**Department of Health and Human Services**

**DEPARTMENTAL APPEALS BOARD**

**Civil Remedies Division**

Dumas Nursing and Rehabilitation, L.P.,
(CCN: 67-5016),

Petitioner

v.

Centers for Medicare & Medicaid Services.

Docket No. C-09-508

Decision No. CR2127

Date: May 4, 2010

# DECISION

Petitioner, Dumas Nursing and Rehabilitation, L.P. (Petitioner or facility), is a long-term care facility located in Dumas, Texas, that participates in the Medicare program. When one of its residents experienced an episode of respiratory distress, the nurse on duty (who was the only nurse in the building) failed to take vital signs, check her airway, or provide any medical care. For this and other reasons, the Centers for Medicare and Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare requirements and that its deficiencies posed immediate jeopardy to resident health and safety. CMS imposed civil money penalties (CMPs) of $7,050 per day for fifteen days of immediate jeopardy, and $700 per day for thirty-four days of substantial non-compliance that was not immediate jeopardy (total CMP: $129,550).

Petitioner appealed, and CMS now moves for summary judgment.

For the reasons set forth below, I find that CMS is entitled to summary judgment. CMS has come forward with evidence establishing that: the facility was not in substantial compliance with Medicare program requirements; its deficiencies posed immediate jeopardy to resident health and safety; and the penalties imposed are reasonable. Petitioner has tendered no evidence suggesting a dispute over any material fact.

## I. Background

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months and more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a), 488.308.

Here, following a complaint investigation survey, completed March 16, 2009, CMS determined that the facility was not in substantial compliance with Medicare participation requirements and that, from February 27 through March 13, 2009, some of its deficiencies posed immediate jeopardy to resident health and safety. Specifically, CMS found that the facility was not in substantial compliance with the following regulations:

- 42 C.F.R. § 483.13(a) (Tag F221 – physical restraints) at an E level of scope and severity (pattern of noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.13(c) (Tags F224 and F226 – staff treatment of residents) at an L level of scope and severity (widespread immediate jeopardy);

- 42 C.F.R. § 483.13(c)(2)-(4) (Tag F225 – staff treatment of residents) at an L level of scope and severity;

- 42 C.F.R. § 483.20(k)(3)(i) (Tag F281 – comprehensive care plans) at a K level of scope and severity (pattern of immediate jeopardy);

- 42 C.F.R. § 483.25(h) (Tag F323 – accidents and supervision) at an E level of scope and severity;

- 42 C.F.R. § 483.25(k) (Tag F328 – special needs) at a K level of scope and severity;

- 42 C.F.R. § 483.75(l)(1) and (5) (Tag F514 – clinical records) at a D level of scope and severity (isolated instance of noncompliance that causes no actual harm with the potential for more than minimal harm).

CMS Ex. 2, at 3-5; CMS Ex. 3. CMS subsequently determined that the facility returned to substantial compliance on April 17, 2009. CMS Ex. 2, at 1-2.

CMS has imposed against the facility CMPs of $7,050 per day for fifteen days of immediate jeopardy (February 27-March 13, 2009), and $700 per day for thirty-four days of substantial noncompliance that was not immediate jeopardy (March 14-April 16, 2009), for a total CMP of $129,550.[1]

Petitioner timely requested a hearing. CMS now moves for summary judgment. With its motion and brief (CMS Br.), CMS has submitted nineteen exhibits (CMS Exs. 1-19). With its brief (P. Br.), Petitioner submitted three exhibits (P. Exs. 1-3).

## II. Issues

My initial order directs the parties to include in their pre-hearing briefs "any argument that a party intends to make" and warns that "I may exclude an argument . . . if a party fails to address it in its pre-hearing brief." Acknowledgment and Prehearing Order at 4, ¶ 7 (June 15, 2009). Thus, because Petitioner does not address the deficiencies cited under 42 C.F.R. §§ 483.13(a) (physical restraints), 483.25(h) (accidents and supervision), and 483.75(l)(1) and (5) (clinical records), Petitioner has waived any challenge to the deficiencies cited under those regulations. The facility was therefore not in substantial compliance with program requirements, and I must sustain a CMP of at least $50 per day. 42 C.F.R. § 488.438(a).

Less evident from its submissions, however, are whether Petitioner: 1) concedes its substantial noncompliance with the other regulations cited; and 2) agrees that this case may appropriately be decided on summary judgment. On the question of summary judgment, Petitioner has simply not responded to CMS's arguments that summary judgment is appropriate, which suggests that it waives the issue. On the other hand, Petitioner disputes some of CMS's factual assertions. So, to the extent that its arguments could be construed as responsive to CMS's arguments in favor of summary judgment, I will consider whether summary judgment is appropriate.

