Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Autumn Hills Nursing and Rehabilitation Center of Niles, LLC,
(CCN: 365672),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-12-449

Decision No. CR3119

Date: February 18, 2014

DECISION

Petitioner, Autumn Hills Nursing and Rehabilitation Center of Niles, LLC (Petitioner or facility), is a long-term care facility located in Niles, Ohio, that participates in the Medicare program. Based on a complaint investigation survey completed November 10, 2011, and a follow-up survey completed December 20, 2011, the Centers for Medicare & Medicaid Services (CMS) determined that, from September 23, 2011 through January 11, 2012, the facility was not in substantial compliance with Medicare program requirements and that, from September 23 through October 27, 2011, one of its deficiencies posed immediate jeopardy to resident health and safety. CMS imposed civil money penalties (CMPs) of $4,400 per day for 35 days of immediate jeopardy and $100 per day for 76 days of substantial noncompliance that was not immediate jeopardy.

Here, Petitioner limits its challenges to the deficiency cited at the immediate jeopardy level (42 C.F.R. § 483.25), the immediate jeopardy determination itself, and the accompanying $4,400 per day CMP.

For the reasons set forth below, I find that the facility was not in substantial compliance with the challenged program requirement; this deficiency posed immediate jeopardy to resident health and safety; and the penalty imposed is reasonable.

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 survey completed November 10, 2011, CMS determined that the facility was not in substantial compliance with three program requirements:

- 42 C.F.R. § 483.15(a) (Tag F241− quality of life – dignity) at scope and severity level E (pattern of noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.25 (Tag F309 – quality of care) at scope and severity level J (isolated instance of immediate jeopardy); and

- 42 C.F.R. § 483.25(a)(3) (Tag F312 – quality of care – activities of daily living) at scope and severity level D (isolated instance of noncompliance that causes no actual harm with the potential for more than minimal harm).

Based on these findings, CMS imposed CMPs of $4,400 per day, beginning September 23, 2011, and $100 per day beginning October 28, 2011. CMS Exs. 1, 5.

On December 20, 2011, surveyors conducted another complaint investigation. Based on their findings, CMS determined that the facility was not in substantial compliance with two program requirements:

- 42 C.F.R. § 483.10(b)(11) (Tag F157 – notification of changes) at scope and severity level D; and

- 42 C.F.R. § 483.30(a) (Tag F353 – nursing services – sufficient staff) at scope and severity level E.

CMS continued the $100 per day CMP. CMS Exs. 1, 20.

Following a January 19, 2012 revisit, CMS determined that the facility returned to substantial compliance on January 12, 2012. CMS Ex. 2.

Petitioner timely requested a hearing. Petitioner limits its appeal to one deficiency cited during the November survey: 42 C.F.R. § 483.25 (Tag F309), which was cited at the immediate jeopardy level. Petitioner does not challenge the other deficiencies cited during the November survey and does not appeal any of the December survey findings. P. Post-hrg. Br. at 2; Transcript (Tr.) of January 30, 2013 Hearing 6-7.[1] It does not challenge the $100 per day CMP. CMS's determinations with respect to the deficiencies that were not appealed are therefore final and binding and provide a sufficient basis for imposing a penalty. From September 23, 2011 through January 11, 2012, the facility was not in substantial compliance with program requirements. The $100 per day CMP that CMS has imposed for 76 days of substantial noncompliance ($7,600 total) is reasonable.

On January 30, 2013, I convened a video hearing from the offices of the Departmental Appeals Board in Washington, D.C. Counsel and most of the witnesses convened in Youngstown, Ohio. Witness Roberta Kaplow testified from Atlanta, Georgia, and Witness Rebecca Hromyak testified from Greenville, North Carolina. Tr. 14, 202. Ms. Marian C. Nealon appeared on behalf of CMS. Ms. Barbara L. Miltenberger and Mr. Scott Martin appeared on behalf of Petitioner. I have admitted into evidence CMS Exhibits (CMS Exs.) 1-20 and 35-43, and Petitioner's Exhibits (P. Exs.) 1-5 and 7-30, Petitioner having withdrawn P. Ex. 6 during the course of the hearing. Tr. 8-11, 14, 181.

The parties have filed pre-hearing briefs (CMS Pre-hrg. Br.; P. Pre-hrg. Br.) and post-hearing briefs (CMS Post-hrg. Br.; P. Post-hrg. Br.); CMS filed a reply brief (CMS Reply).

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[1] In error, the transcript says that petitioner did not appeal the "September" survey findings. It should have said "December" survey findings. Tr. 7.

