Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Life Care Center of Columbia,
(CCN: 42-5337),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-367

Decision No. CR4132

Date: August 18, 2015

DECISION

Life Care Center of Columbia (Petitioner or the facility) challenges the determination of the Centers for Medicare & Medicaid Services (CMS) that it was not in substantial compliance with Medicare program participation requirements. Petitioner also challenges the imposition of a civil money penalty (CMP) of $10,000 per day from October 26, 2012, through November 5, 2012, based on multiple immediate jeopardy level deficiencies, and a $750 per day CMP from November 6, 2012, through November 8, 2012, for deficiencies below the immediate jeopardy level. For the reasons discussed below, I affirm CMS's determination.

I. Background

The Social Security Act (Act) sets forth requirements for a long-term care facility's participation in the Medicare program and authorizes the Secretary of Health and Human Services (the Secretary) to promulgate regulations implementing those statutory provisions. Act § 1819 (42 U.S.C. § 1395i-3). The Secretary's regulations are found at 42 C.F.R. Parts 483 and 488. To participate in the Medicare program, a facility must

maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may "pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state agencies to conduct periodic surveys to determine whether skilled nursing facilities (SNFs) are in substantial compliance. Act § 1864(a) (42 U.S.C. § 1395aa(a)); 42 C.F.R. § 488.10. The Act also authorizes the Secretary to impose enforcement remedies against SNFs that do not comply with the federal participation requirements. Act § 1819(h)(2) (42 U.S.C. § 1395i-3(h)(2)). The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406. Among other enforcement remedies, CMS may impose a per-day CMP for the number of days a facility is not in substantial compliance or a per-instance CMP for each instance of the facility's noncompliance. 42 C.F.R. § 488.430(a). A per day CMP, which CMS imposed in this case, may range from either $50 to $3,000 per day for less serious noncompliance, or $3,050 to $10,000 per day for more serious noncompliance that poses immediate jeopardy to the health and safety of residents. 42 C.F.R. § 488.438(a)(2). "Immediate jeopardy" exists when "the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301.

If CMS imposes a CMP based on a noncompliance determination, then the facility may request a hearing before an Administrative Law Judge to challenge the noncompliance finding and enforcement remedy. Act §§ 1128(c)(2) (42 U.S.C. § 1320a-7a(c)(2)), 1819(h)(2)(B)(ii) (42 U.S.C. § 1395i(h)(2)(B)(ii)); 42 C.F.R. §§ 488.408(g), 488.434(a)(2)(viii), 498.3(b)(13).

Petitioner is a SNF located in Columbia, South Carolina, that participates in the Medicare and Medicaid programs. On October 25, 2012, an individual who, for privacy purposes will be called Resident 1 (R1), was transferred from a hospital to the facility in order to receive therapy following hip replacement surgery. R1, an individual with a variety of health problems, experienced a significant respiratory incident while at the hospital. Accordingly, R1's hospital discharge instructions included an order for the SNF to contact R1's physician or 911 in the event that R1 experienced shortness of breath. October 25 and most of October 26 passed uneventfully with R1 not experiencing pain or having signs or symptoms indicative of a medical problem. At some point between 8 p.m. and 9 p.m. on October 26, R1 repeatedly complained of significant pain in her back to certified nurse assistants (CNA); however, because the only licensed practice nurse (LPN) on duty in R1's hall had to assist another resident to be transported to the hospital, the LPN did not respond to R1's complaints until approximately 10:30 p.m. When the LPN left R1 shortly thereafter, R1 appeared well. However, by approximately 10:45 p.m. to 10:50 p.m., R1 complained to a CNA of shortness of breath. The CNA took R1's vital signs, which included a minimally normal oxygenation rate of 90% (89%

is considered low). The CNA informed the LPN of this information and the LPN stated that she did not have any medication available or authorized to administer to R1. The CNA returned to R1 and R1 indicated that she had previously had congestive heart failure and would call 911 if she did not receive assistance. The CNA did not inform the LPN of R1's intention to call 911 if necessary, but told the LPN that R1 had congestive heart failure and that R1 was gasping for breath. The LPN told the CNA that she did not have any medication for shortness of breath. The LPN then assisted another resident who appeared to wander from his room. During the next 30 to 40 minutes, no facility personnel checked on R1 as her condition worsened. Ultimately, another resident in the facility called 911 to obtain assistance for R1. Emergency Medical Service (EMS) personnel arrived and found R1 unconscious and barely breathing. EMS personnel took charge of R1's care, which included emergency efforts to stabilize R1. EMS transported R1 to a hospital where she died on October 27, 2012.

The South Carolina Department of Health and Environmental Control, Division of Certification (survey agency), completed a complaint survey at Petitioner's facility on November 6, 2012. Based on the findings of the November 6, 2012 survey, CMS found Petitioner was not in substantial compliance with five program deficiencies each cited at a scope and severity level of "J," constituting immediate jeopardy to resident health and safety:[1]

1. 42 C.F.R. § 483.10(b)(11)(i), F157 (physician notification of significant changes to resident);

2. 42 C.F.R. § 483.13(c), F224 (neglect);

3. 42 C.F.R. § 483.20(k)(3)(i), F281 (professional standards);

4. 42 C.F.R. § 483.25, F309 (quality of care); and

5. 42 C.F.R. § 483.75, F490 (administration).

CMS Exs. 1, 2. CMS determined that immediate jeopardy was removed on November 6, 2012, but that Petitioner remained out of substantial compliance. By letters dated November 29, 2012, and April 2, 2013, CMS notified Petitioner that it was imposing the enforcement remedies of a $10,000 per day CMP from October 26, 2012, through

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[1] Scope and severity levels are used by CMS and state survey agencies when selecting remedies. The scope and severity level is designated by letters A through L, selected by CMS or the state agency from the scope and severity matrix published in the State Operations Manual, chap. 7, § 7400.5 (Sep. 10, 2010). Scope and severity levels J, K, or L indicate deficiencies that constitute immediate jeopardy to resident health or safety.

November 5, 2012, $750 per day CMP from November 6, 2012, through November 8, 2012, and a withdrawal of approval of Petitioner's nurse aid training and competency evaluations program for a period of two years. The total CMP imposed was $112,250. CMS Ex. 2; P. Ex. 1.

In a January 25, 2013 letter, Petitioner requested a hearing to dispute CMS's finding that it was not in substantial compliance with program requirements and the imposition of remedies. In response, I issued an Acknowledgment and Initial Prehearing Order.

In compliance with my prehearing order, the parties filed written direct testimony for their proposed witnesses. CMS also filed 15 proposed exhibits, marked as CMS Exs. 1-15, and Petitioner filed 19 proposed exhibits, marked as P. Exs. 1-19. On February 11, 2014, I convened a video hearing; however, due to inclement weather in Columbia, South Carolina, I had to reconvene the hearing on March 10 and 11, 2014. A transcript (Tr.) of the proceedings was prepared. At the hearing, I admitted CMS Exs. 1-15 and P. Exs. 1-19 into the record as well as a corrected version of CMS Ex. 6, all without objection from the parties. Tr. 10, 131. I received testimony from: Robin Lessard, Registered Nurse (RN), surveyor for the survey agency (CMS Ex. 14); Frederick Rose, LPN, (P. Ex. 16); Randall Pruette, Petitioner's Director of Nursing (DON) (P. Ex. 13); William Crigler, M.D., R1's physician while at the facility (P. Ex. 18); Shanderlyne Worthy, CNA, (P. Ex. 17); Kimberly Theuerl, RN, (P. Ex. 15); and Robert Eads, M.D., expert witness for Petitioner (P. Ex. 19). At the end of the hearing, I permitted CMS to submit additional exhibits, subject to objection by Petitioner.

CMS filed a post-hearing brief (CMS Br.) and additional proposed exhibits (CMS Exs. 16-21). Petitioner filed a brief in response (P. Br.) and objected to CMS's newly proposed exhibits. CMS declined the opportunity to file a reply brief.

II. Evidentiary Rulings

I admit CMS Exs. 16, 20, and 21 into the record, but exclude CMS Exs. 17-19. I have authority to admit additional exhibits after completion of the hearing, but before issuing a decision. 42 C.F.R. § 498.60(b). The following is my analysis regarding CMS's proposed exhibits.

