Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Beverly Health & Rehabilitation - Springhill,	)	Date: October 27, 1998
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-98-350
	)	Decision No. CR553
Health Care Financing Administration.	)	
	)	

DECISION

I decide that the Health Care Financing Administration (HCFA) is authorized to impose a civil money penalty (CMP) against Petitioner, Beverly Health and Rehabilitation-Springhill, in the amount of $1000 per day for each day of the period which begins on May 7, 1998 and which runs through June 1, 1998. I decide additionally that I am without authority to bar HCFA from terminating Petitioner's participation in the Medicare program effective June 2, 1998.

Summarized briefly, my decision is as follows:

- Petitioner is a long-term care facility which provided skilled nursing services to beneficiaries of the Medicare program. HCFA determined to impose civil money penalties against Petitioner in the amount of $10,000 per day for each day of the period which begins May 7, 1998 and which runs through June 1, 1998. Additionally, HCFA determined to terminate Petitioner's participation in Medicare effective June 2, 1998. HCFA based its determinations to impose these remedies on findings that surveyors, who are employed by the Florida Agency for Health Care Administration (Florida State survey agency), made at compliance surveys which they conducted of Petitioner on HCFA's behalf on May 4 - 7, 1998 and on May 27 - 29, 1998.

• At each survey, the surveyors found that Petitioner was failing to comply with participation requirements to the extent that residents of Petitioner's facility were placed in a state of immediate jeopardy. The surveyors concluded that Petitioner had caused, or was likely to cause, serious injury, harm, impairment, or death to residents of Petitioner's facility. HCFA determined to impose a $10,000 per day civil money penalty against Petitioner for each day of the May 7 - June 1, 1998 period based on the surveyors' findings that Petitioner had placed its residents in a state of immediate jeopardy throughout this period. HCFA determined to terminate Petitioner's participation in Medicare based on the surveyors' finding that residents of Petitioner's facility continued to be in a state of immediate jeopardy as of May 29, 1998.

• At the center of the immediate jeopardy findings are the surveyors' conclusions that Petitioner and its staff egregiously failed to provide necessary care to some of Petitioner's residents. The alleged failures to provide care include a failure by Petitioner and its staff to: attend to the nutritional needs of a resident; report to a resident's physician medical findings that were related to the resident's diabetes mellitus; and, question the propriety of a physician's diagnosis and treatment of a resident who suffered from gastrointestinal illness.

• The preponderance of the evidence is that Petitioner did not fail to provide necessary care to its residents. Petitioner complied substantially with the participation requirements which underlie the immediate jeopardy allegations. There is no basis for HCFA to impose a civil money penalty against Petitioner that falls within the range of civil money penalties that is reserved for deficiencies at the immediate jeopardy level for any day of the May 7 - June 1, 1998 period.

• At the May 4 - 7, 1998 survey, the Florida State survey agency surveyors found that Petitioner was not complying with some participation requirements at a level of deficiency which did not comprise immediate jeopardy to Petitioner's residents but which posed a threat of more than minimal harm to those residents. These findings of non-immediate jeopardy deficiencies are in addition to the immediate jeopardy findings that the surveyors made at the May 4 - 7, 1998 survey. Petitioner did not prove by a preponderance of the evidence that the allegations of additional deficiencies are without substance. Nor did Petitioner prove that it had corrected the additional deficiencies prior to June 2, 1998.

• Petitioner's failure to comply with some participation requirements during the period which begins on May 7, 1998 and which runs through June 1, 1998, is a basis for HCFA to impose a civil money penalty against Petitioner for each day of

that period in an amount which falls within the range of civil money penalties that is reserved for deficiencies that are not so serious as to place residents in a state of immediate jeopardy.

• It is reasonable to impose a civil money penalty against Petitioner of $1,000 per day for each day of the May 7 - June 1, 1998 period. I base my decision on the relative seriousness of the deficiencies and on Petitioner's history of compliance with participation requirements.

• I am without authority to order HCFA not to terminate Petitioner's participation in Medicare, effective June 2, 1998. I do not have the authority to decide that HCFA's choice of a remedy is incorrect where a basis exists for HCFA to impose a remedy. Here, a basis to impose a remedy exists, consisting of uncorrected deficiencies of a less than immediate jeopardy level, that were first identified by the surveyors at the May 4 - 7, 1998 survey of Petitioner.

I. BACKGROUND

A. Background facts

The background facts which I recite here are not disputed by the parties. Petitioner is a long-term care facility that is located in Brooksville, Florida. Petitioner participated in the Medicare program. It was surveyed on May 4 - 7, 1998, by surveyors who are employed by the Florida State survey agency. HCFA Ex. 3. Petitioner was surveyed again on May 27 - 29, 1998, by surveyors who are employed by the Florida State survey agency. HCFA Ex. 10.

The surveyors' purpose at the May 4 - 7, 1998 survey was to ascertain whether Petitioner was complying with the requirements which govern a long-term care facility's participation in the Medicare program. The surveyors who conducted this initial survey of Petitioner concluded that Petitioner was not complying substantially with various requirements. HCFA Ex. 3. Of these asserted deficiencies, four were found to be so egregious as to place residents of Petitioner in a state of immediate jeopardy. Id. The remaining deficiencies were not found to be so egregious as to place residents in immediate jeopardy. However, they were found to pose the potential for more than minimal harm to residents of Petitioner.

The surveyors' purpose at the May 27 - 29, 1998 survey was to reexamine those deficiencies that the surveyors had found previously to be at the immediate jeopardy level, in order to determine whether residents of Petitioner's facility continued to be in a

state of immediate jeopardy. The surveyors did not survey Petitioner on May 27 - 29, 1998 in order to determine whether any of the non-immediate jeopardy level deficiencies that were identified at the May 4 - 7, 1998 survey persisted. The surveyors found that Petitioner had corrected one of the four previously identified immediate jeopardy level deficiencies. HCFA Ex. 10. However, they found that there remained three deficiencies that persisted at the level of immediate jeopardy. Id.

HCFA concurred with the findings that were made by the Florida State survey agency surveyors. It determined to impose against Petitioner civil money penalties in the amount of $10,000 per day for each day beginning with May 7, 1998 and running through June 1, 1998. The $10,000 per day penalty is the highest penalty that may be imposed under law against a long-term care facility that is noncompliant with participation requirements. Additionally, HCFA determined to terminate Petitioner's participation in Medicare, effective June 2, 1998.

Petitioner requested a hearing and the case was assigned to me for a hearing and a decision. Petitioner requested that the hearing be conducted on an expedited basis in view of the termination of Petitioner's participation in Medicare. HCFA did not object to this request. I granted Petitioner's request for an expedited hearing and held a hearing in Tampa, Florida, on July 13 - 16, 1998. At this hearing I received into evidence exhibits that were presented by HCFA (HCFA Ex. 1 - HCFA Ex. 27). I received into evidence exhibits that were presented by Petitioner (P. Ex. 1 - P. Ex. 13; P. Ex. 15 - P. Ex. 17; P. Ex. 19 - P. Ex. 22; P. Ex. 24 - P. Ex. 77).

HCFA called the following witnesses to testify at the hearing:

- *Richard Lee Fuller, R.N.* (Tr. at 62 - 101; 246 - 544). Mr. Fuller is a surveyor who is employed by the Florida State survey agency. He participated in both the May 4 - 7, 1998 and the May 27 - 29, 1998 surveys of Petitioner. Mr. Fuller has more than 20 years' experience working as a nurse or in other capacities in long-term care facilities.

- *Nancy L. Baker* (Tr. at 103 - 132). Ms. Baker is a registered dietician. She is employed as a surveyor by the Florida State survey agency. Ms. Baker participated in the May 4 - 7, 1998 survey of Petitioner.

- *Janice Rebstock* (Tr. at 133 - 176). Ms. Rebstock is an accredited records technician. She is employed as a surveyor by the Florida State survey agency. Ms. Rebstock participated in the May 4 - 7, 1998 survey of Petitioner.

• *Debra Olsen, R.N.* (Tr. at 176 - 197). Ms. Olsen is a registered nurse specialist. She is employed by the Florida State survey agency. Ms. Olsen participated in the May 4 - 7, 1998 survey of Petitioner.

• *Lynda Hathcock* (Tr. at 198 - 218). Ms. Hathcock is employed as a surveyor by the Florida State survey agency. Ms. Hathcock participated in the May 4 - 7, 1998 survey of Petitioner.

HCFA proposed the testimony of an additional witness. That proposed additional witness was Jay Kumar, M.D. I excluded Dr. Kumar from testifying because HCFA failed timely to list Dr. Kumar as a witness, failed to establish good cause for not listing him timely, and failed to show that there would be no prejudice to Petitioner if Dr. Kumar testified. I explained on the record of the hearing my reasons for excluding Dr. Kumar as a witness. Tr. at 232 - 245; 1032 - 1049.

Petitioner called the following witnesses to testify at the hearing:

• *David McGrew, M.D.* (Tr. at 600 - 721). Dr. McGrew is a practicing physician. His full-time specialty since 1995 has been hospice care and palliative care. He is board certified in the areas of pain management, hospice care, and palliative care. Dr. McGrew was the treating physician of two of the residents whose care by Petitioner forms part of the basis for the determination that Petitioner was noncompliant with participation requirements to the extent that its residents were placed in immediate jeopardy. I accepted Dr. McGrew as an expert concerning the standards of care that apply to the treatment of residents of nursing facilities. Tr. at 688.

• *Nancy B. Barfield, R.N.* (Tr. at 722 - 782). Ms. Barfield is employed as a nurse consultant by Beverly Enterprises North Florida Group.

• *Bruce Robinson, M.D.* (Tr. at 791 - 953). Dr. Robinson is a professor and chief of the division of geriatric medicine at the University of South Florida College of Medicine. He is board certified in internal medicine and is a certified medical director. He has received a certificate of excellence in geriatric medicine. Dr. Robinson has served as the medical director for two community nursing homes and a hospital based skilled nursing facility. I accepted Dr. Robinson as an expert concerning the role played by the medical director of a long-term care facility, the assessment of quality of care provided by nursing facilities, the standards of care applicable to nursing facilities, and the treatment of geriatric patients in long-term care facilities. Tr. at 796 - 797.

• *Claire Hoffman, R.N.* (Tr. at 956 - 1032). Ms. Hoffman is the president of a consulting firm. She served formerly as a surveyor for the Pennsylvania State survey agency. I accepted Ms. Hoffman as an expert concerning the appropriate evaluation of quality of care by a surveyor performing a Medicare compliance survey at a long-term care facility on behalf of HCFA and as to appropriate survey techniques. Tr. at 965 - 966.

B. Summary of the governing law

Under both the Act and applicable regulations, Petitioner is classified as a long-term care facility. In order to participate in Medicare, a long-term care facility must comply with federal participation requirements. The statutory requirements for participation by a long-term care facility are contained in the Act, at sections 1819 and 1919. Regulations which govern the participation of a long-term care facility are published at 42 C.F.R. Part 483.

Sections 1819 and 1919 of the Act give the Secretary of the United States Department of Health and Human Services (Secretary) authority to impose against a long-term care facility a civil money penalty for failure by the facility to comply substantially with participation requirements. These sections state, in effect, that the Secretary's authority to impose a civil money penalty against a long-term care facility is the same as the civil money penalty authority that is conferred on the Secretary under section 1128A of the Act. Act, sections 1819(h)(2)(B)(ii); 1919(h)(3)(C)(ii). Both sections 1819 and 1919 state that: "The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty . . . [imposed under either section 1819 or 1919] in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a)." Id.

The Secretary has delegated to HCFA and the States the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. 42 C.F.R. Part 488. The Part 488 regulations provide that facilities which participate in Medicare may be surveyed on behalf of HCFA by State survey agencies in order to ascertain whether the facilities are complying with participation requirements. 42 C.F.R. §§ 488.10 - 488.28. The regulations contain special survey provisions for long-term care facilities. 42 C.F.R. §§ 488.300 - 488.335. Under the Part 488 regulations, a State or HCFA may impose a civil money penalty against a long-term care facility where a State survey agency ascertains that the facility is not complying substantially with participation requirements. 42 C.F.R. §§ 488.406, 488.408, 488.430. The penalty may be imposed for each day that the facility is out of compliance. Id.

The regulations specify that a civil money penalty that is imposed against a facility will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of civil money penalties, of from $3,050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1), (d)(2). The lower range of civil money penalties, of from $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm to residents. 42 C.F.R. § 488.438(a)(2).

The terms "substantial compliance" and "immediate jeopardy" are defined terms in the regulations which govern participation of long-term care facilities in Medicare. "Substantial compliance" is defined to mean:

> a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

42 C.F.R. § 488.301. "Immediate jeopardy" is defined to mean:

> a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

Id.

There are additional factors which the State and HCFA consider in determining where within a range of penalties the amount of a penalty should be determined, once the range is established. These include the facility's: (1) history of noncompliance, including repeated deficiencies; (2) financial condition; and, (3) culpability for the deficiencies. 42 C.F.R. § 488.438(f). Additionally, the State and HCFA may consider factors specified in 42 C.F.R. § 488.404. These include the relationship that a deficiency may have to other deficiencies, and a facility's prior history of deficiencies.

