It documents that Resident 2 fell within the past 30 days. HCFA Ex. 8 at 16; P. Ex. 3 at 29. It also documents that side rails and trunk restraints were being used. HCFA Ex. 8 at 15. However, Resident 2's care plan was not changed to reflect the physician's order for restraints, her fall (the fall on April 25, 1997 occurred after the quarterly MDS was prepared), or the restraints being used. P. Ex. 3 at 30.

Petitioner asserts that: Resident 2 had no history of falls when she was admitted to the facility; the January 24, 1997 care plan did not address falls, as there had been none; and a care plan need only be reviewed every three months. Moreover, the "lap buddy" restraint ordered by Resident 2's physician is the least restrictive restraint and would include the conditions under which it was to be used. As of April 17, Resident 2 had been found on the floor only one time, and the second fall was after the quarterly review of April 17. Since neither incident resulted in injury, Petitioner contended that one incident does not necessarily require a revision to a resident's care plan. Furthermore, the next quarterly review, due in July, would have addressed the second incident; the care to be provided regarding the restraint was specified in the physician's order. P. Br. at 16. Petitioner argues that Resident 2 had a care plan, and HCFA's contention that Resident 2's care plan should have included more goes beyond the regulatory requirement. P. Br. at 16. I disagree.

A care plan is the central document determining the care a resident receives. HCFA Ex. 21 at 28, 29. Here, the initial care plan prepared for this resident recognized that a potential for falls existed, a concern which was echoed in the occupational therapy screening. Inexplicably, given the results of her occupational therapy screenings and her initial care plan, Resident 2's comprehensive care plan did not include any mention of the potential for falls. It should have. The occupational therapist's recommendations should have been incorporated into the care planning so that Resident 2's care plan addressed her need for a fall prevention care plan. Further, the April 6 incident, where Resident 2 slid out of her wheelchair, should also have caused Petitioner to revise the Resident's care plan--both for fall prevention and to assess the adequacy of restraints. Certainly as of April 17, 1997, this should have been done. Petitioner's argument that a reassessment could have

waited until the quarterly review is unavailing. A care plan should be changed if there is a significant change in a resident's condition. See 42 C.F.R. §§ 483.20(b)(4)(iv), 483.20(b)(5) - (6).

Here, where Resident 2 was falling from her wheelchair, where restraints weren't working and could even harm her, it was Petitioner's duty to revise the comprehensive care plan to come up with strategies to deal with these falls. I agree with HCFA that, without a care plan in place outlining care that could potentially reduce the likelihood of falls, Resident 2's likelihood of falling is increased. Additionally, without a care plan addressing her physician's orders regarding the restraints, she was at increased risk, considering she slid out of her wheelchair twice while the restraints were in place. HCFA Ex. 21 at 57. The potential for more than minimal harm exists here.

III. Petitioner was not in substantial compliance with Medicare participation requirements at the time of the August survey.

Following the August survey, HCFA cited Petitioner with deficiencies in three categories, discussed in sections A through C, below.

A. One regulation subsection cited following the August survey, 42 C.F.R. § 483.13(b), states:

> 42 C.F.R. § 483.13 Resident behavior and facility practices.
>
> > (b) Abuse. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.
>
> 42 C.F.R. § 483.13(b); HCFA Ex. 11 at 1.

To support the allegation that Petitioner failed to comply with this requirement, the situation of two residents, Residents 12 and 5, is detailed at tag F 223 on the HCFA 2567. The specific allegation is that Petitioner failed to take action to prevent the reoccurrence of resident to resident abuse. HCFA Ex. 11 at 1 - 3.

Residents 12 and 5

Both Residents 12 and 5 are cognitively impaired. HCFA Ex. 11 at 1, 2; HCFA Ex. 12 at 56, 89. On June 28, 1997, these two residents were involved in a physical altercation between 4:00 and 5:00 p.m., in the facility's dining room, resulting in the fracture of Resident 5's wrist. This incident is referenced above as a deficiency during the July survey (see section II.A.

above).[13] Resident 12 appears to have been territorial about her seat in the dining room and became physically aggressive toward Resident 5 over that seating.[14] Following the incident on June 28, 1997, Petitioner seated the two at opposite sides of the dining room. Petitioner determined that the incident was an isolated occurrence and that no further action was appropriate. Neither resident's care plan was changed to address the problem of physical aggression. HCFA Ex. 11 at 2; P. Ex. 4 at 1.