A. Proposed CMS Ex. 16

CMS submitted CMS Ex. 16, a letter from David E. Koon, Jr., M.D. to CMS counsel, to clarify the handwriting on a patient transfer form submitted as part of P. Ex. 3. Dr. Koon was the physician who discharged R1 from the hospital following her hip replacement surgery. In the section entitled Worsening Symptoms (symptoms, action plan, MD notification), there is a handwritten notation that an unidentified phone number or 911 should be called if R1 has a fever greater than 101.5, chest pain, shortness of breath,

worsening bloody/drainage or any purulence. P. Ex. 3 at 14. Dr. Koon's letterhead shows a phone number for his clinic, which is part of the University of South Carolina's School of Medicine, Department of Orthopedic Surgery, which is the same as the unidentified phone number on the transfer patient form. CMS did not object to P. Ex. 3, and I admitted it into the record at the hearing. Tr. 9-10.

Petitioner objects to CMS Ex. 16 because CMS does not clearly state why this exhibit is submitted and why it could not have been "produced in the ordinary course." April 11, 2014 P. Reply to CMS's Mot. to Offer Additional Exhibits at 3. CMS's purpose in submitting this document is to clarify handwriting. April 3, 2014 CMS List of Rebuttal Exhibits at 1. Further, as P. Ex. 3 is not CMS's exhibit and Petitioner submitted the exhibit after CMS filed its exhibits in this case, CMS would necessarily have to submit this exhibit after the date for the submission of its exhibits passed. Because this document simply clarifies a statement in an exhibit over which there is no apparent dispute, I will admit it into the record for the purpose of ensuring clarity of the handwritten notes at issue on page 14 of P. Ex. 3.

B. Proposed CMS Ex. 17

CMS submitted CMS Ex. 17, a National Institutes of Health article, because it indicates that "one of the causes of wheezing is heart failure," which allegedly contradicts "Petitioner's witness Dr. Eads [who] testified on cross-examination that wheezing could not be caused by heart failure." April 3, 2014 CMS List of Rebuttal Exhibits at 1. CMS did not specifically cite to the transcript showing this portion of Dr. Eads' testimony. Petitioner objected to this exhibit for a variety of reasons, including that it is not timely and that CMS did not show this article to Dr. Eads. April 11, 2014 P. Reply to CMS's Mot. to Offer Additional Exhibits at 4.

I exclude this exhibit. Dr. Eads testified that wheezing cannot cause a heart attack because it is a symptom. Tr. 458, 472-73. Dr. Eads disputed the emergency room doctor's assessment that R1 "had notable wheezing, which is very likely the cause of her arrest . . ." and indicated he did not understand that statement. Tr. 489-90; CMS Ex. 4 at 25. Therefore, the document does not rebut Dr. Ead's testimony, which is the reason CMS submitted it.

C. Proposed CMS Exs. 18 and 19.

CMS submitted CMS Exs. 18 and 19 (Statement of Deficiencies) as evidence showing that Petitioner's expert witness, Dr. Eads, was the medical director of a different SNF when that SNF was cited for immediate jeopardy level deficiencies, deficiencies that specifically implicated the medical director of the facility. CMS contends that these

Statements of Deficiencies are evidence that Dr. Eads was ineffective in ensuring that the SNF cared for and monitored residents with respiratory problems and pain, issues related to the present case. April 3, 2014 CMS List of Rebuttal Exhibits at 2.

Petitioner objects to the admission of these exhibits because neither exhibit expressly identifies Dr. Eads, or specific acts or omissions on his part. Petitioner also believes that these documents are ambiguous and do not show whether any deficiencies were disputed. April 11, 2014 P. Reply to CMS's Mot. to Offer Additional Exhibits at 5-6.

I exclude these exhibits. Petitioner gave notice that Dr. Eads would be a witness before the hearing and provided written direct testimony and curriculum vitae. P. Ex. 19. CMS did not object to Dr. Eads as an expert witness or seek to voir dire his credentials at the hearing. CMS knew very specific information about the dates and deficiencies of the SNF where Dr. Eads used to serve as medical director (or, according to Dr. Eads, one of the medical directors) because CMS asked him about it at the hearing; however, Dr. Eads had no recollection of the deficiencies. Tr. 453-454. CMS had ample opportunity to have had CMS Exs. 18 and 19 available for the hearing so that CMS could question Dr. Eads further concerning those documents. CMS did not do so. CMS submits these documents, which are ambiguous as to Dr. Eads' exact role in the deficiencies at the other SNF, too late in this proceeding.

D. Proposed CMS Ex. 20

CMS submitted CMS Ex. 20 in order to provide clarity to the issue in this case concerning how many times R1 called 911. CMS obtained documents related to the 911 call and the EMS response. CMS stipulates that, contrary to what the information originally submitted by both parties indicated, there was only one call to 911 and this was made by R1's roommate at 11:22 p.m. on October 26, 2012. April 4, 2014 CMS Memorandum on the Emergency Services Dep't/911 Records at 1-3. Petitioner concedes this evidence is relevant to this case and asserts that it always has been Petitioner's litigating position that R1 could not have made three 911 calls; however, Petitioner suggests that I require further authentication of the documents and order that CMS stipulate that the surveyor in this case incorrectly assumed there were three calls to 911. April 11, 2014 P. Reply to CMS's Mot. to Offer Additional Exhibits at 6-11.

I admit CMS Ex. 20 into the record because it is necessary to clarify the number of calls to 911. As Petitioner concedes, it is relevant to this case. Further, CMS's concession in its memorandum that only one call to 911 was made is sufficient and no other stipulation is needed. Finally, to the extent Petitioner has attempted to imply the surveyor failed to investigate this issue, it is worth noting that the record includes information sent to the South Carolina Office of the Attorney General related to this matter, which included the following statement: "Columbia Police Department has verified that the resident called 911 at 11:22 pm, 11:36 pm and 11:39 pm." CMS Ex. 3 at 2; *see also* Tr. 431. Further,

DON Pruette, who conducted Petitioner's investigation into R1's care following her death, testified that it appeared R1 called 911 three times late on October 26, 2012. P Ex. 13 at 9-10. Therefore, the admission of CMS Ex. 20 will bring clarity to the issue as to how many 911 calls were made.

E. Proposed CMS Ex. 21

CMS submitted CMS Ex. 21 in order to show that R1's roommate had a similar name, RH, to the individual identified as the 911 caller identified in CMS Ex. 20. Petitioner points out that this exhibit does not show the individual indicated was the roommate of R1 on the dates relevant to this case. However, this document, along with CMS Ex. 20, shows that RH, a resident at the facility, is likely the 911 caller. Because Petitioner does not assert that its personnel called 911, this exhibit is useful to clarify that a resident called 911. Therefore, I admit CMS Ex. 21 it into the record.

III. Issues

The issues presented are:

1. Whether Petitioner failed to be in substantial compliance with the Medicare participation requirements.

2. If so, whether CMS's determination of noncompliance at the immediate jeopardy level is clearly erroneous; and

3. Whether the CMP amount that CMS imposed is reasonable.

IV. Findings of Fact

The November 2012 complaint survey stems from the events that occurred on October 26, 2012, pertaining to R1.

Prior to October 26, 2012, R1 had diagnoses including diabetes, obesity, chronic obstructive pulmonary disease (COPD), anemia, osteoarthritis, diastolic congestive heart failure, chronic kidney disease, coronary artery disease, and hypertension. She had a previous coronary artery bypass and received stenting to her vein. P. Ex. 3 at 4, 6. On October 18, 2012, R1 had surgery, a left total hip arthroplasty, which was uneventful. P. Ex. 3 at 1. Prior to her surgery she had been cleared for surgery by her cardiologist. P. Ex. 3 at 6. Following the surgery, hospital records note two "Rapid Response" actions on October 19 and 20, 2012 that may have been due to over sedation from Oxycontin. P. Ex. 3 at 8, 10.