A civil money penalty which falls within the lower range of penalties may not be increased to the upper range based on the presence or absence of factors described in 42 C.F.R. §§ 488.404 and 488.438(f), unless the deficiency at issue is a repeated deficiency. And, a civil money penalty which falls within the upper range of penalties may not be decreased to the lower range based on the presence or absence of factors described in 42 C.F.R. §§ 488.404 and 488.438(f). However, once the range of a penalty is fixed (either

upper or lower) the factors described in 42 C.F.R. §§ 488.404 and 488.438(f) become important in determining where within that range the penalty will be established. And, those factors and only those factors must be considered by an administrative law judge in any case where the amount of a civil money penalty is challenged. 42 C.F.R. § 488.438(e).

A long-term care facility against whom HCFA has determined to impose a civil money penalty is entitled to a hearing before an administrative law judge at which the facility may contest HCFA's determination. Act, section 1128A(c)(2); 42 C.F.R. §§ 488.408(g), 498.3(b)(12),(13); see 42 C.F.R. § 488.438(e). A relevant part of section 1128A of the Act provides that the Secretary shall not impose a civil money penalty against an individual or entity until that individual or entity has been given written notice and an opportunity for the Secretary's determination to be made on the record after a hearing at which the individual or entity is entitled to be represented by counsel, to present witnesses, and to cross-examine adverse witnesses. Act, section 1128A(c)(2). This right to a hearing under section 1128A has been interpreted uniformly to confer on a party against whom the Secretary has determined to impose a civil money penalty a right to a de novo hearing. Anesthesiologists Affiliated, et al., DAB CR65 (1990), aff'd 941 F.2d 678 (8th Cir. 1991); Tommy G. Frazier, DAB CR79 (1990), aff'd 940 F.2d 659 (6th Cir. 1991); Berney R. Keszler, M.D., et al., DAB CR107 (1990).

In a de novo hearing in a case involving a determination to impose a civil money penalty against a party, the party against whom a civil money penalty determination is made is afforded the right to contest both the determination of misconduct which is the basis for the penalty and the amount of the proposed penalty. In such a case, the administrative law judge has authority to impose a penalty that is for an amount which is less than that which the agency determines to impose where the amount that is determined by the agency is not reasonable.

There are potentially two issues to be heard and decided in a case where a long-term care facility requests a hearing before an administrative law judge from a determination by HCFA to impose a civil money penalty against the facility. The first issue is whether the facility was not complying substantially with federal participation requirements on the date or dates for which HCFA determined to impose a civil money penalty. The second issue is, assuming that noncompliance is established, whether the amount of the penalty imposed by HCFA is reasonable. 42 C.F.R. §§ 488.408(g), 498.3(b)(12), (13); see 42 C.F.R. § 488.438(e). The issue of reasonableness of the penalty is not reached unless there is a finding of substantial noncompliance on which a penalty may be predicated. Id.

In a civil money penalty case, a long-term care facility has the burden of overcoming, by a preponderance of the evidence, any prima facie case that HCFA might make that the facility is not complying substantially with federal participation requirements. Hillman Rehabilitation Center, DAB No. 1611 (1997). A long-term care facility potentially bears an additional burden of proof where it challenges the level of the deficiency determined by HCFA. The facility must prove that HCFA's determination of the level of noncompliance is clearly erroneous if the record of the case establishes that the facility is not complying substantially with a participation requirement that is the basis for HCFA's civil money penalty determination. 42 C.F.R. § 498.60(c)(2) (this regulation was formerly published as 42 C.F.R. § 498.61(b)). The facility would not have to meet this additional burden in a case where it was able to prove by a preponderance of the evidence that it was complying substantially with the participation requirement or requirements on which HCFA premised its civil money penalty determination.

A civil money penalty is not the only remedy that HCFA may impose against a long-term care facility that is deficient in complying with participation requirements. The Act and regulations authorize HCFA to impose a variety of remedies in addition to a civil money penalty. These remedies include termination of a facility's participation in Medicare where that facility is not complying substantially with participation requirements. Act, section 1866(b)(2); 42 C.F.R. §§ 488.406(a), 488.410(a), 488.412(a), 488.456(b)(1)(i).

The regulations mandate that a facility's participation in Medicare be terminated after 23 days, based on a finding of a continued immediate jeopardy level deficiency. 42 C.F.R. § 488.410(a). The regulations give HCFA the option of allowing a facility up to six months to correct a deficiency that is at a level of severity that is less than immediate jeopardy prior to terminating that facility's participation in Medicare. 42 C.F.R. § 488.412(a). However, the decision to allow a facility time to correct a deficiency is a matter of discretion that is vested in HCFA. The Act and regulations plainly give HCFA the authority to terminate the participation of a facility that is not complying with participation requirements, regardless of the level of the facility's deficiency, at any time after the deficiency is identified.

A long-term care facility whose participation in Medicare has been terminated is entitled to a hearing to contest the finding of deficiency upon which HCFA's determination to terminate participation is based. Act, sections 1866(h)(1), 205(b). As is true with a hearing to contest a civil money penalty, a hearing held under the authority of section 205(b) of the Act is a de novo hearing. Howard Schreibstein, D.P.M., DAB CR517 (1998). However, a hearing on the issue of termination of participation is limited to the question of whether a deficiency exists that may be the basis for imposition of a remedy against a long-term care facility. A long-term care facility may not challenge HCFA's

choice to impose the remedy of termination of participation assuming that a deficiency is established which is the basis for imposing a remedy. 42 C.F.R. §§ 498.3 (d)(11), 488.408 (g)(2).

II. RULINGS ON PETITIONER'S PREHEARING MOTIONS

Petitioner filed a series of prehearing motions shortly prior to the inception of the hearing of this case. I reserved decision on these motions. My ruling on each of them follows.

A. Petitioner's motion to dismiss civil money penalties and to vacate the termination of Petitioner's provider agreement

In this motion, Petitioner makes several arguments which attack the basis for HCFA's determinations to impose remedies against Petitioner. First, Petitioner asserts that the Florida State survey agency surveyors who conducted the surveys of Petitioner unlawfully failed to conduct their surveys pursuant to the survey criteria which are established at 42 C.F.R. Part 488, Subpart C. Rather, according to Petitioner, the survey was conducted according to protocols that are contained at Appendix P of the State Operations Manual, an instructional manual which HCFA has sent to State survey agencies. Petitioner argues that the use of substitute protocols for conducting the surveys was unlawful reliance by HCFA and the Florida State survey agency on substantive rules that were not published in accordance with the notice and comment requirements of the Administrative Procedures Act.

Second, Petitioner argues that the survey and certification regulations that were published by the Secretary to govern surveys of long-term care facilities were not published lawfully. Therefore, according to Petitioner, the entire survey and certification process is ultra vires the requirements of law.

Additionally, Petitioner asserts that the regulations deny it due process because they promote a survey system that produces inaccurate and inconsistent survey results. Petitioner argues further that the regulations violate the Fourth Amendment to the United States Constitution, in that they allow excessive discretion by surveyors and in that they promote unconstitutional searches to which long-term care facilities have not consented.

I deny Petitioner's motion because I do not have the authority to decide it. Each of Petitioner's arguments attacks either the lawfulness of the procedures which HCFA employs to conduct surveys of long-term care facilities or the lawfulness of the regulations which are the basis for these procedures. As I held in Life Care Center of Hendersonville, DAB CR542 at 10 (1998), I have the authority to interpret regulations

and procedures and to decide whether HCFA has acted properly pursuant to those regulations and procedures. But, I am required to assume that regulations and procedures that the Secretary issues are legal. CarePlex of Silver Spring, DAB CR457, at 12 (1997), aff'd in part, rev'd in part, DAB No. 1627 (1997). I do not have the authority to declare that regulations or procedures are unlawful.

B. Petitioner's motion to strike HCFA's immediate jeopardy finding

This motion attacks the finding of continued immediate jeopardy that the surveyors made at the May 27 - 29, 1998 survey of Petitioner's facility. The motion makes two arguments. First, according to Petitioner, the findings of immediate jeopardy that were made at the May 27 - 29, 1998 survey were based solely on events that predated the survey. Petitioner argues that, assuming the surveyors' characterization of the events to be accurate, these events were isolated occurrences that happened before the May 27 - 29, 1998 survey. Petitioner asserts that no inferences of a *continuing* immediate jeopardy situation may be made from events that occurred in the past. In part, Petitioner premises this argument on its assertion that the Act and regulations do not permit a finding of immediate jeopardy to be made based on past occurrences.

I deny this motion. First, I do not agree with Petitioner's assertion that continuing immediate jeopardy may never be found based on past events. Second, as I discuss below, I find that there were no immediate jeopardy level deficiencies present as of the May 27 - 29, 1998 survey. Thus, Petitioner's motion is moot.

In Petitioner's first argument it asserts that the events on which the May 27 - 29, 1998 immediate jeopardy findings are based occurred prior to the date when Petitioner represented to HCFA that it had corrected the immediate jeopardy circumstances that were identified at the May 4 - 7, 1998 survey of Petitioner (Petitioner does not concede that immediate jeopardy existed as of the dates of the earlier survey). Petitioner contends that it is unreasonable to premise a finding of ongoing immediate jeopardy on events which predate the implementation of corrective action without ascertaining whether the corrective action was implemented.

As I held in the Life Care Center of Hendersonville decision, in the appropriate case an inference of continuing deficiency, including an immediate jeopardy level deficiency, may be drawn from past occurrences. Nor do I agree with Petitioner's assertion that the Act and regulations prohibit HCFA from finding immediate jeopardy based on past occurrences.

In Petitioner's second argument, it contends that it corrected any jeopardy that may have existed as of the May 4 - 7, 1998 survey on dates prior to the May 27 - 29, 1998 survey (although it does not agree that any jeopardy existed as of the May 4 - 7, 1998 survey). Petitioner contends that it is inconsistent with the Act's purpose and the evidence to find a provider to be deficient when, in fact, the deficiency has been corrected.

Petitioner's argument is moot in this case because I find no immediate jeopardy to have been present at Petitioner's facility either as of the May 4 - 7, 1998 survey or as of the May 27 - 29, 1998 survey. However, I agree with Petitioner that events that occurred prior to the implementation of corrective action by a facility may not evidence a deficiency or immediate jeopardy after the implementation date. If, in fact, the corrective action effectively corrects the deficiency, then the acts which occurred prior to the implementation date of the corrective action are irrelevant to the issue of whether a deficiency exists after the implementation date. Whether that may be so in any case is a matter of evidence. I would consider it to be an affirmative defense, which the facility has the burden of coming forward with and proving; that evidence of a deficiency, including a deficiency at an immediate jeopardy level, has been superseded by an effective subsequent corrective action.

C. Petitioner's motion to strike allegations under tags 224, 323, and 157

This motion alludes to three findings of immediate jeopardy-level deficiencies that the surveyors made at the May 4 - 7, 1998 and May 27 - 29, 1998 surveys of Petitioner. Petitioner asserts that HCFA failed to state a prima facie case of deficiency for any of these findings. I have elected to consider the arguments that Petitioner makes in this motion in my discussion of the allegations of deficiencies.

D. Petitioner's motion to dismiss imposition of civil money penalties for inadequate notice

The gravamen of this motion is that HCFA failed to give Petitioner adequate notice of the basis for its imposition of a civil money penalty in the amount of $10,000 per day against Petitioner. I deny this motion for the following reasons.

The May 19, 1998 notice letter which informed Petitioner of HCFA's determination to impose a civil money penalty contained this statement of HCFA's basis for imposing it:

> As a result of your facility's noncompliance . . . we are imposing a civil monetary penalty in the amounts of $10,000 per day effective May 7, 1998. We considered factors identified at 42 C.F.R. 488.438(f) in setting the

> amount of the civil monetary penalty being imposed for each day of noncompliance.

HCFA Ex. 5 at 2. Apart from this laconic statement, HCFA gave Petitioner no notice of how it arrived at the penalty amount of $10,000 per day.

Petitioner argues that HCFA's notice to Petitioner fails to comply with HCFA's regulation governing the content of a notice imposing a civil money penalty. The applicable regulation is 42 C.F.R. § 488.434(a)(2). The regulation provides, at subpart (a)(2)(iv), that the notice must state:

> Any factors specified in [42 C.F.R.] § 488.438(f) that were considered when determining the amount of the penalty.

As I discuss above, at Part I.B. of this decision , 42 C.F.R. § 488.438(f) enumerates specific factors which HCFA may consider in determining the amount of a civil money penalty.

It is obvious that the notice which HCFA sent to Petitioner fails to tell Petitioner which of the factors specified in 42 C.F.R. § 488.438(f) HCFA considered when it determined to impose a civil money penalty against Petitioner. It is impossible from the notice letter to determine how HCFA came to the conclusion that a penalty at the top end of the $3,050 - $10,000 per day range of penalties that applies to immediate jeopardy deficiencies is reasonable in this case.

I would consider HCFA's notice to Petitioner to be fatally defective were I to conclude that my authority to hear and decide this case is anything less than the authority to conduct a full de novo hearing and were I to conclude that my authority to decide the reasonable amount of a civil money penalty is in any respect dependent on the criteria that HCFA used to arrive at its determination of a penalty amount. It would not be possible for me to decide whether HCFA acted reasonably in arriving at its determination if that were the issue in this case. That is because there is nothing in the record which gives notice of the basis for HCFA's action. However, I find here, as I have found in previous cases, that my authority to decide the reasonable amount of a civil money penalty is wholly independent of any determination that HCFA may make. For that reason, HCFA's failure to comply with the notice requirement of its regulation is harmless error.

