Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Embassy Health Care Center
(CCN: 14-5316)

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-09-206

Decision No. CR2107

Date: April 7, 2010

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose remedies against Embassy Health Care Center (Petitioner or facility). For the reasons that follow, I uphold the CMP of $350 per day from November 7 through December 11, 2008, for a total of $12,250.

I. Background

Petitioner is a long-term care facility located in Wilmington, Illinois. Petitioner is authorized to participate in the federal Medicare program as a skilled nursing facility (SNF) and in the Medicaid program as a nursing facility (NF). On November 7, 2008, the Illinois Department of Public Health (IDPH or state agency) conducted a survey of the facility. IDPH determined that Petitioner was not in substantial

compliance with the following 19 Medicare participation requirements:

- 42 C.F.R. § 483.25, Tag F309 (Quality of Care) at a "G" level of scope and severity;[1]

- 42 C.F.R. § 483.25(h), Tag F323 (Accidents and Supervision) at a "G" level of scope and severity;[2]

- 42 C.F.R. § 483.65(a), Tag F441 (Infection Control) at a "F" level of scope and severity;

- 42 C.F.R. § 483.65(b)(3), Tag F444 (Preventing Spread of Infection) at a "F" level of scope and severity;

- 42 C.F.R. § 483.10(f)(1), Tag F165 (Grievances) at an "E" level of scope and severity;

- 42 C.F.R. § 483.15(b), Tag F242 (Self-Determination and Participation) at an "E" level of scope and severity;

- 42 C.F.R. § 483.15(e)(1), Tag F246 (Accommodation of Needs) at an "E" level of scope and severity;

- 42 C.F.R. § 483.15(h)(1), Tag F252 (Environment) at an "E" level of scope and severity;

- 42 C.F.R. § 483.20, Tag F272 (Comprehensive Assessments) at an "E" level of scope and severity;

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[1] According to the scope and severity matrix published in the State Operations Manual (SOM) section 7400E, a scope and severity level of A, B, or C indicates that a deficiency has the potential for no actual harm and has the potential for no more than minimal harm. A scope and severity level of D, E, or F indicates a deficiency that presents no actual harm but has the potential for more than minimal harm that does not amount to immediate jeopardy. A scope and severity level of G, H, or I indicates a deficiency that involves actual harm that does not amount to immediate jeopardy. A scope and severity level of J, K, or L indicates that a deficiency poses immediate jeopardy to resident health or safety. The matrix, which is based on 42 C.F.R. § 488.408, specifies which remedies are required and optional at each level based upon the frequency of the deficiency. *See* SOM section 7400E.

[2] This deficiency was subsequently deleted and is not a subject of this appeal. *See* CMS Ex. 2 at 1.

- 42 C.F.R. § 483.35(c), Tag F363 (Menus and Nutritional Adequacy) at an "E" level of scope and severity;

- 42 C.F.R. § 483.35(d), Tag F364 (Food) at an "E" level of scope and severity;

- 42 C.F.R. § 483.35(i), Tag F371 (Sanitary Conditions) at an "E" level of scope and severity;

- 42 C.F.R. § 483.65(b)(1), Tag F442 (Preventing Spread of Infection) at an "E" level of scope and severity;

- 42 C.F.R. § 483.70(d)(1)(ii), Tag F458 (Resident Rooms) at an "E" level of scope and severity;

- 42 C.F.R. § 483.10(j), Tag F172 (Access and Visitation Rights) at a "D" level of scope and severity;

- 42 C.F.R. § 483.13(a), Tag F221 (Physical Restraints) at a "D" level of scope and severity;

- 42 C.F.R. § 483.20(k)(3)(i), Tag F281 (Comprehensive Care Plans) at a "D" level of scope and severity;

- 42 C.F.R. § 483.25(i), Tag F325 (Nutrition) at a "D" level of scope and severity; and

- 42 C.F.R. § 483.25(n), Tag F334 (Influenza and Pneumococcal Immunization) at a "D" level of scope and severity.

See CMS Ex. 1.

By letter, dated November 18, 2008, the IDPH notified Petitioner that it had imposed directed in-service training, effective December 8, 2008, and would impose a mandatory denial of payment for new admissions (DPNA), effective February 7, 2009. *See* CMS Ex. 3 at 1. The IDPH also recommended that CMS impose a CMP. *See* CMS Ex. 3 at 1.

By letter, dated December 8, 2008, CMS notified Petitioner that, based on its compliance history, it was changing the recommended remedy and imposing a discretionary DPNA effective, December 28, 2008, and a CMP of $350 per day beginning November 7, 2008, until compliance was achieved. CMS Ex. 3.

By letter, dated January 16, 2009, Petitioner timely requested a hearing. In its hearing request, Petitioner listed the 19 tags cited during the November 7, 2008 survey but stated that it was challenging only the citation under Tag F309, Quality of Care. Petitioner stated that it had submitted documentation to refute the deficiencies and that the deficiency under Tag F323 was deleted. Petitioner's Hearing Request.

By letter dated February 4, 2009, CMS notified Petitioner of the final status of the remedies. CMS Ex. 2. CMS stated that the deficiency cited at Tag F323 had been deleted. CMS stated further that a revisit, conducted on January 13, 2009, found the facility to be in substantial compliance with participation requirements effective December 12, 2008. CMS advised Petitioner that it was rescinding the DPNA and imposing a CMP of $350 per day from November 7 through December 11, 2008 (35 days), for a total of $12,250. CMS Ex. 2.

I conducted an in-person hearing in Chicago, Illinois on August 7-8, 2009. CMS offered exhibits (CMS Exs.) 1 through 16, and Petitioner offered exhibits (P. Exs.) 1 through 4. I admitted all of the exhibits into evidence. Hearing Transcript (Tr.) 16, 18. CMS elicited testimony from Joella Daniels, state agency surveyor. Petitioner elicited testimony from Jodi Foster, Petitioner's Director of Nursing, and Roslyn Riley, a Licensed Practical Nurse, employed by the facility.

