Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Life Care Center of Bardstown,
(CCN: 185149),

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-09-338

Decision No. CR2509
Date: February 27, 2012

DECISION

This case is before me pursuant to a March 19, 2009 remand from an appellate panel of the Departmental Appeals Board (Board) (Remand Decision). The Board vacated one of my four findings and remanded the other three findings to me for further deliberation, development of the record, if necessary, and a revised decision. After thoroughly reviewing the evidence, and the arguments of the parties following a re-briefing of the case, I find that the Centers for Medicare & Medicaid Services (CMS) in fact did show, and Petitioner could not rebut, that Petitioner was out of substantial compliance, at an immediate jeopardy level of severity, with Medicare participation requirements including: the physician consultation requirement at 42 C.F.R. § 483.10(b)(11) (Tag F-157); the quality of care requirement at 42 C.F.R. § 483.25 (Tag F-309); and the facility administration requirement at 42 C.F.R. § 483.75 (Tag F-490). I further find that the remedy CMS imposed for the period of immediate jeopardy, a $4,050 per day civil money penalty (CMP), and the duration of that remedy for the immediate jeopardy period of noncompliance (January 3 through March 27, 2007), is reasonable.

I. Procedural Background

Petitioner, a long term care facility located in Bardstown, Kentucky, is authorized to participate in Medicare as a skilled nursing facility (SNF) and in the Kentucky Medicaid program as a nursing facility (NF). On April 3, 2007, the Division of Health Care Facilities and Services for the State of Kentucky (state agency) completed a survey of the facility and determined that Petitioner was not in substantial compliance with participation requirements at Tags F-157, F-309, and F-490 at the immediate jeopardy level and with 42 C.F.R. §§ 483.20(d)(3) and 483.10(k)(2) (Tag F-280) at a scope and severity level of "D" (no actual harm with a potential for more than minimal harm, but not immediate jeopardy). CMS Ex. 3; P. Exs. 1, 2. On April 20, 2007, CMS imposed a $4,050 per day CMP on Petitioner based on the survey completed on April 3, 2007.[1] CMS Ex. 5.

On May 1, 2007, CMS notified Petitioner that a revisit survey completed on April 23, 2007, determined that Petitioner continued not to be in substantial compliance with participation requirements. CMS stated, however, that the per day CMP would be revised to $100 a day because Petitioner only continued out of compliance with Tag F-280 at a scope and severity level "D." CMS Exs. 9, 11; P. Ex. 3. CMS determined that Petitioner had corrected the immediate jeopardy level F Tags as of March 28, 2007, and then later determined that Petitioner corrected the "D" level deficiency at Tag F-280 as of April 10, 2007. CMS Exs. 13, 24.

On May 25, 2007, Petitioner requested a hearing to contest the findings of noncompliance underlying the April 20 and May 1, 2007 CMS determinations and the CMPs imposed by CMS.

I held a hearing on February 19 and 20, 2008, and admitted CMS Exs. 1-26 and P. Exs. 1-35. The parties submitted post-hearing briefs (CMS and P. Br.) and replies (CMS and P. Reply). Based on this record, I found that Petitioner was in substantial compliance with Medicare participation requirements at the relevant times and that there was no basis for CMS to impose remedies against Petitioner. I made four findings of fact:

> 1. Petitioner established by a preponderance of the evidence that it was in compliance with 42 C.F.R. § 483.10(b)(11) (Tag F-157).

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[1] CMS also notified Petitioner that it would impose a denial of payment for new admissions (DPNA), to be effective on April 22, 2007, if Petitioner was not in substantial compliance as of that date, and termination of Petitioner's provider agreement, to be effective on April 26, 2007, if immediate jeopardy to resident health and safety was not removed by that date. CMS Ex. 5. As CMS found Petitioner in substantial compliance with participation requirements prior to those dates, the remedies did not effectuate. CMS Ex. 24.

> 2. Petitioner established by a preponderance of the evidence that it was in compliance with 42 C.F.R. § 483.25 (Tag F-309).
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> 3. Petitioner established by a preponderance of the evidence that it was in compliance with the requirements of 42 C.F.R. § 483.75 (Tag F-490).
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> 4. CMPs of $4,050 and $100 per day respectively, are unreasonable based on the facts of this case as there are no violations and therefore no basis for the imposition of CMPs.

CMS appealed my decision to the Board.

The Board vacated Finding 4 and remanded the case to me regarding the other findings by decision dated March 19, 2009. Specifically, the Board vacated my conclusion that the $100 per day CMP was unreasonable, finding a basis for the imposition of a $100 per day CMP based on the comprehensive care plan deficiency alleged by CMS at Tag F-280. The Board made two findings that:

> FFCL A-1. Petitioner failed to substantially comply with the comprehensive care plan requirements at 42 C.F.R. §§ 483.20(d)(3) and 483.10(k)(2).
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> FFCL A-2. A CMP of $100 per day, extending from January 3, 2007 through April 9, 2007 is reasonable based on Petitioner's noncompliance with 42 C.F.R. §§ 483.20(d)(3) and 483.10(k)(2).

In vacating my finding and remanding the case to me for further proceedings regarding my other three findings, the Board determined that my decision failed to address material evidence that conflicted with my findings of fact and also determined that my decision reflected errors of law. The Board's remand mandate to me was to further deliberate the record, develop the record if necessary, and revise my decision as appropriate. The Board also stated that if I should find Petitioner not in substantial compliance with participation requirements, I am to evaluate whether the CMS determination that the deficiencies posed immediate jeopardy to facility residents was "clearly erroneous." I am also to address the duration of the noncompliance and the reasonableness of the CMP based on the factors at 42 C.F.R. §§ 488.438(f) and 488.404.

I held a telephone pre-hearing conference on May 27, 2009. The parties agreed, and I concurred, that the existing record comprising the hearing transcript, the parties' exhibits as admitted at the hearing, and the parties' pleadings, was sufficient to address the questions raised in the Board's remand and that a second evidentiary hearing would be unnecessary. They agreed, and I concurred, that the best approach to resolving the Board's questions on remand would be a cycle of briefing augmented by the opportunity

to proffer additional documentary evidence as well as an opportunity to submit proposed findings of fact and conclusions of law.

Both parties filed briefs (CMS and P. Remand Br.) and reply briefs (CMS and P. Remand Reply Br.) and findings of fact and conclusions of law (CMS and P. Remand FFCL). Petitioner also submitted proposed exhibits 36-44. In the absence of objection, I admit P. Exs. 36-44 into evidence.

After considering and addressing the Board's questions, the parties' further arguments, and the entire evidentiary record, I revise my prior findings in favor of CMS.

II. Legal Background

To participate in Medicare and Medicaid, long term care facilities, including SNFs, must comply with the requirements in 42 C.F.R. Part 483, subpart B. A facility's compliance with the participation requirements is assessed through surveys performed by state health agencies. Sections 1819 and 1919 of the Social Security Act (Act)[2] ; 42 C.F.R. Parts 483, 488, and 498.

"Substantial compliance" means a level of compliance 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. "Noncompliance," in turn, is defined as "any deficiency that causes a facility to not be in substantial compliance." 42 C.F.R. § 488.301.

CMS may impose remedies against a facility that is not in substantial compliance with the participation requirements. 42 C.F.R. §§ 488.408, 488.440(a). CMS determines the seriousness of each deficiency found during a survey in order to select the appropriate remedies, if any, to impose on the facility. *See* 42 C.F.R. § 488.404. The level of seriousness is based on an assessment of scope (whether the deficiency is isolated, a pattern, or widespread) and severity (the degree of harm, or potential harm, to resident health and safety posed by the deficiency). *Id*. The highest level of severity is "immediate jeopardy," defined at section 488.301 of the regulations as "a situation in which the provider's noncompliance . . . has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident."

CMS may impose a CMP for "either the number of days a facility is not in substantial compliance" (a per day CMP), or "for each instance that a facility is not in substantial compliance" (a per instance CMP). 42 C.F.R. § 488.430(a). If a per day CMP is imposed for noncompliance at the immediate jeopardy level, the CMP must be in the

[2] The current version of the Social Security Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact.htm.

range of $3,050 to $10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). If the noncompliance is less serious, the CMP must be set within the lower range of $50 to $3,000 per day. 42 C.F.R. § 488.438(a)(1)(ii). To determine the amount of a CMP, CMS considers the following factors: The facility's history of noncompliance (including repeated deficiencies), its financial condition, its degree of culpability for the cited deficiencies, the seriousness of the noncompliance, and the relationship of one deficiency to the other deficiencies resulting in noncompliance. 42 C.F.R. §§ 488.404, 488.438(f).

Under 42 C.F.R. § 488.454(a), a per day CMP continues to accrue until "[t]he facility has achieved substantial compliance, as determined by CMS or the state based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit." A "plan of correction" is a plan developed by the facility and approved by CMS or the state agency describing the actions the facility will take to correct its deficiencies. 42 C.F.R. § 488.401. The plan of correction also specifies the date by which the deficiencies will be corrected. *Id*.

III. Factual Background

This case regards deficiencies identified by the state agency relating to Petitioner's care of Resident 1 on the night and early morning of January 2 and 3, 2007.

The Board drew the following undisputed facts from my decision.

> · Resident 1 was an 87-year-old woman who was initially admitted to LCCB [Life Care Center of Bardstown] in the Summer of 2006. ALJ Decision at 7; LCCB Ex. 7; CMS Ex. 17. Resident 1 had diagnoses that included Alzheimer's disease, hypothyroidism, diabetes, and hypertension. Id.
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> · Following a brief hospitalization in mid-November 2006, Resident 1 was readmitted to LCCB on November 17, 2006, at which time her treating physician ordered, among other things, oxygen saturation readings to be monitored "daily," and vital signs "routinely." CMS Ex. 17, at 9.
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> · On the evening of January 2, 2007, Resident 1's granddaughter, Ms. Donna Wherry, visited her grandmother at LCCB. ALJ Decision at 7.
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> · Resident 1 vomited profusely at approximately 8:30 p.m. on the evening of January 2, 2007. ALJ Decision at 7-10 citing CMS Ex. 17, at 30-31; Tr. at 38, 215-216. [Footnote omitted].
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> · At approximately 1:00 a.m. on January 3, 2007, Resident 1 was observed by LCCB staff to have a "sm[all] amount of emesis" on her night clothes. CMS Ex. 17, at 31; CMS Ex. 3, at 6.