On July 6, 1997, a second physical altercation occurred between these two residents in the facility's dining room. A dietary aide saw Resident 12 push Resident 5 down to the floor. Again, the incident occurred between 4:00 and 5:00 p.m. and related to seating in the dining room. Following the incident, Resident 5 complained of pain in her left hip/thigh and coccyx area. She was sent to the hospital for x-rays, which were negative. HCFA Ex. 11 at 2; HCFA Ex. 12 at 61, 92; P. Ex. 4 at 1, 2.

HCFA alleges that Petitioner's staff did not include this problem in the care plan and thereby take action to prevent a recurrence of resident to resident abuse until August 14, 1997, the date of the August survey. HCFA Ex. 11 at 2; P. Ex. 4 at 13.[15] In an August 14, 1997 revision to Resident 12's care plan, prepared at the recommendation of the State surveyor, Petitioner noted that

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[13] During the July survey, Resident 12 is referred to only as an un-named Resident, and Resident 5 is identified as Resident 3. See HCFA Ex. 7 at 2; P. Ex. 4 at 1.

[14] In its response brief, Petitioner asserts that the State surveyor's attribution of a comment allegedly made by a staff member that Resident 12 was known to be territorial was refuted by the staff member's affidavit (P. Ex. 8), and there is no evidence that there was a reason to suspect a continuing issue between the two Residents. P. R. Br. at 7. However, the record reflects that the issue between the two residents during the altercations of June 28 and July 6, 1997, involved seating in the dining room. To that extent, it is appropriate to describe Resident 12 as being territorial about her seat in the dining room. Further, the affidavit reflects only that the staff member in question never told the State surveyor that there was an ongoing problem between the two residents and that the incident on July 6 was unexpected and could not have been predicted. It does not refer to Resident 12 as being either territorial or not territorial about her seating.

[15] The record reflects a third incident of aggressive behavior on the part of Resident 12. Specifically, on July 9, 1997, nurses' notes document an outburst of aggressive behavior related to another resident sitting at Resident 12's table. The two residents were separated by staff. HCFA Ex. 12 at 93.

to prevent such episodes of physical abuse it would redirect Resident 12 when her behavior escalated, obtain orders for a psychiatric evaluation, monitor her behavior in group situations, and provide supervision, especially regarding interactions in the dining room, where both times her physical altercations occurred. Tr. 533; P. Ex. 4 at 13.

Here, I agree with HCFA that, immediately following the July 6, 1997 altercation until the August survey, Petitioner did not take adequate action to prevent resident to resident abuse. While separating the residents in the dining room after the June 28, 1997 altercation may have been an adequate response to an isolated incident (Tr. 244, 245, 495 - 498),[16] it became evident that such intervention was inadequate after the July 6, 1997 altercation. The second altercation, occurring within two weeks of the June 28, 1997 altercation, should have alerted Petitioner that its intervention (separating the two residents in the dining room) was not working. To comply with this section of the regulations, Petitioner should then have taken additional action to prohibit the recurrence of Resident 12's physical abuse of Resident 5.

While there is no evidence of any third incident between these two residents, Resident 12 was involved in another altercation involving dining room seating on July 9, 1997, with a resident other than Resident 5. Resident 12's physically aggressive behavior, behavior that was new for Resident 12 as of June 28, 1997, should have been addressed immediately upon being repeated on July 6. Petitioner failed in its procedures to prevent resident abuse, not even preparing an incident report[17], [18] and failing to provide supervision as Resident 12's aggression became apparent.

Further, Resident 12's actions caused actual harm to Resident 5 on July 6, 1997; Resident 5 was pushed down, and she complained

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[16] No additional interventions, such as increased supervision by Petitioner to address the altercation between these two residents, were provided. Tr. 528, 529.

[17] Petitioner should have promptly revised Resident 12's care plan to address her physically aggressive behavior, as I discuss below at section III.B.

[18] Interestingly, a July 9, 1997 nurses' note in Resident 12's record documents Resident 12's aggression in the dining room and states that Resident 12's family has been spoken to and that a psychiatric evaluation was ordered. Apparently, however, no psychiatric evaluation was done, as the August 14, 1997 care plan amendment states that the facility will "obtain orders for psych evaluation." P. Ex. 4 at 7, 13.

of pain to her left hip/thigh and coccyx area such that she was not able to bear weight on her left leg, necessitating her removal to a hospital for an x-ray. HCFA Ex. 12 at 61. The fact that the x-ray was negative or that Resident 5 did not sustain any lasting injury does not mean that no harm occurred. Further, as should reasonably have been foreseeable on July 6, 1997, not intervening to devise new strategies to deal with Resident 12's physical aggressiveness certainly left open the potential for more than minimal harm to Resident 5 and, potentially, to other residents, based on the facts known by the facility at the time.