On October 25, R1 was transferred to Petitioner's facility for rehabilitation. In the October 25, 2012 Transfer Summary from the hospital, R1's attending physician, Dr. Koon, states that R1 had developed "some acute respiratory failure" during her hospital stay, was weaned from her intravenous pain medications without difficulty, and could take pain medications as dictated by her primary care physician at the healthcare facility. P. Ex. 3 at 1. The last pulse oxygen reading taken in the hospital was 98%. CMS Ex. 3 at 8, 10. The October 25, 2012 Discharge Instructions from the hospital state under the heading "WORSENING SYMPTOMS" to call a telephone number for Dr. Koon or 911 for chest pain or shortness of breath, among other things. P. Ex. 3 at 14; CMS Ex. 16. Petitioner's October 25, 2012 intake form indicates that R1 had regular and clear lung sounds with blood pressure at 140/60, pulse at 86, and respiration at 18. CMS Ex. 4 at 1; P. Ex. 4 at 1. Petitioner's October 25, 2012 pain assessment shows that R1 was currently in pain, at risk for pain, and experienced pain in the past. R1's past pain was due to arthritis in her hip and her current pain was assessed as 0, although this is slightly contradicted by the assessment's currently in pain indication and a score of "1" indicating a mild score for facial expression showing pain. P Ex. 5 at 1. It is undisputed that upon admission to Petitioner's facility, R1's pain was, at most, mild.

R1 was being cared for primarily by CNA Worthy and Nurse Kind during the evening of October 26, 2012. It is undisputed that Nurse Kind, an LPN, was in charge of hall 300 where R1 resided during the evening shift. CMS Ex. 10. It is also undisputed that October 26, 2012, was Nurse Kind's first day working on hall 300. P. Ex. 13 at 5. It is undisputed that a CNA is not qualified or authorized to assess pain or do a lung or respiratory assessment. The record shows that Nurse Kind saw R1 before she complained of shortness of breath and no nurse, including Nurse Kind, saw R1 after the complaint of shortness of breath until after EMS arrived to provide emergency assistance.

The following factual findings, especially those related to the facility's care of and response to R1's complaints of pain and shortness of breath on the evening of October 26, 2012, are primarily taken from the written statements CNA Worthy and Nurse Kind made during the facility's prompt investigation following R1's death. *See* CMS Ex. 9 at 1-2, 9-10. These individuals provided this information nearly contemporaneously with the event and were the primary facility actors related to the event. Nurse Kind was not called by either party as a witness. CNA Worthy testified in this proceeding; however, her testimony tends to minimize and possibly contradicts the statements she made in her written statement during the facility's investigation. *See* Tr. at 223-260; P. Ex. 17. I do not find CNA Worthy's later testimony to be as credible as her written statements made very close in time to R1's death. Further, CNA Worthy is still employed by Petitioner and thus has an interest in her employer avoiding a negative outcome in this case. P. Ex. 17 at 1. She was more likely to have been accurate in a statement made during the facility's internal investigation than during an adversarial sanction proceeding against her employer. *See Beverly Healthcare Lumberton v. Leavitt*, 338 Fed. App'x 307, 312-313 (4th Cir. 2009).

When EMS arrived at the facility, other facility employees became involved at that point and their statements and testimony form the primary evidence for those subsequent events.

Except as otherwise noted, the findings of fact below refer to events on October 26, 2012.

1. A progress note by Azella Walker, LPN, indicates that at 12:01 a.m., Tylenol was administered to R1 and there were no signs or symptoms of respiratory distress. R1's pulse was 86, respiration rate was 18 and blood pressure was 140/60. CMS Ex. 4 at 14; P. Ex. 6 at 5.

2. A progress note by Nurse Theuerl indicated that at 4:06 a.m., R1 did not state she had pain or discomfort. R1's pulse was 77, respiration rate was 20 and blood pressure was 133/46. CMS Ex. 4 at 14; P. Ex. 6 at 7.

3. A nursing note by Aveal S. Cornelius, RN indicated that at 9:07 a.m., R1 was sitting up in bed; the note does not mention pain or discomfort. CMS Ex. 4 at 14.

4. A progress note by Darlene Reddick, RN stated that at 3:05 p.m., R1 attended therapy, that there were no signs or symptoms of cardio/respiratory distress, and that R1 "[d]enies pain/discomfort." R1's pulse was 79, respiration rate was 20, and blood pressure was 133/55. CMS Ex. 4 at 14; P. Ex. 6 at 6. Nurse Reddick considered R1 to be well during the day. P. Ex. 14 at 2.

5. From approximately 6:25 p.m. until 7:15 p.m., R1's daughter visited R1. R1's daughter indicated that R1 spoke to R1's grandson on the telephone, was sitting up, and "was well responsive." CMS Ex. 3 at 8.

6. At approximately 7:45 p.m., R1 asked Nurse Kind about her medications and Nurse Kind told R1 that R1's medications had not arrived yet and that a check of the facility's Pixus machine for R1's medications was unsuccessful. Nurse Kind did not notice R1 having any signs or symptoms of respiratory distress. CMS Ex. 9 at 9.

7. At some time after 7:45 p.m., following Nurse Kind's check of the next resident on the hall, a CNA told Nurse Kind that R1was complaining of pain. CMS Ex. 9 at 9.

8. At the same time that a CNA informed Nurse Kind of R1's complaint of pain, the situation for a male resident in room 320 worsened when he showed signs of a coming stroke. Dr. Crigler, a physician working for the facility, was contacted and he ordered Nurse Kind to place the resident in room 320 on oxygen, to call 911, and to send him to the hospital. In dealing with oxygen for the resident in

room 320, Nurse Kind had significant confusion about where to get oxygen and expended time walking to various places in the facility. Ultimately, EMS arrived before Nurse Kind could provide oxygen to the resident in room 320. The resident in room 320 departed the facility for the hospital prior to Nurse Kind checking R1's Medication Administration Record for any pain medications, which occurred at around 10:30 p.m. CMS Ex. 9 at 9.

9. Nurse Kind stated: "During this whole process [of assisting the resident in room 320], my CNAs kept telling me that [R1] was [complaining of] pain. I repeatedly told them to let her know that I was in the middle of sending a patient to ER and that I would be with her as soon as I could get to her." CMS Ex. 9 at 9.

10. In CNA Worthy's written statement made during the facility's investigation of the events related to R1, she reported that R1 complained of pain and CNA Worthy and another CNA, Lador Jenkins, reported the pain complaints to Nurse Kind four or five times on October 26, 2012. According to CNA Worthy's statement, Nurse Kind said that R1 did not have any medication for pain. CNA Worthy stated that R1 was "hollering and she was getting upset". CMS Ex. 9 at 1.

11. According to Nurse Kind, at about 10:30 p.m., after sending the resident in room 320 to the hospital, she looked up to see if R1 had any medications for pain. Nurse Kind prepared Tylenol and aspirin, and found R1 sitting on the side of the bed with her legs dangling over the side. R1 indicated to Nurse Kind that the CNAs did not tell R1 anything about the emergency in room 320 and that if R1 had known Nurse Kind was dealing with an emergency, she would have been more patient about obtaining pain medications. Nurse Kind reported that R1 was alert and oriented without signs and symptoms of respiratory distress or shortness of breath. CMS Ex. 9 at 10.

12. Nurse Kind began her 9 p.m. medication pass, which was one and one-half hours late, after she saw R1 at 10:30 p.m. CMS Ex. 9 at 10.

13. Between 10:30 p.m. and 10:50 p.m., according to the state surveyor's interview of CNA Worthy, CNA Worthy checked on R1 and R1 stated that Nurse Kind gave R1 pain medication at approximately 10:30 p.m., but R1 started to complain of shortness of breath. R1 grabbed her personal inhaler when CNA Worthy lowered her to lay in bed (nowhere in the record does it indicate that R1 actually used her inhaler). R1 asked CNA Worthy to inform the nurse of her shortness of breath. CMS Ex. 6 at 3.

14. Nurse Kind stated that, at 10:50 p.m., a CNA informed her that R1 was experiencing shortness of breath. Nurse Kind asked the CNA to get R1's vital signs. Nurse Kind stated that the CNA reported that R1's vital signs were: blood pressure 154/75, pulse 100, pulse oxygenation rate 90%, respirations 20, and temperature 97.2. CMS Ex. 9 at 10; P. Ex. 6 at 1, 8: Nurse Kind looked up in the Medication Administration Record to see if there was any type of aerosol or nebulizer, but she did not notice an order for either. CMS Ex 9 at 10.