· At approximately 4:00 a.m. on the morning of January 3, 2007, LCCB certified nursing assistants (CNAs) and the licensed professional nurse on duty, Natalie Suffoletta, found Resident 1 in bed, unresponsive and with unstable vital signs. Nurse Suffoletta attempted to call the on-call physician about Resident 1's condition, but she was unable to reach the physician. Nurse Suffoletta then called LCCB's Director of Nursing (DON), who ordered Resident 1 be sent to the hospital emergency room. ALJ Decision at 7-8.

· At approximately 4:15 a.m. on January 3, 2007, Nurse Suffoletta called emergency medical services (EMS). CMS Ex. 18, at 1. Emergency medical technicians (EMTs) arrived at LCCB at approximately 4:20 a.m. to transport Resident 1 to the hospital. Id.

· Resident 1 was thereafter transferred and died at the hospital at approximately 7:10 a.m. on January 3, 2007. CMS Ex. 18, at 3.

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

Below in boldface type are my numbered conclusions followed by the pertinent findings of fact and analysis.

I do not review the deficiency with regard to Tag F-280 (42 C.F.R. §§ 483.20(d)(3) and 483.10(k)(2)) because the Board made findings with regard to that deficiency and I do not have the authority to alter those findings. I note, however, that the violation of Tag F-280 was based on CMS's finding that Petitioner failed to revise Resident 1's comprehensive care plan to reflect physician orders for routine vital signs and daily oxygen saturation readings to be done. CMS Ex. 3, at 11-12. The deficiency findings specifically state that review of Resident 1's treatment records "revealed the vital signs and oxygen saturation readings were not obtained as ordered. *Id*. Remand Decision at 8. During the hearing, Petitioner admitted that it did not contest this deficiency and expected that I would impose some amount of CMP based on it. Petitioner specifically admitted that it did not document Resident 1's breathing status in the way that was ordered. Tr. at 22; P. FFCL Finding of Fact No. 109; P. FFCL Conclusion of Law No. 31 ["Petitioner has conceded that the evidence is sufficient to find a 'potential for harm' violation of 42 C.F.R. § 483.20(d) in that its staff did not consistently document Resident #1's oxygen saturation level according to a November, 2006 admission order." P. Ex. 14, at 4; P. Ex. 15, at 6; CMS Ex. 17, at 9.]. The Board determined from this admission that $100 per day is a reasonable amount of CMP and that the period of January 3 through April 9, 2007, is the duration for Petitioner's noncompliance based on this violation.[3] Petitioner

[3] The Board found that the admitted violation was a basis for a $50 per day penalty but, since Petitioner has not contended that the regulatory factors to be considered in

addresses the Board's findings regarding Tag F-280 in its remand briefing, arguing that its admission did not mean that it accepted a $100 per day CMP is reasonable based on the noncompliance or that the duration of the CMP as determined by CMS is correct. Petitioner argues that its assessment and documentation errors are at best marginally tangential to the immediate jeopardy citations and should not be used to support an immediate jeopardy citation. P. Remand Br. at 2-7. The Board's findings dictate my decision in this case and, as noted, I do not have the authority to alter them or to consider Petitioner's arguments with regard to whether the $100 CMP or the duration of the CMP is reasonable.

I note Petitioner's argument that while the physician's order with regard to Resident 1's vital signs could have been clearer regarding what the physician meant by having vital signs "routinely" monitored, the record shows that her vital signs were recorded in nursing notes nearly every day. Petitioner argues this presumably qualifies as routine. P. Remand Br. at 2-3 n. 1. While I make no finding regarding this, I observe that it is Petitioner's responsibility to clarify physician orders when those orders are unclear.

1. Petitioner failed to substantially comply with the physician consultation requirement at 42 C.F.R. § 483.10(b)(11) (Tag F-157).

The regulation at 42 C.F.R. § 483.10(b)(11) provides in pertinent part that:

> Notification of changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is–
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> > . . . (B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); . . .

In my initial decision I noted that the central issue in the case turned on the interpretation of what constituted a "significant change" in Resident 1's condition and when that change occurred during the night and early morning of January 2 and 3, 2007. I reversed CMS's determination that Petitioner's conduct violated section 483.10(b)(11) when it failed to immediately notify Resident 1's physician of what CMS had determined were

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determining the penalty amount warrants a reduction of the $100 per day CMP, the Board has no basis to conclude that the per day amount should be revised. Remand Decision at 9. The Board found further that since Petitioner did not dispute that it failed to substantially comply with Tag F-280 during the entire period under review, it was reasonable to conclude that the per day CMP was effective on the first day remedies were imposed, January 3, 2007, and extended until April 10, 2007, when the corrections for the Tag F-280 deficiency were completed. *Id.*

repeat vomiting episodes constituting a significant change in status during that period which required physician notification. CMS Ex. 3, at 3-11.

The Remand Decision at pages 12-14 summarizes my decision at pages 6-12. I briefly discuss my initial decision here in order to discuss my revised findings.

In arguing that Resident 1 did not have a significant change in status prior to 4:00 a.m. on January 3, 2007, Petitioner relies on criteria in its physician notification policy, which is based on the American Medical Directors Association (AMDA) guidelines, whose sufficiency CMS has not challenged. CMS Reply Br. at 6-7. The AMDA guidelines provide that for an episode of emesis (vomiting) a physician must be contacted immediately where there is: (1) bloody or coffee ground vomit; (2) more than one episode of emesis within 24 hours; or (3) the emesis is accompanied by abdominal pain and changes in vital signs. A single episode of emesis need not be reported to the physician until the next office day. P. Ex. 29, at 20. Petitioner's notification policy for emesis echoes the AMDA policy by requiring immediate notification when there is: (1) bloody or coffee ground emesis; (2) repeat episodes of emesis; or (3) pain associated with a change in vital signs. A one-time episode of emesis does not require immediate notification, and the emesis may be reported to the physician the next office day. P. Ex. 30, at 2.

Applying this policy to the evidence and testimony, I found that there was one intermittent episode of emesis extending over a limited period of time and that Petitioner did not have to immediately report the emesis to Petitioner's physician. I found the episode began at approximately 8:30 p.m. on January 2 when the Resident vomited, paused for a very short time, and then vomited again in large quantity. In this regard, I relied on nursing notes prepared by Nurse Suffoletta (CMS Ex. 17, at 30-31) and her hearing testimony (Tr. at 215-16). As neither party defined it, I used a common understanding of the word "episode," referring to the dictionary definition of an "episode" as "an event that is distinctive and separate although part of a larger series." Merriam-Webster's Collegiate Dictionary (10th ed. 2001). I determined that Resident 1's two releases of vomitus around 8:30 constituted one episode of vomiting, because I considered and relied on the short period of time between the two, and my impression that the emesis observed on Resident 1's night clothes at 1:00 a.m. did not constitute a separate episode of emesis at all, but rather a final, much-less-serious, manifestation of the episode that began earlier in the evening. In this I relied on Nurse Suffoletta's description of the emesis as a very small amount of emission, as if Resident 1 "burped" or "coughed up something" and Director of Nursing (DON) Morgeson's testimony regarding Nurse Suffoletta's description to her of Resident 1's 1:00 a.m. emission as a

"golf ball size" stained area which she determined was not an area of vomitus.[4] Neither DON Morgeson nor Nurse Suffoletta stated there were reports from the CNAs that Resident 1 vomited again that evening or that her condition worsened between 8:00 p.m. and 4:00 a.m. Tr. at 192-93, 219-20; CMS Ex. 17, at 31. I concluded from this testimony and evidence that Nurse Suffoletta reasonably concluded that Resident 1 did not vomit at 1:00 a.m. and that under both the AMDA and facility policies Nurse Suffoletta was not required to immediately notify Resident 1's physician.

I also addressed and rejected CMS's argument that changes in Resident 1's condition congruent with the vomiting should have prompted Petitioner's staff to immediately notify Resident 1's physician. In this regard, CMS cited Ms. Wherry's testimony that she observed her Grandmother's demeanor had changed negatively, that her body had become cold and rigid, and her legs had become discolored. Tr. at 33-38. I noted that Ms. Wherry was a very attentive granddaughter who visited Resident 1 on a daily basis. Tr. at 28-29, 165. I found, however, that Ms. Wherry was not a trained health care professional and her observations were those of a lay person. I stated that nurse's notes did not indicate that Ms. Suffoletta or the CNAs observed a significant change in Resident 1's condition until 4:00 a.m. I found that facility policy required immediate notification only when a resident experienced an episode of emesis and a change in vital signs (i.e., body temperature, blood pressure, pulse, respiration rate, etc.). I noted Nurse Suffoletta testified that she checked Resident 1's vital signs twice between 8:00 p.m. and 2:00 a.m. and found them to be stable. Tr. at 217, 227. Although I noted that Nurse Suffoletta failed to document Resident 1's vital signs, and that CMS criticized Petitioner for using a "documentation by exception" system, CMS did not dispute whether staff took Resident 1's vital signs or whether documentation by exception is a common practice. CMS Br. at 11, 14-15; Tr. at 261. Based on her credibility, I found that Nurse Suffoletta took, but did not record, Resident 1's vital signs that evening because they were normal.

Finally, I found that thereafter Petitioner acted in accordance with applicable regulations and facility policy. At 4:00 a.m. on January 3, 2007, staff discovered that Resident 1's vital signs were unstable and recorded them [pulse 43, blood pressure 125/23, respiration 12, and temperature 94.9]. These unstable vital signs and Resident 1's prior episode of emesis triggered Petitioner's responsibility to contact her physician immediately. Staff

[4] DON Morgeson stated in an incident investigation form regarding this 1:00 a.m. incident that Resident 1 "was responding and had such a small amount of emesis stained on her gown the second time the charge nurse used her judgment and did not feel the resident needed to be sent out [at] that time. When [Resident 1's] condition changed the nurse did assess and followed protocol to send her out for [treatment]." P. Ex. 24, at 7. Of course, DON Morgeson did not see this emesis. DON Morgeson was repeating what Nurse Suffoletta told her.

called both the attending and on-call physicians but was unable to reach either of them. Staff eventually reached the DON following which emergency services were called and Resident 1 was transported to the hospital.