Each party submitted a post-hearing brief (CMS Brief and P. Brief, respectively) and a reply brief (CMS Reply and P. Reply, respectively), and each party received a copy of the hearing transcript.

II. Issues

The issues before me are:

(1) whether the facility was in substantial compliance with 42 C.F.R. § 483.25 at the time of the November 7; 2008 survey; and
(2) if the facility was not in substantial compliance, whether the penalty imposed, $12,250, was reasonable.

III. Applicable Law and Regulations

Petitioner is considered a long-term care facility under the Social Security Act (Act) and regulations promulgated by the Secretary of the Department of Health and Human Services (Secretary). The statutory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Act, and at 42 C.F.R. Part 483. Sections 1819 and 1919 of the Act vest the Secretary with authority to impose civil

money penalties (CMPs) and other remedies against a long-term care facility for failure to comply substantially with participation requirements.

Pursuant to the Act, the Secretary has delegated to CMS the authority to impose various remedies against a long-term care facility that is not complying substantially with federal participation requirements. Facilities that participate in Medicare may be surveyed on behalf of CMS by State survey agencies to ascertain whether the facilities are complying with participation requirements. 42 C.F.R. §§ 488.10-488.28; 42 C.F.R. §§ 488.300-488.335. Under Part 488, CMS may impose a per instance, or per day, CMP against a long-term care facility when a State survey agency ascertains that the facility is not complying substantially with participation requirements. 42 C.F.R. §§ 488.406, 488.408, 488.430. The regulations in 42 C.F.R. Part 488 also give CMS a number of other remedies that can be imposed if a facility is not in compliance with Medicare requirements.

Pursuant to 42 C.F.R. Part 488, CMS may terminate a long-term care facility's provider agreement when a survey agency concludes that the facility is not complying substantially with federal participation requirements. CMS may also impose a number of alternative enforcement remedies in lieu of, or in addition to, termination. 42 C.F.R. §§ 488.406; 488.408; 488.430. In addition to termination and the alternative remedies that CMS is authorized to impose, pursuant to section 1819(h)(2)(D) of the Act and 42 C.F.R. § 488.417(b), CMS must impose the "mandatory" or "statutory" DPNA. Section 1819(h)(2)(D) requires the Secretary to deny Medicare payments for all new admissions to a SNF, beginning 3 months after the date on which such facility is determined not to be in substantial compliance with program participation requirements. The Secretary has codified this requirement at 42 C.F.R. § 488.417(b).

The regulations specify that a CMP imposed against a facility can be either a per day CMP for each day the facility is not in substantial compliance, or a per instance CMP for each instance that a facility is not in substantial compliance. 42 C.F.R. § 488.430(a).

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

The regulations define the term "substantial compliance" to mean "a level of compliance with the requirements of participation, such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. Non-compliance that is immediate jeopardy is defined as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." *Id.* The Act and regulations make a hearing before an administrative law judge (ALJ) available to a long-term care facility against whom CMS has determined to impose a CMP. Act, section 1128A(c)(2); 42 C.F.R. §§ 488.408(g); 498.3(b)(13). The hearing before an ALJ is a de novo proceeding. *Anesthesiologists Affiliated*, DAB CR65 (1990), *aff'd*, 941 F2d. 678 (8th Cir. 1991).

A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." *See* 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e) and 498.3. However, the choice of remedies by CMS, or the factors CMS considered when choosing remedies, are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge would affect the amount of the CMP that CMS could collect or impact upon the facility's nurse aide training program. 42 C.F.R. §§ 498.3(b)(14)(i) and (ii). CMS's determination as to the level of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate jeopardy. *Woodstock Care Ctr.*, DAB No. 1726 at 9, 38 (2000), *aff'd*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board or DAB) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g., Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Review of a CMP by an ALJ is governed by 42 C.F.R. § 488.438(e).

In a CMP case, CMS must make a prima facie case that the facility has failed to comply substantially with participation requirements. To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd*, *Hillman Rehab. Ctr. v. U. S. Dep't of Health & Human Servs.*, No. 98-3789, 1999 WL 34813783 (D.N.J. May 13, 1999).

IV. Findings of Fact, Conclusions of Law, and Discussion

I make two findings of fact and conclusions of law to support this decision. I set them forth below as separate headings in bold type and then discuss each in detail.

1. Petitioner failed to comply substantially with the requirement at 42 C.F.R. § 483.25 (Tag F309).

As a threshold matter, Petitioner has not appealed 17 of the 19 deficiencies cited in the November 7, 2008 survey, any one of which would justify the imposition of penalties (see discussion below). The unappealed deficiencies are the following: Tags F165; F172; F221; F242; F246; F252; F272; F281; F325; F334; F363; F364; F371; F441; F442; F444; and F458. Petitioner's Hearing Request; Tr. 18-20.

As to the 17 unappealed deficiencies, CMS's determinations that Petitioner was out of compliance with those Medicare requirements are final and binding. 42 C.F.R. § 498.20(b). CMS was therefore authorized to impose penalties. As discussed below, the unappealed deficiencies, by themselves, provide a sufficient basis for the imposition of a $350 per day CMP from November 7 through December 11, 2008.

The only deficiency Petitioner has challenged is Tag F309, 42 C.F.R. § 483.25. The regulation at 42 C.F.R. § 483.25 provides that:

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the [resident's] comprehensive assessment and plan of care.