With respect to the remaining deficiencies – cited under 42 C.F.R. §§ 483.13(c), 483.13 (c)(2)-(4), 483.20(k)(3)(i), and 483.25(k) – Petitioner appears to concede its substantial noncompliance, noting that "given the facts of this appeal and prior Board decisions interpreting rules, the gravamen of this appeal . . . is the reasonableness of the imposed

[1] $7,050 x 15 days = $105,750. $700 x 34 days = $23,800. $105,750 + $23,800 = $129,550.

civil money penalty." P. Br. at 7.[2] On the other hand, in discussing the deficiencies cited under these regulations, Petitioner repeatedly insists that: its staff "did not abuse or neglect the resident" but "helped the resident" (P. Br. at 14); facility administrators were not obligated to investigate or report the incident because "there was no 'incident' of neglect" (P. Br. at 17); and the nurse "acted appropriately" (P. Br. at 19, 21). These arguments suggest that, in fact, Petitioner challenges CMS's findings of substantial noncompliance.

So, without deciding whether Petitioner has waived any of these arguments, I will consider the following issues:

1) whether, from February 27 through April 16, 2009, the facility was in substantial compliance with 42 C.F.R. §§ 483.13(c), 483.13(c)(2)-(4), 483.20(k)(3)(i), and 483.25(k);

2) if the facility was not in substantial compliance with these regulations from February 27 through March 13, 2009, did its deficiencies pose immediate jeopardy to resident health and safety;

3) were the penalties imposed in excess of $50 per day – $7,050 per day and $700 per day – reasonable?

Petitioner also raises some Constitutional claims, which I have no authority to decide.

## III. Discussion

Summary Judgment. Summary judgment is appropriate if a case presents no genuine issue of material fact, and the moving party is entitled to judgment as a matter of law. *Illinois Knights Templar Home*, DAB No. 2274, at 3-4 (2009), and cases cited therein.

The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law, or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to [that party's] case, and on which [that party] will bear the burden of proof at trial." *Livingston Care Ctr. v. Dep't of Health & Human Servs.*, 388 F.3d 168, 173 (6th Cir. 2004) (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986)). To avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *Matsushita Elec. Indus. Co. v.*

[2] In this regard, Petitioner's only witness, Karl E. Steinberg, MD, CMD, agrees, based on his review of the records, that the facility was not in substantial compliance with program requirements but disagrees with CMS's determinations as to scope and severity. P. Ex. 2 (Steinberg Decl.).

*Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986); *see also Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing and Rehab. Ctr.*, DAB No. 1918 (2004).

> To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact . . . .

*Illinois Knights Templar*, DAB No. 2274, at 4; *Livingston Care Ctr.*, DAB No. 1871, at 5 (2003).

In examining the evidence for purposes of determining the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *Brightview Care Ctr.*, DAB No. 2132, at 2, 9 (2007); *Livingston Care Ctr.*, 388 F.3d at 172; *Guardian Health Care Ctr.*, DAB No. 1943, at 8 (2004); *but see Brightview*, DAB No. 2132, at 10 (entry of summary judgment upheld where inferences and views of non-moving party are not reasonable). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cf. Guardian Health Care Ctr.*, DAB No. 1943, at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.").

***A. CMS is entitled to summary judgment that the facility was not in substantial compliance with 42 C.F.R. §§ 483.13(c), 483.20(k)(3)(i), and 483.25(k), because the undisputed evidence establishes that the only nurse on duty failed to assess a resident in respiratory distress and failed to provide her with any emergency medical care.***[3]

Regulatory requirements: Under the statute and the "quality of care" regulation, each resident must receive, and the facility must provide, the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. Act § 1819(b); 42 C.F.R. § 483.25. The facility must ensure that residents with special needs receive "proper treatment and care" for certain special services, including tracheostomy care, tracheal suctioning, and respiratory care. 42 C.F.R. § 483.25(k).

The services provided or arranged by the facility must meet professional standards of quality. 42 C.F.R. § 483.20(k)(3)(i).

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[3] My findings of fact/conclusions of law are set forth, in italics and bold, in the discussion captions of this decision.

Facilities must develop and implement written policies and procedures that prohibit resident neglect. 42 C.F.R. § 483.13(c). "Neglect" means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. 42 C.F.R. § 488.301. *See Jennifer Matthew Nursing & Rehab. Ctr.*, DAB No. 2192, at 19 (2008); CMS Ex. 15, at 78 (facility's neglect policy echoes the regulatory definition).

Here, CMS has come forward with evidence (primarily the facility's own documents and statements from facility staff) establishing that, when Resident 1 (R1) experienced an episode of respiratory distress, the nurse on duty failed to take her vital signs or provide any medical care, but left her in the care of nurse aides, while he went to call Emergency Medical Services (EMS). Petitioner has not come forward with evidence suggesting a dispute over these facts.

Resident 1. R1 was a 57-year-old woman suffering from a long list of ailments, including morbid obesity, anxiety, and peripheral vascular disease. Following abdominal surgery in 2007, she had difficulty being weaned from a ventilator, and surgeons performed a tracheostomy.[4] R1 had a long history of chronic obstructive pulmonary disease (COPD), gastroesophageal reflux disease (GERD), diabetes, coronary artery disease, and hypertension; she required chronic endotracheal tube therapy. CMS Ex. 5, at 9, 94; CMS Ex. 3, at 65.