In its Remand Decision, the Board determined that: (1) my characterization of what constitutes a single "episode" of emesis was unsubstantiated and my reliance on Nurse Suffoletta's hearing testimony failed to take into account conflicting evidence; (2) my decision did not address evidence that an additional vomiting incident occurred prior to 8:30 p.m.; and (3) my finding that Nurse Suffoletta took Resident 1's vital signs twice between January 2 at 8:00 p.m. and January 3 at 2:00 p.m. is flawed. I discuss each determination below, after first addressing overarching issues regarding Nurse Suffoletta's credibility, which includes a discussion of whether the SOD is evidence or, as Petitioner urges, merely a notice document.

Credibility of Nurse Suffoletta's testimony. Nurse Suffoletta was the licensed practical nurse (LPN) in charge of Resident 1's care from 6:00 p.m. on January 2 to 6:00 a.m. on January 3, 2007. In making my original decision, I relied on Nurse Suffoletta's testimony and the nursing notes she prepared. I found her testimony to be credible, taking into account her demeanor and candor while testifying. I also found her testimony consistent with all other written and oral evidence, her own experience and training, and the absence of impeaching evidence of record. The Board pointed out other evidence of record that should have, and has, caused me to re-evaluate Nurse Suffoletta's testimony and nursing notes against other evidence of record. Although I do not doubt that Ms. Suffoletta's testimony and the notes she prepared are essentially accurate, I find them in retrospect to be incomplete. And where she testified that Resident 1's vital signs were taken on the evening of January 2-3, 2007 prior to 4:00 a.m., I now find that testimony to be outweighed by a preponderance of evidence to the contrary.

I recognize Petitioner's argument that I should not revise my opinion regarding Nurse Suffoletta's credibility. P. Remand Br. at 7-13. Petitioner asserts that the Board relied on the SOD in finding that Nurse Suffoletta admitted to a surveyor that Resident 1 vomited not only at about 8:30 p.m. but again between 12:00 and 1:00 a.m., finding this admission constitutes a prior inconsistent statement and impeaching evidence undercutting my credibility finding. Petitioner asserts that the Board takes the allegations and conclusions set forth in the SOD (CMS Ex. 3) as presumptively correct and evidence of noncompliance. Petitioner admits that in some cases it may be true that an allegation set forth in a SOD stands if not contested or rebutted by Petitioner. However, where Petitioner contests such allegations and offers competing evidence, the appropriate standard for fact-finding is a preponderance of the evidence, taken as a whole. Where the allegations are at best hearsay or conclusions based on hearsay, Petitioner may rebut them by ordinary evidence. P. Remand Br. at 9-10.

As noted by CMS, the Board has stated that a SOD may function as both a notice document and as evidence of the facts asserted therein. If a finding is disputed, the issue is whether a petitioner showed substantial compliance by a preponderance of the evidence and mere denials by a Petitioner are not enough. *The Laurels at Forest Glen*, DAB No. 2182, at 7-8 (2008); *Oxford Manor,* DAB No. 2167, at 2-3 (2008). This is the standard I follow and it does not appear to be materially different than the standard Petitioner urges me to follow.

Petitioner's argument specifically with regard to Ms. Suffoletta notes that the SOD did not allege that she ever "said" to the surveyor that Petitioner vomited more than once. Instead, Petitioner asserts that the SOD statement is that Petitioner "revealed" Resident 1 vomited again between 12:00 a.m. and 1:00 a.m. Petitioner seems to believe that somehow the use of the word "revealed" instead of the use of the word "said" is a surveyor conclusion, and not a quotation from Nurse Suffoletta. Petitioner argues that the SOD does not quote any direct statement by Nurse Suffoletta herself regarding Resident 1 and states that in other cases SODs have quoted "virtually verbatim" from surveyor notes. Petitioner argues that in this case there is nothing in the surveyor notes provided (CMS Ex. 23) to substantiate that Nurse Suffoletta ever told a surveyor that Resident 1 vomited again after 8:30 p.m. or between 12:00 a.m. and 1:00 a.m. Petitioner states that while surveyors Beard and Branham both testified that they interviewed Nurse Suffoletta, there are no notes memorializing those interviews. The only surveyor notes memorializing such interviews record questions about Nurse Suffoletta's orientation training. CMS Ex. 23, at 31-32. Moreover, testimony at hearing made clear that the basis for Surveyor Beard's conclusion that Resident 1 vomited about 1:00 a.m. was her extrapolation from Nurse Suffoletta's nursing notes, not Nurse Suffoletta's statements. Tr. at 106. Petitioner contrasts this with Nurse Suffoletta's denial that she observed anything that caused her to believe that Petitioner vomited again.

I find, as discussed below, that Petitioner has been afforded the chance to rebut the statements in the SOD and that Petitioner did not prove by a preponderance of the evidence that the SOD statements were erroneous or inaccurate. I also find that Petitioner has shown no material difference between the surveyors' use in the SOD of the word "said" or the word "revealed" with regard to what Nurse Suffoletta or any other individual may have told the surveyors during the survey. Although Petitioner argues that CMS did not produce surveyor notes memorializing Nurse Suffoletta's interviews with surveyors, that alone does not impeach the statements in the SOD unless those statements are rebutted by Petitioner by a preponderance of the evidence.

Finally, Petitioner disputes the Board's suggestion that Nurse Suffoletta's credibility is adversely affected because Petitioner terminated her employment. In rebuttal, Petitioner argues, citing DON Morgeson's testimony, that Nurse Suffoletta was let go because Petitioner felt it would be "better for the facility" (Tr. at 204), not because Nurse Suffoletta was untrustworthy or not credible. Tr. at 196. The basis for my credibility

determination, however, does not rest on the fact that Petitioner terminated Nurse Suffoletta's employment.

Determination 1. The Board asked me to clarify what constitutes an "episode" of vomiting for purposes of applying Petitioner's physician notification policy, making clear the authority on which I rely. The Board told me to address Nurse Suffoletta's representation to the surveyor, reflected in the SOD, that Resident 1 vomited "again" between midnight and 1:00 a.m. The Board also asked me to address evidence relating to Nurse Suffoletta's professional judgment that physician consultation was not required prior to 4:00 a.m. Board Remand at 14-16.

In reviewing my finding that Resident 1 had only one episode of vomiting, the Board took exception to my view that it is not uncommon that when an individual vomits there is an initial release followed by a more significant release shortly thereafter and that two releases separated by a short period of time may be considered a single episode. The Board stated that I did not cite any authority or evidence to support my understanding of the physiological process of vomiting nor define what constitutes a short period of time between releases. The Board asserted that I did not rely on any standard of care in defining the term "episode" as used in facility policy. Instead, I relied upon what I considered common knowledge without articulating the basis for my conclusion.

I gave the parties the opportunity to address the issues raised by the Board, which both took. CMS did not offer a definition of what constitutes an "episode" of vomiting. It asserts only that when it uses the word episode it does so in its "ordinary meaning." CMS Remand Reply at 4. Petitioner asserts that there is no standard medical definition of what constitutes an "episode" of vomiting, and asserts that medical references describe episodes of vomiting caused by various conditions as lasting for hours or days. P. Remand Br. at 14-16, referencing P. Exs. 36-38. Petitioner urges in this regard that my interpretation and application of the AMDA guidelines and Petitioner's change of condition policy is reasonable. It asserts that most people know what vomiting is from their ordinary life experiences and that most vomiting is not serious. Petitioner asserts that vomiting can involve repeated gagging and regurgitation until the stomach is purged. Petitioner urges that there is no reason why I should not incorporate this common knowledge into the interpretation and application of what appears to be a non-technical term. P. Remand Br. at 15. Before the Board, and before me citing DON Morgeson's testimony (P. Remand Br. at 15, citing Tr. at 187-89), Petitioner argues that what constitutes an episode of emesis requires some degree of nursing judgment and asserts that Nurse Suffoletta made a reasonable judgment that Resident 1 experienced only one episode of vomiting and did not undergo a significant change in condition prior to 4:00 a.m. Petitioner argues, moreover, that CMS did not show that Nurse Suffoletta's judgment was so unreasonable or outside of any standard of care that it constituted a regulatory violation.

The Board specifically disagreed with Petitioner's contention regarding Nurse Suffoletta's judgment and asserted that Nurse Suffoletta's judgment that Resident 1 had only one episode of vomiting was contradicted by other record evidence, citing Nurse Suffoletta's interview with the surveyor where Nurse Suffoletta, as documented in the SOD, "revealed the resident vomited again between 12:00 a.m. and 1:00 a.m. (CMS Ex. 3, at 7) and Nurse Suffoletta's nurse's note stating that Resident 1 was observed to have a small amount of emesis on her night clothes (CMS Ex.17, at 31). Remand Decision at 15.

The Board also noted other evidence of record, including summaries of survey interviews set forth in the SOD, and in the facility's own investigation documents, which show that Nurse Suffoletta's judgment did not meet professional standards of care. The Board referenced a SOD summary of a February 19, 2007 interview with the "present" DON (apparently DON Morgeson, who took over as DON in January 2007 (Tr. at 179)), who "revealed the nurse should have called the physician after the first episode of vomiting [and that the] documentation revealed this was a change of condition for the resident." CMS Ex. 3, at 8. The Board noted this conclusion is consistent with the attending physician's opinion, reflected in a March 14, 2007 survey interview noted in the SOD, in which the "physician revealed he would have wanted to be called after the first episode of vomiting," and that "he stated he probably would have ordered medication to control the vomiting." *Id*. The Board also noted that the physician reportedly told the surveyor that "if he was called after the second episode of vomiting (at 1:00 a.m.), he would have sent the resident to the hospital." *Id.;* P. Ex. 17, at 2. The Board observed that P. Ex. 17, at 2, is a written note prepared by Petitioner's attending physician on March 19, 2007. The Board noted that the physician stated "the nurse should have called the M.D. when the person first started profusely vomiting at 8:00 p.m. on 1-2-07" and "that the failure to call when the pt. first started profusely vomiting was an exercise in poor judgment." I note, however, that the Board did not address the rest of the physician's note, which states that Nurse Suffoletta "obviously was doing what she thought was right, because the patient appeared stable."