B. One regulation subsection cited following the August survey, 42 C.F.R. § 483.13(c)(1)(i), states:

> 42 C.F.R. § 483.13 Resident behavior and facility practices.
>
> > (c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
> > (1) The facility must--
> > (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

42 C.F.R. § 483.13(c)(1)(i); HCFA Ex. 11 at 3.

To support the allegation that Petitioner failed to comply with this requirement, the situations of two residents, Residents 4, and 13, are detailed at tag F 224 on the HCFA 2567. HCFA Ex. 11 at 3 - 5. The specific allegation is that Petitioner neglected to take adequate action to prevent resident to resident abuse, and to investigate injuries to residents.[19]

Resident 4

On the morning of the August 14, 1997 survey, while touring the facility, the State surveyor noted that Resident 4 had bruising of approximately three-quarters of the top of her right hand. The State surveyor's document review of injuries to residents revealed that this injury was found by an activity worker on the morning of August 5, 1997. An incident report was prepared, the resident's physician was notified of the bruise, an x-ray was ordered, and the results were negative. When the State surveyor interviewed Petitioner's staff, however, the staff did not know how the resident's hand had been bruised. The State surveyor asked which staff member was responsible for tracking, trending, and investigating injuries, and the Assistant Director of Nursing

[19] Footnote 3 regarding the April survey is applicable here to the August survey also.

touring with the surveyor stated that he/she was. The Assistant Director of Nursing told the surveyor that no investigation of the incident was done to determine the etiology of the injury. The Director of Nursing told the surveyor that Resident 4 was unable to verbalize how the injury occurred, due to cognitive deficits. HCFA Ex. 11 at 3, 4; P. Ex. 4 at 17 - 21; Tr. 499. Subsequent to the survey, Petitioner determined that the bruising most likely occurred due to a blood draw. Tr. 499; P. Ex. 4 at 17, 18.

Here, HCFA's argument is that Petitioner did not develop and implement an effective system to protect residents from abuse and neglect because it did not do a sufficient investigation to determine the etiology of the bruise. HCFA Br. at 40; HCFA Ex. 21 at 64. Petitioner appears to have taken all appropriate actions in treating the bruising once it was found. HCFA Ex. 21 at 63 - 64; P. Ex. 4 at 17 - 21. Petitioner's only investigation, apparently, was to ask the resident about the bruise, and her cognitive deficits precluded her from providing an explanation. There was no evidence that the bruise was caused by mistreatment, neglect, or abuse. There was also no evidence that the bruise was not caused by mistreatment, neglect, or abuse. See Section I.A., above, regarding the requirement for a thorough investigation of injuries of unknown source.

Had Petitioner investigated further when the bruising was first apparent, Petitioner could have then discovered, as it did later, that the probable cause of the bruising was the blood draw, not mistreatment, neglect, or abuse. Petitioner's failure to complete a thorough investigation prevented it from knowing whether the bruising was a result of mistreatment, neglect, or abuse, and whether preventative measures were appropriate. The potential for injury here constitutes a potential for more than minimal harm. Consequently, Petitioner's failure to investigate the injury to Resident 4 is a failure to comply with the participation requirement.

Resident 13

Resident 13 was admitted to Petitioner's facility with a diagnosis of dementia and confusion. The HCFA 2567 indicates that nurses' notes documented eight episodes over a 12-day period, from July 19 - 31, 1997, of mood, behavior problems, periods of agitation and wandering into the rooms of other residents. The HCFA 2567 alleges that these behaviors escalated and culminated in a physical altercation which resulted in an injury to another resident. Here, HCFA asserts that Petitioner had not developed or implemented policies to effectively prevent abuse, because facility staff did not provide adequate supervision of this resident to prevent injury to another resident, which injury resulted in actual harm. HCFA Ex. 11 at 4, 5; HCFA Br. at 41. I do not agree.

The record does not reflect a pattern of escalation of behavior in which physical injury to another resident was foreseeable by Petitioner. Resident 13 was admitted to the facility with no history of behavior problems. P. Ex. 4 at 23 - 28. Nurses' notes reveal that while Resident 13 did wander and become agitated, his aggressive behavior was verbal only, was monitored, and that he responded to medication.[20] HCFA Ex. 12 at 103 - 107. On July 31, 1997, nurses' notes indicate that Resident 13 went into another resident's room, picked up a cane and got into a cane fight with the other resident, who sustained skin tears. HCFA Ex. 12 at 104. This is the first incident of physical aggression noted in Resident 13's record. While the other resident was harmed in this incident, Resident 13's history and behavior would not have led the facility to foresee that he would become physically aggressive with another resident. Thus, I find that, with regard to Resident 13, Petitioner did not neglect to take adequate action to prevent resident to resident abuse.