R1's comprehensive care plan recognized that her tracheostomy put her at risk for infection and that "ineffective airway clearance impaired gas exchange." CMS Ex. 5, at 78, 80. The plan set as a goal that her "trach to remain in place and open[,]" enabling her to get the oxygen needed to keep her oxygen ($O^2$) saturation levels in the 90s (normal range is 97 to 99%). Her trach was hooked up to oxygen "at all times," and she was to be administered oxygen at 2-3 liters per minute as needed. The plan directed staff to suction as needed to keep the airway free and clear. CMS Ex. 5, at 78. Physician orders, dated November 19, 2008, are somewhat confusing, because the handwritten physician order ("transcribed by S. Macias") calls for tracheal suctioning every two hours from 6:00 a.m. to 6:00 p.m. and every four hours from 6:00 p.m. to 6:00 a.m. CMS Ex. 5, at 128. But the print-out of the physician orders and the treatment sheets call for suctioning the trach every four hours (without regard to the time of day or night), and suctioning every two hours as needed (again, without regard to the time of day or night). CMS Ex. 5, at 74-75, 97. A November 19, 2008 addition to her care plan also instructed staff to suction every four hours, and every two hours as needed. CMS Ex. 5, at 78.

Nursing failure to provide care. According to nurses' notes, at 2:30 p.m. on February 27, 2009, R1 complained of difficulty breathing and asked to be suctioned. Her vital signs

[4] A tracheostomy (trach) is a surgically-created opening in the neck, which provides a direct airway into the trachea. The term also refers to the surgical procedure by which the opening is created.

were normal, and her $O^2$ level was 97%. The nurse performed the suctioning. At 4:00 and 5:20 p.m., R1 again complained that she was unable to breathe and asked to be suctioned, which the nurse did. The nurses' notes do not reflect the resident's vital signs or $O^2$ levels at those times. CMS Ex. 5, at 60.

At 8:10 that evening, staff told the licensed vocational nurse (LVN) on duty (identified as LVN B) that R1 was "blue." The nurse writes that R1 told him she was having trouble breathing. He called for an ambulance "due to [her continuing] resp[iratory] distress." CMS Ex. 5, at 60. He also asked the nurse aides to put her to bed, but R1 refused, fearful that lying down would further impede her breathing. CMS Ex. 5, at 60; s*ee* CMS Ex. 16, at 3 (Mount Decl.). He did not check her airways. He took no vital signs, and he provided no care. According to staff, he did not even enter the room. CMS Ex. 16, at 2 (Mount Decl.); CMS Ex. 17, at 6 (Courson Decl.).[5]

According to the EMS report, the facility's call came in at 8:09 p.m., and the emergency medical technicians (EMTs) reached the resident at 8:13 p.m. They found her sitting in a wheelchair, in respiratory distress. Their report describes labored respiration and wheezes. Her face was red, and she was unable to speak. Her pulse was 138, her respirations 38 and labored, and her $O^2$ level was 84%. Her trach was clogged. The EMTs immediately suctioned her twice and administered medications (Albuterol, Atrovent, Decadron) through a nebulizer. They applied oxygen with a high concentration mask at 10 liters per minute and transported her to the hospital, suctioning her while in transit until the trach clog was dislodged. CMS Ex. 5, at 1, 3; P. Ex. 1, at 60.

At the emergency room, R1 was described as in respiratory distress with cyanosis (blue discoloration of the skin and mucous membranes caused by lack of oxygen in the blood). Findings showed bilateral pleural effusion and a decreased $O^2$ level – 86% on ambient air. She was also in mild to moderate congestive heart failure. CMS Ex. 5, at 9. She was admitted to the hospital where she remained until March 6, 2009, when she returned to the facility. CMS Ex. 5, at 5, 9-11.

Thus, the undisputed evidence establishes that LVN B took no vital signs, performed no nursing assessment, and offered no oxygen or any other form of emergency treatment. He did not check her airway. He left R1 in the care of the nurse aides while he called EMS. An employee disciplinary report, dated March 9, 2009, reprimands LVN B for

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[5] Although Petitioner asserts, without reference to any evidence in the record, that the "nurse came to the room once or twice, at which time he entered, or did not enter. . . ." P. Br. at 8. In fact, witnesses to the event said that he did not enter the room. CMS Ex. 10, at 91 (Muñoz Statement); CMS Ex.10, at 92; CMS Ex. 16, at 2 (Mount Decl.); CMS Ex. 17, at 6-7 (Courson Decl.). Petitioner has come forward with no actual evidence establishing any dispute over this fact. In any event, whether he entered the room is not material. The critical facts – undisputed – are that he performed no nursing assessment and provided no care.

leaving a resident, who was experiencing respiratory distress, to call 911. The report also admonishes him for failing to make "all attempts to maintain airway . . . (ambu bag)." The report indicates that LVN B's supervisor counseled him, orally and in writing, to remain at all times with a resident in respiratory distress, and to have an aide or other personnel call 911. She also told LVN B that "all attempts to maintain airway must be initiated until EMTs arrive to take over care." CMS Ex. 14, at 39.