The Board asserted that the reported opinions of the DON and the physician are consistent with the facility's investigation (following interview with Nurse Suffoletta, the two CNAs working that night, and DON and Medical Director chart review) which found that Nurse Suffoletta "failed to act appropriately and use good nursing judgment." CMS Ex. 21, at 2, 4 ["The results of our investigation revealed that, although the nurse failed to act appropriately and use good nursing judgement (sic), we cannot determine that her actions were intentional or that they caused harm. We have, however, terminated the employee because we do not have confidence in her ability to perform her assigned job."]. The Board then stated that I did not address this evidence and characterizes it as evidence which suggests that Nurse Suffoletta did not exercise sound professional judgment in assessing Resident 1's condition at the relevant time. Remand Decision at 16.

Petitioner argues that the statements attributed to the DON and attending physician undercut the conclusion that the AMDA guidelines and Petitioner's policy establish the governing standard of care. Petitioner asserts that the statement in the SOD regarding the physician "revealing" he would have wanted to be called after the first episode is a surveyor conclusion rather than a direct statement and is inconsistent with the physician's note, at CMS Ex. 23, at 50, that Nurse Suffoletta "did what she thought was right." Petitioner also questions whether the note written by the physician on March 19, 2007 was actually written by him, but, as Petitioner did not call the physician in question to resolve the issue, I find that argument to be specious. Petitioner argues moreover that the note is based only on the physician's review of Resident 1's record as of March 19, 2007, because he was not available at the time of the pertinent events and his clinical summary is recited from the Resident's chart. Petitioner asserts that the surveyors ignored the physician's note that Nurse Suffoletta "did what she thought was right" because her patient appeared stable. Petitioner argues the physician's opinion provides only the flimsiest basis to conclude that a standard of care required Nurse Suffoletta to contact a physician. Petitioner also argues that the SOD statement that the physician said he would have sent Resident 1 to the hospital after the second episode of vomiting at 1:00 a.m. is peculiar at best, and hypothetical, since he had no first-hand knowledge of the events in question and was not in a position to give orders as events developed. He likely based his response on the survey team having told him about two episodes of vomiting several hours apart. P. Remand Br. at 21-22. Petitioner also asserts that in an interview with DON Dempsey, who was the DON on January 2 and 3, 2007, DON Dempsey revealed that Nurse Suffoletta should have called the physician after the first episode of vomiting, citing CMS Ex. 3, at 8 (a view that was echoed by DON Morgeson, also at CMS Ex. 3, at 8). Petitioner says this is not a fair conclusion of DON Dempsey's actual statements in surveyor notes. Petitioner asserts DON Dempsey told a surveyor on March 14, 2007, that she "did not know" why Nurse Suffoletta did not call the physician at 8:00 p.m. but that she "would have called the 1st time." CMS Ex. 23, at 4. Petitioner argues that this statement is more equivocal than an opinion that Nurse Suffoletta violated any facility policy or standard of care. Petitioner asserts that other interview notes from that night make clear that DON Dempsey did not consider physician notification to be the most significant issue that night. CMS Ex. 23, at 1-2; CMS Ex. 3, at 1.

At the end, I am left with no definition of "episode" other than the one that I used in my original decision. In spite of the Board's dissatisfaction with it, I am unable to feel discomfort with this everyday definition based on what I believe is almost universal human experience, since that is the definition of an "episode" exactly as CMS would have it in its "ordinary meaning." I am left to determine whether the evidence shows that Nurse Suffoletta made a reasonable judgment that only one episode, in its ordinary meaning, of emesis occurred.

There appears to be no argument that the AMDA guidelines and facility policy are the standard of care governing when Petitioner's staff is to contact a physician in a situation where a resident is vomiting. The argument here is whether the standard was met and whether Nurse Suffoletta exercised proper judgment on the night in question and still hinges in part on whether Resident 1's vomiting on January 2 and 3 consisted of more than one episode of emesis. In reviewing the evidence again, paying particular attention to the evidence referred to by the Board, I conclude that the incident of emesis at 1:00 a.m. was another episode of emesis requiring Nurse Suffoletta to contact Resident 1's physician at 1:00 a.m. under both facility policy and the AMDA guidelines. I should have relied on Nurse Suffoletta's statement to the surveyor that Resident 1 vomited *again*, in conjunction with her nurse's note that there was a small amount of emesis on the Resident's night clothes, and found that the preponderance of the evidence indicated that Resident 1 did have at least a second episode of emesis on the night in question. At the relevant time, that is certainly what Nurse Suffoletta believed and her description of it after the fact does not change that she believed it to be an episode of emesis. This conclusion fits within what I found before and find now — in the absence of any other suggested definition to the contrary — to be the common understanding of the word "episode" as an event distinctive and separate, although part of a larger series.

As to the opinions of the DONs and the physician regarding when Nurse Suffoletta should have called the physician, I find Petitioner's point that this evidence would undercut the AMDA guidelines and facility policy as the governing standard of care to be well taken. However, in deciding whether Nurse Suffoletta exercised proper nursing judgment in this situation, upon review, it is now clear to me that as of 1:00 a.m. physician notification was necessary.

Determination 2. The Board required me to address "conflicting" evidence in the record and determine whether the evidence it cited alters my conclusion that the physician consultation requirement was not triggered prior to 4:00 a.m. Board Remand at 16-18. In this regard, the Board was in essence asking whether the evidence it references would lead me to conclude that Nurse Suffoletta should have consulted Resident 1's physician about 8:30 p.m. Put another way, the Board was asking me to thus address whether there were two separate incidents of vomiting by that time of which Nurse Suffoletta had been informed, which two separate incidents should be considered separate episodes, the second requiring physician notification.

In evaluating the evidence discussed by the Board, I do not find that a second "episode" of emesis occurred earlier than 1:00 a.m., although it is not really contested that Resident 1 vomited more than once while Ms. Wherry was visiting Resident 1 that evening. Although the Board suggested that there was more than a one-hour gap between the two incidents of vomiting, indicating to the Board that two episodes of vomiting may have occurred, the evidence is not clear as to the amount of time constituting the gap between the two incidents or its portent.

The Board first noted an undated written statement by CNA Betty Jo Rogers, which the Board believed to have been taken in the course of Petitioner's investigation. It states that CNA Rogers:

> Attempted to toilet [Resident 1] and granddaughter asked staff to put her to bed because "she is too sick & weak." Observed the [Resident] [and] what appeared to be "vomit" on her clothing. Cleaned [the Resident] & put her to bed. Then reported this to Natalie Suffoletta who was the charge nurse.

P. Ex. 19, at 1. This note also records that Resident 1's granddaughter was present in the room at approximately 6:30. The Board observed that at the side of this statement there is a notation that says "@6:00 p.m. – 6:30." However, it is unclear from this notation exactly what is referred to; whether it is the time the CNA attempted to toilet the Resident, whether it is the time the granddaughter attempted to put her to bed, or whether it is the time the Resident vomited. CNA Rogers did not testify, and DON Morgeson, who was the "recorder signature" on the document containing CNA Rogers' written statement, was not asked at hearing to clarify the citation. Tr. at 178-205.

The Board concluded that consistent with CNA Rogers' statement is the SOD summary of a March 14, 2007 interview with Ms. Wherry, where she reported that on January 2, 2007, she found Resident 1 slumped over in her wheelchair and abnormally quiet. She requested Resident 1 be put in bed, the Resident began to vomit profusely and Ms. Wherry asked the nurse if the physician should be called. CMS Ex. 3, at 5. The Board noted that Ms. Wherry testified at hearing that the "first time" she observed her grandmother vomiting was about 7:30 p.m. The Board noted that Ms. Wherry and the staff changed the Resident's clothes and got her cleaned up, the CNAs left, and Ms. Wherry had time to sing "Amazing Grace" to her grandmother before the second incidence. Tr. 33-39. The Board wrote that it is unclear in my description of this timeframe as a "very short time" whether I overlooked Ms. Wherry's testimony about the gap, whether I considered and rejected the testimony, or whether I determined that the gap was a very short time.

In answer to the Board's questions, I have re-weighed the evidence. I have considered Ms. Wherry's testimony about this gap, determined that the conflicting testimony about the timeframe makes it difficult to determine exactly what the duration of the gap was, but now determine that it was still a short time, occurring entirely during Ms. Wherry's visit, constituting a continuing episode of vomiting.

Ms Wherry testified that she arrived around 7:00 p.m., and that the first incidence of vomiting occurred around 7:30 because it took her time to find a nurse and get her grandmother in bed. Ms. Wherry testified regarding her concern that she'd asked for her grandmother to be put to bed by 7:00 p.m. but that she was still awake and at the nurse's

station when she arrived, indicating that it could have been well after 7:00 p.m. Tr. at 32-34. Ms. Wherry testified that she was not positive she arrived at exactly 7:00 p.m., but just at some time around 7:00, p.m., and she said it was possible the second incident of vomiting occurred around 8:30 p.m. Tr. at 60. As Ms. Wherry noted regarding when she received a call from the facility on the morning of January 3, 2007, she's "not good on the times." Tr. at 62. I note as well that the timeframe Ms. Wherry testified to conflicts with the timeframe noted by CNA Rogers, who herself was trying to recall a timeframe from at least a couple of months' distance. Moreover, as noted by Petitioner (P. Remand Br. at 16), surveyor notes of an interview with CNA Rogers reflect that she recalled very little about Resident 1 or the events in question. CMS Ex. 23, at 21-22.

There is no way for me on this evidence to determine by a preponderance of the evidence that the gap between the two incidents of vomiting was as long as an hour. I note in this regard that both Ms. Wherry and Nurse Suffoletta testified that after this episode Resident 1 appeared better and that Ms. Wherry, an attentive granddaughter, felt comfortable enough to leave her grandmother for the evening. Tr. at 39, 45, 61, 218, 221; P. Ex. 16, at 8; CMS Ex. 17, at 30. Thus, on **solely** the issue of whether or not the two incidences of vomiting prior to 8:30 constitute more than one episode of vomiting, I find Petitioner was not required to contact Resident 1's physician.

Determination 3: The Board required me to re-evaluate whether Resident 1 was properly monitored and assessed on January 2 and 3, 2007. Remand Decision at 18-21.