As I held in the decision on remand in CarePlex of Silver Spring, DAB CR536 at 14 - 16 (1998), my authority to decide the amount of a civil money penalty exists independently of HCFA's authority to make an initial determination of what might be reasonable. I am in no respect bound by HCFA's determination, although in making a decision as to what is reasonable, I must consider and apply the same regulatory criteria that HCFA may use in making its determination. The authority to decide independently what is reasonable is the essence of the requirement that a hearing conducted pursuant to sections 1819, 1919, and 1128A of the Act be de novo.

The criteria that HCFA relies on to determine the amount of a penalty are not important once a facility requests a hearing from HCFA's determination. At the hearing, both the facility and HCFA are permitted to present evidence which relates to the criteria for deciding the amount of a penalty. That evidence may include evidence that was not before HCFA when it made its initial determination to impose a penalty.

This is not to suggest that a facility is not entitled to learn in advance of the in-person hearing what evidence HCFA will rely on to assert that a penalty of a particular amount is reasonable. I directed the parties to file supplements to their notices in this case and to exchange proposed exhibits and the names of witnesses prior to the hearing date. I routinely follow this procedure in all of my cases.

III. ISSUES, FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Issues

The issues in this case are whether:

1. A basis exists to impose civil money penalties against Petitioner.

2. The amounts of the civil money penalties, assuming that a basis to impose a civil money penalty exists, are reasonable.

3. A basis exists to impose a remedy against Petitioner other than civil money penalties.

B. Findings of fact and conclusions of law

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

1. Petitioner did not fail to provide necessary care to its residents.

The core of the Florida State survey agency surveyors' conclusions at both the May 4 - 7, 1998 and May 27 - 29, 1998 surveys is that Petitioner placed its residents in a state of immediate jeopardy by egregiously failing to provide necessary care to five of its residents. The surveyors identified these residents in the reports of the two surveys as Resident 6 (May 4 - 7, 1998 survey) and Residents 5, 2, 1, and 4 (May 27 - 29, 1998 survey). HCFA Exs.3 and 10.

Below, I consider the allegations of deficient care in the context of the surveyors' specific deficiency findings. However, it is helpful as an overview first to look at the broad allegations of deficient care that the surveyors made and to decide whether these allegations are supported. I conclude that the preponderance of the evidence rebuts the surveyors' allegations about the care that Petitioner gave to the five residents.

a. Resident 6 (May 4 - 7, 1998 survey)

The surveyors make two central allegations about Petitioner's care of Resident 6. First, they assert that Petitioner and its staff failed to identify and to treat appropriately the resident's malnutrition and dehydration. Second, they contend that Petitioner's staff failed to report the resident's deteriorating condition to the resident's physician or to other professionals on Petitioner's staff. HCFA Ex. 3 at 10, 14.

i. Resident 6's medical problems and the history of her stays at Petitioner's facility

Resident 6 had three stays at Petitioner's facility. These were from: March 6, 1998 until April 17, 1998; April 20, 1998 until April 22, 1998; and, from April 28, 1998 until May 6, 1998. P. Ex. 6. The resident died at the end of the third stay. Id. Dr. McGrew served as the treating physician for Resident 6 during the resident's second and third stay at Petitioner's facility. Tr. at 662 - 663.

Resident 6 suffered from, among other problems, progressive dementia. P. Ex. 6 at 2; Tr. at 666 - 667. The resident's dementia progressed rapidly in the final months of her life. During the resident's second stay at Petitioner's facility, her dementia was manifested in part by extreme agitation. Id. at 667. The resident's agitation included unprovoked aggressive behavior towards Petitioner's staff and towards other residents of Petitioner. Id. at 668. The resident's agitation was also marked by unceasing restless activity.

On April 22, 1998, Resident 6 was transferred to a psychiatric facility, based on a certification that the resident posed a danger to herself and to other individuals. Tr. at 670 - 671. A psychiatrist prescribed psychoactive medications. The resident returned to Petitioner's facility from the psychiatric facility on April 28, 1998. She was no longer agitated. However, over the next several days, the resident became increasingly non-responsive to the point where she lost the ability to chew and to swallow foods and liquids. Tr. at 675 - 679.

Resident 6 sustained a steady and substantial loss of weight during the period which commenced with the beginning of her first stay at Petitioner's facility and which ended with her death. On March 6, 1998 (not March 17, 1998, as the surveyors mistakenly state in their survey report of May 4 - 7, 1998), the beginning date of the resident's first admission to Petitioner's facility, the resident's weight was recorded as being 105 pounds. P. Ex. 6 at 52. On April 8, 1998, Resident 6's weight had declined to 98.6 pounds. HCFA Ex. 3 at 5. On April 23, 1998, the date when Resident 6 was admitted to a psychiatric facility, the resident's weight was recorded at 94.5 pounds. Id. at 12. On April 28, 1998, on readmission to Petitioner's facility, the resident's weight had declined additionally, to 80.2 pounds. Id.

The loss of weight that Resident 6 sustained while at Petitioner's facility paralleled the resident's loss of appetite and the staff's increasing difficulty feeding the resident or getting the resident to consume liquids. During the resident's second stay, the resident's increasing agitation manifested as an inability to sit still long enough to consume a meal. Petitioner's staff followed the resident as the resident wandered through the corridors and public areas of the facility, attempting to get the resident to eat finger foods and to consume liquids. Tr. at 671 - 672. One of the reasons that Resident 6 was hospitalized at the end of her second stay was the resident's continued unwillingness or inability to eat. Id. at 436. During the resident's third and final stay at Petitioner's facility, the resident became increasingly incapable of eating and drinking. The resident's consumption of food declined over the resident's final days at the facility. Id. at 441 - 446. The resident began chewing but not swallowing her food. Id. at 447 - 448. An evaluation of Resident 6 by a speech therapist showed that the resident was beginning to manifest a tonic bite reflex, consisting of an involuntary clenching of her teeth when substances were placed in her mouth. Tr. at 455 - 456.

ii. Evaluation of the surveyors' allegations of deficient care

The surveyors make a series of allegations which relate to their conclusions that Petitioner's staff failed to treat appropriately Resident 6's malnutrition and dehydration or to notify the resident's physician about changes in the resident's condition. These

include the following alleged failures by Petitioner's staff to notify the resident's physician of:

- the weight loss that the resident sustained between the date of admission and April 8, 1998. HCFA Ex. 3 at 5;

- increased episodes of incontinence and of inadequate fluid intake by Resident 6 on April 21, 1998 and again during the dates from May 1, 1998 through May 4, 1998. HCFA Ex. 3 at 5 - 6;

- the weight loss sustained by Resident 6 while the resident was hospitalized between April 22, 1998 and April 28, 1998. HCFA Ex. 3 at 12;

- the resident's lethargy on April 30, 1998, due to medication. HCFA Ex. 3 at 13;

- reductions in the resident's psychoactive medications that were implemented on May 1, 1998, prior to May 4, 1998. HCFA Ex. 3 at 13;

- reductions in fluid intake by the resident in the days between May 1 and May 4, 1998. HCFA Ex. 3 at 13.

Additionally, the surveyors alleged that Petitioner's staff failed to:

- document an admission weight for the resident on April 20, 1998, at the beginning of the resident's second stay at Petitioner's facility. HCFA Ex. 3 at 11; and,

- identify a fluid loss by Resident 6 and a lack of fluid intake by the Resident between April 20, 1998 and April 21, 1998, and between April 21, 1998 and April 22, 1998. HCFA Ex. 3 at 12.

The question that must be resolved in assessing whether Petitioner was deficient in giving care to Resident 6 is not so much whether Petitioner accomplished or failed to accomplish the specific actions that are the basis for the surveyors' allegations, but, rather, whether Petitioner gave Resident 6 the care that was necessary to address her nutrition and hydration problems consistent with the resident's physician's orders and the requirements of applicable regulations. It is a matter of judgment in a particular case for a facility's staff, in consultation with a resident's treating physician, to decide precisely which interventions are appropriate in each case. The regulations do not prescribe the specific interventions that a facility's staff must undertake with a resident. There is no

requirement in the regulations, for example, that a facility's staff document a resident's admission weight. And, there is no requirement in the regulations that a facility's staff chart fluid losses and intakes by residents.

There is a general requirement in the regulations that a facility immediately inform a resident's physician of any deterioration in a resident's health status and inform the physician of any need to change the manner in which care is provided to a resident. 42 C.F.R. § 483.10(b)(11) (below, I discuss the surveyors' allegations that Petitioner failed to comply with this requirement). How this general notification requirement is implemented is left up to the facility. No specific act (e.g., notifying a physician of the quantity of fluid intake by a resident) is required by the regulation. What constitutes adequate notification in a particular case is a matter of agreement between a resident's treating physician and a facility's staff, although that notification must satisfy the general requirements of the regulation.

The picture that the surveyors paint in their May 4 - 7, 1998 survey report, of the care that Petitioner's staff gave to Resident 6, is one of almost total indifference to the nutrition and hydration needs of the resident. If the surveyors' allegations are credible, then the conclusion that must be drawn from them is that the resident was allowed to die of starvation and dehydration as a consequence of the Petitioner's staff's indifference to the resident's needs.

However, the preponderance of the evidence paints a much different picture of the care that Petitioner's staff actually gave to Resident 6. This resident declined, not as a consequence of any dereliction of care by Petitioner's staff, but as an inevitable consequence of her progressive dementia. That dementia affected the resident's ability to eat and consume fluids to the extent that, at the end of her life, she was unable to chew or swallow. Tr. at 678 - 679.

Petitioner's staff was attentive to the needs of Resident 6. The interventions taken by physicians and by Petitioner's staff on behalf of Resident 6 establish that the facility's staff gave appropriate care to the resident. The record documents intensive efforts by the staff to get Resident 6 to eat and drink. The efforts included having the staff follow the resident with finger foods during the resident's periods of agitation in an attempt to get the resident to eat. Tr. at 671-672. These efforts also included efforts at changing the resident's diet in order to encourage Resident 6 to eat. Id. at 453. Numerous evaluations were made of the resident in order to determine the cause of the resident's declining ability to consume food. Tr. at 455 - 459. There was no failure by the staff to notify the physician who attended Resident 6 during her first stay or Dr. McGrew, who attended the resident during the resident's second and third stay, of changes in the resident's condition

or of the resident's steady deterioration. The resident's physicians were aware of the resident's nutrition status and her weight loss.

Thus, the overall picture of the care that Petitioner gave to Resident 6 is that of an attentive, not an indifferent, facility. Furthermore, the preponderance of the evidence shows that many of the specific examples of alleged derelictions of care alleged by the surveyors are largely unfounded.

The surveyors' allegation that Petitioner's staff failed to apprize Resident 6's treating physician of weight losses sustained by the resident between the date of admission and April 8, 1998 is belied by evidence showing the degree of involvement of the resident's physician in the resident's case during the resident's first stay at Petitioner's facility. I do not find it credible that the physician was unaware of the resident's weight loss in light of the interventions that the physician ordered. These interventions would only make sense if the physician was aware of the resident's nutrition problems. Thus, the fact that treatment records do not record specific contacts between Petitioner's staff and the resident's physician, in which the resident's weight was related to the physician, do not mean that the resident's physician was unaware of the resident's weight loss.

The interventions which were ordered by the physician show knowledge of the resident's nutrition problems include ordering that the resident be administered a nutrition supplement three times daily. P. Ex. 6 at 23,55; Tr. at 114. They include also the physician's ordering of speech therapy assessments of the resident in order to assess whether the resident was suffering from neurological or mechanical chewing and swallowing problems that interfered with the resident's ability to eat. Id. at 119 - 120. They include also nutrition assessments that Petitioner's dietician performed of Resident 6 during the period beginning March 13, 1998 and extending through April 5, 1998. P. Ex. 6 at 52 - 54; Tr. at 111 - 113.

The surveyors' assertion that Petitioner's staff failed to apprize Resident 6's treating physicians of the resident's increased episodes of incontinence and inadequate fluid intake likewise is belied by the weight of the evidence. Dr. McGrew testified credibly that he was aware of the resident's incontinence. Tr. at 669 - 670. According to Dr. McGrew, the resident's incontinence did not produce substantial quantities of urine such as to pose a danger to the resident. Id. He based this conclusion on the information that had been given to him by the nurse on Petitioner's staff. Id. Furthermore, Dr. McGrew

was informed by Petitioner's staff that the staff was having difficulty getting Resident 6 to drink adequate quantities of fluids. As he testified:

> If there was any dehydration . . . it wasn't because she was having this frequent urination because they couldn't get any fluids into her. They were having real problems getting anything into her orally.

Id. at 669.

Nor does the preponderance of the evidence substantiate the surveyors' assertion that Petitioner's staff failed to apprize Dr. McGrew of the weight loss that Resident 6 sustained during her hospitalization for agitation. Dr. McGrew testified credibly that, although he did not comment on the resident's weight loss in the progress notes that he generated immediately after the resident returned from the hospital to begin her third stay at Petitioner's facility, that weight loss was apparent to him and he observed it. Tr. at 673.