II. Issues

Based on the uncontested issues, the facility was not in substantial compliance with Medicare program requirements from September 23, 2011 through January 11, 2012, and I must affirm a CMP of at least $100 per day.

The remaining issues are:

1. From September 23 through October 27, 2011, was the facility in substantial compliance with 42 C.F.R. § 483.25 (Tag F309), the quality-of-care regulation, which mandates that the facility provide necessary care and services to each resident;

2. If the facility was not then in substantial compliance with 42 C.F.R. § 483.25, did that deficiency pose immediate jeopardy to resident health and safety; and

3. Is the CMP imposed – $4,400 per day for that period – reasonable?

Tr. 6-7.

III. Discussion

A. The facility was not in substantial compliance with 42 C.F.R. § 483.25, because facility staff did not closely monitor a resident's deteriorating respiratory condition nor immediately report to her physician the changes in her condition.[2]

Program 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.

Resident 145 (R145). This case revolves around R145. R145 was a 75-year-old woman suffering from diabetes, chronic obstructive pulmonary disease (COPD),[3] coronary artery disease, hypertension, atrial fibrillation, anxiety, and many other disorders. CMS Ex. 15

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

[3] COPD involves chronic inflammation of the lungs' air sacs. CMS Ex. 38 at 4 (Kaplow Decl. ¶ 23).

at 45. She developed gangrene, and, in June 2011, her right leg was amputated above the knee. In September 2011, her left leg was amputated above the knee. CMS Ex. 15 at 23, 45; CMS Ex. 19 at 171. Following her left-leg amputation, she was readmitted to the facility on September 10, 2011. CMS Ex. 15 at 23, 35; CMS Ex. 19 at 175. At the time of her readmission, her physician ordered 2.5mg/3mL Albuterol aerosol every four hours, as needed (Q4° prn), to treat wheezing/shortness of breath related to her COPD. CMS Ex. 15 at 56; P. Ex. 20 at 2.

R145's treatment records show that her condition remained stable for the week following her readmission. Until the evening of September 18, nursing staff reported no complaints of shortness of breath or other respiratory difficulties, almost always responding "none" or "not applicable" to questions about her oxygen/respiratory needs. CMS Ex. 15 at 28-34. Even her medication order is referred to only a couple of times ("prn aerosols"). CMS Ex. 15 at 29, 31, 34.

Progress notes indicate that, at 8:15 p.m. on September 18, R145 complained of shortness of breath. She was administered Albuterol aerosol "with good effect" and voiced no further complaints. CMS Ex. 15 at 28.

At 6:41 the following morning (September 19), R145 again complained of shortness of breath, and nurses reported audible wheezes throughout her lungs.[4] Her oxygen saturation level was 86%. The nurses administered Albuterol aerosol "with good effect"; her wheezes diminished; and she expressed no further complaints about shortness of breath (according to the notes). CMS Ex. 15 at 28.

In a respiratory progress note dated September 19 at 4:29 p.m., the facility's respiratory therapist, Christine Hunkus, indicated that she checked on the resident "after hearing from staff that she was short of breath." Respiratory Therapist Hunkus found that the resident's respirations were labored and noted that she was asking for aerosol treatment. Her oxygen saturation level was 88% on room air, though the therapist noted that a "nursing assistant had been working with [R145] and had just turned her." The therapist heard wheezing "both audibly and throughout [the resident's] lung fields." The resident had a moist and productive cough. After the aerosol treatment, her breathing was less labored, and her oxygen saturation level was up to 94% on room air. Respiratory Therapist Hunkus indicated that she would ask the physician to order a chest x-ray. CMS Ex. 15 at 27-28.

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[4] For individuals suffering from COPD, fluid leaks from the vessels that surround the air sacs of the lungs into the air sacs themselves. Tr. 28. When air passes through the fluid, it causes sounds, referred to as crackle, rhonchi, or rales. CMS Ex. 38 at 4 (Kaplow Decl. ¶ 23); Tr. 30. Wheezing indicates that air is passing through a narrow passageway. This narrowing causes breathing difficulties. CMS Ex. 38 at 4 (Kaplow Decl. ¶ 23).

A note dated September 20 at 1:41 p.m. indicates that R145 again complained of shortness of breath and was administered the aerosol at 11:30 a.m. "with effect noted." CMS Ex. 15 at 26-27.