CMS's allegations of noncompliance with 42 C.F.R. § 483.25 centers on the care provided to Resident 27 (R27) during an eight-day period, October 24-31, 2008. With respect to this citation, the Statement of Deficiencies (SOD) alleges that, based upon observation, record review, and interview, Petitioner failed to:

> -- closely monitor oxygen saturation and respiratory status on [R27] with compromised respiratory status;
>
> -- obtain timely medical evaluation after any of 3 separate episodes of respiratory distress in an 8-day period;
>
> -- follow physician orders to maintain oxygen saturation levels greater than 90% and to encourage oxygen use; and
>
> -- obtain orders for resident access as needed to his bronchodilator inhaler.

CMS Ex. 1 at 18-19.

The SOD alleges further that those failures "resulted in recurrent episodes of respiratory distress with oxygen saturations dropping into the 70s and re-occurrence of infiltrates in the lung." CMS Ex. 1 at 19.

R27 was a 52-year old male, who was admitted to the facility from the hospital on September 25, 2008, with diagnoses that included asthma and chronic obstructive pulmonary disease (COPD). *See* CMS Exs. 9, 10. R27 had a recent episode of pneumonia. *See* CMS Ex. 1 at 19; Tr. 32, 44. The record shows that on September 26, 2008, his physician, Dr. Jurak, ordered, among other things, a Combivent inhaler to be used every four to six hours as needed for shortness of breath. CMS Ex. 12 at 9.

R27's care plan, dated September 28, 2008, noted that he had "altered respiratory function secondary to" COPD and asthma. CMS Ex. 9. The care plan's goal was for R27 to "be free from signs of respiratory distress" through December 28, 2008, the date of the next review. The care plan stated, *inter alia*, the following interventions:

> Observe and report signs of congestion, lethargy, labored breathing, wheezing, etc.; oxygen as ordered by physician; ausculate the lung fields for diminished and abnormal breath sounds; notify the physician, as needed; assess for signs and symptoms of dyspnea and/or cyanosis, administer medications, as ordered; and check oxygen saturation as ordered and PRN.

CMS Ex. 9.

R27's Minimum Data Set Assessment (MDS), dated October 6, 2008, indicates that he displayed resistance to care in the last seven days, but his behavior was easily altered. CMS Ex. 10 at 4.

The facility's nurse's notes show that, on October 23, 2008, at 11:00 a.m., R27 complained of weakness all over his body and not feeling well. R27's lungs were congested on expiration, and his oxygen (02) saturation level was 66% on room air. Staff administered oxygen to R27 by mask, and his 02 saturation level increased to 98%. Staff paged his physician Dr. Jurak. P. Ex. 3 at 4; CMS Ex. 8 at 5.

On October 23, 2008, Dr. Jurak gave orders for Albuterol, back-to-back nebulizer treatments, a chest x-ray, a course of Prednisone over eight days, and ordered that R27's oxygen be titrated to keep saturation levels above 90%. P. Ex. 4 at 2; CMS Ex. 12 at 6. According to the SOD, R27's chest x-ray showed a normal examination. *See* CMS Ex. 1 at 20. There does not, however, appear to be a copy of the x-ray report itself in the exhibits before me.

At 11:30 a.m. on October 23, 2008, a nurse's note indicates that staff had received and carried out Dr. Jurak's orders. According to the note, R27 had received nebulizer treatments, his lungs were still congested, and staff would continue to monitor. The nurse's note stated that R27's 02 saturation level was at 98% on 6 liters per mask. P. Ex.

3 at 5; CMS Ex. 8 at 8. At 1:30 on October 23, 2008, R27's skin was noted to be warm and dry, and his 02 saturation level was at 90% on room air. P. Ex. 3 at 5; CMS Ex. 8 at 8. A little while later, at 2:15 p.m., staff noted that R27's 02 saturation level was at 92% on room air. P. Ex. 3 at 5; CMS Ex. 8 at 8. Several hours later, at 10:00 p.m., another entry in the nurse's notes indicates that R27's 02 saturation level was at 92%. The note states that R27 requested breathing treatment, and staff gave him a nebulizer.

A nurse's note, dated October 24, 2008, but unclear as to the precise time of day, indicates that R27's 02 saturation level was at 90% on room air and that he had his nebulizer at his side. P. Ex. 3 at 7; CMS Ex. 8 at 7.

There are no nurse's notes entries for October 25, 2008. On October 26, 2008, an entry in the nurse's notes indicates that, at 1:00 a.m., R27 was resting in bed, and his respirations were full and unlabored. P. Ex. 3 at 7; CMS Ex. 8 at 7. A 7:00 p.m. nurse's note states that R27's lung sounds were clear, his respirations were unlabored, and his color was "good." P. Ex. 3 at 7; CMS Ex. 8 at 7. Another nurse's note, at 7:30 p.m., indicates that R27's lungs were clear, with no respiratory distress noted, and no concerns voiced. P. Ex. 3 at 5; CMS Ex. 8 at 8.[3]

A nurse's note entry on October 27, 2008, at 1:55 a.m., states that R27 was resting, and his respirations were full and unlabored. P. Ex. 3 at 5; CMS Ex. 8 at 8. R27's skin was warm and dry, and he had no complaints of pain or discomfort. P. Ex. 3 at 5; CMS Ex. 8 at 8. Later that day at 6:00 p.m., the nurse's notes indicate that R27 had no complaints of pain or discomfort, his skin was warm, dry, and pink, and his lungs were clear. P. Ex. 3 at 7; CMS Ex. 8 at 7; *see* Tr. 86.