Petitioner does not dispute any of these facts. Nor has Petitioner come forward with any additional evidence suggesting a dispute concerning any other material fact. Instead, Petitioner challenges CMS's purported assertion that more than ten minutes passed before R1 received emergency treatment. Petitioner concedes that staff who witnessed the events of February 27, 2009 reported waiting "ten-plus" minutes, but, citing EMS records, Petitioner points out that only four minutes elapsed between the time the call came in from the facility (8:09 p.m.) and the time the EMTs reached R1 (8:13 p.m.). P. Br. at 9; P. Ex. 1, at 60.

That EMS quickly responded to the facility's call is undisputed, but Petitioner fails to consider the amount of time that elapsed between the *onset* of R1's symptoms and her receipt of emergency care. Petitioner offers no argument or evidence to rebut CMS's evidence as to what occurred before LVN B called EMS. Facility staff (two nurse aides and a medication aide) told surveyors, in interviews and in written statements, that they made two to three trips to the medication room to summon LVN B before he responded. Some additional time passed before he left the medication room and went to R1's room. He then did not enter the room, although, for summary judgment purposes, I accept Petitioner's assertion that he spoke to and made eye contact with the resident. When he left, he returned to the medication room. He told the medication aide that he would *not* take R1's vitals but would call 911. Thereafter, he called 911. CMS Ex. 10, at 91 (Muñoz Statement); CMS Ex. 10, at 92; CMS Ex. 16, at 2 (Mount Decl.); CMS Ex. 17, at 6 (Courson Decl.). In the meantime, the medication aide went to R1's room, where she found her "slumped over in her wheelchair . . . her eyes were big, her lips were purple and she was sweating profusely. . . . [W]hite foam [was] coming out of her tracheostomy." CMS Ex. 16, at 2; CMS Ex. 17, at 7; CMS Ex. 10, at 92. Again, Petitioner has not come forward with any statements from staff (including LVN B) or any other evidence suggesting any dispute over these facts.

Fortuitously, the EMTs immediately responded to the call, but that quick response does not excuse LVN B's failures to assess an obviously distressed and deteriorating resident and to provide her with emergency care.

Petitioner argues, however, that LVN B "did not need to make a traditional assessment of vitals [sic] signs in order to" conclude that R1's oxygen levels were low and that she was working hard to breathe. According to Petitioner, R1's "physical appearance . . . made it clear without the measurement of numbers for the sake of charting." P. Br. at 10. Not surprisingly, Petitioner offers absolutely no support for this remarkable assertion, and nothing in the record suggests that Petitioner's argument represents any responsible

medical opinion. A nurse's failure to assess a resident in obvious distress violates professional standards of quality and the facility's own policies, which required the nurse to: obtain vital signs, including temperature; observe for alterations in consciousness or change in personality; observe for sensory weakness; observe for generalized weakness; and observe for flushing or cyanosis. "Do not leave the resident alone." P. Br. at 14; CMS Ex. 15, at 97-99. The policy also directed the nurse to document the resident's vital signs, assessment, and observations. CMS Ex. 15, at 114.

Petitioner claims that, because LVN B left R1 with two nurse aides, who were later joined by a medication aide, the resident was "assessed and . . . supervised by multiple staff at all times." P. Br. at 14. I find it insufficient to leave a resident in obvious respiratory distress with staff who are not trained to perform assessments or to provide nursing-level care. On the other hand, any one of these aides would have been capable of calling EMS, freeing the only trained nurse on duty to provide critical nursing services. *See* CMS Ex. 14, at 39. Even Dr. Steinberg concedes that LVN B "probably could have managed the situation . . . better, particularly by staying in the room with the resident who was starting to show respiratory distress. . . ." P. Ex. 2, at 4 (Steinberg Decl. ¶ 10).

Petitioner also suggests that LVN B's refusal to suction R1's trach was justified, because the resident so often requested the procedure when it was not necessary. Petitioner cites almost a dozen times when R1 asked for suctioning, although no clinical symptoms indicated a need for the procedure. P. Br. at 11-12; P. Ex. 1, at 30-35. In fact, nine of these instances occurred on February 26 and 27, immediately prior to R1's being hospitalized for bilateral pleural effusion, congestive heart failure, and decreased $O^2$ levels. Otherwise, the record reflects that she *rarely* asked to be suctioned. Petitioner cites one instance on February 13, and no other until almost a week later, on February 19. The next two requests occurred several days later, on February 23 and February 25. But, starting February 26, the rate of her requests increased dramatically – four times on February 26 and more than 5 times prior to the arrival of the EMTs on February 27. It seems apparent that her increased complaining was related to her deteriorating respiratory condition. Petitioner's expert witness (Dr. Steinberg) opines that she "was suffering from a serious exacerbation of her pulmonary and cardiac disease . . . and these were the ***direct and sole cause*** of her week-long hospitalization. . . ." P. Ex. 2, at 4 (Steinberg Decl. ¶ 9) (emphasis in original). In Petitioner's words, the "exacerbations" of her congestive heart failure and chronic obstructive pulmonary disease "gradually develop[ed] over the course of several days." P. Br. at 13. I accept this. Plainly, R1 was having more and more difficulty breathing, which she (wrongly, according to Dr. Steinberg) attributed to clogs in her trach. Unfortunately, at the time, no one seems to have noticed the "exacerbations." Indeed, had staff taken more seriously R1's escalating complaints of breathing difficulties, they might have avoided February 27's emergency.