Finally, the preponderance of the evidence does not support the surveyors' assertion that Dr. McGrew was not kept apprized of the deteriorating status of Resident 6 after April 30, 1998. Tr. at 681 - 682. Dr. McGrew's credible testimony is that the facility was not deficient in any respect in notifying him of changes in the resident's condition. Id.

b. Resident 5 (May 27 - 29, 1998 survey)

The principal allegation that the surveyors make with respect to the care that Petitioner gave to Resident 5 is that Petitioner's staff failed to notify timely the resident's physician of dangerous changes in the resident's condition. HCFA Ex. 10 at 4, 6. They allege, furthermore, that the care that Petitioner gave to Resident 5 did not comport with professionally recognized standards of care. Id. at 12. These allegations are premised on the surveyors' conclusion that Petitioner's staff failed to treat the resident's allegedly severe hypoglycemia consistent with the resident's physician's order thereby causing deterioration in the resident's medical condition. HCFA Ex. 10 at 6 - 7.

i. Resident 5's medical problems and the history of her stay at Petitioner's facility

Resident 5 suffered from several medical conditions, including poorly controlled insulin dependent diabetes mellitus, congestive heart failure, cardiomyopathy, and acute and chronic renal failure. P. Ex. 25 at 412, 414, 421. Her diabetes mellitus was characterized as "very brittle." Id. at 423. The resident had been hospitalized on several

occasions in early 1998. Id. at 412 - 446. Resident 5 was a resident of Petitioner's facility for a period which began on February 19, 1998 and which continued through May 12, 1998 when the resident was again hospitalized. P. Ex. 25 at 1. The resident's treating physician throughout her stay at Petitioner's facility was Dr. Kumar. The resident died on May 13, 1998. P. Ex. 25 at 3.1.

ii. Evaluation of the surveyors' allegations of deficient care

The surveyors base their allegations that Petitioner's care of Resident 5 was deficient on their analysis of events that occurred on May 11 and May 12, 1998. These events involve some low blood sugar readings that were recorded of Resident 5 and the actions taken by Petitioner's nursing staff in response to these low blood sugar readings. A chronology of these events is as follows.

- *4:00 p.m. on May 11, 1998*: the resident's blood sugar was recorded at 68 mg/dl. The nursing staff gave fruit juice to the resident along with the resident's afternoon meal.

- *10:30 p.m. on May 11, 1998*: the resident's blood sugar was recorded at 34 mg/dl. At that time, the resident appeared to be pale. The nursing staff administered lemonade and 8 teaspoons of sugar to the resident. The resident's blood sugar was taken again and recorded at 80 mg/dl.

- *11:15 p.m. on May 11, 1998*: the resident's blood sugar was recorded at 80 mg/dl. The resident was observed to be lethargic.

- *12:45 a.m. on May 12, 1998*: the resident was observed to be alert and verbal. The resident's blood sugar was recorded at 147 mg/dl.

- *4:15 a.m. on May 12, 1998*: the resident's blood sugar was recorded at 43 mg/dl. The resident was given fruit punch and four packets of sugar along with milk and chocolate ice cream mixed with graham crackers.

- *5:45 a.m. on May 12, 1998*: the resident's blood sugar was recorded at 76 mg/dl.

- *7:30 a.m. on May 12, 1998*: the resident's blood sugar was recorded at 114 mg/dl. The resident was administered her prescribed dose of humulin insulin. At that time, wheezing and crackles throughout the resident's lungs was noted. The

resident's upper extremities displayed edema. The nursing staff called the resident's physician.

• *9:30 a.m. on May 12, 1998*: the resident continued to display labored breathing with wheezes and crackles. The nursing staff again called the resident's physician, who ordered the resident be sent to the hospital emergency room.

• *10:15 a.m. on May 12, 1998*: the resident was transferred to the hospital.

P. Ex. 25 at 376 - 377.

The surveyors also premise their allegations of deficient care by Petitioner's staff on an order that Dr. Kumar had issued to Petitioner's staff on May 1, 1998. The order was a prescription for insulin to be administered to Resident 5. It contained the following instructions:

< 70 give OJ + notify MD
> 400 give 10U SQ + notify MD

P. Ex. 25 at 44. The surveyors assert that this order mandated Petitioner's staff to contact Dr. Kumar immediately at any time that the resident's blood sugar fell below 70 mg/dl.

According to the surveyors, Petitioner's staff was derelict in not notifying Dr. Kumar immediately of the resident's episodes of decreased blood sugar because it was in violation of Dr. Kumar's order that he be notified of such an event. The surveyors characterize the three episodes of decreased blood sugar which occurred during the period of time in question on May 11 and May 12, 1998 as constituting "severe hypoglycemia." HCFA Ex. 10 at 8. They assert that this allegedly severe hypoglycemia led to deterioration in the resident's condition and caused harm to the resident. Id. The implication of the report of the May 27 - 29, 1998 survey is that the unreported episodes of reduced blood sugar that were experienced by Resident 5 resulted in her experiencing breathing problems and upper extremity edema and caused the resident to hospitalized.

At the hearing, Mr. Fuller amplified on these allegations by asserting that, as a consequence of Petitioner's staff's alleged derelictions of care, Resident 5 suffered life threatening hypoglycemia. He averred further that Petitioner's staff gave the resident incorrect treatment for low blood sugar consisting of lemonade and sugar accompanied on one occasion with ice cream and graham crackers as opposed to the orange juice that had been ordered by Dr. Kumar. Tr. at 275 - 276.

Petitioner asserts that Dr. Kumar's order is ambiguous. According to Petitioner, Dr. Kumar's order may be read to mean that he wanted to be notified only if Petitioner's staff was unsuccessful in raising the resident's blood sugar above 70 mg/dl. This is not a wholly unreasonable reading of Dr. Kumar's order. But, it is at least equally likely that Dr. Kumar meant that the staff should notify him of any blood sugar reading that was below 70 mg/dl.

There is no question that Petitioner's staff erred by not at least obtaining a clarification from Dr. Kumar of the meaning of his order. However, the failure by Petitioner's staff to notify Dr. Kumar of the resident's blood sugar when it fell below 70 mg/dl did not place the resident at risk of harm. That is because the treatments that the staff administered to reverse the low blood sugar promptly and effectively raised it back to a safe level. The weight of the evidence is that the resident neither suffered from an episode of severe hypoglycemia nor did she experience other medical problems as a consequence of her episodes of low blood sugar.

I base my conclusion that there was neither harm nor the potential for harm to Resident 5 primarily on the credible testimony of Dr. Robinson. He is a board certified physician, a medical director of skilled nursing facilities, and an expert in geriatric medical care. He is far better qualified to evaluate the care that was given to Resident 5 than are the surveyors who testified on behalf of HCFA.

Dr. Robinson's credible expert opinion is that Resident 5 suffered not even the potential for harm as a consequence of Petitioner's staff's failure to notify Dr. Kumar of the resident's blood sugar readings of below 70 mg/dl. Tr. at 870 - 871. Based on Dr. Robinson's opinion, I conclude that there is no meaningful difference between the treatments that Petitioner's staff administered to Resident 5 in order to raise the resident's blood sugar – administering fruit juice, lemonade, and sugar – and Dr. Kumar's prescription that orange juice be administered in order to raise the resident's blood sugar. Id. at 875 - 876. Dr. Robinson established that these treatments were effective in promptly raising the resident's blood sugar to an acceptable level. I conclude also, based on Dr. Robinson's credible expert testimony, that the resident never suffered an episode of severe hypoglycemia on May 11 and May 12, 1998. Id. at 872. Finally, and most significantly, I find from Dr. Robinson's credible expert testimony that the breathing problems and edema that the resident experienced were unrelated to, and not exacerbated by, her low blood sugar readings. Id. at 876 - 878.

c. Resident 2 (May 27 - 29, 1998 survey)

The surveyors assert that Petitioner's staff was derelict in caring for Resident 2 by failing to react to or to take remedial action to address indications that the resident was suffering from a bowel obstruction. HCFA Ex. 10 at 11 - 12. The surveyors allege additionally that Petitioner's staff did not perform necessary assessments of the resident's medical signs which might have led the staff to conclude that Resident 2 was suffering from a bowel obstruction. Id. At the hearing, it became evident that the surveyors believed that Petitioner's staff should have questioned the diagnosis that had been made of the resident's condition by Dr. McGrew, the resident's treating physician, and the treatments that were ordered for Resident 2 by Dr. McGrew.

i. Resident 2's medical problems and the history of her stays at Petitioner's facility

Resident 2 resided at Petitioner's facility from March 24, 1998 until April 25, 1998, and again from April 30, 1998 until May 25, 1998. P. Ex. 22 at 1, 177, 184. The resident suffered from, among other things, severe Alzheimer's dementia. Id. at 177. On May 13, 1998, the resident received out-patient surgery for amputation of the third toe on her right foot, due to gangrene. Id. at 121. Resident 2 was under the care of Dr. McGrew during her stays at Petitioner's facility.

ii. Evaluation of the surveyors' allegations of deficient care

The surveyors ground their allegations that Resident 2 received deficient care on developments in the resident's case which began on May 14, 1998, the day after the resident returned to Petitioner's facility from out-patient surgery. HCFA Ex. 10 at 8. The resident experienced repeated episodes of loose stools and diarrhea, beginning with that date. HCFA Ex. 10 at 8; P. Ex. 22 at 122 - 124. Over the next 12 days, Dr. McGrew treated the resident for her loose stools and associated bowel problems. On May 26, 1998, the resident was transferred to a hospital for evaluation of her bowel problems at the request of the facility's director of nursing. Id. at 146.

The surveyors allege that, during the period which began on May 14, 1998 and which ended with the resident's transfer to a hospital, Resident 2 was evidencing signs of a bowel obstruction. The surveyors assert that during this period Petitioner's staff failed to assess the resident's condition. They contend that Petitioner's staff should have challenged Dr. McGrew's failure to diagnose and treat a bowel obstruction in the resident. They contend that Petitioner's staff's failure to do so – and, if necessary, to seek intervention from a physician other than Dr. McGrew – constituted an abdication of

responsibility by the staff in contravention of professionally recognized standards of care that are applicable to staffs of long-term care facilities.

I do not find merit in the surveyors' allegations that Petitioner's staff failed to perform the necessary assessments of Resident 2's condition and to communicate their findings to Dr. McGrew. The nursing notes are replete with such assessments and recorded contacts between staff and Dr. McGrew. P. Ex. 22 at 122 - 147.

Nor do I find merit in the surveyors' assertion that Petitioner's staff was derelict in caring for Resident 2 because it failed to challenge the diagnosis of the resident's condition made by Dr. McGrew or the treatment that Dr. McGrew ordered for the resident. I do not find that there is any professional standard of care or requirement incorporated in the regulations which govern long-term care facilities which requires that a facility's professional staff challenge the subjective decisions of a physician that are beyond the training and expertise of the staff to evaluate. Furthermore, I find that the preponderance of the evidence establishes that Dr. McGrew's diagnosis and treatment plan for Resident 2 were reasonable given the information that was available to him and the wishes of the resident's family concerning the type of treatment that the resident was to receive.

The surveyors and HCFA assert that there is a professionally recognized standard of care which obligates a nursing staff to challenge any action by a medical professional which appears on its face to be wrong. The premise which underlies the alleged failure by Petitioner's staff to adhere to this standard is that Dr. McGrew plainly was wrong to not diagnose or treat a bowel obstruction in Resident 2. HCFA argues that its asserted standard of care is contained in the American Nurses Association (ANA) Code for Nurses. HCFA Ex. 25. This code instructs nurses to take "appropriate action" to safeguard a patient's interests where the actions of any member of a health care team jeopardize the best interests of a patient. Id. at 5.

I am not persuaded that the standard asserted by HCFA attaches to the type of subjective diagnosis by a physician and the corresponding treatment orders that are at issue here. The ANA standard would, on its face, require a nurse to challenge any decision that the nurse – based on his or her training and expertise – suspects to be jeopardizing the best interests of a patient. It does not require a nurse to presume that he or she possesses the unique skills and experience that a physician possesses and to second-guess those judgments that a physician might make that are uniquely within the skill and training of the physician.

The surveyors and HCFA are incorrect to conclude that the ANA standard of care obligated Petitioner's staff to challenge Dr. McGrew's diagnosis and treatment of Resident 2's condition. That is because Dr. McGrew relied on his professional training and expertise as a physician to make his diagnosis and to order treatment for the resident. There is nothing of record in this case to show that any non-physician professional on Petitioner's staff had the training and expertise that would enable that individual to second guess Dr. McGrew. Nor is there any evidence to show that Dr. McGrew's diagnosis and treatment plan were objectively wrong in a way that a nurse would have been able to recognize.

Dr. McGrew made his decisions based on a complex and subtle set of medical findings. He made subjective judgments that only he was qualified to make, based on his training and expertise as a physician. The decisions by Dr. McGrew, which the surveyors assert Petitioner's staff ought to have challenged, are not decisions which a non-physician medical professional with limited training and experience might be able to evaluate. This is not a case where, for example, the physician prescribed a dosage of medication that a nurse, based on his or her training and expertise, would know was in the wrong quantity, or where the physician ordered care that a nurse, based on his or her training and expertise, could say was clearly contraindicated by the medical signs exhibited by a patient.