15. CNA Worthy's written statement is consistent with Nurse Kind's email statement: "Then [R1] was short of breath and I had got her [vital signs] and [oxygen] stat and I reported it to the nurse. [Nurse Kind] did not move from the [medication] cart." CMS Ex. 9 at 1. When CNA Worthy went back to R1, R1 said "she was going to call 911 and [that Nurse Kind] did not care about her . . . ." CNA Worthy further stated: "I went back down to the nurse and inform[ed] her that [R1] has congestive heart failure and she was gasping for breath . . . ." and [Nurse Kind looked at R1's Medication Administration Record and said that she didn't have anything for shortness of breath." CMS Ex. 9 at 1. CNA Worthy testified that she did not inform Nurse Kind that R1 stated she would call 911. Tr. 241-43. CNA Worthy also testified that she thought R1 was in distress related to the shortness of breath. Tr. 243.

16. At this point, Nurse Kind states: "I then went to her chart to check for any type of treatments. Before I could get to her chart, another patient came out of his room, 303, and appeared confused and unstable. I immediately went to him, to help him back to his room." CMS Ex. 9 at 10.

17. At 11:22 p.m., EMS received a 911 call regarding R1. CMS Ex. 20 at 1, 4.

18. RM, a resident at the facility made the call to 911. CMS Ex. 20 at 4, 8; *see also* CMS Ex. 21.

19. Between 11:23 p.m. and 11:27 p.m., an EMS unit was dispatched and on its way to the facility. CMS Ex. 20 at 1, 4.

20. At about 11:30 p.m. the 911 operator called the facility to inquire after the 911 call concerning R1. Frederick Rose, an LPN on another floor answered the call and transferred it to the 300 hall where R1 was located. No one on the 300 hall answered the call. A minute or two later, Nurse Rose answered a second call from the 911 operator, who informed LPN Rose that R1 was having trouble breathing and no one was helping her. The 911 operator also stated an ambulance was dispatched. P. Ex. 16; *see also* CMS Ex. 20 at 5 (EMS log indicating that at 11:27 p.m., "CALLED LIFE CARE NO ANSWER.").

21. Nurse Rose transferred the 911 operator's call again to hall 300, and Kimberly Theuerl, RN, the nurse who had just entered hall 300 to relieve Nurse Kind, answered the call and said she would check into the matter. P. Ex. 16.

22. Nurse Theuerl, who started her shift at 11:30 p.m., indicated that she received the call from 911 relayed by Nurse Rose concerning a resident in Room 318. Nurse Theuerl asked Nurse Kind about the resident in Room 318 and Nurse Kind responded: "that was already taken care of." CMS Ex. 9 at 5. Nurse Theuerl testified that Nurse Kind's response to the call from 911 was stated in a way that indicated that she was unconcerned and did not even know there was anything actively occurring. Tr. 274-276.

23. Nurse Kind's statement is consistent with Nurse Theuerl. Nurse Kind indicates that she assisted the patient in room 303 from the time that R1 started to complain of shortness of breath until the second call from the 911 operator: "While I was with the patient in room 303, the third shift nurse came on the floor, and answered the phone. It was 911 wanting to know if a call had been made to 911 stating we had a patient in respiratory distress. I told the nurse that we had just sent a patient out about an hour before." CMS Ex. 9 at 10.

24. The EMS unit arrived at the facility at 11:34 p.m. CMS Ex. 20 at 1, 4; *see also* CMS Ex. 9 at 8.

25. The EMS unit sent to assist R1 called the facility requesting that someone open a door for them. CMS Ex. 9 at 3.

26. CNA Tanisha Anderson had just started her rounds at approximately 11:30 p.m., when she answered a call light for room 318 and found R1 unresponsive. She stated that "I alerted the nurse [Nurse Theuerl] and opened the door for EMS." Nurse Theuerl went to Room 318 and EMS personnel, who were already present, told Nurse Theuerl to get assistance. Nurse Theuerl noticed that R1 was in respiratory distress. Nurse Theuerl "called a CODE [blue]." CMS Ex. 9 at 4-6; Tr. 277.

27. The EMS report (CMS Ex. 20 at 1) states:

> Found 69 [year old] female sitting on side of bed, head slumped over, unconscious, pulseless, w/agonal respirations with cellular phone and inhaler next to her. Facility staff were unaware that patient had called EMS and unaware of patient's state. Patient . . . bagged . . . and chest compressions initiated (and continued throughout until ER

> arrival). . . . [Patient] now apneic. Backup called. Staff finally alerted. Poor chest rise and decreased breath sounds noted . . . . Upper airway appears clear, however poor visibility and thick substance in throat obscuring glidoscope. Unable to suction on scene. Bagging continued. [Patient] has very poor vasculature . . . edema to upper and lower extremities . . . . [Patient] 350+ LBS; unable to move [Patient] until additional assistance arrived. Thumper applied. 318 arrived as backup. . . . [Patient] intubated . . . tube placement reconfirmed after each [Patient] movement, and confirmed by physician upon ER arrival. . . . [Patient] remained asystole until ER arrival.

28. Nurse Kind's only Progress note for R1 concerning October 26 (P. Ex. 6 at 1), authored on October 27, 2012 at 1:36 a.m., states in relevant part:

> At approximately 10:50pm, patient had [complaint of] difficulty breathing. [Vital signs] checked. BP [blood pressure] 154/76; Pulse 100; Pulse [oxygenation] 90%; Resp[iration] 20; Temp[erature] 97.2. At approximately 11:30 p.m., patient called 911 with [complaint] of distress. 911 arrived at approximately 11:37 p.m. Within minutes, resident was unresponsive, and CPR was immediately initiated. [Doctor], family, and DON were immediately notified of resident's status, and orders were given to transport to [hospital]. Report given to ER nurse.

29. The first time Dr. Crigler was called concerning R1's condition was when R1 was being transported to the hospital. Tr. 191.

30. No one from the facility's staff assessed R1 for her shortness of breath on October 26. Tr. 350.

31. Although the ER reports indicate possible causes of death (possible embolus with myocardial infarction), the ER physician stated that this was a case for the coroner. CMS Ex 4 at 33.

32. R1's death certificate states that the cause of death was: Ischemic Cardiomyopathy and Cardiovascular Disease. The death certificate indicates an autopsy was performed and that the Deputy Coroner was the certifier of this information. CMS Ex. 10 at 1; *see also* Tr. 492-493.

33. Ischemic Cardiomyopathy means that a heart can no longer pump enough blood to the rest of the body due to coronary artery disease. “Ischemic Cardiomyopathy is a common cause of heart failure.” “Patients with this condition often have symptoms of angina or a heart attack.” Symptoms include: shortness of breath that occurs after lying down. P. Ex. 11 at 1. Symptoms of heart attack include shortness of breath. CMS Ex. 11 at 2. There are many treatments for ischemic cardiomyopathy, including cardiac catheterization or angioplasty to improve blood flow to the damaged or weakened heart. P. Ex. 11 at 2.

V. Conclusions of Law and Analysis

1. Petitioner was not in substantial compliance with 42 C.F.R. § 483.10(b)(11)(i) because Petitioner failed to immediately consult with Resident 1’s physician when Resident 1 experienced a significant change in her ability to breath.

The regulation entitled “Resident rights” requires:

> (11) 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 respresentative (sic) or an interested family member when there is --
>
> (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
>
> (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**);
>
> (C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
>
> (D) A decision to transfer or discharge the resident from the facility as specified in Sec. 483.12(a).

42 C.F.R. § 483.10(b)(11)(i) (emphasis added).

It is clear from the regulatory language that the requirement to consult with a resident’s physician is not discretionary and requires more than merely informing or notifying the physician. The preamble to the final rule reflects the Secretary’s intention that the facility should “inform” the resident of the changes that have occurred but must “consult with the physician about actions that are needed.” 56 Fed. Reg. 48,826, 48,833 (Sept. 26, 1991). Consultation implies the requirement for a dialogue with and a responsive

directive from the resident's physician as to what actions are needed. The use of the term "immediately" in the regulation indicates that consultation is expected to be done as soon as the change is detected, without any intervening interval of time. The preamble to the final rule indicates that originally the proposed rule granted the facility up to 24 hours in which to consult with the resident's physician and to notify the legal representative or family. However, after the receipt of comments stating that time is of the essence in such circumstances, the final rule amended that provision to require that the physician be consulted and the legal representative or family be notified immediately. 56 Fed. Reg. at 48,833. The point of using the word "immediately" recognized that in such situations a delay could result in a situation where a resident is beyond recovery or dies. Consultation with a physician must occur immediately, that is, without delay, after a significant change is detected or observed. *See Magnolia Estates Skilled Care*, DAB No. 2228 at 9 (2009).