C. One regulation subsection cited following the August survey, 42 C.F.R. § 483.20(d)(1), states:

> 42 C.F.R. § 483.20 Resident assessment.
>
> The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.
>
> > (d) Comprehensive care plans. (1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describer [sic] the following--
> > (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under § 483.25; and
> > (ii) Any services that would otherwise be required under § 483.25 but are not provided due to the resident's exercise of rights under § 483.10, including the right to refuse treatment under § 483.10(b)(4).

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[20] HCFA alleges that Resident 13 wandered into a resident's room on July 25, 1997 and threatened to kill the resident. HCFA Br. at 41; HCFA Ex. 12 at 105, 106. However, my understanding of the nurses' note in question is that Resident 13 made a verbal threat to kill the staff member who was attempting to remove him from the other resident's room. Resident 13 does not appear to have been physically aggressive at this time. HCFA Ex. 12 at 105, 106.

42 C.F.R. § 483.20(d)(1); HCFA Ex. 11 at 5.

To support the allegation that Petitioner failed to comply with this requirement, the situations of two residents, Residents 12 and 2, are detailed at tag F 279 on the HCFA 2567. The specific allegation is that Petitioner failed to develop comprehensive care plans. HCFA Ex. 11 at 6, 7.[21]

Resident 12

The HCFA 2567 states that as of August 14, 1997, there was no care plan in place to address the problem of Resident 12's physical aggression toward Resident 5. HCFA Ex. 7 at 6. Resident 12, and the incident referred to here, were discussed above at section III.A.

I agree with HCFA that following the incident on July 6, 1997, and certainly sooner than August 14, 1997, Resident 12's care plan should have been revised to address her physically assaultive behavior, in order to maintain her highest physical, mental and psychosocial well-being (for instance, in order that she not harm others, incite others to harm her, maintain appropriate interaction with others, and learn to control her aggressive tendencies). HCFA Ex. 21 at 45; HCFA Br. at 42. Petitioner argues that Resident 12's physical aggression was an isolated incident that did not require a specific care plan and the fact that there was no recurrence after July 6, 1997 substantiates the staff's conclusion. P. Br. at 22, 23.[22] Petitioner's witness stated that not every incident requires a change in the care plan because a facility has 14 days to evaluate a resident to see if a problem is permanent. Tr. 509.

A facility has 14 days after the date of admission to conduct the initial assessment. After a significant change in a resident's physical or mental condition, an assessment must be conducted promptly. 42 C.F.R. § 483.20(b)(4). Certainly as of July 6, 1997, there was sufficient evidence which should have alerted Petitioner that new measures had to be taken, a view which should have been reinforced by the third altercation regarding Resident

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[21] In paragraph 1 on page six of the HCFA 2567 (HCFA Ex. 11 at 6), another deficiency under this part of the regulation is cited with regard to Residents 1, 4, 8, 10, and 12, regarding cognitive loss. HCFA has not addressed this deficiency citation and I do not consider it here.

[22] Although there is no evidence of a recurrence of the problem between Residents 5 and 12 after July 6, 1997, Petitioner ignores the third episode of aggressive behavior involving Resident 12 and another resident on July 9, 1997.

12's dining room seating which took place on July 9, 1997.[23] By 14 days after the June 28, 1997 incident, two more incidents of aggressive behavior had occurred. This should have been addressed by a change in Resident 12's care plan. Failure to do so is a deficiency.

Resident 2

Resident 2 is 94 years old and confined to a wheelchair. During the tour of the facility on August 14, 1997, the State surveyor observed that the entire left side of Resident 2's face was black and blue, and that Resident 2 had a black left eye and a hematoma on her left forehead. A quarterly MDS of November 13, 1996 indicated that Resident 2 had actually been falling. Care plan documentation in place since February 20, 1997, noted that there was a risk for falls related to Resident 2's problems with poor balance, cognitive deficit, functional decline, and episodes of syncope and wandering. Nurses' notes on June 30, 1997, at 5:00 p.m., document that Resident 2 was trying to transfer from bed to wheelchair and slipped to the floor, hitting her mouth on the trash can. Resident 2's dentures broke, cutting her mouth area. On July 3, 1997, Resident 2 was evaluated by physical therapy, and it was documented that Resident 2 needed stand-by assistance for transfers. On August 10 at 4:10 p.m., the nurses' notes document that Resident 2 was found lying on the floor on her left side, having sustained facial injuries and injuries to her left knee from sliding out of bed to get her glasses. The State surveyor's review of Resident 2's record on August 14, 1997, revealed that Resident 2's care plan (P. Ex. 4 at 71) had not been revised since February 20, 1997, to address the problem of actual falls with injury. HCFA Ex. 11 at 6, 7; HCFA Ex. 12 at 36 - 44.

