

# VHCA Legal Quarterly

## October 2005

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### Administrative Law Judge Rejects Medicare/Medicaid Termination of Virginia Nursing Facility

By *Dominic P. Madigan, Esquire*  
McCandlish Holton, PC  
Richmond, Virginia

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Rejecting the findings of Virginia surveyors, a federal administrative law judge in August determined that the Centers for Medicare and Medicaid Services (CMS) improperly terminated a Virginia nursing facility from the Medicare program. The administrative judge concluded that CMS failed to prove that the skilled nursing facility was out of compliance with Medicare standards at the time of a state survey in May, 2005.

Although CMS has appealed the administrative law judge's ruling, the decision is noteworthy because of the success of the facility in reversing the termination decision. In finding for the facility, the administrative law judge concluded that not one of the five deficiencies cited against it withstood legal scrutiny. Upholding a single deficiency would have been enough to support the facility's termination from both Medicare and Medicaid. Although the administrative law judge's ruling focused on the facility's Medicare participation, the ruling also applies to its Medicaid participation. (Because VHCA does not seek to publicize individual facilities' survey allegations, the facility is not identified in this article.)

At issue in the federal appeal were five deficiencies cited in the May survey. (The surveyors had found a sixth deficiency, but CMS dropped that deficiency.) Because the May survey alleged that the facility was not in "substantial compliance" with Medicare participation requirements, it had been terminated from

the Medicare and Medicaid programs – the facility had been found to be out of compliance in previous surveys beginning in December, 2004. Under Medicare and Medicaid rules, a facility found to be out of compliance for six months is terminated from these programs. Unless the facility successfully appeals the adverse survey findings, it must reapply as a new Medicare and Medicaid provider, and prove compliance at an initial certification survey.

#### *Cited Deficiencies*

The facility appealed the May survey findings. (The facility also continued operating, providing care to its non-private pay residents without federal or state reimbursement.) Specifically, the facility appealed the surveyors' allegations that:

- 1) A resident's "lap buddy" was not removed at two-hour intervals, and was present during mealtime, contrary to physician orders;
- 2) The facility did not revise plans of care for three residents;
- 3) The facility failed to comply with a physician's order to weigh a resident weekly, and to monitor the resident's intake and output of fluids;
- 4) The facility failed to continue a resident's "restorative dining program," contrary to physician's orders; and
- 5) The facility failed to prevent two residents from falling.

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Virginia Health Care Association  
2112 W. Laburnum Avenue, Suite 206  
Richmond, Virginia 23227  
(804) 353-9101  
[www.vhca.org](http://www.vhca.org)

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### ***Use of Restraints***

CMS and the state surveyors first alleged that the facility did not remove a resident's "lap buddy" – a device used to keep a seated person from standing – at prescribed two-hour intervals. The surveyors also alleged that they had seen the resident with the lap buddy in place during a meal, contrary to the resident's care plan.

In overturning this deficiency, the administrative law judge, or "ALJ," rested on two conclusions. First, the ALJ determined that CMS and the state did not have adequate proof that the facility staff failed to release the lap buddy every two hours – the ALJ found no evidence, for instance, that the surveyors had continually monitored the resident to see whether the lap buddy was being removed. Second, CMS had argued that the facility's staff had failed in some instances to initialize blocks in a chart documenting the release of the lap buddy. The ALJ rejected CMS's argument that failing to initial a chart proved non-compliance. "The omission to initial the block may be simply that," the ALJ wrote, "a failure by the staff to complete its paperwork – and may not signify that the staff failed to provide care."

Finally, on the issue of the release of the lap buddy during meal times, the ALJ concluded that the staff had complied with the physician's order. The care plan provided for the release of the restraint during meals, and a surveyor alleged that the lap buddy was in place during a meal. But the ALJ concluded that because it was the *staff's* care plan that ordered the release of the lap buddy during meals – not the *physician's* order – leaving the lap buddy in place during meals was consistent with the physician's order. Thus, concluded the ALJ, the deficiency should not have been cited.

### ***Plans of Care***

CMS and Virginia surveyors next alleged that the facility had failed to revise the plans of care for three residents. In ruling in the facility's favor, the ALJ held that "not every change in care that is provided to a resident automatically triggers a requirement that the facility revise the resident's care plan to document that change." The ALJ concluded that the facility was required to update the care plans only if CMS could prove that (i) the facility had performed a new or revised comprehensive assessment on each of the three residents, or (ii) the facility failed to perform a required comprehensive assessment.