The inexorable consequence of HCFA's assertion that Petitioner's staff ought to have challenged the subjective judgments that were made by Dr. McGrew is that a facility's nursing staff would be obliged to challenge *every* subjective judgment made by a physician that is based on equivocal signs and findings. HCFA has not drawn any line between allegedly what ought to have been done here by Petitioner's staff and what might arguably be required of any nursing staff in the circumstance where a physician who supervises a patient's case makes a subjective diagnosis of the patient's illness. I find this proposition to be untenable. It would stand on its head the relationship between a physician and subordinate medical staff. There is no basis for this proposition, either in applicable professional guidelines for nurses or in HCFA's own regulations.

HCFA asserts that its regulations require a nursing staff to challenge a physician's subjective judgments. According to HCFA, the requirement that services provided by a facility must meet professional standards of quality, contained in 42 C.F.R. § 483.20(d)(3)(i), encompasses this asserted standard of care. I am not persuaded that this regulation lends any support to HCFA's argument. The regulation says only that a facility must comply with standards of quality. It does not define any particular standard of care, much less the asserted standard which HCFA advocates.

HCFA observes also that a nursing facility's medical director must evaluate reports of possibly inadequate medical care. HCFA asserts that this requirement anticipates instances where members of a facility's staff report possibly inadequate or inappropriate care. I do not disagree with this assertion. But it begs the question of whether the training and experience of Petitioner's staff imposed on it the duty to question Dr. McGrew's judgment.

Finally, HCFA asserts that a response to a comment to the regulations supports its argument that Petitioner's staff was obligated to challenge Dr. McGrew's diagnosis of Resident 2's condition and the care that Dr. McGrew prescribed for the resident. The response, contained in 59 Federal Register at 56227, states that a facility may not be excused from its obligation to provide a resident services to which a resident is entitled by relying on the order of a physician. I find nothing in that comment to suggest that a facility has a duty to *challenge* the order of a physician where that order is not wrong on its face and where the facility's staff lacks the training and expertise that would be necessary to evaluate the physician's order for correctness.

HCFA argues in its reply brief that the deficient care that Petitioner's staff committed in the case of Resident 2 was its asserted failure to challenge Dr. McGrew's orders that a bowel paralytic – lomotil – be administered to the resident instead of some other more suitable medication. This argument is somewhat of a shift from the surveyors' assertion that Petitioner's staff should have challenged Dr. McGrew's diagnosis of the resident's condition. Perhaps this is an attempt to make the alleged deficiency appear on its face to be a failure by staff to challenge the use of a palpably incorrect medication. However, Dr. McGrew's prescription of lomotil to the resident is distinguishable from a situation where a physician might prescribe a drug in the wrong dosage amount. And, his decision to prescribe lomotil to the resident is connected inextricably to his diagnosis of the resident's condition.

Here, the medication that Dr. McGrew prescribed was entirely consistent with his diagnosis of the resident's condition. The prescription was reasonable assuming Dr. McGrew's diagnosis to be reasonable. At bottom, any challenge of Dr. McGrew's prescription of lomotil would constitute a challenge of Dr. McGrew's diagnosis and plan of care for the resident.

To support its argument that Dr. McGrew plainly prescribed the wrong medication, HCFA relies on Mr. Fuller's testimony that Resident 2 received a different medication – magnesium citrate – while she was hospitalized. HCFA asserts that the treating physician's choice of a different medication (apparently, a laxative instead of a bowel

paralytic) than that which Dr. McGrew prescribed proves that Dr. McGrew made the wrong diagnosis and treatment plan for Resident 2.

I am not persuaded by this argument. First, it is not entirely clear that the hospital actually administered a laxative to the resident. HCFA's assertion that this happened is based on Mr. Fuller's hearsay recitation of what he allegedly was told by an unnamed person at the hospital. There is nothing in the treatment records in evidence which supports this testimony. I am not prepared to accept it as true absent some corroboration. More important, the fact that the physician who treated the resident at the hospital might have opted to treat the resident differently than did Dr. McGrew is not a basis to conclude that Petitioner's staff had the training or expertise, and the duty, to challenge Dr. McGrew's subjective diagnosis and treatment plan.

The preponderance of the evidence does not support an assertion that Dr. McGrew made an incorrect diagnosis of the resident's condition. Nor does it show the resident to have been suffering from a bowel obstruction as is contended by the surveyors. Rather, the weight of the evidence is that Dr. McGrew made an appropriate subjective diagnosis and prescribed appropriate care for Resident 2, based on his knowledge of the resident's medical signs. I base my conclusions on Resident 2's treatment records, the testimony of Dr. McGrew, and on the analysis of the care given to the resident that was offered by Petitioner's expert witnesses, particularly Dr. Robinson.

One assumption which underlies the surveyors' assertions is that Resident 2 was suffering from a bowel obstruction which Dr. McGrew failed to diagnose. The surveyors – evidently to support this assumption – assert specifically that the resident ultimately was transferred to a hospital where she was "treated for small bowel obstruction." HCFA Ex. 10 at 11. In fact, the medical records of Resident 2 do not support the conclusion that the resident suffered from a small bowel obstruction. The x-rays done prior to the resident's hospitalization were inconclusive. Although the resident was diagnosed *on admission* to the hospital to be suffering from a small bowel obstruction, x-rays performed subsequent to the resident's admission were inconclusive. P. Ex. 22 at 184 - 192. In any event the physicians who treated the resident while she was hospitalized ordered conservative treatment for the resident, as had Dr. McGrew, in light of the resident's family's wish that the resident not be treated surgically. Id.

Dr. Robinson's credible expert opinion is that the care which Dr. McGrew and Petitioner's staff gave to Resident 2 was reasonable and appropriate. Tr. at 805 - 806. He found nothing in the record of care of that resident to suggest that Petitioner's staff should have challenged the care that was provided to Resident 2 by Dr. McGrew. Id. at 806.

Dr. Robinson's testimony concerning the care that Dr. McGrew and Petitioner's staff provided to Resident 2 includes an extensive event-by-event review of that care. Tr. at 804 - 869. I find it to be a credible recounting of events. I accept as credible and persuasive Dr. Robinson's expert opinion that the care demonstrated in the records which he reviewed establishes that Dr. McGrew and Petitioner's staff acted reasonably in the case of Resident 2. I accept also his opinion that the actions of Petitioner's staff in caring for Resident 2 caused neither harm nor the potential for harm to the resident. Dr. Robinson's testimony is ample support for my conclusion that there was no clear evidence of inappropriate diagnosis or treatment by Dr. McGrew which ought to have motivated Petitioner's staff to challenge Dr. McGrew's diagnosis of Resident 2's condition or the treatment that he ordered be administered to Resident 2.

It is not necessary for me to restate in detail Dr. Robinson's evaluation of the care that Petitioner and Dr. McGrew gave to Resident 2. I summarize aspects of his testimony which I find to be critical to my conclusion that Petitioner's staff did not contravene professionally recognized standards of nursing care when it did not challenge Dr. McGrew's diagnosis and treatment of Resident 2's condition.

- The quality of nursing assessments performed throughout the period in question was excellent. Tr. at 804 - 869.

- The resident's distended abdomen, which she manifested beginning with May 18, 1998, was not necessarily a sign of acute illness in the resident, particularly given the absence of other signs of acute illness such as resistance to palpation of the resident's abdomen ("guarding"). Tr. at 814 - 815.

- The signs of illness displayed by Resident 2 did not mandate that Petitioner's staff perform a digital rectal examination of the resident. Tr. at 816 - 817.

- The fact that Resident 2 manifested hypoactive (diminished) bowel sounds suggested that the resident did not have a bowel obstruction. Typically, a bowel obstruction is accompanied by hyperactive (increased) bowel sounds. Tr. at 817.

- The resident's production of a large quantity of stool on May 19, 1998 is inconsistent with a diagnosis of a bowel obstruction. Usually, there is no stool produced by an individual with a bowel obstruction. Tr. at 818.

- The diagnosis of gastroenteritis, which Dr. McGrew made of Resident 2 on May 19, 1998, is consistent with the clinical evidence that was available to Dr. McGrew and is a reasonable diagnosis. Tr. at 823.

• Diagnosing an abdominal illness technically is difficult. Only a physician is qualified to do an abdominal examination of a patient leading to a diagnosis of that patient's illness. Tr. at 826 - 827.

• Dr. McGrew's declaration on May 20, 1998 that he was aware of the resident's bowel distention but was not concerned about it was not a basis for Petitioner's nursing staff to challenge his diagnosis or treatment of the resident. Tr. at 829 - 831.

• Dr. McGrew's decision to order that lomotil be administered to Resident 2 on May 21 and May 22, 1998 was not a basis for Petitioner's staff to challenge either Dr. McGrew's diagnosis of the resident's condition or the treatment that he ordered to be administered to the resident. Tr. at 833 - 835.

• The care that Dr. McGrew ordered for Resident 2, beginning with May 22, 1998, was appropriate in light of the decision of the resident's family to opt for palliative care of the resident rather than aggressive curative care. There was no basis for Petitioner's nursing staff to challenge Dr. McGrew's diagnosis or treatment of the resident in light of the decision to give the resident palliative care. Tr. at 836 - 843.

• The report of an abdominal x-ray that was made of Resident 2 on May 22, 1998, which included the statement that the findings were worrisome for a small bowel obstruction, was not in and of itself either a basis for Dr. McGrew to change his diagnosis of the resident's condition or his treatment of the resident, nor was it a basis for Petitioner's staff to challenge Dr. McGrew's decisions. The report was not conclusive. Furthermore, it could not be a basis for a diagnosis of the resident's condition in the absence of an examination of the resident's abdomen. Tr. at 844 - 848.

• Dr. McGrew's May 22, 1998 order to Petitioner's staff to increase the administration of lomotil to Resident 2 was not inappropriate, in light of the decision to give palliative care to the resident. Tr. at 848 - 849.

• There was nothing about the single episode of fecal (foul smelling) emesis (vomiting) that the resident experienced on May 25, 1998 which was a basis for Petitioner's nursing staff to challenge either Dr. McGrew's diagnosis of or treatment of Resident 2. Tr. at 854 - 858.

• Dr. McGrew's decision on May 26, 1998 not to order that Resident 2 be hospitalized was appropriate in light of the resident's condition and in light of the decision to give palliative care to the resident. There was no basis for Petitioner's staff to challenge that decision. Tr. at 859 - 862.

d. Resident 1 (May 27 - 29, 1998 survey)

The surveyors assert that Petitioner's staff was derelict in caring for Resident 1 in that it failed to react to or take action to counter an allegedly significant loss of weight that the resident experienced. HCFA Ex. 10 at 19.

i. Resident 1's medical problems and the history of her stay at Petitioner's facility

Resident 1 resided at Petitioner's facility, beginning on April 27, 1998, in order to recuperate from surgery. P. Ex. 21 at 1. The resident had been hospitalized from April 23, 1998 until April 27, 1998 for surgical repair of a fractured hip. Id. at 276 - 277. The resident was discharged from Petitioner's facility to her home on June 5,1998. Id. at 1.

ii. Evaluation of the surveyors' allegations of deficient care

The surveyors premised their findings that Petitioner's staff gave deficient care to Resident 1 on the resident's apparent loss of weight while at Petitioner's facility. They contend that the resident weighed 138.6 pounds on May 4, 1998 and weighed 124.8 pounds on May 12, 1998. HCFA Ex. 10 at 18. The surveyors assert that the resident continued to lose weight and weighed 120 pounds on May 28, 1998. Id. at 19. The surveyors assert further that Petitioner's staff misplaced two calorie counts that were performed on May 16 and 17, 1998, on Resident 1, and thereby precluded Petitioner's dietician from reviewing the counts. Id. at 18 - 19.

The preponderance of the evidence is that Petitioner's staff was attentive to Resident 1's nutrition needs while the resident resided at Petitioner's facility. I do not find that Petitioner's care of the resident caused either harm or the potential for harm to the resident.

I find that the resident's weight on admission to Petitioner's facility was closer to 125 pounds than to the 138.6 pounds which the surveyors cite as the resident's initial weight. The preponderance of the evidence of the resident's weight is that her weight was recorded incorrectly on admission to Petitioner's facility. It is true that on April 27, 1998 (and not on May 4, 1998 as the surveyors inaccurately contend), the resident's weight

was recorded as being 138.6 pounds. See P. Ex. 21 at 46. This weight was more than eight pounds above the resident's ideal body weight. See Id. I find the recorded weight to be inconsistent with a description of the resident as being "thin," which is contained in the report of the resident's hospitalization on April 23, 1998. P. Ex. 21 at 279. Furthermore, I find it to be inconsistent with a resident interview which appears to have been conducted on April 28, 1998, in which the resident stated her weight to be 125 pounds. Id. at 45.

However, whatever the resident's weight may have been on her admission, it is apparent that no harm was caused to the resident during her stay at Petitioner's facility. The fact that two records of calorie counts may have been misplaced for a few days did no demonstrable harm to the resident, nor did it pose a potential for more than minimal harm in light of all of the efforts that Petitioner's staff made to attend to the resident's nutritional needs.

Resident 1's weight never declined to the point that it was below the range of weights that were ideal for the resident. P. Ex. 21 at 46; see Tr. at 484. And, contrary to the assertions that were made by the surveyors, the record of care given to Resident 1 by Petitioner's staff demonstrates a high level of attentiveness to the resident's nutritional needs. The record establishes that, rather than ignoring the needs of the resident, the staff was working hard to assure that they were being met. These efforts included: identifying the resident's unique nutrition problems; prescribing a special diet for the resident; assuring that the resident was given an ample quantity of calories to consume; and, continuous monitoring and assessing of the resident's condition.