CMS argues that prior to the evening of October 26, 2012, R1 was not experiencing pain, at least not significant pain, had no shortness of breath and did not have a need to call 911 to receive care and services. RN Reddick, the nurse on the 7:30 a.m. to 4:00 p.m. shift, stated that R1 was in a good mood and there was no sign of distress. CMS Ex. 4 at 14; P. Ex. 6 at 6. CMS argues that at about 7:30 to 8:00 p.m. on October 26, 2012, R1 started to complain about pain. CNA Worthy and CNA Jenkins informed Nurse Kind that R1 was having significant, even severe pain, four or five times, but Nurse Kind did not go to see R1 until 10:30 p.m. CMS Ex. 9 at 1. In her written statement, CNA Worthy stated that R1 was "hollering" and "getting upset" and "needed medication real bad." CMS Ex. 6 at 2; CMS Ex. 9 at 1.[2] Nurse Kind gave R1 Tylenol and aspirin at approximately 10:30 p.m., which was about two hours after R1 first started complaining of pain; however, there is no evidence that Nurse Kind performed an assessment of R1. *See* CMS Ex. 9 at 9-10; P. Ex. 6 at 1. CMS argues that R1's pain was "something new," that R1's pain required an assessment, and was a significant change that required physician notification and consultation. The nursing staff did not consult with Dr. Crigler, the physician assigned to be R1's physician while she was at the facility, until after R1's roommate called 911 and EMS arrived. Tr. 191.

At about 10:30 p.m. Nurse Kind indicated that R1 was alert and oriented without any signs and symptoms of respiratory distress or shortness of breath. CMS Ex. 9 at 10. Up to this point, R1 had not experienced any respiratory distress or shortness of breath during her stay at the facility. However, between 10:30 and 10:50 p.m., CNA Worthy

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[2] As indicated earlier, CNA Worthy's testimony in this proceeding minimizes her observations of R1 on the evening of October 26, 2012. However, I place more weight on CNA Worthy's written statement made on October 27, 2012 that was made contemporaneously with this incident and used descriptors such as "hollering," "getting upset," "gasping for breath" and concluded by stating, "I was really upset cause [sic] the resident was in so much pain and I did my best to comfort her." CMS Ex. 9 at 1-2.

reports that R1 started to complain of shortness of breath. R1's complaints of shortness of breath occurred after the male resident in room 320 suffering a possible stroke was sent to the hospital. R1 had her inhaler with her but there is no indication that R1 used her inhaler at that time. CMS Ex. 6 at 3. Nurse Kind was informed of R1's shortness of breath but did not go to assess R1. CNA Worthy provided Nurse Kind with R1's vital signs but Nurse Kind did not move from the medication cart to assess R1. CNA Worthy informed Nurse Kind that R1 had congestive heart failure and that she was gasping for breath. CMS Ex. 9 at 10; CMS Ex. 9 at 1. R1's pulse oxygen rate had dropped to 90%.[3] Still, Nurse Kind did not go in to see R1. At 11:22 p.m. 911 was called and EMS arrived at 11:34p.m. Dr. Crigler, R1's physician, testified that he received no contact from anyone at the nursing home about R1 until R1 was transported to hospital. Tr. 191. Dr. Crigler also testified that only a licensed nurse, not a CNA, is qualified to do an assessment. Tr. 194.

Petitioner argues that R1's pain was not significant. Petitioner asserts that some pain was normal due to R1's recent hip surgery and the fact that R1 had just started physical therapy. In addition, R1 was sitting in a wheelchair and moving around more since she entered the facility. The surveyor, Nurse Lessard, testified that it is reasonable to anticipate that R1's pain from her surgery would decrease over time and that an assessment should be done to determine the cause of R1's increasing pain. Tr. 144. Both R1's severe pain and her shortness of breath were new symptoms and Nurse Kind did not react to these changes. Whether R1's pain was significant or whether R1's pain may or may not have been related to the respiratory problem later, the failure to administer the pain medication timely shows the general lack of responsiveness of the facility that preceded R1 becoming unconscious. I do not address whether R1's pain is a significant change because I find, without doubt, that R1's shortness of breath was a new and significant change under 42 C.F.R. § 483.10(b)(11)(i) requiring consultation with a physician.

Petitioner argues that a pulse oxygen level of 90% is considered within normal limits. P. Br. at 23. Petitioner claims that shortness of breath with normal vital signs is consistent for R1 who had COPD, and was agitated, citing Dr. Eads' testimony.[4] Tr. 469-

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[3] A pulse oxygen rate of below 90% is considered low and Nurse Theurerl testified that a drop in the pulse oxygen rate is something that required attention from a nurse. Tr. 289-90; CMS Ex. 13 at 1. There is no other documentation of a pulse oximeter reading being taken at the nursing home. Prior to being admitted in the nursing home on October 25, 2012, R1's lowest oxygen saturation rate in the hospital was 98%. P. Ex. 3 at 8, 10.

[4] I place little weight on Dr. Eads' testimony. Dr. Eads was offered as an expert witness by Petitioner. At the hearing, Dr. Eads did not clearly recall the record he was provided concerning R1. Tr. 449-453, 458, 459, 479. I found Dr. Eads' testimony generally evasive and as such his testimony was not credible. Tr. 442-516.

472. In addition, R1 had her inhaler at her bedside which she was holding. CMS Ex. 6 at 3; CMS Ex. 20 at 1. However, an oxygen rate of 90% is at the edge of being considered low. Petitioner does not account for: R1's drop in oxygen rate from 98% to 90%, which should require attention from staff: the report from a CNA that R1 was gasping for breath; the fact that the inhaler, even if used, was apparently not providing R1 with any improvement; and the fact that no nurse ever went to check on R1 after she started having shortness of breath until EMS was already on the scene with an unconscious R1. Importantly, Petitioner simply overlooks the hospital discharge instructions to call a doctor or 911 if she experienced shortness of breath which was based on the fact that R1 had "some acute respiratory failure" during her hospital stay. P. Ex. 3 at 1.

Petitioner makes several additional arguments. Petitioner argues that CMS has failed to make a prima facie case for any violation. Petitioner argues that Nurse Kind was simply inefficient and waited too long to respond to R1's complaint that her back was sore and this by itself would never have resulted in an immediate jeopardy finding if R1 had not died. Petitioner's characterization of R1 as having a sore back is not significant to this decision. I base my decision not on R1's complaints of pain but primarily on events that occurred when R1 started to complain about shortness of breath. The essential fact that the evidence shows is that Nurse Kind saw R1 before she complained of shortness of breath, but that Nurse Kind never saw R1 after that, even though Nurse Kind was aware of the shortness of breath and R1's minimally satisfactory pulse oxygenation rate of 90%. Indeed, no nurse saw R1 after she started complaining about shortness of breath; instead, EMS found R1 unconscious before a nurse appeared in R1's room. I include the events concerning R1's complaints of pain to demonstrate Petitioner's staff lack of response to R1. Petitioner's argument about failure to make a prima facie case is unavailing because the evidence plainly shows that CMS has established a prima facie case. Further, I conclude that CMS not only has proven that a prima facie case for this violation exists, but also that a preponderance of the evidence of record shows this as well.

Petitioner asserts that Nurse Kind's actions were not regulatory violations because of her "appropriate response to a far more serious emergency the same night." P. Br. at 6. A male resident in room 320 was complaining of possible stroke symptoms and Dr. Crigler ordered that this male resident be sent to the hospital. Petitioner asserts that Nurse Kind spent a considerable time assessing the male resident, conferring with his physician and preparing him to send him out to the hospital and that a possible stroke is more serious than a complaint of a sore back. However, the male resident was sent to the hospital before 10:30 p.m. CMS Ex. 9 at 9. As a result of sending the male resident to the hospital, Nurse Kind fell behind in the evening medication pass. Petitioner claims that nurses must prioritize their duties and actions and here Nurse Kind gave priority to the emergency situation with the male resident in room 320 and to a time limited medication pass. The evening shift was very busy for the nurse on duty. Petitioner argues giving priority to the resident in room 320 was appropriate and that a sore back was normal considering Resident 1 had nearly three hours of both physical and occupational therapy

earlier that day (P. Ex. 8), was recovering from hip surgery, had prolonged bed rest and was spending time sitting up in a wheelchair.