The Board concluded that, in finding that Nurse Suffoletta took Resident 1's vital signs twice between 8:00 p.m. on January 2 and 2:00 a.m. on January 3, and found those vital signs were normal, I misstated CMS's position and failed to address material evidence directly contradicting this finding. In so finding, the Board referred to my statement that CMS did not dispute whether Nurse Suffoletta or other facility staff actually took Resident 1's vital signs. The Board noted, however, that the allegation of noncompliance in the SOD with section 483.10(b)(11) states that Petitioner failed to ensure the Resident's vital signs and oxygen saturation levels were monitored as per physician's orders (CMS Ex. 3, at 4) and CMS argues in its CMS Reply Br. at 9, citing Tr. at 83-84, that Nurse Suffoletta did not monitor Resident 1's vital signs or oxygen saturation levels. The Board found that my finding with regard to CMS's position was thus in error.

The Board also stated that the record includes additional evidence and testimony that I did not address. Specifically the Board cited evidence that neither Nurse Suffoletta nor any other of Petitioner's staff took Resident 1's vital signs during the evening and early morning of January 2 through 3, 2007. They cite as evidence summaries of survey interviews in the SOD, the surveyors' hearing testimony, and Ms. Wherry's hearing testimony. They also cite to two interviews Nurse Suffoletta had with the surveyors where Nurse Suffoletta herself reported that she did not take Resident 1's vital signs. CMS Ex. 3, at 7, 12, 17. Both Surveyors Beard and Branham testified that they found no

documentation that Resident 1's vital signs were taken prior to 4:00 a.m. on January 3. *See* Tr. at 84, 86-87, 115-16, 131-33, 137-38. The Board determined also that I did not address Ms. Wherry's testimony that during the course of her visit on the evening of January 2 she did not observe any member of Petitioner's staff take Resident 1's vital signs. Tr. at 36-37.

The Board noted that while Nurse Suffoletta testified that she took, but did not record, Resident 1's vital signs at approximately 8:30 p.m. on January 2, in other testimony Nurse Suffoletta implied that she did not personally take Resident 1's vital signs after that point. Tr. at 216-17, 227, 240. She testified that she checked on Resident 1 by walking past the room and "would look in and check on her, make sure she hadn't thrown up. I know I did twice." Tr. at 221. However, in response to whether Resident 1's vital signs were taken after 8:30 p.m. but before 4:00 a.m., Nurse Suffoletta stated "[w]e checked them again probably – between midnight and 2:00." Tr. at 227. Nurse Suffoletta later confirmed she "didn't personally check the resident's vital signs each time," and that the vital signs were taken by CNAs, who reported their findings to her on pieces of paper which were then discarded, and these vital signs were not otherwise documented in the medical record. Tr. at 240-41. However, the SOD relates that in an interview with the CNA who cared for Resident 1 on January 2-3, 2007, the CNA told the surveyor that she was not instructed to take Resident 1's vital signs at 8:30 p.m. or 1:00 a.m. CMS Ex. 3, at 6, 18-19; *see also* Tr. at 138-39. The SOD relates that between 2:00 and 2:30 a.m., the CNA performed an incontinence check on the Resident, during which "the resident kept her eyes closed and there was no response from the resident." CMS Ex. 3, at 6. The CNA allegedly told the surveyors that this behavior "was unusual for this resident because she would normally resist removal of the blanket during incontinence care." CMS Ex. 3, at 19. The Board also noted that Nurse Suffoletta did not testify unequivocally that any staff member took vital signs.

The Board stated that the evidence it cited conflicts with my finding that Nurse Suffoletta checked Resident 1's vital signs twice between 8:00 p.m. and 2:00 a.m. and found them to be stable. ALJ Decision at 11. The Board directed me to consider the SOD summary interviews and hearing testimony cited and explain whether they change my prior assessment of the weight of the evidence relating to the charge that the facility failed to timely consult Resident 1's physician due to a change in the Resident's condition, as required by Petitioner's policy and 42 C.F.R. § 483.10(b)(11).

CMS also asserts this evidence calls into question Nurse Suffoletta's credibility. Summaries of surveyor interview with her indicate she made prior inconsistent statements that constitute impeaching evidence on the point. The Board noted that my assessment of her "experience and training" does not take into account evidence that Petitioner terminated Nurse Suffoletta's employment based on its determination that she "failed to act appropriately and did not use good nursing judgment" and "the facility management [did] not have confidence in [her] ability to perform her assigned job."

CMS Ex. 21, at 2, 4. The Board directed me to discuss my assessment of Nurse Suffoletta's credibility and her hearing testimony and nursing notes in light of the conflicting evidence discussed.

Petitioner argues initially with regard to the physician's order to monitor vital signs routinely that, in fact, it did so, 29 times between November 17, 2006 and January 2, 2007. P. Remand Br. at 27. The specific issue here, however, is not so much whether Petitioner was routinely monitoring Resident 1's vital signs, but whether, in this instance, Petitioner should have been monitoring and assessing Resident 1's oxygen saturation level and vital signs on January 2-3, 2007.

Although Petitioner initially argues that the Board was wrong when it disagreed with my finding that Nurse Suffoletta took Resident 1's vital signs at least twice during the relevant time, in its reply on remand Petitioner recognizes that while Nurse Suffoletta may not have personally taken the Resident's vital signs, the evidence shows that she was not unaware of the Resident's vital signs between 8:00 p.m. and 1:00 a.m. Indeed, Nurse Suffoletta testified that she was so aware. Tr. 217-18, 221, 227. She testified that CNAs took the Resident's vital signs, wrote the values on the scraps of paper and gave the information to her. Although CMS ardently demands corroboration of this, Petitioner quite reasonably asserts that "short of finding the scraps of paper, it is not clear what else would suffice to credit Nurse Suffoletta's testimony. . . ." P. Remand Reply at 9.

Petitioner argues further that the gist of CMS's argument is that Nurse Suffoletta should have documented even normal vital signs in the Resident's chart and, in the absence of such documentation, I cannot in my role as a fact-finder determine that vital signs were ever taken. According to Petitioner, CMS is asserting either that a policy of documentation by exception is unacceptable or that Nurse Suffoletta used that policy as a rationale to cover up her failure to take vital signs at all. Petitioner asserts that there is no reason to disbelieve Nurse Suffoletta's straightforward testimony about what she did and that documentation by exception is a common, generally acceptable practice. P. Remand Br. at 30-33; P. Remand Reply Br. at 10.

Petitioner argues that the real issue is rather whether Nurse Suffoletta was taking reasonable steps during the night in question to inform her analysis as to whether Resident 1 was seriously ill, including reviewing Resident 1's chart to determine a reason for her illness and evaluating whether the Resident was seriously ill by considering her appearance and demeanor thereafter, and by visually monitoring her and measuring vital signs.

I agree with Petitioner that the question is whether Nurse Suffoletta monitored the Resident on the night in question. Moreover, the Board has specifically asked me to re-evaluate whether Resident 1 was properly monitored and assessed on that night. After consideration of the Board's own observations in this regard, I find that Nurse Suffoletta

did not properly monitor and assess Resident 1 on the night in question and find, moreover, that my initial finding that Nurse Suffoletta took unrecorded but normal vital signs of Resident 1 twice between 8:00 p.m. and 2:00 a.m. is erroneous.

In re-evaluating the evidence I need not address the issue of whether Petitioner could properly monitor and assess Resident 1 by documenting her vital signs by exception, because other evidence cited by the Board should have led me to conclude that Resident 1's vital signs were not taken that evening and that Petitioner was thus not properly monitoring and assessing Resident 1 during the evening and early morning of January 2-3, 2007.

The Board's reference to summaries of survey interviews in the SOD, the surveyors' hearing testimony, and Ms. Wherry's hearing testimony, as well as Nurse Suffoletta's interviews with the surveyors, in conjunction with the lack of documentation regarding whether vital signs were taken (CMS Ex. 3, at 7, 12, 17; Tr. at 36-37, 84, 86-87, 115-16, 131-33, 137-38), should have led me to conclude that by a preponderance of evidence, despite Nurse Suffoletta's testimony directly before me to the contrary, Resident 1's vital signs were not taken that evening. Although Petitioner argues that the physician's orders to monitor and assess Resident 1's oxygen saturation and vital signs were for routine monitoring, not for monitoring in an acute situation such as occurred on the night of January 2-3, Petitioner's policy and AMDA guidelines require immediate physician notification where a resident has emesis combined with pain associated with a change in vital signs. P. Ex. 29, at 20; P. Ex. 30, at 2. Unless Nurse Suffoletta took Resident 1's vital signs she would not know whether that, combined with Resident 1's profuse vomiting, required immediate physician notification.[5]

2. Petitioner failed to substantially comply with the quality of care regulation at 42 C.F.R. § 483.25 (Tag F-309).

The Board's remand asked me to reconsider my finding that that Petitioner was in compliance with this participation requirement. Board Remand at 21-26. Having done so, I find Petitioner failed substantially to comply with this participation requirement.

The Board noted that the quality of care regulation at 42 C.F.R. § 483.25 provides:

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and

[5] While Petitioner might argue that Resident 1 was not in pain, her profuse vomiting was certainly not something that would make her comfortable. Moreover, given Resident 1's mental acuity, it is not clear whether or not she would be a valid reporter of pain. Thus, it was even more incumbent that Nurse Suffoletta ensure that vital signs be taken.

> psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Applying this language, the Board noted it has previously held that a facility's failure to implement physician orders, to comply with its own policies, or to furnish care and services in accordance with a resident's plan of care can constitute a deficiency under section 483.25. *Woodland Village Nursing Center*, DAB No. 2053, at 9 (2006), citing *Lakeridge Villa Health Care Center*, DAB No. 1988, at 22 (2005), citing *The Windsor House*, DAB No. 1942, at 55-56 (2004), *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Center*, 129 Fed.Appx 181 (6th Cir. 2005), and *Spring Meadows Health Care Center*, DAB No. 1966, at 16-17 (2005). The Board stated it has also held that the quality of care provision "implicitly imposes on facilities a duty to provide care and services that, at a minimum, meet accepted professional standards of quality 'since the regulations elsewhere require that the services provided or arranged by the facility must meet such standards.'" *Sheridan Health Care Center*, DAB No. 2178, at 15 (2008), quoting *Spring Meadows*, DAB No. 1966, at 17.