A nutrition screening and assessment was made of the resident on April 27, 1998. P. Ex. 21 at 46. The assessment noted that the resident had problems eating secondary to some confusion and chewing difficulties. Id. at 47. A mechanical soft diet was prescribed for the resident. Id. A subsequent nutrition screening and assessment was done of the resident. Id. at 48 - 49. Additionally, the resident's condition was reviewed by Petitioner's nutrition risk committee, which made weekly progress reviews of the resident's condition. Id. at 49 - 51. There were frequent communications between Petitioner's nursing staff and Petitioner's dietician concerning the resident's nutrition. Id. at 53 - 61.

Indeed, if the resident encountered nutrition problems during her stay at Petitioner's facility, those problems were in some respects a consequence of the choices made by the resident to not comply with the nutrition program that Petitioner's staff had devised for her. On May 21, 1998, Petitioner's family requested that the resident's diet be changed

from a mechanical soft diet to a regular diet. Petitioner's staff advised the family that this was not appropriate in light of the resident's poor intake of food. P. Ex. 21 at 47.

e. Resident 4 (May 27 - 29, 1998 survey)

The surveyors' assertion of deficient care with respect to this resident is limited to an allegation that a certified nurse assistant (CNA) failed to report episodes of vomiting by the resident to a nurse or to a physician. HCFA Ex. 10 at 19.

i. Resident 4's medical problems and the history of her stay at Petitioner's facility

Resident 4 had been a resident of Petitioner's facility since December 17, 1997. P. Ex. 24 at 1. Her diagnoses upon admission to the facility included upper gastrointestinal bleeding and diverticulitis. Id. at 2. The resident had a history of vomiting due to gastrointestinal problems. Id. at 23.

ii. Evaluation of the surveyors' allegations of deficient care

The assumption which underlies the surveyors' allegations of deficient care with respect to Resident 4 is that failure by a CNA to report contemporaneously two episodes of vomiting by the resident either caused the resident harm or placed the resident at risk for harm. I find this assumption and the surveyors' allegation of deficiency to be without merit. The vomiting which Resident 1 manifested in May, 1998, was consistent with her history and her documented illnesses. Tr. at 898. A delay of a few days in reporting two of these episodes did not pose a risk of more than minimal harm to the resident. Id. I base my conclusion on the resident's treatment records and on the credible expert testimony of Dr. Robinson. Tr. at 889 - 899.

As I note above, the resident had a history of vomiting. But, moreover, her episodes of vomiting were well-known to Petitioner's staff and to the resident's physician and were a regular event caused by the resident's documented gastrointestinal problems. A physician's progress note of January 21, 1998, observes that the resident was vomiting about 50 percent of the time. P. Ex. 24 at 22. On January 30, 1998, an upper endoscopy was performed on the resident which established the resident to be suffering from a number of illnesses that might produce vomiting. Id. at 24; Tr. at 895. These included multiple small duodenal ulcers, a deformed gastric bulb, an antral ulcer, erosive gastritis, and a hiatal hernia with reflux. Ids. Nursing notes record the resident as having vomited on the following dates: January 3, 1998, January 5, 1998, January 11, 1998, January 15, 1998, January 21, 1998, January 22, 1998, February 6, 1998, and February 13, 1998

(there are no nursing notes in evidence for the period between February 13, 1998 and May 9, 1998). P. Ex. 24 at 167 - 176.

2. Petitioner complied substantially with the participation requirement that the surveyors cited at Tag 157 of the reports of the May 4 - 7, 1998 and May 27 - 29, 1998 surveys.

At Tag 157 of the reports of the May 4 - 7, 1998 and May 27 - 29, 1998 surveys, the surveyors asserted that Petitioner failed to comply with the participation requirement that is stated at 42 C.F.R. § 483.10(b)(11) to the extent that residents of Petitioner were placed in a state of immediate jeopardy. HCFA Ex. 3 at 4 - 6, HCFA Ex. 10 at 2 - 5. The regulation requires in pertinent part that a facility must consult with a resident's physician where there is a significant change in a resident's status, where there is a need to alter a resident's treatment significantly, or where there is a need to transfer a resident. Essentially, the surveyors asserted that Petitioner failed to comply with the participation requirement in that Petitioner allegedly failed to give residents' physicians appropriate notification of potentially serious developments in the residents' medical conditions.

The preponderance of the evidence is that Petitioner complied substantially with the requirements of 42 C.F.R. § 483.10(b)(11). There is no basis to find under this regulation that Petitioner's conduct harmed or posed a potential to harm residents, either at a level of immediate jeopardy, or at some lesser degree of endangerment. The surveyors' findings, as stated in their report of the May 4 - 7, 1998 survey, rest entirely on the allegedly deficient care that Petitioner's staff gave to Resident 6. At Finding 1.a., I explain why the preponderance of the evidence establishes that the care given to Resident 6 was not deficient. The surveyors' findings as stated in their report of the May 27 - 29, 1998 survey rest entirely on the allegedly deficient care that Petitioner's staff gave to Resident 5. At Finding 1.b., I explain why the preponderance of the evidence establishes that the care given to Resident 5 was not deficient.

3. Petitioner complied substantially with the participation requirement that the surveyors cited at Tag 224 of the reports of the May 4 - 7, 1998 and May 27 - 29, 1998 surveys.

At Tag 224 of the reports of the May 4 - 7, 1998 and May 27 - 29, 1998 surveys, the surveyors asserted that Petitioner failed to comply with the participation requirement that is stated at 42 C.F.R. § 483.13(c)(1)(i) to the extent that residents of Petitioner were placed in a state of immediate jeopardy. HCFA Ex. 3 at 10 - 17, HCFA Ex. 10 at 5 - 12. The regulation requires in pertinent part that a facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of

residents. In the reports of the two surveys, the surveyors asserted that Petitioner had failed to assure that changes in residents' conditions were reported to the residents' physicians. According to the surveyors, these alleged failures to report changed conditions established that Petitioner had failed to implement a written policy and procedure to prohibit neglect of its residents. HCFA Ex. 3 at 10, HCFA Ex. 10 at 6.

Petitioner argues that HCFA's case against it lacks any proof of an essential predicate element to establishing a deficiency under 42 C.F.R. § 483.13(c)(1)(i), in that HCFA offered no evidence to show that Petitioner had failed to develop and implement written policies and procedures that prohibit neglect of residents. Petitioner asserts that the surveyors and HCFA relied on evidence which they characterized to be proof of "neglect," and then assumed from the presence of "neglect" that Petitioner had not implemented policies and procedures to prevent neglect. Thus, according to Petitioner, HCFA failed to establish even a prima facie case that Petitioner had not complied with the participation requirement that is at issue under Tag 224.

Evidence of an isolated act of neglect is not prima facie proof of a failure by a long-term care facility to implement a policy or procedure to prevent neglect. Life Care Center of Hendersonville, DAB CR542 at 33 (1998). I would not infer failure by Petitioner to implement a policy to prevent neglect from proof of a random incident or incidents of neglect at Petitioner's facility. Id.

The preponderance of the evidence shows that Petitioner's staff did not neglect residents even randomly. Consequently, I find no basis to support the contention that Petitioner failed to implement a policy or procedure to prevent neglect of its residents.

a. What constitutes "neglect"

The term "neglect" is defined by 42 C.F.R. § 488.301 to mean:

> failure [by a long-term care facility or its staff] to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

A showing of neglect therefore requires prima facie evidence that: (1) goods and services have been withheld from a resident; and (2) that the withheld goods and services are *necessary* to avoid physical harm, mental anguish, or mental illness.

b. Evaluation of the surveyors' allegations in their report of the May 4 - 7, 1998 survey

The surveyors, in their report of the May 4 - 7, 1998 survey, based their allegations that Petitioner did not implement policies or procedures to prevent neglect of residents on their findings concerning Petitioner's allegedly deficient care of Resident 6 and on additional findings made from interviews of residents. As I find above at Finding 1.a. of this decision the preponderance of the evidence is that Petitioner was not deficient in providing care to Resident 6. That finding subsumes my conclusion that there was no neglect of the resident.

I am not persuaded by the additional allegations of neglect in the report of the May 4 - 7, 1998 survey that Petitioner neglected its residents. See HCFA Ex. 3 at 14 - 16. Many of these allegations arise from the hearsay assertions of anonymous residents. Id. at 14 - 16. I do not find these allegations to be credible and, therefore, I do not make any findings from them that Petitioner neglected to provide care to its residents.

I routinely admit hearsay statements into evidence. I have held on innumerable occasions that I am unlikely to be prejudiced by hearsay as might be a juror in a civil lawsuit. For that reason, I do not find it necessary to preclude the admission of hearsay in a hearing that I conduct. But, I have also held on innumerable occasions that my admitting hearsay does not mean that I will find it to be probative. The credibility of hearsay evidence is inherently suspect because it is always difficult for the party against whom that evidence is offered to test or impeach the credibility of the declarant.

The hearsay that the surveyors and HCFA rely on to support their allegations that Petitioner failed to implement a policy or procedure to prevent neglect is precisely the kind of evidence that I find to be inherently suspect. Most of the allegations come from anonymous sources. That makes it difficult or impossible to test or impeach the credibility of the declarants. Furthermore, HCFA has offered virtually no evidence to corroborate these anonymous complaints. I infer that the surveyors failed to look for evidence to corroborate or refute the allegations. Yet, at least some of the anonymous complaints might have been corroborated or refuted had the surveyors looked for corroborating evidence. For example, the surveyors reported in a "group consensus" of residents they interviewed that residents were being denied the opportunity to take showers. HCFA Ex. 3 at 15 - 16. Yet, the surveyors apparently made no effort to ascertain whether any residents appeared to be unkempt or unwashed.

I find further that Petitioner succeeded in rebutting the allegations to the extent that it was able to identify the declarants or was able to ascertain the facts which were the basis for the complaints reported by the surveyors. For example, one of the anonymous complainants asserted that he requested a plastic cover for a bandage in order to facilitate taking a shower, did not receive that cover, took a shower after a long wait, and was scolded by Petitioner's staff for having taken a shower with an uncovered bandage. HCFA Ex. 3 at 15. The credible testimony of Ms. Barfield is that the resident was told at 9:30 a.m. on the date in question not to take a shower without first receiving bandage covers. However, on his own volition, the Resident took a shower at some time between 9:30 and 10:30 a.m. on the date in question without receiving the bandage covering. Tr. at 752 - 755. A one hour delay in taking a shower -- assuming that the resident waited a full hour before showering -- is hardly a "long wait." Moreover, there is no evidence that the resident was harmed or even potentially harmed by the wait for the shower.

Two of the hearsay complaints involved identified residents, Residents 19 and 11. Resident 19 complained that she had repeatedly requested a cold pack for pain relief and had to wait for three hours before one was supplied to her. HCFA Ex. 3 at 16. Resident 11 complained that she had been left unattended for 10 minutes in a whirlpool bath due to a faulty call light during which time the water became cold. Id.

I am not persuaded that, assuming these alleged episodes to be true, HCFA offered prima facie evidence that either Resident 19 or Resident 11 experienced the potential for even minimal harm from the alleged derelictions of Petitioner's staff. Moreover, Petitioner offered persuasive evidence which refuted the allegations. In the case of Resident 19, Petitioner established that the delay in providing a cold pack to the resident resulted from the resident's initial reluctance to accept an ice pack for fear that it might leak. Tr. at 759 - 760. The delay in providing a cold pack was resolved within 15 minutes. Id. In the case of Resident 11 and the whirlpool bath, Petitioner acknowledged that there was a defective call light. However, the call buzzer, which works in tandem with the light, was not defective. Furthermore, the water in the whirlpool bath would not have cooled significantly in a ten minute period of time. Tr. at 756 - 757.

c. Evaluation of the surveyors' allegations in their report of the May 27 - 29, 1998 survey

The surveyors base their assertions, in the May 27 - 29, 1998 survey report, that Petitioner did not implement policies and procedures to prevent neglect entirely on the allegedly deficient care that Petitioner gave to Residents 5 and 2. HCFA Ex. 10 at 6 - 12. I have discussed the care that Petitioner gave to Residents 5 and 2 above, at Findings 1.b. and 1.c., respectively. I have not found the care to be deficient for either resident. In

particular, I do not find that the care that Petitioner gave to these two residents posed even the possibility of more than minimal harm to the residents. Based on these findings, I do not find that Petitioner neglected either Resident 5 or Resident 2. Therefore, I do not find that Petitioner failed to implement policies or procedures to prevent neglect of its residents as is alleged in the report of the May 27 - 29, 1998 survey.

My discussion of the care which Petitioner's staff gave to Resident 5 includes an evaluation of the staff's failure to comply with Dr. Kumar's possible order to report to him blood sugar readings of below 70 mg/dl that were observed in Resident 5. As I discuss above, at Finding 1.b., this omission by Petitioner's staff posed no potential to harm the resident in light of the staff's prompt and effective care of the resident's low blood sugar. Therefore, I do not find this omission by the staff to constitute an act of neglect. However, I would not find the failure by the staff to report the resident's low blood sugar to be a basis for finding that Petitioner had not implemented a policy or procedures to prevent neglect of residents even were I to conclude that the omission constituted neglect of Resident 5. That is because the omission is at most a random act of neglect from which I do not infer a failure by Petitioner to implement any policy or procedure to prohibit neglect of its residents.