On October 28, 2008, the surveyor, Joella Daniels, entered R27's room. Tr. 24; *see* CMS Ex. 1 at 20. Ms. Daniels testified that his door was closed, so she knocked before entering. She stated that R27 was alone in the room, which was dark. Ms. Daniels testified that R27 appeared to be in distress and that he stated that he was "having difficulty breathing." She stated that R27 was "having trouble talking" and that she "could hear from across the bed his respirations were wet and gurgling, and when he would try and talk, he was coughing . . . nonproductively." Tr. 24; *see* Tr. 43; *see also* CMS Ex. 1 at 20. Ms. Daniels noted in the SOD that R27 complained that staff would not allow him to have his inhaler at his bedside. *See* CMS Ex. 1 at 20; CMS Ex. 7 at 1.

Ms. Daniels testified that she immediately called a nurse to check R27, and a nurse came and evaluated his vital signs and checked his oxygen saturation level, which was in the 70s. Tr. 24.

The nurse's notes indicate that, on October 28, 2008, a nurse was summoned to R27's room, because he had complaints of shortness of breath. The nurse gave R27 his

[3] This October 26, 2008, 7:30 p.m. entry appears to have been written out of sequence.

Combivent inhaler and instructed him to take two puffs. R27 self-administered the inhaler and took three puffs. The nurse checked his 02 saturation level and noted that it was at 71% on room air. R27's lung sounds showed inspiratory and expiratory wheezing, as well as a non-productive cough. The nurse administered oxygen to R27 at two liters/minute, and his oxygen saturation level increased to 96-99 %. The nurse paged R27's physician, Dr. Jurak, at noon. P. Ex. 3 at 5; CMS Ex. 8 at 8; *see* CMS Ex. 1 at 20-21; *see also* Tr. 87-88.

A nurse's note at 12:30 p.m. states that R27 was resting comfortably, and his 02 saturation level was at 99% on two liters/minute. The note states further that R27 wished to remove the oxygen, and, when it was removed, his oxygen level went down to 87%. The nurse advised R27 to keep the oxygen on and noted that she would provide a portable oxygen tank if he wished to get up. P. Ex. 3 at 6; CMS Ex. 8 at 9; *see* Tr. 88.

At 1:00 p.m., staff paged Dr. Jurak. At this time, R27 was receiving oxygen at two liters/minute, and his 02 saturation level was at 97%. P. Ex. 3 at 6; CMS Ex. 8 at 9. At 1:20 p.m., Dr. Jurak's office called, and staff described R27's condition. R27 was stable at this time, but staff noted that he refused to wear his oxygen. P. Ex. 3 at 6; CMS Ex. 8 at 9.

At 2:00 p.m., Dr. Jurak returned the call. The record shows that, on October 28, 2008, Dr. Jurak ordered staff to continue to monitor R27 and encourage him to wear his oxygen. Dr. Jurak also ordered that R27 keep his Combivent inhaler at his bedside for use every six hours, two puffs. CMS Ex. 12 at 2, 8; P. Ex. 3 at 6; CMS Ex. 8 at 9; *see* P. Ex. 3 at 2.

A nurse's note entry, dated 10/29/08 at 12:15 a.m., indicates that R27's 02 saturation level was at 94% on room air, and he had no complaints of pain or discomfort. P. Ex. 3 at 7; CMS Ex. 8 at 7; *see* P. Ex. 3 at 1.[4]

On October 30, 2008, an untimed nurse's note shows that R27 was resting in bed, his skin was warm and dry, he had no complaints of pain and discomfort, and his 02 saturation level was at 93% on room air. The note also stated that R27's respirations were full and unlabored. P. Ex. 3 at 7; CMS Ex. 8 at 7.

On October 31, 2008, at 1:55 a.m., a nurse's note states that R27 was resting in bed, his respirations were full and unlabored, his skin was warm and dry, and he had no complaints of pain or discomfort. P. Ex. 3 at 7; CMS Ex. 8 at 7.

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[4] In its post-hearing brief, Petitioner states that, for October 29, 2008, there are "[n]o observations recorded since no change in condition." P. Brief at 4. However, the nurse's notes contain one entry recorded for this date.

Later in the morning of October 31, 2008, Ms. Daniels went to check R27 again and observed him at 9:50 a.m. in bed in his room. Tr. 27; *see* CMS Ex. 1 at 21. Ms. Daniels testified that R27 was again experiencing shortness of breath and told her that he "didn't feel good." Tr. 27. She stated that she again summoned a nurse to the room, who checked R27's 02 saturation level, which was in the 70s. Tr. 27. According to Ms. Daniels, the nurse administered oxygen to R27 and called Dr. Jurak. Tr. 27.

An entry in the nurse's notes, dated October 31, 2008 at 9:50 a.m., indicates that R27 had "slight dyspnea" and that he received two liters of oxygen per minute per nasal cannula. P. Ex. 3 at 6; CMS Ex. 8 at 9; *see* P. Ex. 3 at 2. The note states that R27's 02 saturation level was at 79-85%, and lung sounds were diminished bilaterally. R27 used his inhaler. His oxygen was increased to a rate of four liters per minute, resulting in an increased 02 saturation level to 90 to 95%. R27's lung sounds continued to be diminished. The nurse's note goes on to state that staff called Dr. Jurak for instructions, and he gave new orders. The note also indicates that R27 is a chronic smoker and that he refuses to wear the nasal cannula at times. P. Ex. 3 at 6; CMS Ex. 8 at 9; *see* CMS Ex. 1 at 21.

The record shows that, on October 31, 2008, Dr. Jurak ordered staff to: discontinue R27's Combivent inhaler; start Symbicort inhaler at one puff, twice daily; start nebulizer treatment with Albuterol every four hours as needed for dyspnea; and continue oxygen two to four liters titration to keep 02 saturation levels above 90%. Dr. Jurak also ordered a chest x-ray. P. Ex. 4 at 2; CMS Ex. 12 at 6; *see* P. Ex. 3 at 2.