R145's physician, Dr. Bahaa Awadalla, ordered a chest x-ray, which was performed on September 21, 2011. The x-ray showed that R145 had left lower lobe pneumonia or atelectasis (collapsed lung). CMS Ex. 15 at 26. Dr. Awadalla prescribed the antibiotic Avelox. According to progress notes, at 3:30 p.m. that day, the resident again complained of shortness of breath; her oxygen saturation level was 79%. "Crackles" were heard in her left lower lobe, and wheezing was heard throughout her left lung fields. Registered Nurse (RN) Autumn Lopez notified R145's physician of her status and administered oxygen via nasal cannula. CMS Ex. 15 at 26. RN Lopez reported that, by 9:00 p.m., the resident said that she felt better. CMS Ex. 15 at 26. Staff administered Albuterol treatments three times on September 21. CMS Ex. 15 at 57; Tr. 43.

Progress notes for the next day or two record no significant problems. They indicate that, on September 22, R145 continued to receive oxygen via nasal cannula. CMS Ex. 15 at 25. As of 1:50 a.m. September 23, the notes describe her as "pleasant and cooperative with staff." She is "alert and oriented to self," but at times is "confused as to facility and date." CMS Ex. 15 at 25. She continued on oxygen per nasal cannula. CMS Ex. 15 at 25. According to the resident's Medication Administration Record (MAR) she required few Albuterol treatments – just one on September 22 and one on the morning of September 23. CMS Ex. 15 at 57; Tr. 45.

By 3:31 p.m. on September 23, 2011, however, the resident's condition had changed. According to a note written by Respiratory Therapist Hunkus, the resident's breath sounds revealed "high pitched wheezing and rhonchi throughout." The resident continued receiving oxygen via nasal cannula, and was given Lasix and aerosol treatments. Her oxygen saturation level was 93%. For the first time since her admission, she had swelling in her hands and elbows. The respiratory therapist wrote that the resident required close monitoring, and she discussed that need with nursing staff. CMS Ex. 15 at 25.

At 8:15 p.m., R145 "was found," unresponsive, with no vital signs. Staff initiated CPR and sent the resident to the emergency room, where she was pronounced dead. CMS Ex. 15 at 24.

Failure to report changes. CMS faults the facility for not immediately reporting the September 23 changes – a significant deterioration in the resident's respiratory condition and swelling in her arms/elbows – to the resident's physician. According to CMS's expert witness, Roberta Kaplow, RN, Ph.D., failing to report deviates from standard nursing practices, which require that such changes in status be reported to the physician

immediately.[5] *See Spring Meadows Health Care Ctr.*, DAB No. 1966 at 17 (2005) ("[M]eeting professional standards of quality may not always be sufficient, but, at the very least, such standards define the minimum services that must be provided . . . ."). Failing to do so, according to CMS, risked further deterioration in the resident's condition "without her receiving necessary treatment as determined by her physician." CMS Ex. 38 at 3-4 (Kaplow Decl. ¶¶ 21, 24).[6]

Petitioner, on the other hand, argues that R145's condition did not change, so staff had no reason to contact her physician. At the same time, Petitioner claims that staff, in fact, contacted her physician.

Most obvious, the swelling in R145's extremity or extremities (referred to as peripheral edema) unquestionably presented a significant change in her condition that staff should immediately have reported to her physician. Peripheral edema can be a sign of heart failure. CMS Ex. 38 at 4 (Kaplow Decl. ¶ 23). Dr. Awadalla eventually learned about it, but this record does not indicate when he learned. In her written declaration, Licensed Practical Nurse (LPN) Rebecca Hromyak stated that she worked the day-shift on September 23 (7:00 a.m. to 7:00 p.m.) and noted that R145 had swelling in her right arm, though not "pitting edema." Although her declaration suggests that she noticed swelling at the start of her shift, progress notes do not mention the symptom until 3:31 p.m. that afternoon ("some swelling noticed in hands and elbows"). LPN Hromyak asserts that she assumed that the swelling was due to the resident's positioning, so she elevated the arm. According to her declaration, the swelling decreased throughout the day, a claim supported primarily by LPN Hromyak's own statements, not by any actual medical evidence. P. Ex. 3 at 1 (Hromyak Decl. ¶ 3).

Petitioner suggests that staff were not required to report the arm swelling because it affected only one arm and was likely caused by positioning rather than a more serious underlying condition. But the contemporaneous treatment note refers to swelling in both "hands" and "elbows" (plural). CMS Ex. 15 at 25. Moreover, as Dr. Kaplow pointed

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[5] Dr. Kaplow is a clinical nurse specialist at Emory University Hospital and an adjunct member of the faculty at Emory's Neil Hodgson Woodruff's School of Nursing. In addition to her bachelor of science degree in nursing, she has a master's degree in delivery of nursing services, a doctorate in research and theory development, and a post-masters certificate as a clinical nurse specialist. CMS Ex. 35; *see* CMS Ex. 38 at 1-3 (Kaplow Decl. ¶¶ 1-18).