The Administrative Law Judge ruled that neither of these conditions was met, and that the facility was

not required to revise the residents' care plans. The key issue was whether the residents had experienced "significant changes" in their medical conditions that would prompt a revised comprehensive assessment – and hence a revised plan of care. The ALJ determined that none of the residents had experienced a "significant change" mandating a revised care plan:

- A resident suffering from severe cerebral palsy was moved from a bed with raised side rails to a concave floor mattress, but this move was not triggered by a change in the resident's condition;
- Another resident was unable to self-release her lap buddy, but again, because this was not the result of a significant change in condition, the matter was not required to be addressed on her care plan; and
- A third resident was provided with a bed alarm, not as a result of a significant change in condition.

The ALJ's decision does not conclude that such changes should never be addressed on a care plan, however. Upon performing a new or revised comprehensive assessment, the issues would need to be care-planned.

### ***Physicians' Orders and Monitoring***

The third deficiency under appeal stemmed from two allegations. First, CMS and the state surveyors alleged that the facility failed to meet a physician's order that a resident be weighed weekly. Second, the agencies alleged that the facility staff failed to monitor a resident's fluid intake and output. The ALJ ruled that this deficiency should not have been cited.

The ALJ's decision was based on a close examination of the facts, which are highly specific to the case. With regard to the weekly weighing of a resident, the ALJ concluded that when all of the facts were considered, CMS had failed to prove that the facility had not weighed the resident on a weekly basis. Because the resident had been in the hospital for three days, the facility had not failed by waiting until the following week to resume the weekly weight monitoring.

The facility did not dispute the fact that it had failed to monitor a resident's fluid intake/output. It argued, however, that because the monitoring was not medically necessary, there was no potential for harm to the resident. The ALJ was persuaded by

this argument. He determined that the resident's physician had not ordered the intake/output monitoring, and other steps to monitor the resident's hydration status were in place. He thus ruled that the facility's failure to monitor fluid intake/output in this instance did not adversely affect the quality of care.

### ***Physician-Ordered Restorative Dining***

Under the fourth cited deficiency, CMS and the state surveyors alleged that the facility had improperly discontinued a physician's order that a resident be given a "restorative dining program." The surveyors relied on statements from the facility staff that staffing shortages had required the facility to discontinue its restorative dining program. The surveyors concluded that the facility had thus failed to implement a physician's order.

The ALJ ruled that the facility's staff "implemented the physician's orders and did all that it could reasonably be expected to do to provide nutritional care" for the resident. The ALJ indicated that the resident at issue was in the last stages of his life, and declined to eat much of the time. The ALJ concluded that facility staff sought to spoon-feed the resident, fed him "super cereal" and high-energy foods, and that by May, 2005, the resident was unable to eat. Given these circumstances, the ALJ ruled that the deficiency should not have been cited.

### ***Prevention of Accidents***

The fifth, and final, deficiency under appeal related to the allegation by CMS and the state surveyors that the facility failed to protect two residents from the risk of falling. Specifically, the agencies alleged that neither resident was supplied with a bed or body alarm that had been ordered for them.

The ALJ determined that CMS' evidence was unpersuasive. He found that the facility monitored the residents using other alarm systems. Accordingly, the ALJ concluded that "the issue is not so much what type of alarm the resident wears but whether the alarm is reasonably effective ... . If the alarm works as intended its exact nature and mechanism is unimportant" in determining whether the facility was in compliance. The ALJ ruled that because the alternative alarm system worked effectively, the facility had complied with the applicable standard of care.

### ***Conclusion***

In light of these findings, the administrative law judge ruled that CMS was not authorized to terminate the facility's participation as a Medicare provider. (The same decision applies to Medicaid participation.)

For now, the case is one that bears monitoring. The decision is significant now because it overturns a Medicaid and Medicare termination, and because portions of the decision – whether missing initials represents missing care, or simply missing documentation, for instance – are potentially applicable for facilities responding to adverse survey findings. The long-term impact of this decision, of course, depends on the outcome of CMS's appeal of the decision.

### ***ABOUT THE AUTHOR***

Dominic Madigan practices health care law at McCandlish Holton, PC, in Richmond, Virginia. Dominic may be contacted at 804.775.3858 and [dmadigan@lawmh.com](mailto:dmadigan@lawmh.com). McCandlish Holton does not represent the facility at issue. McCandlish Holton represents long-term care providers across a range of issues, including survey & certification, reimbursement, development and COPN matters, and strategic partnering.