Of course, that the EMTs suctioned her repeatedly until a trach clog was dislodged strongly suggests that, notwithstanding the underlying causes for her acute difficulties,

R1 also needed to be suctioned the night of February 27. CMS Ex. 5, at 1, 3; P. Ex. 1, at 60.[6] But the actual cause of R1's respiratory distress is not material. The problem was not that the nurse declined to suction someone who had been suctioned too often, or did not need suctioning. The problem was that a woman was turning blue – she was obviously in respiratory distress – and the nurse neither assessed her condition nor provided her with any care.

Petitioner simultaneously suggests that R1 was not ill enough to require nursing-level care and that she was so ill that only a hospital could have provided her the care she needed. R1 indisputably required hospitalization, but she also needed more immediate attention – she simply could not wait until she reached the hospital. When the EMTs arrived on the scene, they immediately performed an assessment, took vital signs, and measured her $O^2$ level. In addition, they suctioned her, administered medications, and gave her oxygen. These are precisely the kinds of emergency interventions that a facility nurse should be able to perform.

Petitioner asserts that the nurse's inaction caused R1 no actual harm, apparently relying on the opinion of Dr. Steinberg that she returned from the hospital "at the same functional level." P. Ex. 2, at 3 (Steinberg Decl. ¶ 6). For summary judgment purposes, I accept as true that R1 suffered no long-term physical harm. I also accept that her hospitalization was not related to LVN B's inaction. I do not accept, however, that she suffered no harm. What Dr. Steinberg characterizes as "undoubtedly an unpleasant experience" is actual harm. P. Ex. 2, at 4 (Steinberg Decl. ¶ 11). The regulation (as well as the facility's policy) recognizes this, and includes in its definition of neglect, "failure to provide . . . services necessary to avoid . . . mental anguish." CMS Ex. 15, at 109. R1 indisputably suffered significant mental anguish as a result of the nurse's refusal to provide her any emergency care when she felt unable to breathe. *See* CMS Ex. 16, at 5 (Mount Decl.) (R1 cried when asked to recount the details of the night of 2/27/09.).

Moreover, although I think R1 suffered significant actual harm, I do not consider this a material fact. The facility is not in substantial compliance if its deficiencies pose the *potential* for causing more than minimal harm. 42 C.F.R. § 488.301. Refusing to provide emergency care to someone in respiratory distress poses the potential for causing significant harm. Leaving that person in the care of staff who are not equipped to provide necessary care poses the potential for causing significant harm.

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[6] Without reference to any of the medical evidence, Dr. Steinberg says that, when the paramedics arrived, they found "no evidence of tracheal obstruction (hence no compelling need for immediate suctioning) . . . ." P. Ex. 2, at 3 (Steinberg Decl. ¶ 5). I find this puzzling since Dr. Steinberg has no independent knowledge of the events and purportedly bases his assertions on the medical records. The EMS report (which he presumably reviewed) says "blockage in trach." CMS Ex. 5, at 1; P. Ex. 1, at 60. Nevertheless, as discussed in the body of this decision, even if Dr. Steinberg's unsupported assertion creates a factual dispute, it is not material.

Finally, Petitioner argues that the facility should not be charged with neglect for what it characterizes as an "isolated" incident. I disagree. First, as I discuss below, surveyors found additional examples of nursing inadequacies with respect to R1's care. I also discuss below the administration's failure to investigate the incident, all of which contributed to the findings of neglect. Moreover, I do not consider the events of February 27 an isolated incident involving just one nurse's poor judgment. The only nurse on duty that night was a new hire, and the facility had not insured that he was adequately trained in caring for tracheostomies.[7] P. Br. at 17, 19; P. Ex. 2, at 3, 4 (Steinberg Decl. ¶¶ 7, 10). According to Petitioner, this was the best the facility could do.

> In a perfect world there would have been several registered nurses available to immediately tend to the multitude [of ] tasks required of LVN B in a very short period of time. But, nursing homes operate in a world created by cost-conscious legislators. So, on February 27, 2009, Dumas Nursing and Rehabilitation, LP was not a perfect world.[8]

P. Br. at 19. But the facility did not merely fall short of "perfect"; it fell short of "adequate." Knowing that one of its residents required regular tracheostomy care and was at a foreseeable risk of suffering a significant – even life-threatening – respiratory episode, the facility did not insure that a trained and competent nurse would be available to provide her the care she needed. I consider this neglect. Because the facility did not implement its policies and procedures that prohibit resident neglect, it was not in substantial compliance with 42 C.F.R. § 483.13(c).

The services provided R1 did not meet professional standards of quality, and the facility did not ensure that R1 received proper treatment and care for her tracheostomy and her respiratory difficulties. The facility was therefore not in substantial compliance with 42 C.F.R. §§ 483.20(k)(3)(i) and 483.25(k).