[6] The regulations also mandate that staff immediately consult the resident's physician when there is a significant change in the resident's physical, mental or psychosocial status or a need to alter treatment. 42 C.F.R. § 483.10(b)(11). However, CMS did not cite the facility under that regulation.

out, all swelling is positional, since "[t]he fluid will move with gravity." Tr. 53. In any event, the swelling represented a significant, and potentially very serious, change, and staff were bound to report it to the physician, no matter what they thought its cause. This is particularly true in this case, because swelling can indicate heart failure or infection, conditions to which R145 was especially vulnerable. Tr. 54.

At the time, LPN Hromyak apparently recognized that she should notify the physician. According to her declaration, at about 10:00 a.m. that morning, she told her colleague, LPN Jo Ellen Liboratore, that she (LPN Hromyak) "needed to contact Dr. Awadalla about R145's swelling to her right arm and complaints of shortness of breath." P. Ex. 3 at 1 (Hromyak Decl. ¶ 4). But Petitioner has not established that LPN Hromyak or any other staff member timely reported the changes. On the one hand, LPN Liboratore wrote a new physician's order, and she might have placed the call while covering for LPN Hromyak, sometime after 10:00 a.m. but before 12:15 p.m. On the other hand, according to Respiratory Therapist Hunkus, as late as 2:00 p.m., staff were administering Albuterol pursuant to Dr. Awadalla's earlier (prn) order, which suggests that the call was made much later in the day. Tr. 98. Neither Dr. Awadalla nor any staff member remembers a specific call, nor do any contemporaneous records indicate that a call was made, even though standard nursing practice requires nurses to document such calls. Tr. 218. Thus, without regard to her increased breathing difficulties (discussed below), the evidence does not show that staff promptly reported a new and troubling symptom; this violates the standard of care and puts the facility out of substantial compliance with the quality-of-care regulation.

Even assuming that staff contacted the physician sometime that morning (an assumption not supported by any reliable documentary or testimonial evidence), the evidence also establishes that, by 3:31 p.m. on September 23, R145's respiratory condition had deteriorated significantly. From September 18 to 23, the Albuterol treatments seem to have been controlling R145's breathing difficulties. Even when she contracted pneumonia, she did not require treatment more than three times a day. Treatment records show that she responded well to them and that the Albuterol aerosol sustained her for at least four to six hours at a time. CMS Ex. 15 at 57. But, as of 3:31 p.m. on September 23, the aerosol treatments were no longer sustaining R145 for any significant period. Though treated at 10:00 a.m. and 2:00 p.m. that day, she was wheezing and complaining about shortness of breath at 3:31 p.m., only an hour and a half after her last treatment. This represented a significant change. Tr. 74-75 ("So that indicates to me that this patient has taken a turn for the worse . . . . Something . . . has happened to her and it needs to be reported and investigated further.").

At 3:31 p.m., the respiratory therapist was plainly disturbed by the resident's condition, as evidenced by her assessment and note that R145 needed to be monitored closely. CMS Ex. 25 at 160. Yet, no reliable evidence establishes that either she or any of the nursing staff reported those concerns to the resident's physician until much later.

How much later is impossible to determine. The resident's treatment record is replete with glaring omissions and misleading entries. The witness testimony is characterized by faulty memories and inconsistent statements. According to the progress notes, at 4:50 p.m., with the resident's family voicing concerns about the resident's deteriorating condition, LPN Hromyak called R145's physician, who ordered that the resident's Lasix be changed "to qd" (every day) and that her Albuterol be administered qid (four times daily) instead of every four hours, prn (as needed). CMS Ex. 19 at 22.

I note first that this change in the resident's order for Albuterol is puzzling. Prior to the change, she could receive the medication every four hours, as needed. CMS Ex. 15 at 56. By the afternoon of September 23, the four-hour interval was too long; after just an hour and a half, she was again short of breath and wheezing. But, instead of allowing more frequent treatments, her physician *decreased* their frequency to four times a day, which means roughly every six hours. *See* Tr. 62-63. According to Dr. Awadalla's written declaration, he ordered that the aerosol treatments be given four times a day rather than on an as needed basis, because "she was getting those treatments regularly anyway." P. Ex. 7 at 6 (Awadalla Decl. ¶ 27). He thought (incorrectly) that he was changing the order to reflect the practical frequency of the medication's administration. This suggests that staff did not accurately describe to him the resident's current medication order, her deteriorating condition, or both.