The Board cited specific areas for me to consider on reconsideration. The Board first referenced that I described CMS's allegations of noncompliance with this requirement as "essentially based on the same set of facts and circumstances involving Resident 1." ALJ Decision at 12. The Board stated that my decision was unsupported by sufficient analysis when I determined that Petitioner had established Resident 1 received the necessary care and services, that CMS did not demonstrate that Petitioner failed to act based on a particular standard of care, and that CMS did not demonstrate that Petitioner's care plans or assessments failed to meet Resident 1's needs. The Board noted that I found that Petitioner's staff acted in a manner consistent with professional standards of care and quality and that there was no failure on Petitioner's part to properly monitor or assess Resident 1.

The Board noted that on appeal CMS argues that I did not fully address its allegations that between the times that Resident 1 began vomiting, and Resident 1's transport to the hospital, Petitioner did not institute any interventions to help her condition or alleviate her symptoms. CMS points out that there is no evidence or testimony that Petitioner administered any treatment to Resident 1 between 4:00 and 4:21 a.m. on January 3 and that based on physician orders and generally accepted standards of care for patients in distress Petitioner should have provided suctioning or administered oxygen to her during that period. CMS further argues that my analysis did not address Petitioner's failure to implement the physician's November 17, 2006 orders regarding vital signs and oxygen saturation levels.

The Board candidly and explicitly stated its view that CMS's contentions have merit. The Board noted that my summary factual findings that Resident 1 received the necessary care and services and that Petitioner did not fail to properly monitor or assess Resident 1 were based on my evaluation of the evidence and factual findings supporting my finding

that Petitioner was in compliance with the participation requirement reflected at Tag F-157. As the Board remanded the finding at Tag F-157 to me, the Board determined to also remand my finding with regard to Tag F-309 for a revised analysis of whether Petitioner was in substantial compliance with section 483.25.

The Board concluded that I erred by limiting my analysis to the same questions addressed and resolved in the facility's favor with regard to Tag F-157. Its view of the matter, the view by which I am obliged to proceed, was that the allegations of noncompliance are not "merely duplicative or derivative" of CMS's allegation of noncompliance regarding the physician consultation requirement or limited to addressing the care and services provided Resident 1 from the evening of January 2 until 4:00 a.m. on the morning of January 3 when Resident 1 was found unresponsive. The Board cited six SOD findings on which CMS's determinations and allegations of Petitioner's noncompliance with section 483.25 are based. They include:

> 1. From November 2006 until Resident 1's death, the facility failed to implement the November 17, 2006 physician orders for routine vital signs and daily oxygen saturation readings for Resident 1. The treatment administration records for November and December 2006 showed only 10 oxygen saturation readings from November 17, 2006 through December 31, 2006, and none for January 2007. The records also showed that the Resident's vital signs had not been taken daily as ordered by the physician. CMS Ex. 3, at 14-15, 19-20; CMS Br. at 12-13, citing CMS Exs. 3, 17, P. Ex. 12, Tr. at 22, 137-38.
>
> 2. "Documentation by exception" of vital signs and oxygen saturation levels is not acceptable when there are explicit physician's orders for monitoring those signs and levels. CMS Br. at 13, citing Tr. at 22, 234-40; P. Ex. 12.
>
> 3. Between 4:00 and 4:21 a.m. on the morning of January 3, 2007, Petitioner failed to suction or administer oxygen to Resident 1, contrary to the physician's orders for oxygen to be administered when Resident 1's oxygen saturation levels fell below 88% and to professional standards of care. CMS Ex. 3, at 13-14, 17; CMS Br. at 13, citing P. Ex. 12; Tr. at 147-48.
>
> 4. Petitioner did not give EMS a verbal report of the Resident's allergies, recent medical history or inform them that the Resident had been vomiting when EMS arrived to transport Resident 1 to the hospital on January 3, 2007. CMS Ex. 3, at 16.
>
> 5. The transfer paperwork prepared by the facility for EMS and the hospital did not reveal the Resident had been profusely vomiting. CMS Ex. 3, at 16.

> 6. In a survey interview with the attending physician on-call for the facility on January 3, 2007, the physician stated he reviewed Petitioner's nursing documentation and the notes, and he stated it looked like the facility did not do anything for the Resident until they "found her on death's door." CMS Ex. 3, at 16.

The Board also pointed out that while Petitioner argues CMS pressed the quality of care tag only cumulatively, Petitioner presented evidence and argument to contest these six allegations. The Board noted that I did not address these material disputes.

The Board also noted its finding that Petitioner admitted it did not follow physician orders to document Resident 1's oxygen saturation levels, citing Tr. at 22 and CMS Ex. 3, at 12 [where the SOD states that in a survey interview the DON revealed she was unaware vital signs and oxygen saturation readings were not obtained as ordered. The DON stated that nurses were to record Resident 1's vital signs and oxygen saturation on the treatment administration record (TAR)]. The Board found this failure material to the question of whether Petitioner was in substantial compliance with section 483.25.

The Board stated that I also erred in finding that there was no allegation or evidence that Petitioner's care plans or assessments failed to meet Resident 1's needs. The Board noted that CMS's determination was based on findings in the SOD, conceded by Petitioner, that Petitioner failed to revise Resident 1's care plan to reflect physician orders for vital signs to be taken routinely and oxygen saturation readings to be done daily. CMS pointed to other record evidence, including November 17, 2006 physician orders, facility records indicating that the orders were not reflected in Resident 1's plan of care, and the SOD summary of the survey interview with the DON where she stated "the care plan should have been revised when new orders were obtained." CMS Exs. 3, at 12; 17, at 9; P. Exs. 12-15. The Board directed that in light of CMS's allegations and Petitioner's admission of noncompliance, I must consider whether Petitioner's failure to update Resident 1's care plan to implement physician's orders constitutes noncompliance with 42 C.F.R. § 483.25.

I address the six SOD findings referenced by the Board.

1. I do not have to decide whether Resident 1's vital signs were taken "routinely" or only sporadically. Petitioner admits that it did not monitor Resident 1's oxygen saturation levels daily, and that is a deficiency under this quality of care tag as the failure to implement physician orders here constitutes a deficiency. Moreover, I have found that Petitioner did not take Resident 1's vital signs during the night in question, which at the least constitutes a failure to follow its own emesis policy, and the failure to comply with its own policies here also constitutes a deficiency under this participation requirement.

2. With regard to documentation by exception, Petitioner argues that the Board "mixes apples and oranges" in evaluating Nurse Suffoletta's observations during the night in question in terms of a general admission order to periodically "monitor" oxygen saturation and vital signs. Petitioner argues that the physician's order had nothing to do with her illness. Petitioner queries whether there is evidence in the record supporting a finding that some standard of care or regulation required Nurse Suffoletta to record all her vital sign observations when not abnormal. Petitioner notes unrebutted testimony by Susan Lincoln, R.N., that there is nothing inherently wrong with the common practice of documenting routine observations by exception, i.e., documenting only abnormal findings, although what she actually testified is that it is a "customary practice." Tr. at 261. Petitioner argues that in the absence of evidence to the contrary Nurse Lincoln's testimony regarding documenting routine observations by exception should be conclusive. Petitioner references also excerpts from nursing textbooks and manuals to buttress its argument that documenting by exception is a common practice and not *per se* unreasonable. P. Remand Br. at 30-33, citing P. Exs. 39-44. Petitioner does note, however, that the practice is not "universally employed" and that specific training and implementation of special flow sheets is recommended. P. Br. at 33.

I find that documentation by exception of vital signs and oxygen saturation levels is not acceptable here, and thus Petitioner's failure to document vital signs and oxygen saturation levels on January 2-3, 2007, constitutes a deficiency. While Nurse Lincoln testified that documentation by exception is a common practice, Petitioner did not prove by a preponderance of the evidence that documentation by exception was a common practice at Petitioner's facility during the time in question. Petitioner has not shown that it specifically trained its employees regarding documentation by exception, that there was a written facility policy describing documentation by exception, or that special forms were implemented to embrace that practice. Moreover, while Petitioner argues that it is "mixing apples and oranges" to discuss whether Nurse Suffoletta's actions on the night in question should be evaluated against whether Petitioner should have been routinely documenting physician's orders for monitoring vital signs and oxygen saturation levels by exception, the Board's remand is not specific to the night in question but goes to the broader question as to whether Resident 1's physician's orders could be documented by exception and not charted. Petitioner has not shown that they could.

3. Petitioner argues that the Board set forth a "laundry list" of actions Nurse Suffoletta should have done differently between 4:00 a.m. and 4:21 a.m. and that such discussion is entirely speculative. P. Remand Br. at 37. Petitioner references the "extraordinarily compressed" time frame in which these events unfolded and asserts the Board's discussion did not address this in a "realistic context" given Nurse Suffoletta's actions which included assessing the Resident, trying to call the attending and on-call physician, discussion with the DON, calling 911, calling the local hospital, and returning to Resident 1's room to check her vital signs prior to emergency services arriving at 4:21 a.m. P. Remand Br. at 37-39.

Petitioner acknowledges that Nurse Suffoletta might have administered oxygen to Resident 1 given her low observed oxygen saturation level of 46% at 4:00 a.m. and 36% at 4:10 a.m., and that Resident 1's physician had a standing order to administer oxygen to Resident 1 if her oxygen saturation level fell below 88%. P. Remand Br. at 40. Petitioner argues, however, that CMS offered no evidence that such intervention was feasible given the circumstances noted above, and that the critique is thus at best "hypothetical and speculative." Petitioner argues that CMS did not prove that Nurse Suffoletta was "indifferent or impassive" during the emergency and "accomplished a great deal in a very few minutes." P. Remand Br. at 41.