A nursing note, dated October 31, 2008 at 10:15 a.m., indicates that R27 was given nebulizer treatment as ordered, and his 02 saturation level was at 95-96%. The note states that the resident was resting comfortably, and x-ray was on the way. CMS Ex. 8 at 10.

Petitioner argues that the testimony and documentary evidence demonstrate that its nursing staff closely monitored R27's oxygen saturation levels and carried out Dr. Jurak's orders to maintain his oxygen levels above 90%. Petitioner claims that CMS's allegation concerning the failure to monitor is premised on "the mere failure to document." P. Brief at 12. Petitioner argues that even though R27 was not physically seen by Dr. Jurak, he did receive medical evaluations after his episodes of respiratory distress. Finally, Petitioner claims that R27 had access to his inhaler at all times after Dr. Jurak issued an order authorizing it.

There is no dispute that R27 had COPD and asthma and that his respiratory system was compromised. For this reason, R27 required especially-careful assessment and monitoring. On September 26, 2008, the day after he was admitted to Petitioner's facility, his physician, Dr. Jurak, ordered a Combivent inhaler to be used every four to six hours, as needed, for shortness of breath. CMS Ex. 12 at 9. Petitioner's staff put in place a care plan that specifically addressed R27's altered respiratory function, listing interventions that included, *inter alia*: observing and reporting signs of congestion,

labored breathing, and wheezing; administering oxygen as ordered by the physician; assessing for signs and symptoms of dyspnea; and checking oxygen saturation as ordered and PRN (as needed). Moreover, staff noted on the care plan that the stated goal was for R27 to "be free from signs of respiratory distress" through December 28, 2008, the date of the next review. CMS Ex. 9.

As discussed above, R27 first experienced respiratory distress on October 23, 2008. On this date, he complained of weakness and not feeling well. R27's lungs were congested on expiration, and his 02 saturation level was 66% on room air. After he received oxygen by mask, his 02 saturation level increased to 98%. That same day, after being paged, Dr. Jurak gave orders for Albuterol, back-to-back nebulizer treatments, a chest x-ray, a course of Prednisone over eight days, and ordered that R27's oxygen be titrated to keep saturation levels above 90%. P. Ex. 4 at 2; CMS Ex. 12 at 6. According to the nurse's notes, dated October 23, 2008, which were timed at 11:30 a.m., 1:30 p.m., 2:15 p.m., and 10:00 p.m., staff monitored R27 and maintained his 02 saturation level at 90% or above for the rest of the day.

Despite the fact that Dr. Jurak had given an order that R27's 02 saturation level be maintained above 90%, R27 again suffered respiratory distress on October 28, 2008, and October 31, 2008. I note that, on both these occasions, it was Surveyor Daniels who found R27 to be in a state of distress, experiencing shortness of breath and difficulty breathing. On both occasions, Surveyor Daniels summoned a nurse for assistance. The nurse checked R27's 02 saturation level and administered oxygen to him. With respect to the October 28, 2008 episode, R2's 02 saturation level was at 71% room air, and his lung sounds showed wheezing and a non-productive cough. After he received oxygen, his 02 saturation level increased to 96-99%. P. Ex. 3 at 5; CMS Ex. 8 at 8; *see* CMS Ex. 1 at 20-21; *see also* Tr. 87-88. Similarly, with the October 31, 2008 episode, R27's 02 saturation level was at 79-85%, and his lung sounds were diminished bilaterally. After the nurse administered oxygen to R27, R27's 02 saturation level increased to 90 to 95%.

I agree with CMS that the fact that R27 had three episodes of respiratory distress in an eight-day period indicates that Petitioner's staff failed to monitor R27's respiratory status and failed to maintain his 02 saturation level above 90% as Dr. Jurak ordered. Although Petitioner insists that there was monitoring and documentation on October 23, October 28, and October 31, 2008, it is clear that the record does not support this. *See* P. Brief at 13.

At the hearing, Surveyor Daniels testified that a normal 02 saturation level would be at 90% or above, for "a normal person breathing at room air." Tr. 25. She stated that if the 02 level drops below that, then a person would experience lack of oxygenation to the organs, brain, and tissues. Surveyor Daniels testified further that if a person's 02 level drops to 70%, the person would be "very compromised" and would need assistance to get

the oxygen levels back up. Tr. 25. When asked how one would "titrate 02 levels to 90 percent," Surveyor Daniels stated:

> [Y]ou need to frequently monitor the oxygen saturation levels to determine the need for oxygen increases or decreases to maintain that 90 percent or higher level. Once you determine there's a need to increase or decrease, you need to go back and recheck that saturation level to see if you've obtained that level, so you have to do periodic levels.

See Tr. 28; Tr. 53.

To measure the 02 saturation level, Surveyor Daniels testified that a device called a pulse oximeter is used. She stated that it is attached to a person's finger, and it "records the oxygen saturation level with a specific number percent." Tr. 28. According to Surveyor Daniels, the machine would not show a range of numbers, only a specific number. Tr. 28. Surveyor Daniels stated that, with a compromised resident who has respiratory distress, the 02 saturation level should be monitored on every shift. Tr. 28.

The record contains no evidence that R27's 02 saturation level was being closely monitored by Petitioner's staff on October 23, 28, and 31, 2008, to ensure that it stayed above 90%. Nothing in the nurse's notes indicates that Petitioner's staff had taken pulse oximetry readings on these dates prior to R27's episodes of compromised oxygen intake, which would have been required to ascertain R27's 02 saturation level.