I am not sure that Dr. Awadalla ever fully understood what he had done. However, he agreed that staff "absolutely" needed to call him and ask for an additional order, if administering the drug four times a day did not sustain the resident. Tr. 157.

In her written declaration, LPN Hromyak asserts that "at 4:50 p.m.," she documented that the resident's condition had not worsened over the shift; that the resident had edema to her right arm and both arms were elevated; and that "the family was voicing concern over the resident's condition and asked me numerous times if I had spoken with the physician." According to the note, she told the family that she had spoken to the physician and that he had changed his orders. P. Ex. 3 at 2 (Hromyak Decl. ¶ 6). But LPN Hromyak now admits that she had not then called the physician. Someone else did, and no one knows when the call was placed nor what was reported. And she could not remember when she wrote the note, but considered it "most likely" that she did so at the end of her shift. Tr. 215. She admitted that she altered the facility's computer system, so that it would record the earlier time ("You have the ability to change dates and times in our computer system") and insisted that it was perfectly appropriate to alter a record to indicate that an entry had been made at a time other than when it was made. Tr. 212-214, 216, 218.

In her written declaration, LPN Hromyak also claims that she called Dr. Awadalla at about 5:00 p.m. and told him that the resident was doing better. P. Ex. 3 at 3 (Hromyak

Decl. ¶ 13). There is no record of such a call. Moreover, under cross-examination, LPN Hromyak admitted that she did not know when she called Dr. Awadalla; that any call she made "had nothing to do with the breathing treatment" or the resident's respiratory condition; and that she did not record any call. Tr. 210, 218-220. She also said (somewhat inconsistently) that she did not recall but "believed" that she reported the respiratory therapist's findings to the physician. She ultimately testified that she updated the doctor "to let him know that the patient show[ed] improvement." Tr. 220-222. The witness's testimony was inconsistent and completely unreliable. I find it unlikely that she spoke to the doctor until very late in the day, but, if, in fact, she told him that the resident's condition was improving, she seriously misrepresented the situation.[7]

Under cross-examination, LPN Hromyak said that LPN Jo Ellen Liboratore called the physician and obtained the order change sometime between 10:15 a.m. and 12:15 p.m., while LPN Hromyak was out of the unit. Tr. 210-211; 218. But she also testified that she did not know when LPN Liboratore took the order, and the medical record includes no documentation of such a call. Tr. 211, 218.

For her part, LPN Liboratore claims that, at LPN Hromyak's request, she called R145's physician, Dr. Awadalla, who changed R145's medication – increasing her Lasix (from 20 mg every other day to 20 mg every day) and changing her Albuterol aerosol from "every four hours as needed" to "every four hours." P. Ex. 11 at 1 (Liboratore Decl. ¶ 5). But LPN Liboratore misstates the changes in the Albuterol order; Dr. Awadalla changed it from "every four hours as needed" to "four times a day." Moreover, she does not say when she called Dr. Awadalla. She prepared a written physician order, but, significantly, left blank the space for indicating the time the order was given. CMS Ex. 15 at 90.[8]

At the time of the survey, Dr. Awadalla reported that he "did not recall being called and updated regarding [R145's] change in condition." CMS Ex. 5 at 12; CMS Ex. 37 at 2 (Zuschlag Decl. ¶¶ 3, 4); Tr. 129. In his written declaration, he claimed that he "was notified" about the resident's right arm edema and shortness-of-breath complaints, but, again, did not mention when he was so notified. P. Ex. 7 at 5-6 (Awadalla Decl. ¶ 27). Inasmuch as the timing of the calls is critical, I find these omissions telling.

Dr. Awadalla later testified that he received the call at 4:50 p.m., which is a problem, inasmuch as LPN Hromyak admitted that she did not place the call at that time. Tr. 138-

[7] To determine whether the resident's condition was improving, staff should have compared her vital signs over time. Because she did not record vital signs, the LPN lacked sufficient information on which to base that determination. *See Life Care Ctr. of Bardstown*, DAB No. 2479 at 20-21, 26 (2012).

[8] To make matters even more confusing, LPN Hromyak denies telling LPN Liboratore to call the physician. Tr. 211.

139. Ultimately, the physician admitted that his testimony as to the time was based on the (erroneous) entry in the progress notes, and that he had no independent recollection of receiving the call. Tr. 139; *see* Tr. 212-213. He produced no records of his own documenting contact from the facility. *See* Tr. 139.