HCFA asserts that the need to change the care plan occurs because Petitioner needed to track the circumstances of a fall to intervene with an approach to prevent future falls. HCFA states that the approaches in the care plan could change as well, because they needed to do more to meet her needs and address the circumstances under which she was actually falling. HCFA Ex. 21 at 48.

Petitioner contends that the issue here is one of semantics, not substance. Petitioner asserts that if a resident has actual falls, it is still the "potential" for falls which is what needs to be addressed. P. Br. at 23, 24. Petitioner asserts also that the care plan was appropriate with regard to the June 30 incident, as it listed approaches for dealing with falls during

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[23] Again, someone took these incidents seriously enough to suggest in a nurses' note that a psychiatric consultation be obtained. P. Ex. 4 at 5.

transfers, and that the August 10, 1997 incident was unrelated to any previous risk of falling. HCFA Ex. 4 at 69, 70.

This resident's care plan, under "potential for falls," includes as approaches to her care, the putting of a call bell within her reach, encouraging her to use the call bell for assistance, and assisting her with transfers/ambulation. Even though the approaches are all appropriate to address potential falls, they appear to have been inadequate. While I agree with Petitioner that the issue here is the potential for falls, not actual falls, I disagree with Petitioner's contention that the care plan in place adequately dealt with the June 30 fall.[24]

HCFA is correct in asserting that Petitioner needed to track the circumstance of these falls, in order to intervene, if necessary, with new approaches to prevent them. The goal of the comprehensive care plan is to set forth measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs and to allow a resident to achieve his or her highest practicable physical, mental, and psychosocial well-being. Here, the approaches developed by the facility were not working with regard to Resident 2's June 30 fall (which certainly encompasses Resident 2's physical well-being). Petitioner should have noted on the problem section of the care plan that the June 30 incident had occurred and then reassessed whether the approaches detailed there were sufficient. Petitioner should also have tried to determine whether other approaches were necessary. By not doing so, Petitioner left open the possibility that, by its inaction, Resident 2 might experience a preventable fall. The potential here is for more than minimal harm.

IV. HCFA was authorized to terminate Petitioner's Medicare agreement.

Even though HCFA had found Petitioner to be out of compliance with Medicare participation requirements, HCFA refrained on more than one occasion from imposing the remedy of termination, choosing other remedies instead. That choice was within HCFA's discretion. 42 C.F.R. § 488.412. However, when a facility is not in substantial compliance within six months from the last day of a survey from which it was found to be out of substantial compliance, HCFA terminates the facility's provider agreement. 42 C.F.R. § 488.412.

Petitioner was in substantial compliance at the time of the April survey. Consequently, Petitioner was not out of substantial

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[24] I will not address the August 10 fall, because the August 14 survey so closely followed the August 10 fall. The Petitioner may not have had adequate time to assess and care plan.

compliance continuously for six months, at any time through the August survey. HCFA may choose to refrain from terminating Petitioner's Medicare agreement, but that choice is within HCFA's discretion. The parties have assumed throughout this proceeding that I would find HCFA authorized to terminate Petitioner's Medicare agreement only if Petitioner remained out of substantial compliance continuously for six months. That assumption is incorrect.

HCFA's letters dated August 8 and 15, 1997 notified Petitioner that its Medicare agreement would be terminated because Petitioner was not in substantial compliance with participation requirements. The August letters did not allege specifically that Petitioner had failed to be in substantial compliance for six months or more. HCFA is authorized to terminate Petitioner's Medicare agreement when Petitioner no longer meets Medicare participation requirements. 42 C.F.R. §§ 488.456(b)(1)(i), 489.53(a)(3). Petitioner was not in substantial compliance with participation requirements at the time of either the July survey or the August survey. Consequently, HCFA is authorized to terminate Petitioner's Medicare agreement.

CONCLUSION

Petitioner was in substantial compliance with Medicare participation requirements at the time of the April survey, but was not in substantial compliance with Medicare participation requirements at the times of the July and August surveys. HCFA was authorized to terminate Petitioner's Medicare agreement.

/s/

Jill S. Clifton

Administrative Law Judge