Petitioner asserts that it is not a regulatory violation that Nurse Kind was very busy on October 26th and states that CMS did not cite Petitioner for a violation of the staffing regulation. Petitioner overlooks that the male resident who occupied Nurse Kind's time had been sent to the hospital prior to 10:30 p.m., before R1 started to complain about shortness of breath. Nurse Kind never looked in on R1 in spite of the fact that R1 was gasping for breath and she had been informed of R1's shortness of breath by a CNA. Rather, then check R1, Nurse Kind decided to assist, for a prolonged period, a resident who appeared confused. CMS Ex. 9 at 10. Nurse Kind, in her statement, did not indicate that there was any imminent health threat to the confused resident such that she could not check on R1, who was having trouble breathing. The call to 911 from another resident, along with the fact that EMS arrived on the scene before a facility nurse, shows that the facility failed in its duty.

Petitioner argues that R1's shortness of breath was not a significant change since R1 had COPD. However, R1's hospital discharge instructions explicitly warned to call R1's hospital attending or "911" if she exhibited shortness of breath. R1 had not had any shortness of breath since her admittance to the facility until the evening of October 26, 2015. Further, Nurse Kind made no attempt to ascertain why R1 was having shortness of breath. The inability of R1 to breath properly required consultation with a physician and there is no dispute that R1's physician was not consulted about Resident 1's shortness of breath.

Petitioner, relying on Dr. Eads opinion, argues that at some point after Nurse Kind administered Tylenol and before the time the EMS unit found R1 unresponsive, some kind of significant change occurred that was catastrophic and unrelated to the complaints of back pain and shortness of breath, and that the facility could not have done anything about it. P. Ex. 19 at 4. I give little weight to Dr. Eads' opinion. Had Petitioner's staff reviewed R1's chart, and consulted Dr. Crigler at 10:50 p.m. or contacted 911 promptly, it is possible that R1 could have received necessary treatment. *See* P. Ex. 11 at 2.

R1 was experiencing severe pain and shortness of breath, both of which are symptoms of possible medical emergencies such as pulmonary embolism and heart attack. R1 was at risk from both of these conditions due to her bed rest, recent hip surgery, history of heart disease, obesity, diabetes, high blood pressure and her age. Tr. 179, 180, 213-14, 323, 320. R1 repeatedly asked for assistance from the nursing staff but the nursing staff failed to respond to R1. I also believe it is significant that Nurse Kind indicated to other facility employees that her actions were culpable. LPN La Tasha Nickerson, who responded to the code blue call for R1, heard Nurse Kind state that she "would probably lose her job and license over what happened." CMS Ex. 9 at 3. Further, on October 29, 2012 during

DON Pruette's investigative interview, Nurse Kind stated: "I quit, I'm turning in my nursing license." CMS Ex. 9 at 11.

The record is clear that the nursing staff failed to timely assess R1 and failed to immediately consult with her physician when she had a significant change in her condition.

2. **Petitioner was not is substantial compliance with 42 C.F.R. § 483.13(c) because Petitioner failed to provide services necessary to avoid physical harm to R1.**

Section 1819(c)(1)(A)(ii) of the Act requires that a SNF protect its residents and promote their "right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms." The Act does not specifically address neglect. However, the Secretary requires that a facility must develop and implement written policies and procedures prohibiting mistreatment, **neglect**, and abuse of residents and the misappropriation of residents' property. 42 C.F.R. § 483.13(c).

Neglect is defined in the regulations as "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 488.301. The regulatory definition of "neglect" includes two elements: (1) any "failure to provide goods and services" and (2) the goods and service are "necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 488.301. The definition of neglect does **not** include an element of knowledge or notice, and the definition of neglect may be satisfied whether or not staff was aware that the resident was in need of goods and services to avoid physical harm, mental anguish, or mental illness. The definition of neglect does not consider the intent of Petitioner's staff. Neglect may occur even if the failure to deliver necessary goods and services was unintended. Under a strict application of the definition of neglect, neglect is complete the instant that staff fails to deliver care or services necessary to avoid physical harm, mental anguish, or mental illness. The definition of neglect does not specifically permit a period for a facility to assess and intervene to meet the need for goods and services. However, SNFs are generally not treated as being "strictly liable" for violations of statutory and regulatory requirements for participation. *See, e.g.*, *Tri-County Extended Care Ctr.*, DAB No. 1936, at 7 (2004), *aff'd*, *Tri-County Extended Care Ctr. v. Leavitt*, No. 04-04199 (6th Cir. Dec. 14, 2005); *Cherrywood Nursing & Living Ctr.*, DAB No. 1845 (2002).

A limited number of defenses have been recognized for specific noncompliance, such as unavoidability, unforeseeability, and reasonableness. SNFs are not subject to enforcement remedies for unavoidable negative outcomes, or unforeseen or unpreventable circumstances that produce a risk for or an actual negative outcome. *Tri-*

County Extended Care Ctr., DAB No. 1936, at 7; *Woodstock Care Ctr.*, DAB No. 1726, at 21, 25, 40. Furthermore, not all regulatory or statutory violations, including instances of neglect, are subject to the imposition of enforcement remedies by CMS. Noncompliance occurs and CMS is authorized to impose an enforcement remedy, only if a statutory or regulatory violation poses a risk for more than minimal harm. 42 C.F.R. §§ 488.301, 488.402(b).

CMS argues that because of R1's severe pain and her shortness of breath, R1 was in need of goods and services, i.e., assessing her condition, consultation with a physician, treatment or care, and monitoring, none of which were timely received. Surveyor Lessard, a registered nurse, testified that Nurse Kind should have assessed R1 after she complained of severe pain and shortness of breath. CMS Ex. 14 at ¶¶16, 19, 20.

In regard to R1's complaint of shortness of breath on October 26, the only action taken by the facility staff was to take R1's vital signs. CMS Ex. 9 at 1-2, 10; P. Ex. 6 at 1. Staff did not assess R1 for her shortness of breath (Tr. 350) even though shortness of breath could be a symptom for a serious medical problem (*see* Tr. 180-181, 345), R1 was at risk for several serious medical conditions and, importantly, the hospital transfer order specifically listed shortness of breath as a reason to contact R1's physician or 911. P. Ex. 3 at 14; Tr. 179, 180, 213-14, 323, 320. Yet, the facility staff did not provide R1 with an assessment and any additional care that she needed, even if this was limited to calling 911 to obtain care from a hospital.

Petitioner's policy concerning neglect is identified as P. Ex. 12. Although Petitioner's anti-neglect policy is not very specific, Petitioner's policy defines neglect as "the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." P. Ex. 12 at 35. Petitioner's neglect policy gives examples of ways in which staff may either intentionally or unintentionally cause harm to residents including:

> Not responding to a resident who frequently rings the call bell because "they do it all the time."
> Telling a resident you will come back in a minute to provide care and then not return.

P. Ex. 12 at 34. Here, Petitioner's staff did not implement its policy on neglect and failed to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness in violation of 42 C.F.R. § 488.301 and in violation of its own policy on neglect.

Although the situation in this case pertained to a single resident and primarily two or three facility employees, I believe that the record is sufficient for me to conclude that a violation of 42 C.F.R. § 488.13(c) occurred because Petitioner failed to implement its policies regarding neglect. As stated in one case:

> Section 483.13(c) "addresses a deficiency related to lack of an effective policy as opposed to one directed at the occurrence of neglect itself." *Emerald Oaks*, DAB No. 1800 at 12 (2001). However, the drafters of the regulation characterized as "inherent in [section] 483.13(c)" the requirement that "each resident should be free from neglect as well as other forms of mistreatment," 59 Fed. Reg. 56,130 (Nov. 10, 1994). The regulation requires that the facility "implement" its anti-neglect policies. 42 C.F.R. § 483.13(c). Implementing a policy requires more than drafting and maintaining documents. Staff must carry out and follow the policy.