Petitioner misapprehends its burden on this point. While Petitioner argues that there is no evidence that Resident 1 had an airway obstruction or was not breathing, and that therefore suctioning or oxygen administration was necessary treatment (P. Remand Reply at 12), it is impossible on this record to know whether she displayed those conditions or not because there is no evidence that Petitioner's staff assessed the Resident for these conditions. Petitioner did not show that staff contacting the Resident's physician and treating the Resident were mutually exclusive activities. Petitioner acknowledges that when Resident 1's oxygen saturation fell below 88% her physician ordered the administration of oxygen. Petitioner's argument that it might not have been "feasible" to do so does not show that at 4:00 a.m., on January 3, 2007, Nurse Suffoletta or Petitioner's other staff recognized the order for oxygen administration, assessed whether that order should have been followed, and then determined that they did not have the time to do so. In fact, there is no evidence of record that this was considered. *See* Tr. at 148. Petitioner's failure to comply with physician's orders is a failure to comply substantially with this participation requirement.

4 and 5. Petitioner argues there is no direct evidence in the record regarding what Nurse Suffoletta wrote or said to EMS personnel. The EMS "run report" does not reflect what Nurse Suffoletta told them. P. Remand Br. at 41- 42. Petitioner argues that it is unrealistic to expect that in a compressed period of time Nurse Suffoletta should have left Resident 1's bed and delayed what she was doing to draft a more complete history regarding Resident 1's allergies, recent medical history, or inform them the Resident had been profusely vomiting. Petitioner argues that CMS did not offer any evidence that Nurse Suffoletta's actual nursing judgments in this regard were outside of any applicable standard of care. P. Remand Br. at 40.

The run report prepared by EMS contains no evidence of Resident 1's allergies, recent medical history, or that the Resident had been vomiting. CMS. Ex. 18, at 1-2. The ER physician caring for Resident 1 on January 3, 2007, told a surveyor that the paperwork the facility prepared did not reveal Resident 1 had been profusely vomiting and that EMS did not provide any information concerning Resident 1's history of recent vomiting. The ER physician stated to the surveyor that the vomiting could have contributed to Resident

1's decline in condition. CMS Ex. 3, at 16. Given that Resident 1's condition declined after a recent bout of vomiting, this was information that should have been provided to the EMS personnel while they were in the building. Even arguing that Nurse Suffoletta may have believed that her vomiting was due to a minor stomach upset caused by medicine or a minor flu bug, that the Resident had just been ill was something EMS personnel should have been made aware of so that they, in turn, could relay that information to the ER. That the information was not given to the EMS personnel I find to constitute noncompliance with the participation requirement.

6. I note the attending physician on-call's statement to the surveyor, after his review of the documentation regarding the incident, that it appeared to him that the facility did not do anything for Resident 1 until they "found her on death's door." CMS Ex. 3, at 16. While that may be his opinion, I do not find his statement, based as it is on a review of uncertain documentation, and regarding which he did not testify, supports my basing a regulatory violation on it.

Finally, as discussed above, I find that Petitioner's failure to update Resident 1's care plan to implement physician's orders that routine vital signs be taken and oxygen saturation readings be done daily constitutes noncompliance with this participation requirement. In this regard I rely on the SOD summary of the DON's statement that Resident 1's care plan should have been revised when the physician's order regarding vital signs and oxygen saturation readings was obtained.

3. Petitioner failed to substantially comply with the Facility Administration Requirement at 42 C.F.R. § 483.75 (Tag F-490).

The facility administration regulation at 42 C.F.R. § 483.75 requires that:

> A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

The Board discussed this deficiency at pages 26-29 of its decision. The Board noted that I rejected CMS's allegations in finding that CMS did not establish that systemic breakdowns on the part of Petitioner's administration caused a deficient facility practice. The Board noted that I found the administration deficiency to be a derivative deficiency based on the findings of other deficiencies, citing *Cross Creek Health Care Center*, DAB No. 1665, at 19 (1998). It noted my conclusion that CMS's case was refuted regarding the predicate issue of its staff's response to Resident 1's episode of vomiting and that failure of the predicate case thus doomed the derivative citation.

The Board observed that a determination that a facility fails to substantially comply with this requirement may be derived from findings that it was not in substantial compliance

with other participation requirements. The Board pointed out that in prior decisions, including in *Cross Creek*, it has held that where a deficiency finding under this section is derivative, i.e. based on surveyors' identification of other deficient practices, the existence of those separately identified deficiencies "may constitute a prima facie case that a facility has not been administered efficiently or effectively as required by section 483.75." *Odd Fellow and Rebekah Health Care Facility*, DAB No. 1839 (2002), citing *Asbury Center at Johnson City*, DAB No. 1815 (2002). However, neither regulations nor Board precedent requires that all administration deficiencies be exclusively derived from findings of noncompliance with other, separately identified, deficiencies. Findings of noncompliance with this requirement may be identified in the course of investigation of other deficiencies but not wholly derived from them. Thus, a finding that a facility is in substantial compliance with a separately identified requirement does not "doom" the administration deficiency as I suggested. The reviewer must consider whether any of the allegations of noncompliance with the requirement, standing alone, are supported by the evidence and independently constitute noncompliance with this requirement. Thus, the Board concluded that even if I find Petitioner complied with the quality of care and physician consultation requirements, I should address whether Petitioner was "administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."

Given that I now find Petitioner out of substantial compliance with the quality of care and physician participation requirements, at a level of immediate jeopardy as discussed below, it is perhaps unnecessary that I address this requirement, since the Board has held that "where a facility has been shown to be so out of compliance with program requirements that its residents have been placed in immediate jeopardy, the facility was not administered in a manner that used its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident." *Asbury Center at Johnson City*, DAB No. 1815, at 11. Thus, these two deficiencies alone justify a finding that Petitioner was out of substantial compliance with this participation requirement. However, to address the Board's concerns, I note the parties' arguments and briefly discuss them.

The Board stated that CMS's determination is based on SOD findings that:

> 1. Petitioner's "Administrator failed to take necessary actions to correct deficient practices involving residents with a significant change in condition, and investigate events contributing to the deficient practice."
>
> 2. Petitioner's "Administrator failed to assure all staff were properly trained in regard to their policy and procedure of notification of the physician when a resident experienced a change in condition that required alteration or treatment."

> 3. Petitioner's "Administrator failed to investigate the incident of 01/02/07-01/03/07 to determine the causative factors related to the care and services that were not provided Resident #1."

CMS Ex. 3, at 20-21.

The Board observed that to support the second finding, the SOD cited facility training records, and survey interviews with Nurse Suffoletta, the Administrator, the DON, and the nurse training consultant. CMS Ex. 3, at 3-4, 9-10, 19, 23-24. The SOD stated that nursing staff had not received training and all materials on the facility's physician notification policies and that Petitioner did not review whether staff received, reviewed and understood the policies and procedures. *Id*.

The Board noted that to support the third finding, the SOD cited, among other things, a March 14, 2007 survey interview with the Administrator who stated that "a thorough clinical review should have been done after the incident, but had not." CMS Ex. 3, at 22-23. According to the SOD, only after this interview did Petitioner conduct a thorough clinical review of whether appropriate care and services were provided to Resident 1. The SOD also stated that findings from the investigation "revealed the nurse did not follow the facility's policy and procedures for change in condition and physician notification." *Id*. The Board references CMS Ex. 21, at 4, a letter received on March 21, 2007, by the Kentucky Inspector General, in which Petitioner's Senior Executive Director states that following the investigation of neglect regarding Resident 1 Petitioner terminated Nurse Suffoletta's employment because she "failed to act appropriately and use good nursing judgment" and that although they could not determine whether her actions were appropriate or caused harm, Petitioner did "not have confidence in her ability to perform her assigned job."

The Board noted that Petitioner argues, among other things, that before the survey started its administrators did investigate the incident and concluded that Nurse Suffoletta's clinical response was not inadequate. P. Ex. 24; Tr. at 245. However, as noted in footnote 6 of the Board's decision, P. Ex. 24, a seven-page document titled "Incident Investigation Levels III & IV (Root Cause Analysis) Form" actually concluded that Nurse Suffoletta "failed to follow facility policy & procedure of documentation, assessment, and physician notification." P. Ex. 24, at 7. The Board also noted Petitioner's contention that the state agency previously concluded Petitioner's training was effective, and written evidence and Nurse Suffoletta's hearing testimony establish that she received adequate training in Petitioner's physician notification policy and, in fact, knew the content of Petitioner's physician notification policy. Tr. at 144-46, 222-24.

In its remand, the Board required me to consider whether CMS's allegations that Petitioner failed to conduct a timely and thorough investigation of the circumstances

surrounding Resident 1's death, and failed to ensure that staff were properly trained in facility policy and procedures, are supported by a preponderance of the evidence and constitute noncompliance with the administration regulation.

CMS argues in its remand briefing that systemic failures existed at the facility and that the administrator is responsible for those failures. CMS Remand Reply Br. at 11-13. It cites to Surveyor Branham's testimony regarding immediate jeopardy at the facility with regard to those systemic failures, stating that,

> [I]t's the system. I looked at the facility's system of they didn't have an effective system to identify when a resident had a change in status. They didn't have an effective system to notify that doctor when there was a change in status. And even after the occurrence, there was no care and services provided this resident. Even when she was found at 4:00 a.m. unresponsive and her vital signs was nothing and her 02 SATs was 42 I think it was or 46, there was no -- there was nothing provided to this resident. I asked the nurse what do you do. She went to call the doctor. Well, I understand that but there was -- there was no suctioning, there was no oxygen provided for her.

Tr. at 147-48. CMS notes that Petitioner's administration was unaware of many of the issues surrounding Resident 1's sudden decline and death. CMS acknowledges that the administrator would not be responsible for knowing the smallest details of Resident 1's condition, but argues that he should have investigated whether the care provided to Resident 1 was appropriate. Moreover, CMS argues that the facility should have looked deeper into the issue regarding the on-call physicians being unavailable prior to the surveyors bringing the issue to the facility's attention. CMS argues that during the "scramble" to locate the on-call physician, staff lost time they could have used to care for Resident 1's acute needs. CMS also references that the administrator was not aware that Petitioner's training was flawed, in that its nurses had not all received the relevant training materials or had understood the material evaluated.