Petitioner downplays R27's shortness of breath on October 28, 2008, questioning whether "the mere occurrence of an episode of shortness of breath is tantamount to the lack of monitoring of oxygen saturation levels." P. Brief at 11. When R27 had difficulty breathing on October 28, 2008 episode, his 02 saturation level was at 71% room air. Contrary to Petitioner's rather glib description that he had a "mere occurrence" of shortness of breath, R27's dangerously low 02 saturation level shows that his oxygen intake was seriously compromised. Even Petitioner's counsel admitted at the hearing that when Surveyor Daniels went into R27's room, "he was in some way respiratorily compromised." Tr. 20.[5]

In fact, I find that the only reason R27's 02 saturation levels were checked at all on October 28 and 31, 2008, is because Surveyor Daniels happened personally to observe him as he was experiencing respiratory distress. I find credible Surveyor Daniels' testimony, including her observations of R27 on October 28 and October 31. Had Petitioner's staff provided the appropriate care and monitored R27's 02 saturation levels as ordered, his 02 levels would not have fallen dangerously low into the 60s and 70s.

[5] I note that Petitioner's counsel does not indicate in his statement to which of the room visits by Surveyor Daniels, one or both visits, he is referring.

In addition to the failure of care described above, CMS contends that the record also shows that Petitioner's staff failed to monitor closely R27's 02 saturation levels and respiratory status on October 24, October 25, October 26, October 27, October 29, and October 30, 2008. CMS points out that, aside from a few out-of-sequence nursing notes, there is no evidence that staff was taking pulse oximetry readings to ensure that R27's 02 saturation level was monitored and kept above 90%, as Dr. Jurak ordered.

In its defense, Petitioner maintains that its staff did closely monitor R27's respiratory condition and his 02 saturation levels. Petitioner asserts that its staff carried out the monitoring not only by obtaining pulse oximetry readings, but also through observation of R27's physical condition. P. Brief at 14. Moreover, Petitioner argues that "a failure to document is not tantamount to failing to maintain R27's oxygen saturation levels at 90 percent." P. Brief at 11. As further support for its claim that its staff monitored R27 as Dr. Jurak ordered, Petitioner states that R27 was resistant to care and would refuse to wear his oxygen.

According to the entries in the nurse's notes, staff took: one pulse oximeter reading (90%) on October 24; one pulse oximeter reading (94%) at 12:15 a.m. on October 29; and one pulse oximeter reading (93%) on October 30. For October 25, there are no nursing note entries. For October 26 and 27, the nursing notes contain staff's observations of R27 and indicate that R27 had full and unlabored respirations, and his lung sounds were clear. I note that some of these notes appear to be out of sequence.

At the hearing, both Surveyor Daniels and Petitioner's Director of Nursing, Jodi Foster, testified that the only way to measure 02 saturation levels is through pulse oximetry. Tr. 28, 104.[6] Ms. Foster testified further that it is not possible to determine 02 saturation levels through observation. Tr. 104. Like Surveyor Daniels, Ms. Foster testified that the pulse oximeter does not give a range of saturation levels. Tr. 94-95. When asked why a range would have been written in the nurse's notes, Ms. Foster testified that a nurse may have taken three different pulse oximeter readings, showing three different numbers (e.g., "a range of 79 to 85"). Tr. 95.

Based on the testimony of Surveyor Daniels and Ms. Foster, it follows that, for staff to carry out Dr. Jurak's order to maintain R27's 02 saturation level above 90%, they would need to check his 02 saturation level at various times during the day by pulse oximetry and, as Surveyor Daniels explained, determine whether R27's oxygen intake should be increased or decreased. According to Surveyor Daniels, if a resident has had recent

[6] I note that, at the hearing, Ms. Foster provided a description of the pulse oximeter similar to that given by Surveyor Daniels, stating that the device "can be a hand-held machine . . . [that] has a digital reading on the front with a little device that is placed on the tip of your finger to monitor the oxygen level in the blood." Tr. 94. Ms. Foster also stated that some facilities have pulse oximeters "on rollers." Tr. 94.

episodes of respiratory distress and needs oxygen titration, the resident should be monitored on every shift.

As stated above, the nurse's notes covering the period October 24-27, 2008, and October 29-30, 2008, show that staff took R27's pulse oximetry readings a total of three times. Staff measured R27's 02 saturation level once on October 24, once on October 29, and once on October 30. On the other dates, staff either recorded their observations of R27 or made no nurse's note entries at all.

In Petitioner's view, the three pulse oximetry readings, combined with staff's observations of R27, show that staff monitored his 02 saturation levels. With respect to the pulse oximetry readings, Petitioner, citing Ms. Foster's testimony, argues that "R27's physician did not specify how often these readings needed to be done or that they must be taken on any kind of regular basis." P. Brief at 12. According to Ms. Foster, taking a pulse oximetry reading would have been "a nursing judgment . . . because there was no order for [the nurses] to take a daily pulse ox or a weekly pulse ox." Tr. 99. Ms. Foster expressed her opinion that when a physician has written an order to monitor a patient and has not provided a specific level of monitoring, then it is up to the nursing staff's judgment as to how to monitor the patient. Tr. 100. When questioned about the nursing notes, Ms. Foster testified that she wrote one of the October 26, 2008 nursing notes and noted her observations of R27 but did not take a pulse oximetry reading. Tr. 84-85. When asked why she did not take a reading, Ms. Foster responded that she did not believe it was medically necessary or that it was ordered by a physician. Tr. 85.

Further, Petitioner claims that, by noting their observations of R27's physical condition, staff were also able to check R27's 02 saturation levels in this manner. As an example, Petitioner noted that R27's skin is "warm and pink in color [which indicates] normal oxygenation." P. Brief at 15.

I find Petitioner's arguments unpersuasive. There was only one way for Petitioner's staff to ensure that R27's 02 saturation level was kept above 90% in accordance with Dr. Jurak's order, and that was by taking the necessary pulse oximetry readings. Even Petitioner's own witness, Ms. Foster, confirmed that 02 saturation levels cannot be determined through observation, and the only way to measure the 02 level is by pulse oximetry. Tr. 104.