Hanover Hill Health Care Ctr., DAB CR3745, at 5 (2015). Therefore, I conclude that Petitioner failed to implement its policy concerning neglect when it failed to provide R1 with the services "necessary to avoid physical harm, mental anguish, or mental illness" in violation of 42 C.F.R. § 488.301 and its own anti-neglect policy.

3. Petitioner was not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(i) because Petitioner did not meet professional standards of quality in relation to the care provided to R1.

The regulations require that:

> The services provided or arranged by the facility must -
>
> (i) Meet professional standards of quality . . . .

42 C.F.R. § 483.20(k)(3)(i).

Professional standards of quality means that services are provided in accordance with accepted standards of clinical practice which may be determined based on a number of suggested sources.

Nurse Kind was assigned to care for R1. CMS asserts that Nurse Kind's care of R1 fell short of professional standards of quality and no one else at the facility provided care that complied with the professional standards of quality. Surveyor Lessard, a registered nurse, testified that Nurse Kind should have assessed R1 after she complained of severe pain and shortness of breath. CMS Ex. 14 at ¶¶ 16, 19, 20. Petitioner's witness, Nurse Theuerl testified that a timely assessment of R1's pain should have been done. Tr. 284. Nurse Theuerl agreed that waiting more than two hours to receive pain medication is not timely. Nurse Theuerl also testified that an assessment for shortness of breath would

include listening to the resident's lungs. Tr. 286-87. Petitioner's witness, Nurse Rose testified that he would have assessed R1 if he knew that Nurse Kind was too busy to do so herself. He would have assessed both R1's pain and her shortness of breath. Tr. 210-12. No one at the facility listened to R1's lungs or did any kind of assessment of her shortness of breath.

Nurse La Tasha Nickerson told DON Pruette that she had concerns about Nurse Kind's care of R1 and DON Pruette reported these concerns to the state officials as possible abuse. Tr. at 328. Petitioner's policies and procedures state that an assessment should be done with each new report of pain and that the facility is responsible to provide each resident with aggressive pain treatment. CMS Ex. 15 at 4, 6.

DON Pruette testified that he would have assessed R1, and depending on what the assessment revealed would have "taken some action including calling the physician, garner a crash cart, being prepared for something . . . I would have auscultated her lungs [listen with a stethoscope to her lungs] . . . checked her positioning, her breathing, rate, depth, oxygen saturation, vital signs." Tr. 433-34. DON Pruette agreed that nursing staff should have responded immediately to R1 after 911 was called. Tr. 350-51.

Even Petitioner's expert witness, Dr. Eads, testified that one cannot really determine the seriousness of a resident's shortness of breath without an assessment, including listening to the resident's lungs observing the resident, asking the resident how she feels and checking her oxygen levels. Tr. 511-513. Additionally, Dr. Eads' testimony never addressed Nurse Kind's response to the 911 operator's call.

Nurse Kind indicated that she had already taken care of the situation when 911 inquired about R1 without even actually seeing R1, let alone assessing her. Dr. Crigler, R1's treating physician, testified that someone should assess a resident before answering a question from 911 concerning a resident who called 911 for assistance.[5] Tr. at 194. At another point in his testimony, Dr. Crigler indicated that an assessment should include a visual examination of the patient if there is difficulty breathing. Tr. 200. Dr. Crigler also testified that a licensed nurse, not a CNA, is qualified to do an assessment. *Id.* Nurse Theuerl testified that she would expect Nurse Kind to go to R1's room to see if she was okay when answering an inquiry from 911. Tr. at 276. Nurse Theuerl also testified that a thorough assessment should be done before responding to 911. Tr. 295. Nurse Rose testified that he would assess a resident quickly whenever 911 was called to see if there was a medical emergency. Tr. 214-15. Dr. Crigler also testified that he would expect a nurse to know who they are caring for or that they were speaking about the right resident. Tr. 195-96. Instead, Nurse Kind assured 911 that the resident was fine and never

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[5] Dr. Crigler's testimony was straightforward and not at all evasive, in contrast to Dr. Eads' testimony. I place more weight on Dr. Crigler's testimony than I do on Dr. Eads' testimony.

assessed the resident which clearly did not comply with professional standards of care in violation of 42 C.F.R. § 483.20(k)(3)(i).

4. Petitioner was not in substantial compliance with 42 C.F.R. § 483.25 because Petitioner provided insufficient quality of care to R1.

The regulations at 42 C.F.R. § 483.25 require that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical . . . well-being, in accordance with the comprehensive assessment and plan of care." In this case, CMS determined that Petitioner failed to substantially comply with that requirement of 42 C.F.R. § 483.25.

In *Woodstock Care Center*, DAB No. 1726, at 25 (2000), quoting 54 Federal Register at 5,332, the Board said:

> We recognize that a facility cannot ensure that the treatment and services will result in a positive outcome since outcomes can depend on many factors, including a resident's cooperation (i.e., the right to refuse treatment), and disease processes. However, we believe that it is reasonable to require the facility to ensure that 'treatment and services' are provided, since the basic purpose for the residents being in the facility is for the 'treatment and services' and that is why the Medicare or Medicaid program makes payment on the residents' behalf. We also think it is reasonable to require the facility to ensure that the resident does not deteriorate within the confines of a resident's right to refuse treatment and within the confines of recognized pathology and the normal aging process.

CMS determined that R1 needed a licensed nurse to assess her pain and shortness of breath in a timely and complete manner and needed the nursing staff to consult with her physician so that the staff could address her pain and shortness of breath.

Although I do not base my decision on R1's complaints of pain, I note that Dr. Crigler testified that complaints of pain should be responded to promptly because pain can increase blood pressure and heartbeat. Tr. 182-184. Pain is obviously an indication that something is seriously wrong and can be a symptom of a heart attack.

As I have discussed, I base my decision on the issue of R1's shortness of breath. Petitioner had suffered some acute respiratory problems while at the hospital. The hospital discharge summary indicated that if R1 experienced shortness of breath the facility should contact her doctor or call 911. P. Ex. 3 at 13. R1 was reported to be

gasping for breath. No licensed nurse paid any attention to R1's complaints of shortness of breath since 10:50 p.m. Because no qualified staff at the facility was paying attention to her shortness of breath, another resident at the facility had to call 911. R1 told CNA Worthy that she was going to call 911 but CNA Worthy did not alert a nurse. The call to 911 occurred at 11:22 p.m. and the EMS team arrived at 11:34 p.m. and found R1 unconscious. For that period of 44 minutes, R1 received no care or services from the nursing home even though she was in a grave medical condition of which they were on notice. As already discussed, Petitioner failed to provide R1 with the necessary care and services she required.

5. Petitioner was not in substantial compliance with 42 C.F.R. § 483.75.

The regulation at 42 C.F.R. § 483.75 provides 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 regulation also includes specific requirements with federal, state, and local laws and professional standards and in other areas, including licensure, training, registry verification, in-service education, staff qualifications, provision of laboratory, radiology and other diagnostic services, and clinical records. 42 C.F.R. § 483.75(a)-(p). The language of section 483.75 is such that any failure of management which adversely affects a resident constitutes a violation. Further, any violation of federal or state law or professional standards constitutes a violation of section 483.75(b).

As stated in one case:

> The administrative deficiency [at 42 C.F.R. § 483.75] is a derivative deficiency based on findings of other deficiencies . . . 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 Ctr. at Johnson City, DAB No. 1815, at 11 (2002); *see also Odd Fellow & Rebekah Health Care Facility*, DAB No. 1839 (2002).

The evidence demonstrates that Petitioner failed to ensure that Nurse Kind would provide appropriate care to R1 and that Nurse Kind would seek out another nurse either at the

facility or on-call if she was overwhelmed or needed to perform some nursing function that she was not qualified or too busy to do. Not only did Nurse Kind not care for R1 but Nurse Kind was still doing the 9:00 p.m. medication pass at 11:30 p.m. Tr. 297. Further, Petitioner also failed to ensure that CNAs would know what to do in a situation where a nurse was unresponsive to requests for care or would know how to handle a statement by a resident that the resident was going to call 911. Petitioner failed to ensure that CNAs would report a resident planning to call 911 to the nursing staff so that the nursing staff could respond to the resident. Petitioner failed to ensure that the nursing staff would actually lay eyes on any resident about which the 911 operator called.