Petitioner argues that there is nothing so noteworthy about Resident 1's situation that should have prompted its Administrator to "investigate" and that what CMS is really saying is that its Administrator should have anticipated the deficiencies found by the survey team only weeks after the fact. In this regard, Petitioner asserts: Resident 1 died a natural death after a period of declining health; if the administrator found out that Resident 1 had been vomiting he would have learned that Nurse Suffoletta believed it to be a single episode of emesis as she reported to the DON; the administrator would not have discussed the matter with the physician because he was out of town; the state agency had approved Petitioner's change of condition policy the day before Resident 1 became ill, so it is unlikely the administrator would have questioned its efficacy; and thus it is unclear what an investigation at that time might have found. Petitioner notes that the facility did investigate Ms. Wherry's complaint regarding the advanced directive, found

the complaint valid, and the DON discussed the matter with Nurse Suffoletta. P. Remand Reply Br. at 14-15; P. Remand Br. at 44, 47-48. Once the state agency brought the issue of physician notification to the facility's attention, the DON immediately conducted a full investigation. Referencing decisions in *Cedar View Good Samaritan,* DAB CR997 (2003) and *Pathfinder Healthcare, Inc.,* DAB CR958 (2002), Petitioner argues that the regulatory requirement to investigate is triggered only when an administrator actually learns of facts or allegations that require investigation. P. Remand Br. at 48-49.

With regard to CMS's critique of Petitioner's clinical training practices, Petitioner argues that CMS did not explain the basis for a non-clinician administrator's obligation personally to participate in, much less to oversee, clinical training. There is no regulatory requirement that an administrator grade or review test grades. DON Morgeson testified she was responsible for clinical training and she assured herself that the new change of condition policy was implemented appropriately, via staff training of nurses, including Nurse Suffoletta, both face-to-face and via written material and testing of nurses who work at night. Nurse Suffoletta was trained in the facility's new change of condition policy, as indicated by her signature on the sign-in sheet regarding the training (Tr. at 222; P. Ex. 28, at 2). P. Remand Reply Br. at 15-16; P. Remand Br. at 46.

I disagree with Petitioner that is logically inconsistent to find Petitioner's implementation of the new physician notification policy deficient the same day SSA and then CMS approved it. The problem in this case has never been the policy, which essentially re-states the AMDA guidelines. The problem is Nurse Suffoletta's understanding and application of that policy. I accept that Petitioner trained Nurse Suffoletta on the policy. However, assuming Petitioner did so, the training was deficient. Nurse Suffoletta came out of the training not understanding what the policy required when she had to apply it on January 2-3, 2007. Moreover, although she apparently missed questions on the written test following reading the information left for her, nobody at the facility followed up to ensure that her (and presumably any other staff's) understanding of the obligations was correct. While it may not be an administrator requirement to make up, administer, or grade a test, it is certainly a facility administrator's ultimate responsibility to ensure that staff are properly trained in facility policy and procedures. Petitioner has not shown that its administration showed that they were here.

Petitioner argues that a decision by a federal appellate court, *Emerald Shores Health Care Associates, LLC v. DHHS*, 545 F.3d 1292 (11th Cir. 2008), warns against imposition of regulatory liability based on unknown and unknowable standards. Petitioner's argument asserts that CMS's interpretive guidelines to the administration regulation are worded in general terms and it is difficult to see how an administrator could find a regulatory obligation to anticipate and correct a deficiency even the survey team had trouble developing. P. Remand Br. at 45. In this case, however, the survey team had problems precisely because Petitioner did not conduct a timely and thorough investigation of what occurred that night and was thus unaware of issues surrounding

Resident 1's decline and death. Given the change in its physician notification policy following a change in condition, Petitioner should have been acutely conscious of how it was fulfilling this obligation. Staff was certainly cognizant of the problems Nurse Suffoletta had in reaching the physician. But nobody in authority at the facility asked whether those issues could have affected Resident 1's treatment. While a facility administrator does not, and as CMS notes perhaps should not, focus on the minutia of day-to-day care provided to individual residents, the administrator is ultimately responsible for the care the facility provides to residents. *See* Tr. at 121; CMS Br. at 16.

4. CMS's determination that the facility's noncompliance 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 includes an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a heavy burden to show no immediate jeopardy and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1962, at 11 (2005); *Florence Park Care Center*, DAB No. 1931, at 27-28 (2004), *citing Koester Pavilion*, DAB No. 1750 (2000).

I find CMS's determination of immediate jeopardy is not clearly erroneous. Petitioner acknowledges that a finding of immediate jeopardy is "presumptively correct . . . after a finding of noncompliance is sustained." P. Remand Reply Br. at 16. Here I have found substantial noncompliance to exist. The noncompliance has to do with, among other things, Petitioner's staff's failure to recognize that Resident 1's physician needed to be contacted after her second episode of emesis; Petitioner's failure to monitor Resident 1's vital signs on the night of January 2 and early morning of January 3, 2007 to determine whether a change in vital signs would necessitate contacting the physician or treating the Resident; and Petitioner's failure to consider treatment options when Resident 1 was found in distress at 4:00 a.m. on January 3, 2007, staff not recognizing that it should have assessed the Resident for, and considered implementation of, the physician's order for oxygen when Resident 1 had low oxygen saturation levels. This noncompliance, at the very minimum, was certainly likely to cause serious harm to the Resident even if it did not actually cause her death.

5. Petitioner's noncompliance at a level of immediate jeopardy extended from January 3 through March 27, 2007.

As noted above, the Board has determined that a CMP of $100 per day, extending from January 3 through April 9, 2007, is reasonable based on Petitioner's noncompliance with

42 C.F.R. §§ 483.20(d)(3) and 483.10(k)(2) (Tag F-280) a participation requirement not cited at an immediate jeopardy level. The Board's determination precludes my finding that noncompliance began later than January 3 or concluded prior to April 9, 2007. My only inquiry is whether the noncompliance with the three other participation requirements at issue constitutes immediate jeopardy for the period January 3 through March 27, 2007.

Petitioner argues that it took several months for the state agency to identify that anyone was placed in jeopardy by Nurse Suffoletta's judgments. Petitioner argues that where noncompliance focuses on a specific incident or incidents CMS has an obligation to define the temporal boundaries of the noncompliance with some specificity. Petitioner argues that where noncompliance focuses on the care of a specific resident as opposed to a systemic failure, the period of noncompliance ends when the resident dies or leaves the facility. *See Heron Pointe Health and Rehabilitation*, DAB CR1401 (2006); *Britthaven of Havelock*, DAB CR1392 (2006). Petitioner argues that here CMS actually reviewed the policy at issue and determined that the policy was compliant on the same day the incident occurred. Petitioner asserts that the only basis to extend the period of noncompliance beyond the time Resident 1 left the facility would be to extrapolate, from staff who trained Nurse Suffoletta stating that they could not recall whether Nurse Suffoletta was inserviced on the physician notification policy, to a conclusion that Petitioner's training policies were so lax as to pose immediate jeopardy to all residents. Petitioner notes that Nurse Suffoletta testified she was aware of the policy on the evening and early morning of January 2-3, 2007. Tr. at 224. Petitioner argues that Nurse Suffoletta's judgment was not so unreasonable as to be inconsistent with the terms of Petitioner's policy.

Petitioner's arguments are unavailing. I have found Nurse Suffoletta's judgment inconsistent with Petitioner's policy. It is clear from her actions (busy or not as she may have been that evening) that she did not understand when she had a duty to contact Resident 1's physician. I am able to extrapolate her failure to be a failure on the part of the facility. Her training appears to have been conducted by her reading some material and taking a written test on which she failed to answer several questions correctly. While this type of training may be effective in a given circumstance, it is not effective when a test is not reviewed and misconceptions or outright errors reflected in the test-taker's answers addressed. There were also other problems at the facility found during the investigation. For example, on the evening in question Resident 1's code status was not immediately accessible; the physician on-call system did not work; and pertinent information regarding Resident 1's condition was not passed to the emergency room.

Although Petitioner urges that the period of noncompliance ended when Resident 1 left the facility, the fact is that a facility's noncompliance is deemed to be corrected only when incidents of noncompliance have ceased and a facility has implemented appropriate measures to ensure that similar incidents will not occur. The cases alluded to by Petitioner are extremely fact-specific and hardly go so far as to say that once a resident

leaves a facility — or dies — the facility is back in substantial compliance even where the conditions that contributed to the deficiency still exist. What I consider instead is evidence regarding when the noncompliant conduct comes to an end. According to the state agency and CMS, it was not until March 28, 2007, that the state agency deemed the immediate jeopardy canceled, after Petitioner conducted additional in-services regarding physician notification, documentation, and carrying out physician orders. CMS Remand Reply Br. at 15. Petitioner has not shown that it was in compliance any earlier.

6. The CMP imposed for the period of immediate jeopardy, $4,050 per day from January 3 through March 27, 2007, is reasonable.

To determine whether the CMP imposed is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f), which are: (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 circumstance in reducing the amount of the penalty. The factors listed in 42 C.F.R. § 488.404 include: (1) the scope and severity of the deficiency; (2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and (3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

In reaching a decision on the reasonableness of the CMP, I must 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 Petitioner with the kind of deficiency found, in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Center*, DAB No. 1848, at 21 (2002).

In evaluating the regulatory factors, I find that Petitioner has not submitted evidence regarding its financial condition. CMS does not contest aggravating factors in Petitioner's history. The deficiency is serious and Petitioner is culpable in that Petitioner's actions had a serious negative effect on Resident 1's care, comfort, and safety. Petitioner's staff failed to recognize Resident 1's change in condition, did not monitor her vital signs, and did not attempt to contact her physician until the Resident was unresponsive and had an oxygen saturation level of 46%, a level which continued to drop until she left the facility. CMS Ex. 17, at 31. The only intervention attempted by Petitioner's staff was to make phone calls, finally calling EMS, despite physician orders for treatment for low oxygen saturation levels.

The CMP range for immediate-jeopardy level noncompliance is from $3,050 to $10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). Here CMS imposed a penalty of $4,050 per day,

which is at the lower end of the range. Given that the noncompliance was serious, the $4,050 per day CMP is reasonable.

V. Conclusion

For the reasons discussed above, I find that Petitioner's facility was not in substantial compliance with Medicare participation requirements and that its noncompliance posed immediate jeopardy to resident health and safety. In accordance with the dictate of the Board, I now find that a $4,050 per day CMP, from January 3 through March 27, 2007, is reasonable.

/s/
Richard J. Smith
Administrative Law Judge