Pulse oximetry readings were thus required for R27. They were not unimportant or medically unnecessary given the fact that Dr. Jurak had specifically ordered that R27's oxygen be titrated to keep saturation levels above 90%. The fact that Petitioner's staff took R27's pulse oximetry reading only three times over the period October 24-27, 2008, and October 29-30, 2008, shows that staff failed to carry out Dr. Jurak's order. Staff were required to ensure that R27's 02 saturation level stayed above 90%, and they could only carry this out by diligently monitoring his respiratory status and taking pulse

oximetry readings on a regular basis. The observations of R27's physical condition noted by Petitioner's staff, while a part of his assessment, are not a substitute for these readings. The fact that Dr. Jurak did not explicitly order that pulse oximetry readings be taken does not excuse Petitioner's staff's failure to take them, since the only way to ensure that his order was properly executed was by taking the readings. Contrary to Petitioner's misguided claim that CMS is requiring it to go beyond what Dr. Jurak recommended, I find that a more apt conclusion is that Petitioner's staff fell far short of complying with his order.

With respect to Petitioner's "failure to document" argument, Petitioner has not produced any evidence that its staff took pulse oximetry readings during the period October 24-27, 2008, and October 29-30, 2008, at other times than the three times noted in the nurse's notes. To explain why staff did not write any nursing notes at all on October 25, 2008, Petitioner states that staff did not write any observations because R27 had "no change in condition." P. Brief at 3. I note that, at the hearing, Ms. Foster confirmed that "some of the time, actual pulse oxes were taken, and other times, there were observation but no pulse ox taken." Tr. 98. Ms. Foster stated that nurses could have taken readings, but not recorded them. Tr. 98-99.

It is generally accepted that the absence of documentation that a service or treatment was not delivered gives rise to the inference that the service or treatment was not delivered. The burden is upon Petitioner to show that necessary care and services were delivered and, absent documentation and/or other credible evidence, Petitioner cannot meet the burden. If Petitioner's staff had taken R27's pulse oximetry readings on a regular basis on the dates mentioned above, Petitioner had the burden to produce documentation or other credible evidence of this. Petitioner failed to do so.

To the extent that Petitioner argues that R27 was resistant to care, this does not excuse Petitioner's staff's failure to comply with Dr. Jurak's order to keep R27's 02 saturation level above 90%. R27's MDS, dated October 6, 2008, indicated that R27 had been resistant to care one to three times in the previous seven days, but his behavior was easily altered. CMS Ex. 10 at 4; *see* Tr. 46. At the hearing, Surveyor Daniels testified that the nurse's notes did not indicate that R27 was "noncompliant" or "resistant." Tr. 46. She stated further that when she observed R27 when he was receiving oxygen and treatment from staff, he was not noncompliant. Tr. 46.

According to the nurse's notes, R27 refused to wear his oxygen on October 28 and October 31, 2008. These are the only instances of resistance to care recorded by staff. Interestingly, it is on these dates when Surveyor Daniels found R27 suffering respiratory distress with dangerously low 02 saturation levels and summoned a nurse, who then administered oxygen to R27. Petitioner does not claim, and the record does not show, that R27 refused the oxygen treatment from staff. R27 did, on these dates, later refuse to wear his oxygen. Focusing on these refusals, Petitioner argues that any drop in oxygen

levels was "largely caused by R27's refusal to follow Dr. Jurak's orders, not [Petitioner's] purported failure to monitor oxygen saturation levels." P. Reply at 5.

Given that the evidence clearly shows that Petitioner's staff failed to take pulse oximetry readings as necessitated by Dr. Jurak's order, it is a misguided argument by Petitioner to attempt to minimize its own staff's failure in care by blaming R27. Further, as CMS correctly points outs, nothing in the record shows that R27's resistance to care, or refusal to wear his oxygen, affected staff's ability to take a pulse oximetry reading.

With respect to CMS's argument that R27 did not receive timely medical evaluations after his episodes of respiratory distress on October 23, October 28, and October 31, 2008, the record shows that staff called Dr. Jurak each time and made him aware of the situation. Surveyor Daniels testified on cross-examination that, after R27 suffered respiratory distress on October 28, 2008, the staff should have asked Dr. Jurak to come to the facility to see R27, or R27 should have been taken to Dr. Jurak or the hospital. Tr. 59. When asked to explain the bases for her opinion, Surveyor Daniels stated that it was based on "nursing standards . . . professional judgment." Tr. 60. Surveyor Daniels testified further that a medical evaluation "could mean x-rays. It could mean labs. Medical evaluation doesn't have to necessarily be eye to eye." Tr. 60. She then acknowledged that R27 had a chest x-ray taken on October 23, 2008, and again on October 31, 2008. Tr. 60. Surveyor Daniels also did not appear to dispute that R27 received a medical evaluation on October 28, 2008. Tr. 60.

Based on the record, including Surveyor Daniels' testimony, I find that R27 did receive timely medical evaluations on October 23, October 28, and October 31, 2008. For R27 to be medically evaluated after his episodes of respiratory distress, it was not necessary that Dr. Jurak actually examine him in person. Staff contacted Dr. Jurak, described R27's condition, and Dr. Jurak then acted by giving orders to staff, which included medication, x-rays, and keeping R27's 02 saturation levels above 90%.