R145's medical record establishes that, at most, two calls were made to the physician on the last day of R145's life: one at an undisclosed time that resulted in the medication changes, and a second at 8:30 p.m., after staff found the unresponsive resident, at which time Dr. Awadalla ordered them to send her to the emergency room. CMS Ex. 15 at 90.

The record includes other evidence of the resident's deteriorating condition that afternoon and her family's increasingly frantic efforts to persuade staff to help her. When she later called to complain about her grandmother's treatment, R145's granddaughter told the state agency that she, her mother, and her aunt arrived at the facility in the early afternoon of September 23. She described her grandmother as "in physical distress." Her hands and fingers were "very swollen"; her face "was ashen"; she complained that she felt "really, really bad," and breathing treatment did not help. CMS Ex. 11 at 2.

LPN Hromyak documented that "[f]amily is voicing concerns over [the resident's condition] and this nurse has reassured numerous times that we will keep the doctor updated and follow his orders." CMS Ex. 19 at 22. In a statement dated November 30, 2011 (and submitted during the Informal Dispute Resolution (IDR) process), she admitted that the resident's anxious family member approached her four times during the afternoon of September 23, concerned about the arm swelling. In her testimony, she claimed that R145's daughter was not concerned about her mother's shortness of breath, only about the swollen arm ("She said, 'What if she goes to the hospital? What if she needs to go to the hospital? Her arm is swollen. Should she go to the hospital?'"). Tr. 234. But, when pressed, she admitted that the daughter also bothered her about giving her mother another aerosol treatment: "When is she going to get her next breathing treatment?"). Tr. 234.

The facility's Director of Nursing (DON), Brenda Bergman, confirmed that she went to R145's room for the explicit purpose of speaking to the resident's daughter, because the woman was so anxious.[9] Tr. 160.

Petitioner justifies its actions by claiming that R145 experienced similar difficulties, at least with respect to wheezing, during her hospitalization. I do not see how this helps

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[9] Petitioner has suggested that the complaints expressed by R145's family should be given no credence, because certain family members were unreasonably anxious and troublesome. Given the severity of R145's condition, their anxiety seems to have been justified. They were describing real symptoms that merited close monitoring and physician intervention.

Petitioner's case. That the resident was acutely ill while admitted to an acute-care setting is hardly surprising. If anything, it would seem that a long-term-care resident's experiencing symptoms similar to those she experienced in an acute-care setting would make it all the more important for staff to report those symptoms to her physician, since it suggests that she might again require acute care.

Nor am I persuaded that the facility should prevail because it allegedly provided care comparable to that provided by the hospital. Petitioner has not demonstrated that a complete set of her hospital records have been submitted. I see neither nursing notes nor medication administration records from R145's hospitalization. *See, e.g.*, Tr. 187, 189. So, even if this issue were properly before me (which it is not), I could not assess the level of monitoring R145 received while hospitalized.

What matters here are R145's hospital discharge records, which indicate that she had "an episode of shortness of breath" for which she was treated, and "since then, her respiratory status has improved." P. Ex. 20 at 10, 31. Her condition at discharge was characterized as "stable." P. Ex. 20 at 14. As the evidence establishes, her respiratory condition declined about a week later, then stabilized until the afternoon of September 23, when it deteriorated. Staff's failure to report that deterioration violated the standard of care and put the facility out of substantial compliance.

<u>Inadequate monitoring</u>. Notwithstanding the respiratory therapist's instructions that nursing staff closely monitor R145, progress notes show virtually no monitoring between 3:31 p.m. and 8:15 p.m., when the resident was found unresponsive, with no vital signs.[10] CMS Ex. 15 at 24.

According to Dr. Kaplow, staff should have checked and recorded the resident's vital signs, particularly heart rate, blood pressure, and respiratory rate, at least every 30 minutes to an hour. Her pulse oximetry readings should have been noted hourly. CMS Ex. 38 at 4 (Kaplow Decl. ¶ 25). The standard of care also mandates that nursing staff listen to the resident's breath sounds, observe how her chest wall is moving, note changes in her coughing, and observe whether she is using accessory muscles to assist in her breathing (which indicates respiratory distress). Staff should also have assessed the resident's mental status and checked for signs of diaphoresis (excessive sweating), another sign of respiratory distress. CMS Ex. 38 at 4 (Kaplow Decl. ¶ 26); *see also* CMS Ex. 43 (providing the standard of care for monitoring residents with acute illnesses or

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[10] LPN Hromyak, on the other hand, claims that *Respiratory Therapist Hunkus* "agreed that *she* would closely monitor the resident. . . ." (emphasis added) P. Ex. 3 at 2 (Hromyak Decl. ¶ 6).

infections). To monitor adequately, staff should have assessed and documented R145's lung sounds, color of the resident's skin, lips, and fingernail beds, changes in mental status or level of consciousness, increased restlessness, shortness of breath or other difficulty breathing, presence/absence of cough, and the presence/absence of signs and symptoms related to a specific infection. CMS Ex. 43.