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[7] The evidence shows that another nurse had been in the facility, but, at about 7:30 p.m., she called the assistant director of nursing (ADON) to complain about LVN B's repeated refusals to suction R1, and, inexplicably, the ADON gave her permission to leave. CMS Ex. 10, at 95; CMS Ex. 16, at 3 (Mount Decl.).

[8] To prevent the triumph of financial considerations over resident needs, penalties imposed should be at a level reasonably related to an effort to produce corrective actions. *See* discussion *infra* section E.

***B. CMS is entitled to summary judgment that the facility was not in substantial compliance with 42 C.F.R. §§ 483.25(k) (special needs) and 483.20(k)(3)(i) (professional standards of quality), because the undisputed evidence establishes that facility staff: failed to use appropriate sterile techniques when caring for R1's trach; failed to follow physician's orders for trach care; and falsified records, claiming to have provided care that was not provided.***

Nor were the events of February 27, 2009, the only examples of the facility's deficiencies with respect to resident care.

Nursing failure to use sterile techniques in suctioning R1. CMS also charges that the facility failed to provide proper tracheostomy treatment and care, because, on three separate occasions, surveyors observed three different nurses provide tracheostomy care using nonsterile techniques. Specifically:

- On March 9, 2009, at 4:00 p.m., Surveyors Andrea Mount and Barbara Courson observed a licensed vocational nurse, identified as LVN C, provide R1's tracheostomy care. LVN C touched soiled surfaces with her sterile gloves and then performed the suctioning. CMS Ex. 16, at 14 (Mount Decl.); CMS Ex. 17, at 30 (Courson Decl.); CMS Ex. 10, at 27-28; CMS Ex. 3, at 98;

- On March 10, 2009, at 3:40 p.m., Surveyor Mount observed yet another LVN, identified as LVN F,[9] open the sterile suction catheter kit without first washing her hands. She then picked up a jug of sterile water and poured it into the kit's contaminated reservoir. Then, she put her gloves on but removed them and, with her bare hands, opened three vials of normal saline. She put the gloves back on and turned on the unsterile machine with a gloved hand. She used both hands in the procedure. CMS Ex. 16, at 14-15 (Mount Decl.); CMS Ex. 10, at 45; CMS Ex. 3, at 99;

- On March 11, 2009, at 4:40 p.m., Surveyor Mount observed LVN B suctioning R1. Between suctioning passes, his left gloved hand brushed the soiled gauze dressing around her trach site, which contaminated the suction tubing. CMS Ex. 16, at 15; CMS Ex. 3, at 99-100.

Petitioner does not dispute these facts, although it maintains, without supporting evidence, that LVN C's error was "minimal" and "quickly corrected" and that all of the errors were insignificant, because they resulted in no actual harm. P. Br. at 21-22.

[9] An apparent typographical error in Surveyor Mount's declaration identifies this employee as LVN S.

Dr. Steinberg is not quite so dismissive. He concedes that lapses in sterile techniques are "not optimal for tracheostomy care." He agrees that they "certainly had the potential to cause actual harm" and that the facility needed to provide additional training in trach care to its staff. Nevertheless, he also excuses the deficiencies, because they caused R1 no actual harm. P. Ex. 2, at 5 (Steinberg Decl. ¶ 14).

Again, actual harm is not required, so long as the deficiency poses the potential for more than minimal harm. 42 C.F.R. § 488.301. More important, Petitioner's position disregards the facility's more serious underlying problem: its staff were simply not adequately trained in either basic tracheostomy care or sterile techniques. Even under surveyor observation, when they would presumably be making their best efforts, these nurses could not get it right.[10]

Facility failure to follow physician orders for tracheostomy care. In addition to suctioning R1's trach every four hours and up to every two hours, as needed, R1's physician ordered that staff: 1) clean the inner canula of the trach with hydrogen peroxide and sterile water daily;[11] 2) irrigate her trach with normal saline every shift, and as needed, up to six times a day; and 3) change the trach's inner canula every one to three days. CMS Ex. 5, at 93. According to the facility's treatment sheet, a registered nurse, identified here as RN D, cleaned the trach during the day shift (6:00 a.m. to 2:00 p.m.) on March 7, 2009. CMS Ex. 5, at 135. However, at 2:35 p.m. on March 7, R1 told Surveyor Mount that the cleaning had not been done that day. CMS Ex. 16, at 15 (Mount Decl.); CMS Ex. 10, at 8. Surveyor Mount observed that the exposed port end of the trach tube and flange were dirty with yellow-brown residue that appeared to be tinged with blood. CMS Ex. 16, at 15 (Mount Decl.); CMS Ex. 10, at 7. Surveyor Mount interviewed RN D later that day. RN D acknowledged that she had initialed the treatment sheet, claiming to have completed R1's tracheostomy care, when, in fact, she had not provided the care. She said that another nurse, LVN E, had provided the care, although RN D admitted that she had neither witnessed the cleaning nor verified that it had been done. CMS Ex. 16, at 15 (Mount Decl.); CMS Ex. 10, at 13; CMS Ex. 10, at 99 (RN D statement). The surveyor spoke to LVN E who confirmed that she had not provided the tracheostomy care. CMS Ex. 16, at 15.