I next address CMS's allegation that Petitioner's staff failed to obtain orders for R27's access to his inhaler. According to the SOD, during the October 28, 2008 episode of respiratory distress, R27 had told Surveyor Daniels that the staff would not allow him to keep his inhaler with him, and the nurse had informed both R27 and Surveyor Daniels that R27 did not have a physician's order to keep the inhaler. CMS Ex. 1 at 20-21. CMS claims that Petitioner's staff ignored R27's request to have access to his inhaler rather than obtain an order from Dr. Jurak. CMS asserts that, through Surveyor Daniels' intervention, R27 received an order from Dr. Jurak authorizing him to keep his inhaler with him. CMS Reply at 3. The record shows that, later in the day on October 28, 2008, Dr. Jurak ordered that R27 be able to keep his Combivent inhaler at his bedside for use every six hours, two puffs. CMS Ex. 12 at 2, 8; P. Ex. 3 at 2, 6; CMS Ex. 8 at 9.

Prior to October 28, 2008, R27 did not have any orders that authorized him to have his inhaler at his bedside. Other than R27's statement to Surveyor Daniels, there is nothing in the record as to what he may have told staff regarding his inhaler. Surveyor Daniels testified that after Dr. Jurak issued the order on October 23, 2008, authorizing R27 to keep his inhaler with him, R27 had the inhaler available to him at all times. Tr. 45. While Petitioner's staff should probably have acted on R27's request sooner, it appears that once they received Dr. Jurak's order, they complied with it.

Based on my review of all of the evidence before me, I find that Petitioner did not provide R27 the care and services he needed to attain or maintain his highest practicable physical well-being and was therefore not in substantial compliance with Tag F309, 42 C.F.R. § 483.25. CMS established a prima facie case, and Petitioner did not successfully rebut it by a preponderance of the evidence.

2. The proposed CMP of $350 per day from November 7, 2008, through December 11, 2008, is reasonable.

In determining the amount of the CMP, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of non-compliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404; and (4) the facility's degree of culpability.

The lower range of CMP, from $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii).

CMS seeks to impose a CMP of $350 a day from November 7, 2008, through December 11, 2008, for a total CMP of $12,250.

I note that, with respect to facility history, CMS submitted documentation, which Petitioner does not challenge, that shows that the facility has a significant history of substantial noncompliance. CMS Ex. 13. In prior survey cycles, Petitioner has been cited under various tags, including a citation under Tag F309 at the immediate jeopardy level twice, and several citations at the "G" scope and severity level. CMS Ex. 13 at 3, 5. Although Petitioner claimed that the CMP was "excessive" in its hearing request, I note that Petitioner has not provided any evidence to show that its financial condition precludes it from paying the proposed CMP. *See* CMS Ex. 14.

As previously noted, Petitioner did not appeal 17 deficiencies identified during the November 7, 2008 survey. These unappealed deficiencies comprised five deficiencies at the "D" scope and severity level, 10 deficiencies at the "E" scope and severity level, and

two deficiencies at the "F" scope and severity level. These deficiencies are now final and binding against Petitioner. 42 C.F.R. § 498.20(b). As such, CMS has established a finding of noncompliance that provides a basis for its imposition of a CMP at the lower range of $50 to $3,000 per day for deficiencies that do not constitute immediate jeopardy, but either cause actual harm or caused no actual harm, but have the potential for more than minimal harm. *See* 42 C.F.R. § 488.438(a)(1)(ii).

Furthermore, with respect to the deficiency that Petitioner appealed, I found that Petitioner was not in substantial compliance with Tag F309, 42 C.F.R. § 483.25, at the "G" scope and severity level. The evidence shows that the deficiency under Tag F309 was serious and further justifies CMS's imposition of a CMP against Petitioner at the lower range of $50 to $3,000 per day. Petitioner's staff failed to monitor closely R27's respiratory status and take necessary pulse oximetry readings to monitor his 02 saturation levels, in accordance with his physician's orders. The record shows that R27's 02 saturation levels fell to dangerously low levels, causing him respiratory distress. Based on the evidence, I find that Petitioner was culpable.

In contesting the CMP remedy, Petitioner disputes CMS's position that the 17 unappealed deficiencies in themselves are sufficient to support a CMP of $350 per day. P. Reply at 6. Petitioner asserts that the unappealed tags are non-immediate jeopardy level deficiencies and were cited at scope and severity levels of "D", "E," and "F." Petitioner claims that it made a strategic decision to only contest Tag F309 and that its "failure to appeal these tags was not an admission of liability or an inference that these tags were not worthy of attention." P. Reply at 6. Petitioner acknowledges that "some sort of CMP is warranted," based on the uncontested deficiencies, but takes the position that they are not the type of deficiencies associated with $350 per day CMPs. Petitioner requests that I not impose any CMP for the unappealed deficiencies, but if this is not possible, then Petitioner seeks a reduction in the CMP amount from $350 per day to $50 per day. P. Reply at 7.

Petitioner's arguments must fail. The 17 unappealed deficiencies are now final and binding determinations that Petitioner was out of compliance with program requirements that were serious enough to pose the potential for more than minimal harm. Although Petitioner seeks a reduction in the CMP from $350 to $50 per day, no reduction is warranted. At $350 per day, the imposed penalty is at the low end of the range. Moreover, while, by itself, the gross number of deficiencies does not dictate the reasonableness of a CMP, neither is it irrelevant (*see Pacific Regency Arvin*, DAB No. 1823 at 17-18 (2002)), and the presence of 17 deficiencies is significant enough to justify a CMP of $350 per day. Accordingly, on the basis of the unappealed deficiencies, I find that CMS is authorized to impose a CMP of $350 per day and that this figure is reasonable.

Further, while the 17 now-final deficiencies, in themselves, support a $350 per day CMP, I also find that, in light of the relevant factors, the deficiency cited under Tag F309 gives CMS a separate basis to impose a $350 per day CMP and that this amount is reasonable.

V. Conclusion

For the foregoing reasons, I conclude that there is a basis for the imposition of a CMP. I further find that a CMP of $350 per day from November 7 through December 11, 2008, for a total of $12,250, is reasonable.

/s/
Richard J. Smith
Administrative Law Judge