Dr. Awadalla agreed that he expected staff to be monitoring the resident's vital signs. Tr. 145-146. At a minimum, staff should have assessed the effectiveness of the Albuterol, by noting the resident's vital signs before and after the medication was given. Dr. Awadalla testified that he considered it "important, for sure," that staff assess to see if the resident exhibits improvement as a result of the treatment. Heart rate, respiratory rate, and blood pressure should be checked after every treatment and noted in the progress notes. Tr. 148, 151.

DON Bergman agreed that standard nursing practice requires that assessment results be written down. Tr. 162. Even LPN Hromyak admitted (albeit grudgingly) that "if you don't write it down, it didn't happen." Tr. 232.

The record shows that facility staff fell far short of the standard of care. Between 4:50 p.m. and 7:55 p.m., nothing is recorded in the progress notes. CMS Ex. 19 at 22. Based on the resident's entire medical record, it seems that a nurse took the resident's pulse just once, when she administered ordered medication and noted the resident's oxygen levels. According to notes from the emergency room, staff reported that R145 had been down *for an unknown amount of time*, and that they found her during a medication pass. CMS Ex. 15 at 4.

Although staff members subsequently claimed to have performed assessments and administered treatments during this time, the resident's treatment record does not support their claims.

For example, in her IDR statement, LPN Hromyak said that she administered an aerosol breathing treatment at 6:00 p.m. on September 23. CMS Ex. 19 at 164. According to the progress notes, however, she administered the aerosol at 7:55 p.m. CMS Ex. 19 at 22. During these proceedings, she said that she administered the treatment at 6:00 p.m., Tr. 223, 225; but elsewhere she said she did so "probably closer to 6:45." Tr. 232. Even assuming that she administered the treatment at 6:00 p.m. or 6:45 p.m., she violated the standard of care by inaccurately recording the time of administration as 7:55 p.m. The nurse must document late entries by indicating both the documentation time and the administration time. CMS Ex. 38 at 5 (Kaplow Decl. ¶ 28).

LPN Hromyak also failed to document the treatment in the facility's MAR, which shows treatments administered at 10:00 a.m. and 2:00 p.m., but no other time. Even if I accepted that she administered the treatment (which I do not), I would find that she

violated standard of care by failing to document and/or inaccurately documenting that she had done so. CMS Ex. 15 at 56; CMS Ex. 43 at 1 ¶ 7 (instructing nurses to "[d]ocument the results of monitoring, observations, nursing interventions, notifications, and the resident's response in the nurses' notes.").[11]

Nor is this the only example of staff's failing to document a necessary assessment or ordered treatment:

- At 4:00 p.m. on September 23, LPN Hromyak should have measured R145' blood sugar and administered Novolin. CMS Ex. 15 at 69. She claims to have tested the resident's blood sugar, although she did not write that down. She could not remember whether she administered the Novolin, but she did not document that she had done so. Tr. 240-241.

- LPN Liboratore claims that she would have assessed the resident before calling the physician. P. Ex. 11 at 1 (Liboratore Decl. ¶ 5). But she has no memory of the resident nor of performing an assessment; she does not mention when she performed the assessment. Most significant, she did not document and the facility has no record that she ever performed an assessment.

- DON Brenda Bergman, claims that she assessed the resident between 4:00 and 4:30 p.m. on September 23. P. Ex. 2 at 2 (Bergman Decl. ¶¶ 6, 8). However, she documented no findings.

- Notwithstanding a physician order to take vital signs every shift for the first three days following her admission and weekly thereafter, no record shows that staff did so. CMS Ex. 15 at 65; *see* Tr. 229-232.

Petitioner acknowledges that its "documentation was not perfect," but minimizes the significance of this inadequacy, arguing that nurses cannot be expected to document everything that occurs with a patient. P. Post-hrg. Br. at 16-17. The problem here was not that staff failed to document everything, but that staff documented so little, including necessary assessments and administration of medications. Inaccurately recording the time an aerosol treatment is administered, for example, means that staff and the physician cannot tell how long the medication is effective. CMS Ex. 38 at 5-6 (Kaplow Decl. ¶ 28).