4. Petitioner complied substantially with the participation requirement that the surveyors cited at Tag 281 of the reports of the May 4 - 7, 1998 and May 27 - 29, 1998 surveys.

At Tag 281 of the reports of the May 4 - 7, 1998 and May 27 - 29, 1998 surveys, the surveyors asserted that Petitioner was not complying with the participation requirement that is stated in 42 C.F.R. § 483.20(d)(3)(i). This requirement is that the services provided or arranged for by a long-term care facility must meet professional standards of quality.

a. Evaluation of the surveyors' allegations in their report of the May 4 - 7, 1998 survey

The surveyors base their assertions of deficiency in the May 4 - 7, 1998 survey report on an alleged failure by Petitioner to meet professional standards of quality in caring for "one resident who experienced a decline in medical condition." HCFA Ex. 3 at 27 - 28. The surveyors assert further that Petitioner's staff failed to follow physician orders and failed to identify and/or notify the resident's physician of changes in the resident's condition. Id.

The resident whose care is at issue is not identified specifically in the survey report. However, it is possible to tell from the context of the statements in the survey report that the resident is Resident 6, whose care I have discussed in detail above, at Finding 1.a. That is made evident by the surveyors' description of the allegedly deficient care that was given to the resident.

I find no failure by Petitioner to comply with professional standards of quality as is alleged by the surveyors. As I discuss at Finding 1.a., the care that Petitioner gave to Resident 6 was not deficient. It certainly complied with professional standards of quality.

The allegations which the surveyors make under Tag 281 about the care that Petitioner gave to Resident 6 include the assertion that the resident was transferred to a hospital for control of aggressive behavior rather than having that behavior assessed by facility staff. The weight of the evidence is that Resident 6 was transferred to a psychiatric hospital for evaluation of extreme agitation which posed a danger to the resident and to other individuals, including other residents of Petitioner's facility. I find this transfer to have been appropriate and reasonable given the resident's mental state at the time. The resident needed to be evaluated and assessed by a trained psychiatric staff.

b. Evaluation of the surveyors' allegations in their report of the May 27 - 29, 1998 survey

The surveyors base their allegations of deficiency under Tag 281, in the report of the May 27 - 29, 1998 survey, entirely on the care that Petitioner's staff gave to Residents 5, 2, 1, and 4. HCFA Ex. 10 at 12 - 19. I have discussed the care which Petitioner's staff gave to these residents above at Findings 1.b., 1.c., 1.d., and 1.e. I found that none of the care at issue was deficient. For that reason I conclude that Petitioner was not deficient under Tag 281 as is alleged by the surveyors in their report of the May 27 - 29, 1998 survey.

5. Petitioner complied substantially with the participation requirement that the surveyors cited at Tag 327 of the report of the May 4 - 7, 1998 survey.

At Tag 327 of the report of the May 4 - 7, 1998 survey, the surveyors allege that Petitioner was not complying with the requirements of 42 C.F.R. § 483.25(j). This requirement states that a long-term care facility must provide each resident with sufficient fluid intake to maintain the proper hydration and health of the resident.

I find no deficiency under this tag. The surveyors base their assertions entirely on the allegedly deficient care that Petitioner gave to Resident 6. HCFA Ex. 3 at 31 - 34. At Finding 1.a. of this decision I find that Petitioner's care of Resident 6 was not deficient.

6. HCFA did not establish a basis to impose a civil money penalty against Petitioner in the range of civil money penalties that is imposed to remedy noncompliance at the immediate jeopardy level for any day of the period that begins with May 7, 1998 and which runs through June 1, 1998.

The premise for HCFA's determination to impose a civil money penalty against Petitioner of $10,000 per day for each day of the period which begins on May 7, 1998 and which runs through June 1, 1998 is that, for each day of the period, Petitioner was not complying with a participation requirement or requirements to the extent that residents of Petitioner were placed in immediate jeopardy. The requirements at issue were cited at Tags 157, 224, 281, and 327 of the report of the May 4 - 7, 1998 survey and at Tags 157, 224, and 281 of the report of the May 27 - 29, 1998 survey. I have concluded at Findings 2 - 5 of this decision that Petitioner complied substantially with the participation requirements that were cited under the tags at issue. There is no basis to impose a civil money penalty at the immediate jeopardy level of from $3,050 - $10,000 per day against Petitioner for any day of the May 7 - June 1, 1998 period.

It is not necessary here for me to decide whether the surveyors conclusions as to the levels of Petitioner's noncompliance under tags 157, 224, 281, and 327 were clearly erroneous. See 42 C.F.R. § 498.60(c)(2). That is because I conclude that Petitioner complied substantially with the participation requirements that are cited under each of the tags in the reports of the May 4 - 7, 1998 and May 27 - 29, 1998 surveys of Petitioner.

7. As of May 7, 1998 Petitioner was deficient in complying with participation requirements other than those cited under Tags 157, 224, 281, and 327 in the report of the May 4 - 7, 1998 survey, at a level of noncompliance that was less than the immediate jeopardy level of deficiency.

As I discuss above, at Part I of this decision, the surveyors found Petitioner to be deficient in numerous respects at the May 4 - 7, 1998 survey of Petitioner. Those deficiency findings included the four citations of immediate jeopardy which I have ruled on in Findings 1 - 6. They include also findings that Petitioner was not complying with additional participation requirements, albeit at a level of deficiency that is less than the immediate jeopardy level. Several of the additional alleged deficiencies involve

Petitioner's asserted failure to complete assessments of residents mandated by the Act and implementing regulations.

The evidence which HCFA offered concerning these additional alleged deficiencies establishes a prima facie case of noncompliance by Petitioner with the participation requirements that are cited. I have reviewed the evidence which the parties introduced concerning the additional alleged deficiencies. I conclude that Petitioner did not rebut by the preponderance of the evidence the prima facie of noncompliance established by HCFA. I discuss these additional deficiencies below.

a. Tag 203 (HCFA Ex. 3 at 6 - 8)

The participation requirement that the surveyors cite under Tag 203 is stated at 42 C.F.R. § 483.12(a)(4) - (6). The regulation requires, generally, that before a facility transfers or discharges a resident it must notify the resident and other responsible individuals in a comprehensible written notice of the reason for the transfer. The regulation contains requirements that specific items be included in the notice. 42 C.F.R. § 483.12(a)(6).

I find HCFA's prima facie case under Tag 203 not to have been rebutted by Petitioner. The surveyors alleged that, in three instances, Petitioner had transferred or discharged residents without providing them or their families with the requisite notices. HCFA Ex. 3 at 8. Petitioner did not dispute this assertion nor did it offer evidence to refute it.

b. Tag 205 (HCFA Ex. 3 at 8 - 10)

The participation requirement that the surveyors cite under Tag 205 is stated at 42 C.F.R. § 483.12(b)(1), (2). This regulation generally requires a long-term care facility to give a resident or other responsible persons written notice of the facility's bed hold policy prior to transferring the resident to a hospital or allowing the resident to go on therapeutic leave. The plain purpose of the regulation is to assure a resident whether, and under what circumstances, a bed will be available to that resident if and when the resident seeks to return to a facility after a stay in a hospital or therapeutic leave from the facility.

I find that Petitioner did not rebut the prima facie case of noncompliance that HCFA established under Tag 205 in the report of the May 4 - 7, 1998 survey. The surveyors asserted that in two instances Petitioner failed to give the requisite bed hold notice to residents who had been transferred to hospitals or to other responsible persons who represented these residents. Petitioner did not dispute this assertion or offer evidence to refute it.

c. Tag 241 (HCFA Ex. 3 at 17 - 18)

The participation requirement that the surveyors cite under Tag 241 is stated at 42 C.F.R. § 483.15(a). This regulation requires that a facility must promote care for its residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

The surveyors allege that Petitioner failed in two respects to promote care for a resident in a manner that showed respect for the dignity of that resident. In one instance, the surveyors observed that a nurse failed to treat with respect a resident who had been incontinent. HCFA Ex. 3 at 17 - 18. In another instance, the surveyors observed that a wheelchair bound resident complained that he had not been taken for a walk despite repeated requests made to the staff that the resident be walked. Id. at 18.

I find that HCFA's prima facie case of noncompliance under Tag 241 was not rebutted by Petitioner. Petitioner offered no evidence to challenge the surveyors' findings.

d. Tag 246 (HCFA Ex. 3 at 18 - 19)

The participation requirement that the surveyors cite under Tag 246 is stated at 42 C.F.R. § 483.15(e)(1). This regulation provides that a resident of a long-term care facility has the right to reside and receive services in the facility with reasonable accommodations by the facility of the resident's individual needs and preferences, provided that such accommodations not endanger the health or safety of the resident or of other residents.

The allegation that the surveyors make under Tag 246 was that Petitioner failed to accommodate the needs of a resident who suffered from seizures. Petitioner's staff is alleged essentially to have ignored the resident's need for special positioning and physical support. HCFA Ex. 3 at 19.

Petitioner offered no evidence to rebut this assertion. I find that HCFA's prima facie case under Tag 246 was not rebutted by the preponderance of the evidence.

e. Tag 272 (HCFA Ex. 3 at 19 - 23)

The participation requirement that the surveyors cite under Tag 272 is stated at 42 C.F.R. § 483.20(b). The regulation requires that a facility must make a comprehensive assessment of each resident's needs which is based on a uniform data set that is established by the Secretary. The facility must use a form that is specified by the State in which it does business and which is approved by the Secretary. The document must

describe the resident's capability to perform the functions of daily life as well as the resident's impairments and significant limitations. The regulation further prescribes the specific elements that must be contained in each comprehensive assessment.

The regulation essentially duplicates a requirement that is stated in the Act at sections 1819(b)(3) and 1919(b)(3). The regulation adopts a congressional mandate that a long-term care facility perform a comprehensive assessment according to precisely stated standards. And, it implements a congressional finding that such an assessment is necessary to promote the health, safety, and well-being of each Medicare beneficiary and Medicaid recipient who resides in a participating long-term care facility.

The surveyors assert that Petitioner did not make requisite comprehensive assessments in the cases of 16 residents whose records the surveyors reviewed. HCFA Ex. 3 at 20 - 23. Petitioner does not dispute these fact assertions. It argues, however, that HCFA failed to prove that there was a potential for more than minimal harm in any of the instances cited by the surveyors. Therefore, according to Petitioner, it did not fail to comply substantially with the requirements of 42 C.F.R. § 483.20(b).

I disagree with Petitioner's contention that HCFA failed to make out a prima facie case of more than the potential for minimal harm under Tag 272. Implicit in Congress' requirement that a facility perform the mandated assessment in the case of each resident is a finding that a failure to do so poses a threat of more than minimal harm.

Furthermore, the credible and unrebutted testimony of Ms. Rebstock supports the conclusion that there is a potential for significant harm in the case where the required assessments are not completed. As Ms. Rebstock observed:

> The assessments – you know, it all follows a logical sequence. You do the MDS [minimum data set] and it triggers the problem areas. Once you have the problem areas, you're doing an in-depth evaluation of what's causing the problem. Without knowing that, you cannot have a meaningful care plan or treatment plan to meet . . . [a resident's] needs.

Tr. at 144.

What is established, through the testimony of Ms. Rebstock, confirms the congressional finding of a need to perform assessments. An assessment performed under 42 C.F.R. § 483.20(b) is an essential and basic instrument for planning a resident's care. Failure to do so poses a potential for harm because it creates a risk that the resident will not be cared for in an orderly and systematic manner.

Petitioner argues also that it offered rebuttal evidence – through the testimony of Dr. Robinson – that its residents were, in fact, assessed. Although I do not question the credibility of Dr. Robinson's testimony, I do question its relevance to the issue of whether Petitioner assessed its residents according to the requirements of law. Dr. Robinson testified that he found that Petitioner had done extensive assessments of its residents. Tr. at 924. That may be so, but the testimony begs the question of whether any of the residents whose cases are cited by the surveyors received the assessments that the law requires.

f. Tag 273 (HCFA Ex. 3 at 24)

The participation requirement that the surveyors cite under Tag 273 is stated at 42 C.F.R. § 483.20(b)(4)(i). The regulation requires a long-term care facility to complete the assessment that is prescribed for each resident under 42 C.F.R. § 483.20(b) no later than 14 days after the resident's admission to the facility.

The surveyors allege that they reviewed the records of 16 resident records and found Petitioner not to have met the 14-day deadline for completion of the initial assessment for any of these residents. Petitioner asserts that HCFA did no more than show that the surveyors had reviewed the residents' records. Petitioner contends that there is no evidence that the surveyors questioned the staff about the allegedly uncompleted assessments.

I find that HCFA established a prima facie case of deficiency under Tag 273 which Petitioner did not rebut. The surveyors' assertion that the assessments were not present in the residents' treatment records is sufficient to establish a prima facie case and to shift to Petitioner the burden of showing by the preponderance of the evidence that the records were, in fact, completed. The reasonable place for the surveyors to have looked for the assessments was the residents' treatment records. Petitioner had the opportunity to prove at the hearing that the assessments had been completed but were present in some location that had not been examined by the surveyors. It failed to put in any evidence which rebutted the surveyors' specific assertions that assessments had not been completed for the 16 residents.

g. Tag 274 (HCFA Ex. 3 at 25)

The participation requirement that the surveyors cite under Tag 274 is stated at 42 C.F.R. § 483.20(b)(4)(iv). This regulations directs a long-term care facility to conduct a resident assessment promptly after a significant change in the resident's physical or mental condition.