[10] Especially puzzling was LVN F's failure to wash her hands before opening the sterile suction kit. Hand-washing prior to providing *any* type of patient care is so basic that any staff member would be expected to do it at a matter of course.

[11] An inner canula is a small tube used with the tracheostomy tube to keep the trach clear and free of secretions.

Petitioner again dismisses this as "merely the result of a misunderstanding between two nurses." P. Br. at 22.[12] Again, I disagree. First, the nurses did not follow the doctor's order in treating R1's trach, which unquestionably puts the facility out of substantial compliance with §§ 483.25(k) and 483.20(k)(3)(i).[13] Then, RN D greatly compounded the deficiency by falsifying the documentation to claim that she had provided a service that neither she nor anyone else had provided. A nurse should *never* document that she provided care that she did not provide. Such an action jeopardizes resident safety and undermines the integrity of the facility records, making it impossible for a reviewer to know whether necessary care has been provided. I consider this falsification of a treatment record very serious and find baffling the facility's dismissive attitude toward that falsification. No evidence suggests that the facility's administration investigated or counseled the nurses, or took any other actions to insure the reliability of its documentation.

***C. CMS is entitled to summary judgment that the facility was not in substantial compliance with 42 C.F.R. § 483.13(c)(2)-(4), because the undisputed evidence establishes that the facility failed to investigate thoroughly allegations that the only nurse on duty neglected a resident exhibiting symptoms of respiratory distress.***

Facility failure to investigate. Consistent with the regulatory requirement (42 C.F.R. § 483.13(c)), facility policy requires that staff "report in accordance with the law any incident/event in which there is cause to believe a resident's physical or mental health or welfare has been or may be adversely affected by abuse or neglect caused by another person." CMS Ex. 15, at 78, 136. The policy also specifically directs that staff immediately report alleged violations to the administrator or alternate. The administrator must investigate thoroughly all allegations. Staff must prepare an incident report. The facility must report the results of the investigation to the state agency within five working days, providing specific information. CMS Ex. 15, at 136-37.

CMS maintains that the facility violated the regulation and its own policy, because its administrative staff did not investigate or report the incident as required. CMS Br. at 12.[14]

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[12] I note that Dr. Steinberg does not defend the nurse's action. P. Ex. 2.

[13] Nursing failure to follow the doctor's order also puts the facility out of substantial compliance with 42 C.F.R. § 483.20(k)(3)(i), because staff did not meet professional standards of quality. However, CMS has not cited that regulation here.

[14] CMS also says that the DON eventually reported the incident, citing CMS Ex. 11. But that document refers to an entirely different incident involving a different resident. I note, however, that the incident referred to in the report was not reported until three weeks after it occurred, not within five days, as called for in the facility's policy.

Petitioner does not claim that its administrator (or anyone else) investigated the incident, nor has Petitioner come forward with any evidence of an investigation. To the contrary, Petitioner insists that no investigation was warranted because LVN B acted appropriately, and, Petitioner charges, the witnesses, and "those commenting on the nurse's actions, are either not qualified to question his actions or have made statements based on second-hand information." P. Br. at 17.

Petitioner also claims that "[b]ased on the unwarranted comments of staff members who were not qualified to question" the nurse's judgment, the Director of Nurses (DON) "took the initiative" to question the staff members instead of immediately dismissing the grumblings. She concluded that the "'incident' was not an incident at all . . . and that it did not warrant formal investigation or reporting." In Petitioner's words: she "thankfully" was able to "sort through all the statements and determine that LVN 'B' had acted appropriately and thus there was no 'incident' to report." P. Br. at 15, 18.

I accept that the DON questioned staff members and then decided not to investigate or report. However, as the above discussion shows, her conclusions were simply wrong. This was a serious incident that put a vulnerable resident at risk for serious harm, and even death. Moreover, the regulation requires that "*all alleged* violations" involving neglect be "reported immediately" to the facility administrator and to the appropriate state officials. 42 C.F.R. § 483.13(c)(2). The facility *must have evidence* that all alleged violations are thoroughly investigated, and the results of those investigations must be reported to the administrator or his designee and to the appropriate state officials within five working days of the incident. 42 C.F.R. § 483.13(c)(3) and (4). The DON was not free to dismiss the allegations as unfounded without conducting and documenting a thorough investigation. Her admitted failure to do so puts the facility out of substantial compliance with 42 C.F.R. § 483.13(c).

I note, finally, that, by not investigating, the facility loses an opportunity to analyze and correct its problems. *Century Care of Crystal Coast*, DAB No. 2076, at 21 (2007), *aff'd*, No. 07-1491, 2008 WL 2385505 (4th Cir. 2008).[15]

### *D. CMS's determination that the facility's deficiencies posed immediate jeopardy to resident health and safety is not clearly erroneous.*

For summary judgment purposes, I am not bound to accept Dr. Steinberg's legal conclusions with respect to the scope and severity of the deficiencies cited. *See Guardian Health Care Ctr.*, DAB No. 1943, at 11. Dr. Steinberg suggests that an

[15] Professional standards of quality also require that incidents be reported and investigated, so the facility's failure to investigate also puts it out of substantial compliance with 42 C.F.R. § 483.20(k)(3)(i).

immediate jeopardy determination should be reserved for cases involving deaths that are "directly and definitively attributed to grossly negligent practices or equipment in a facility." P. Ex. 2, at 5 (Steinberg Decl. ¶ 12). Dr. Steinberg misconstrues the legal standard.