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[11] LPN Hromyak implied that others also neglected to document that they administered medications. Tr. 227 ("I'm not the only person who had ever forgot[ten] to initial something on the MAR."). Given the sorry state of the facility's documentation, I find incredible the opinion of Petitioner's expert witness, Jeanne Rutledge, RN, that "the majority of skilled nursing facilities would not document as frequently as found in this case." P. Ex. 8 at 6 (Rutledge Decl. ¶ 28).

Finally, that staff were unable to say how long R145 had been unresponsive before they found her shows that did not closely monitor her condition.

The facility's "monitoring" was inadequate for an individual exhibiting the symptoms R145 was exhibiting. The facility was thus not providing necessary care and services so that she could attain her highest physical well-being, and was not in substantial compliance with 42 C.F.R. § 483.25.

B. CMS's determination that the facility's deficiency under 42 C.F.R. § 483.25 posed immediate jeopardy to resident health and safety is not clearly erroneous.

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. 1931 at 27-28 (2004) (citing *Koester Pavilion*, DAB No. 1750 (2000); *Daughters of Miriam Ctr.*, DAB No. 2067 at 7, 9 (2007)).

I need not find that the facility's noncompliance actually caused serious harm or injury to R145, or that it caused her death. So long as the deficiencies are likely to cause serious injury or harm, they pose immediate jeopardy. As recognized by Respiratory Therapist Hunkus, R145 was in distress and in need of careful monitoring during the afternoon and evening of September 23. When her ordered treatments were no longer sufficient to sustain her, staff should have accurately reported that fact to her physician, so that he could respond immediately and appropriately. Staff then failed to monitor her closely and kept inadequate records of her condition and the treatments they provided (if, in fact, they provided them). In light of the resident's fragile condition, these inadequacies were likely to cause the resident serious harm or even death. CMS's immediate jeopardy determination is therefore not clearly erroneous.

C. The penalty imposed is reasonable.

To determine whether a CMP is reasonable, I apply 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.

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 section 488.438(f) 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. 1638, at 8 (1999).

CMS imposes a penalty of $4,400 per day for 35 days of immediate jeopardy, which is in the low-to-middle penalty range for deficiencies constituting immediate jeopardy ($3,050 − $10,000 per day). 42 C.F.R. §§ 488.408(e)(iii); 488.438(a)(1)(i).

Considering the relevant factors, the penalty is reasonable. First, the facility has a significant history of noncompliance. Since at least 2004, the facility has not been found in substantial compliance during an annual survey. CMS Ex. 3. In 2010 (the year before the survey in this case), it was cited for G-level (actual harm) deficiencies under quality-of-care (42 C.F.R. § 483.25 – Tag F309), as well as failing to prevent pressure sores (42 C.F.R. § 483.25(c) – Tag F314), and failing to prevent accidents (42 C.F.R. § 483.25(h) – Tag F323). Nor were these the facility's only deficiencies. It was not in substantial compliance with the Life Safety Code (Tag 0056). In subsequent complaint-investigation surveys that year, the facility was again not in substantial compliance with 42 C.F.R. § 483.25(h) and 42 C.F.R. § 483.13(b) (Tag F223), which addresses resident behavior and facility practices, including preventing abuse. The latter deficiency caused actual harm. CMS Ex. 3 at 2.

Petitioner argues that the facility's history "demonstrates a pattern of addressing surveyor concerns prior to the surveyors leaving the building, of immediate corrections, and of expectations that all staff will meet the highest standards for consistent quality care." P. Post-hrg. Br. at 23. That substantial deficiencies were found during every survey since 2004, and during three separate surveys in 2010 suggests that the facility has not consistently provided quality care. Its history alone supports imposing a significant penalty.

Petitioner does not claim that its financial condition affects its ability to pay the CMP.

With respect to the remaining factors, the evidence establishes that R145 was seriously ill. Yet, as her condition deteriorated, staff did not timely report changes to her physician. Notwithstanding explicit instructions from the respiratory therapist (and prodding from the resident's family), staff did not closely monitor her condition. Nurses either failed to administer ordered treatments or failed to document that they had done so. I find the deficiency extremely serious and the staff culpable. The penalty imposed is therefore reasonable.

IV. Conclusion

Petitioner has conceded that, from September 23, 2011 through January 11, 2012, it was not in substantial compliance with Medicare program requirements. From September 23 through October 27, 2011, it was not in substantial compliance with 42 C.F.R. § 483.25, and its noncompliance posed immediate jeopardy to resident health and safety. I affirm as reasonable the penalty imposed − $4,400 per day – for the period of immediate jeopardy.

/s/

Carolyn Cozad Hughes
Administrative Law Judge