The surveyors base their assertion of a deficiency under Tag 274 on their review of the record of a single resident, Resident 12. The resident had been transferred from one treatment unit to another treatment unit within Petitioner's facility due to a decline in the resident's activities of daily living. HCFA Ex. 3 at 25. The surveyors found that, as of May 5, 1998, Petitioner had not completed assessments or a care plan for the resident. Id.

Petitioner has offered no defense to these findings by the surveyors. I find that HCFA established a prima facie case of a deficiency under Tag 274 which Petitioner did not rebut.

h. Tag 279 (HCFA Ex. 3 at 26 - 27)

The participation requirement that the surveyors cite under Tag 279 is stated at 42 C.F.R. § 483.20(d). This regulation requires a long-term care facility to develop a comprehensive care plan for each of its residents. The plan must include measurable objectives and timetables to meet those needs of the resident that are identified in the comprehensive assessment of the resident that is required by 42 C.F.R. § 483.20(b). The regulation requires that the care plan contain certain specified elements.

The surveyors allege that Petitioner did not develop comprehensive care plans for nine of the 16 residents whose records the surveyors reviewed. HCFA Ex. 3 at 26. The surveyors allege also that in other specified instances care plans were incomplete. Id. at 26 - 27. In a supplemental statement filed by HCFA, it amplified on these allegations by asserting that seven of the care plans that the surveyors reviewed were only preliminary plans that were developed upon admission by physical and occupational therapists for their limited purposes.

Petitioner responds to these allegations by arguing that it is not unreasonable that seven of the care plans were therapy-oriented plans. According to Petitioner, that reflects the fact that Petitioner provided extensive rehabilitation services to short-term residents with acute therapy needs. Petitioner contends that HCFA presented no evidence to show that these seven residents' needs were not actually planned. Petitioner argues further that in the case of one of the residents whose care plan allegedly had not been completed, the plan had in fact been completed but was stored electronically on a computer and had not been printed. Petitioner asserts that the regulation does not require that a care plan be printed in hard copy.

I find that Petitioner did not rebut HCFA's prima facie case that Petitioner failed to complete care plans for several of its residents. The fact that a physical therapy care plan had been developed for some of these residents is insufficient to comply with the requirements of the regulation that a care plan be developed for each resident which addresses *all* of that resident's needs. Petitioner has not contended – much less proved – that the *only* need of these residents was for physical therapy. I do not disagree with Petitioner's assertion that the regulation does not require that a care plan be printed. But, even assuming that the care plan in issue was stored on computer, and assuming further that it was accessible in that form to all of Petitioner's staff who needed to have access to it, that only accounts for one of the several instances in which the surveyors found inadequate care planning to have occurred.

i. Tag 311 (HCFA Ex. 3 at 28 - 30)

The participation requirement that the surveyors cite under Tag 311 is stated at 42 C.F.R. § 483.25(a)(2). This regulation requires a long-term care facility to give a resident the appropriate treatment and services to maintain or improve his or her abilities as specified in 42 C.F.R. § 483.25(a)(1).

The surveyors allege that, in the cases of two residents, Petitioner did not provide restorative ambulation therapy that had been recommended for the residents. HCFA Ex. 3 at 28. They allege additionally that, in the case of one other resident, Petitioner did not provide the resident with requisite hand splints. Id. at 30.

Petitioner has not offered any evidence to refute these allegations. HCFA established a prima facie case of deficiency under Tag 311 which Petitioner did not rebut.

j. Tag 323 (HCFA Ex. 3 at 30 - 31)

The participation requirement that the surveyors cite under Tag 323 is stated at 42 C.F.R. § 483.25(h)(1). This regulation requires a long-term care facility to assure that the environment of the facility remains as free of accident hazards as is possible.

The surveyors allege that Petitioner was deficient in complying with the requirement in that Petitioner failed to assure that the wheels of its residents' beds were locked. HCFA Ex. 3 at 30. Ms. Rebstock, who is one of the surveyors, testified credibly that unlocked bed wheels in a long-term care facility pose a safety hazard for residents who are unsteady or weak and who are vulnerable to injuries from falls. Tr. at 150 - 151.

Petitioner did not offer evidence which responded to the surveyors' findings. HCFA established a prima facie case of deficient care which Petitioner did not rebut.

k. Tag 500 (HCFA Ex. 3 at 36 - 37)

The participation requirement that the surveyors cite under Tag 500 is stated at 42 C.F.R. § 483.75(h)(1), (2). This regulation provides, generally, that a long-term care facility must have written agreements with outside suppliers of services.

The surveyors allege that Petitioner did not comply with the requirement in that it did not have a written agreement to cover dialysis services being provided to two of its residents by an outside supplier of such services. HCFA Ex. 3 at 36. Petitioner has not offered evidence which responds to this allegation. HCFA established a prima facie case of a deficiency which was not rebutted by Petitioner.

l. Tag 490 (HCFA Ex. 3 at 35)

The participation requirement that the surveyors cite under Tag 490 is stated at 42 C.F.R. § 483.75. This regulation requires a long-term care facility to be administered in a manner that enables the facility to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

The surveyors allege that Petitioner failed to comply with the requirement in that Petitioner's administrator did not promptly identify the lack of implementation of systems in order to meet requirements and in order to assure that residents of Petitioner received necessary care. The surveyors alleged specifically that, during the nine months of operation of Petitioner's facility, Petitioner's administrator had not recognized the absence of resident assessments and care plans, transfer and discharge notices, bed hold notices, and agreements with outside suppliers.

Petitioner does not deny the fact allegations which are the basis for the deficiency finding. Petitioner contends, however, that the surveyors contravened survey procedures by reviewing quality assurance records. Petitioner argues also that the surveyors' citation under Tag 490 is counter productive in that the surveyors have cited areas of deficiency that Petitioner was working to improve.

I am not persuaded that Petitioner effectively rebutted the prima facie evidence of deficient care that HCFA introduced. The surveyors' allegations under Tag 490 address more than quality assurance documents. Therefore, assuming for argument's sake that

the surveyors exceeded the scope of their review authority under Tag 490, they nevertheless based much of their findings on material which they properly reviewed. Furthermore, the fact that Petitioner may have been working to improve its operations does not derogate from the fact that it was deficient as of the date of the survey.

8. Petitioner did not prove that it corrected its deficiencies prior to June 2, 1998.

The civil money penalties which HCFA determined to impose against Petitioner run from May 7, 1998 through June 1, 1998. The other remedy that HCFA determined to impose against Petitioner, termination of Petitioner's participation in Medicare, became effective on June 2, 1998. The assumptions that underlie these remedies is that Petitioner: (1) was not complying substantially with participation requirements, effective May 7, 1998; and (2) had not attained compliance with all participation requirements as of June 2, 1998, the date when HCFA terminated Petitioner's participation in Medicare.

At Finding 7, I find that Petitioner was not complying substantially with all participation requirements as of May 7, 1998. That noncompliance would be a basis for HCFA to impose remedies against Petitioner – although not in the immediate jeopardy range – for the period which begins with May 7, 1998. In this Finding, I address the second assumption which underlies HCFA's determination to impose remedies against Petitioner. I conclude that Petitioner did not establish that it attained compliance with all participation requirements at any date after May 7, 1998, including June 2, 1998, the date of termination of participation.

In Wellington Specialty Care & Rehabilitation Center, DAB CR548 at 18 - 19 (1998), I held that a provider who is deficient in providing care is presumed to remain deficient until it proves by the preponderance of the evidence that it attains compliance with participation requirements. In this case it is up to Petitioner to prove that it attained compliance with participation requirements at any time after May 7, 1998.

HCFA asserts that the only way a long-term care facility can establish compliance with participation requirements, once it is shown to be deficient in complying with those requirements, is by being resurveyed and by proving compliance at the resurvey. I do not accept that argument. If that were so, it would serve as a license for HCFA to act arbitrarily to reject facilities' assertions of correction of deficiencies. For example, HCFA could impose a civil money penalty of indefinite duration against a facility simply by not having the facility resurveyed, despite the facility's protestations that it had attained compliance with participation requirements.

A facility may prove at a hearing that it has attained compliance with participation requirements whether or not it has been resurveyed on behalf of HCFA. However, the facility bears the burden of establishing its compliance. It must do so with persuasive and credible evidence. A mere representation of compliance may not suffice to overcome the presumption that it remains out of compliance until it proves otherwise.

I do not infer from the absence of findings by the surveyors in their report of the May 27 - 29, 1998 resurvey of Petitioner concerning the non-immediate jeopardy deficiencies that these deficiencies were corrected as of May 27 - 29, 1998. The Florida State survey agency did resurvey Petitioner on May 27 - 29, 1998. However, that resurvey addressed *only* those deficiencies that were identified by the surveyors at the May 4 - 7, 1998 survey as being at the immediate jeopardy level. No effort was made by the surveyors to ascertain whether Petitioner had attained compliance with any of the non-immediate jeopardy level deficiencies that were identified at the May 4 - 7, 1998 survey and which I find to have been established above at Finding 7.

Petitioner did not prove that it corrected the deficiencies that were identified at the May 4 - 7, 1998 survey at any time prior to June 2, 1998, the date when HCFA imposed the remedy of termination of participation against Petitioner. Petitioner did not offer affirmative proof which established when the deficiencies were corrected. Petitioner did submit a plan of correction to HCFA in response to the May 4 - 7, 1998 survey. P. Ex. 26 at 39 - 74. However, that plan of correction does not suggest that all deficiencies were corrected prior to June 2, 1998. Indeed, the plan of correction states that most of the deficiencies would not be corrected until June 21, 1998. Id.

9. A basis exists to impose remedies against Petitioner for deficiencies that are at less than the immediate jeopardy level of deficiency.

HCFA has established the elements that are a necessary prerequisite for imposing remedies for deficiencies that are at less than the immediate jeopardy level of deficiency. These include civil money penalties in the range of from $50 - $3,000 per day beginning with May 7, 1998. HCFA may also terminate Petitioner's participation in Medicare.

HCFA based its determination to terminate Petitioner's participation in Medicare on the surveyors' incorrect conclusions that as of May 4 - 7, 1998 and May 27 - 29, 1998, Petitioner was deficient at the immediate jeopardy level of deficiency. In fact, HCFA normally would not terminate a facility's participation in Medicare on such short notice where there are present only deficiencies that are of less than the immediate jeopardy level. My experience in such cases is that HCFA usually will give a deficient facility up to six months to correct the outstanding deficiencies before imposing the remedy of

termination of participation. See 42 C.F.R. § 488.412(a). However, HCFA is not obligated to give a facility that is deficient at less than the immediate jeopardy level six months to correct its outstanding deficiencies. Under both the Act and regulations, HCFA has the authority to terminate immediately the participation of a deficient facility regardless of the level of the deficiencies.

I have no authority to decide whether termination of participation is an inappropriate remedy under the unique facts of this case. As I discuss above, at Part I.B. of this decision, I do not have the authority to hear and decide the appropriateness of any remedy that HCFA might impose in a case,, assuming that a basis exists to impose a remedy, except that I may decide whether the amount of a civil money penalty is reasonable.

10. A civil money penalty of $1,000 per day for each day of the period which begins on May 7, 1998, and which runs through June 1, 1998, is reasonable.

I sustain a civil money penalty of $1,000 per day against Petitioner for each day of the period which begins on May 7, 1998 and which runs through June 1, 1998. A penalty of this amount falls in the middle of the range of penalties which may be imposed for deficiencies that are at less than the immediate jeopardy level of deficiency. 42 C.F.R. § 488.438(a)(2). The beginning date of the penalty is the date that HCFA first determined Petitioner not to be complying substantially with participation requirements. 42 C.F.R. § 488.440(a). The end date of the penalty is the date when HCFA terminated Petitioner's participation in Medicare. 42 C.F.R. § 488.440(b).

I base the amount of the penalty on the factors which are prescribed in regulations for determining the amount of a civil money penalty. Essentially, I rely on evidence which addresses the seriousness of the deficiencies manifested by Petitioner. 42 C.F.R. § 488.404(b). I also rely on evidence relating to Petitioner's past performance as a participating long-term care facility. 42 C.F.R. §§ 488.404(c)(2), 488.438(f)(1).

The evidence in this case shows Petitioner's deficiencies to be relatively serious in nature. That is particularly so with the failures of Petitioner to complete the assessments and plans of care for residents mandated by the Act and regulations and cited by the surveyors under Tags 272, 273, 274, and 279. I am satisfied from the evidence that it is a necessary prerequisite for giving care to a resident of a long-term care facility that the resident be assessed and that the resident's care be planned in accordance with the requirements of law. It is not possible to treat a resident appropriately and effectively if the resident's needs are not assessed and the resident's care is not planned. Here, the

evidence shows a relatively widespread dereliction of duty by Petitioner, which put at risk the health and well being of several of its residents. A relatively substantial civil money penalty is merited by these deficiencies.

However, my determination to impose a substantial civil money penalty is tempered in some respect by Petitioner's previous unblemished history of compliance. The record establishes Petitioner to be a new facility which had been certified to participate in Medicare about eight months prior to May, 1998. There is no evidence of any deficiencies by Petitioner as of the date of initial certification.

/s/

Steven T. Kessel
Administrative Law Judge