Immediate jeopardy exists if a facility's noncompliance has caused, or is likely to cause, "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld, unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Departmental Appeals Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1962, at 11 (2005); *Florence Park Care Ctr.*, DAB No. 1931, at 27-28 (2004), *citing Koester Pavilion*, DAB No. 1750 (2000); *Daughters of Miriam Ctr.*, DAB No. 2067, at 7, 9 (2007).

Because I find that a nurse's refusal and/or inability to provide emergency care to a resident in respiratory distress is likely to cause serious harm or even death, I do not find clearly erroneous CMS's immediate jeopardy determination. Moreover, although the cited deficiencies most dramatically affected R1 on the night of February 27, they represent systemic problems relating to facility staffing, staff training, and administrative policies.

### *E. The penalties imposed are reasonable.*

I next consider whether the CMPs are reasonable by applying the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating factor. The factors in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

In reaching a decision on the reasonableness of the CMP, I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848, at 21 (2002); *Community Nursing Home*, DAB No. 1807, at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800, at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1683, at 8 (1999).

CMS has imposed penalties of $7,050 per day for the period of immediate jeopardy, which is in the middle of the penalty range ($3,050-$10,000). For the remaining period of substantial noncompliance, CMS imposed a penalty of $700 per day, which is at the low end of the penalty range ($50-$3,000). 42 C.F.R. § 488.438(a)(1).

CMS does not cite facility history as a factor that justifies a higher CMP. Petitioner has not argued that its financial condition affects its ability to pay the penalty.

With respect to the remaining factors, I consider *all* of the facility's deficiencies, which were substantial. In addition to those discussed above, the facility was not in substantial compliance with 42 C.F.R. § 483.13(a), which provides that each resident be free from any physical or chemical restraints not required to treat the resident's medical symptoms, because it restrained residents without adequate assessments and without any showing of medical necessity. CMS Ex. 3, at 1-10.

The facility was also not in substantial compliance with 42 C.F.R. § 483.25(h), which requires that the facility insure that the resident's environment remain as free of accident hazards as possible. The facility must "take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents." *Briarwood Nursing Ctr.*, DAB No. 2115, at 5 (2007). The surveyors found multiple instances of resident falls, some resulting in injuries, attributable to misuse of restraints and/or inadequate supervision. CMS Ex. 3, at 78-82.

Nor was the facility in substantial compliance with 42 C.F.R. § 483.75(l)(1) and (5), which requires that facilities maintain their clinical records in accordance with accepted professional standards and practices. Records must be complete and accurately documented and must reflect the services provided. CMS based this citation on RN D's falsely documenting that she provided services that she did not provide. CMS Ex. 3, at 103-05.

Thus, the facility had multiple deficiencies in addition to those that centered on its treatment of R1. And its neglect of R1, specifically with respect to her tracheostomy care, tracheal suctioning, and respiratory care, was widespread. Staff were not adequately trained. They were incapable of properly suctioning her trach using sterile techniques. At least one nurse falsely claimed to have provided tracheostomy care that she did not provide. Administrative staff neither investigated the deception nor took steps to insure that it not be repeated, for which I find it culpable.

Moreover, I have already commented at length on the facility's deficiencies relating to R1's treatment on the night of February 27. Only one ill-trained LVN was on duty that night. Petitioner itself admits that financial considerations affected its decision to limit the number and qualifications of nurses on duty. I find the facility culpable for failing to insure that a sufficient number of adequately-trained professional staff were available to handle this easily foreseeable emergency. Moreover, the penalty here must be significant

enough to induce the facility to have sufficient, trained professional staff available at all times.

Finally, the facility is culpable, because the only nurse on duty neglected its vulnerable resident, placing her at risk of serious harm or even death. Then, when the situation finally came to the DON's attention, she dismissed it as insignificant and failed to investigate or report. Again, the facility is culpable for the neglect and for its failure to investigate.

Based on all of these significant deficiencies, I do not find the penalties imposed unreasonable.

## IV. Conclusion

Accepting as true all of Petitioner's factual assertions, I find that the facility was not in substantial compliance with Medicare requirements governing 42 C.F.R. §§ 483.13(a); 483.13(c) and (c)(2)-(4); 483.20(k)(3)(i); 483.25(h); 483.25(k), and 483.75(l)(1) and (5). The facility's deficiencies posed immediate jeopardy to resident health and safety and the penalties imposed ($7,050 per day for fifteen days of immediate jeopardy and $700 a day for thirty-four days of substantial noncompliance that was not immediate jeopardy) are reasonable in light of the scope and severity of the deficiencies and the facility's culpability. I therefore grant CMS's motion for summary judgment.

/s/
Carolyn Cozad Hughes
Administrative Law Judge