Petitioner argues that Nurse Kind could not have done a respiratory assessment because she is an LPN and under North Carolina law only a registered nurse can do a respiratory assessment. Tr. 530-31. Petitioner's argument is meritless and only points to another failure by Petitioner's administration--Petitioner failed to have a registered nurse available to do a respiratory assessment, if needed, as there was no registered nurse on duty during the 3:00 p.m. to 11:00 p.m. shift (Tr. 532) and Nurse Kind did not even go into see R1 for any sort of assessment. Further, in the absence of such a registered nurse, Petitioner ought to have ensured that LPNs prompted contacted a physician regarding a significant change in conditions.

Any failure of management that adversely affects a resident constitutes a violation of section 483.75. I have found that Petitioner violated the Medicare participation requirements at sections 483.10(b)(11)(i), 483.13(c), 483.20(k)(3)(i), and 483.25, and that these violations posed immediate jeopardy. The same evidence that supports these deficiency findings also supports my conclusion that Petitioner failed to comply with the administration requirement.

6. CMS's determination that Petitioner's deficiencies posed immediate jeopardy was not clearly erroneous.

Immediate jeopardy exists when 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 that a deficiency constitutes immediate jeopardy must be upheld unless the facility shows that the determination is clearly erroneous. 42 C.F.R. § 498.60(c)(2); *see also Beverly Health Care Lumberton,* DAB No. 2156, at 4 (2008), *citing Woodstock Care Ctr.*, DAB No. 1726, at 39 (2000), *aff'd, Woodstock Care Ctr. v. Thompson,* 363 F.3d 583 (6th Cir. 2003). The "clearly erroneous" standard means that CMS's immediate jeopardy determination is presumed to be correct, and the burden of proving the determination clearly erroneous is a heavy one. *See, e.g., Owensboro Place & Rehab. Ctr.*, DAB No. 2397, at 9 (2001)*, citing Azalea Court*, DAB No. 2352, at 16-17 (2010), *aff'd, Azalea Court v. HHS*, 2012 WL 2913808 (11th Cir. July 18, 2012).

In the present case, CMS alleges that Petitioner's violations amounted to a scope and severity level of "J," constituting immediate jeopardy to resident health and safety. As indicated above, the record establishes that the violations occurred. A review of the record also shows that CMS's immediate jeopardy determination was not clearly erroneous. Immediate jeopardy does not require actual harm but, as the regulatory definition indicates, only a likelihood of serious harm. *Dumas Nursing & Rehab., L.P.*, DAB No. 2347, at 19 (2010), *citing Life Care Ctr. of Tullahoma*, DAB No. 2304, at 58 (2010), *aff'd, Life Care Ctr. of Tullahoma v. Sebelius*, No. 10-3465 (6th Cir., Dec. 16, 2011).

R1 was at an increased risk of heart attack and pulmonary embolism. Petitioner's own witnesses, Dr. Eads, Dr. Crigler, Nurse Rose, Nurse Pruette and Nurse Theuerl, all agreed that R1 was at risk for and/or could have been having a heart attack or a pulmonary embolism on October 26. Tr. 179, 180, 213-14, 290, 320, 323, 455, 465. R1 never received an assessment for her severe pain. She never received an assessment for her shortness of breath. Her treating physician was never contacted. She suffered pain for about two and one half hours before receiving any pain medication and even when she received medication there is no evidence that an assessment was made. Petitioner's staff was not responsive to R1's pain. This lack of response carried over to R1's shortness of breath. As I already discussed, shortness of breath was a new significant change and the staff continued not to respond to R1. Neither Nurse Kind nor any other nurse ever saw or assessed R1's shortness of breath from 10:50 p.m. until the EMS team found R1 unconscious sometime after 11:30 p.m. R1's oxygenation level dropped to 90%, a change from her previous level of 98%. The hospital discharge instructions indicated that the facility should call R1's doctor or 911 for shortness of breath. R1 was gasping for breath. R1 never threatened to call 911 during the several hour wait for her pain medication. But R1 was so concerned about her shortness of breath and stated she would call 911 within a short time of starting to have shortness of breath. DON Pruette testified: "If [R1] was at home, certainly she would call 911 or the doctor's office. In the nursing facility she would have a nurse there that hopefully she would rely on for an assessment to start with." Tr. 319. Petitioner failed to give R1 a nurse she could rely on, and without an assessment, no treatment was provided to R1. No nurse even saw R1 from 10:50 p.m., until EMS arrived on the scene. Petitioner's expert witness, Dr. Eads, testified that one cannot really determine the seriousness of a resident's shortness of breath without an assessment, including listening to the resident's lungs observing the resident, asking the resident how she feels and checking her oxygen levels. Tr. 511-513.

Facility personnel did not even call 911, leaving that instead for another resident at the facility to do, which surely caused a delay in medical assistance reaching R1. Dr. Crigler testified that a patient might survive a heart attack or respiratory distress if given prompt appropriate care. Tr. 191. Petitioner's staff was unresponsive to R1 until the EMS team found R1 unconscious and took steps to treat her by giving her oxygen, suctioning her airways, and starting CPR. The basic purpose for residents being in a facility is for care,

treatment, and services and that is why the Medicare or Medicaid program makes payment on the residents' behalf. Here, the facility failed in its basic purpose. CNA Worthy knew about R1's intention to call 911, failed to inform any nurse of R1's intention to call 911, and in any event, Nurse Kind was obligated to respond to R1's complaint of a serious symptom, such as being unable to breathe properly. The chances for survival increase if there is prompt appropriate care. CMS has clearly shown that Petitioner's failures were likely to result in serious harm and injury to R1.

7. CMS's determinations concerning the amount and duration of the CMP are reasonable.

In determining whether the CMP amount imposed here is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f). 42 C.F.R. § 488.438(e)(3). These factors include: (1) the facility's history of compliance; (2) the facility's financial condition; (3) the factors specified at 42 C.F.R. § 488.404; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort, or safety. The absence of culpability is not a mitigating factor. The factors at 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.

Here, Petitioner has not challenged the reasonableness of the CMP amount imposed in its pre or post hearing briefs, but does challenge the reasonableness of the penalty amount in its hearing request. Petitioner has not argued its inability to pay the CMP and, unless a facility contends that a particular regulatory factor does not support the CMP amount, an Administrative Law Judge must sustain it. *Coquina Ctr.*, DAB No. 1860 (2002). The five deficiencies cited here are extremely serious, constituting immediate jeopardy. Petitioner demonstrated neglect. Nurse Kind failed to respond to R1's repeated complaints, failed to assess R1, and failed to consult with the resident's physician. The CNA failed to seek out another nurse when it became apparent that Nurse Kind was not responding the R1's needs. The CNA failed to let any nurse know that R1 was going to call 911. No nurse ever looked in on R1 when the 911 operator called inquiring about R1. The nursing home did not train Nurse Kind to seek assistance when she was overwhelmed, to call in a registered nurse who would be able to do a proper respiratory assessment, or to contact a resident's physician when a significant change occurred. R1 died shortly after she was transported to the hospital. Had R1 received prompt competent care from the nursing staff the result might have been different. Petitioner's staff did not check R1, which ultimately necessitated that a resident call 911 due to its complete lack of response to R1's needs. These failures were systemic. Petitioner's noncompliance was egregious and supports the high CMP amount imposed.

Petitioner questions why the immediate jeopardy persisted for days after Nurse Kind resigned her position. Petitioner trained CNAs on reporting resident's change in condition to the charge nurse from October 29 through November 6, 2012. All facility nurses received education on the facility's policies and procedures regarding the reporting of residents change in condition and physical assessments from October 29 through November 6, 2012. The finding of immediate jeopardy was lifted on November 6, 2012, consistent with the dates training was completed. I find that the duration of the immediate jeopardy was appropriate.

Accordingly, I conclude that the CMP imposed in this case is reasonable. Further, in this case, the state is required by law to withdraw any approval given, or to deny any approval sought, by Petitioner to conduct a nurse aid training and competency evaluations program for a period of two years. *See* 42 C.F.R. § 483.151(b)(2), (e)(1).

VI. Conclusion

I conclude that Petitioner was not in substantial compliance with five deficiencies cited by CMS. Further, I conclude that CMS's determination that each of those violations posed immediate jeopardy was not clearly erroneous. Finally, I conclude that the CMP amount CMS imposed was reasonable.

/s/
Scott Anderson
Administrative Law Judge